



Intensive Care Unit  
Intensive Care Waiting

- Intensive Care Unit
- Ambulatory Treatment Unit
- Pre-Op
- Outpatient services
- Main Lobby
- Restrooms/Telephones
- Elevators To Patient Rooms
- Inpatient Admitting
- Gift Shop
- Cafeteria



# QUASER | The Guide for Payers

A research-based tool to assess and facilitate quality improvement strategies in hospitals

## Funding

The research leading to these results has received funding from the European Union Seventh Guide Programme (FP7/2007-2013) under grant agreement n° 241724.



## Foreword

We are delighted to present the QUASER Guide for payers to health care leaders throughout Europe. The guide is based on extensive research in five European countries funded by the European Commission's Guide Seven Programme. The QUASER study builds on previous research in leading hospitals in Europe and the U.S. (Bate *et al*, 2008) and focuses on the organisational and cultural factors important for quality improvement.

Findings from an early part of our research on the use of guides by hospitals suggested that we produce a different kind of guide from others available. We have therefore produced a guide with the aim of 'changing conversations' about quality improvement in health care. This QUASER Guide has been designed to be used by payers to provide a focus for discussions with hospitals and other health care organisations about quality improvement. It can be used at all stages of the quality journey – with hospitals that already have a quality strategy and wish to improve, and those that are just beginning the journey.

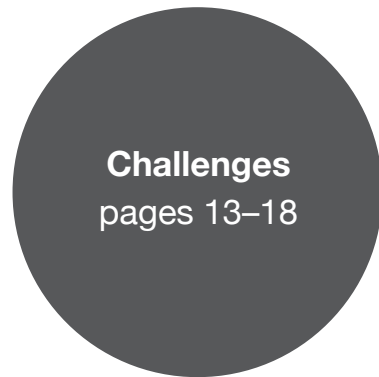
The Guide is based on detailed research conducted in hospitals in five European countries during the period April 2011-March 2012 and takes into account the national health care context in each of the participating countries. In total, 387 interviews and 796 hours of observation (including 176 meetings relating to quality improvement) have been undertaken. The research methods are set out in the published QUASER study protocol (Robert *et al*, 2011).

Based on this research, the Guide is structured around nine challenges for quality improvement, and provides strategies and examples from our data as a focus of discussion for payers and health care organisations.

We hope you will find this Guide useful in your quality improvement journey!

**Professor Naomi Fulop**  
**Project director, QUASER, on behalf of the QUASER team**  
**University College London**

## Contents



# QUASER | Introduction

## What is it for?

The purpose of this research-based Guide is to help payers of hospital services in Europe identify the strengths and weaknesses of a hospital's approach to quality improvement, and reflect on their actions and behaviours to support quality improvement in hospitals. This is to ensure that patients across Europe receive high quality health care. There is a parallel QUASER Hospital Guide to assist hospital leaders in their quality improvement work.

The Guide focuses on the organisational and cultural factors that are important in ensuring that quality improvement efforts are implemented and sustained. These aspects of quality have not received as much attention as others, such as technical factors, but our research shows they are crucial to the success of quality improvement efforts. The Guide has been designed to be used by payers to provide a focus for discussions with hospitals and other health care organisations about quality improvement. It can be used at all stages of the quality journey – with hospitals that already have a quality strategy and wish to improve, and those that are just beginning the journey. It can also be used flexibly to meet specific needs and although we describe some ways of using it, this is not prescriptive. For example, the extensive examples that are provided in the Guide might be used to guide

discussions at all stages. We encourage people to use it in the way that makes most sense for their organisation.

## Who should use it?

This Guide can be used by payers or funders of hospital services. Different payer organisations across Europe have different roles and responsibilities, but a common trend is to build quality considerations into funding/commissioning decisions. This Guide assists payers to understand whether a hospital is managing the quality improvement process effectively. It could also be used as a basis for discussions between payers and hospitals about quality improvement.

## Overview of content

The Guide can be used by payers to identify the strengths and weaknesses of a hospital's quality and safety improvement efforts, and what a hospital may need to do to improve the quality and safety of the care it provides. The Guide is intended as a reflective tool which prompts payers to think about:

- The progress a hospital has already made on the journey to providing high quality and safe health care
- Which quality improvement challenges commonly faced by hospitals in Europe, a particular hospital has focused on to date, and which need more attention
- What questions payers should ask hospitals about their quality improvement strategies
- What role payer organisations can play in helping to facilitate quality improvement

The QUASER payer guide is therefore organised around the following structure:



## Overview (continued)

The Guide is based around eight common, inter-connected challenges found in our research faced by hospitals in Europe, and a ninth challenge for payers:

**Leadership** – providing clear, strategic direction

**Political** – addressing the internal organisational politics and negotiating the ‘buy in’, conflict and relationships of change surrounding any quality improvement effort

**Cultural** – giving ‘quality’ a shared, collective meaning, value and significance within the organisation

**Educational** – creating and nurturing a learning process that supports continuous improvement

**Emotional** – inspiring, energising, and mobilising people for the quality improvement effort

**Physical & Technological** – designing physical systems and technological infrastructures that support improvement and quality of care

**Structural** – structuring, planning and co-ordinating quality efforts

**External demands** – enabling a more facilitative external context

**Role of payers** – facilitating quality improvement in hospitals.

The involvement of patients in developing and prioritising quality improvement strategies is addressed in the political and the educational challenges.

Of course, the possible combinations of strategies to these common challenges faced by senior leadership teams are innumerable.

Furthermore, what works for one hospital may not work for another.

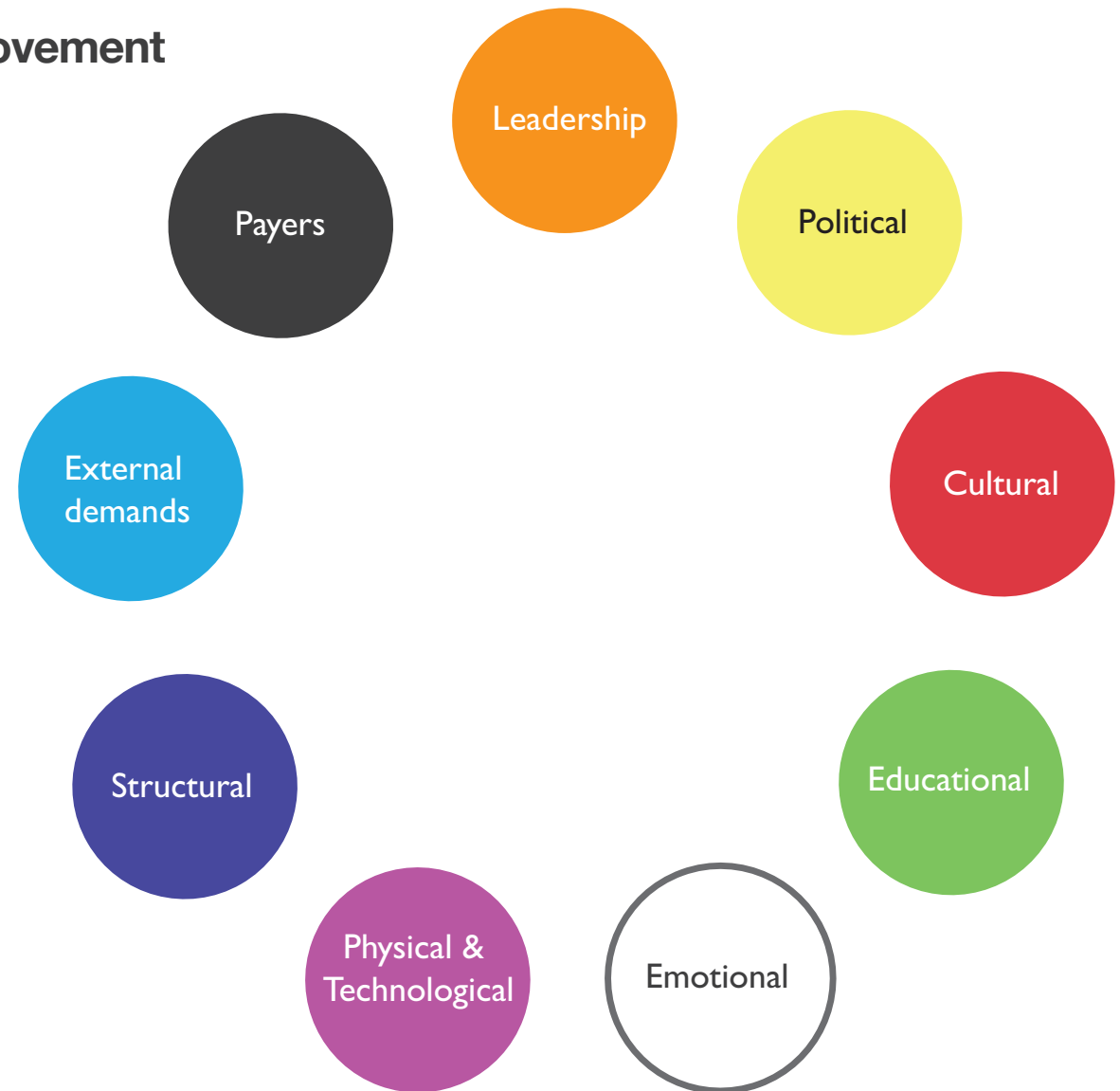
Our overall advice to payers about quality improvement, is to:

- be aware that a hospital needs to respond to each and every one of these eight organisational challenges to some extent
- be aware that a hospital needs to find strategies to meet the challenges that fit locally and are contextually appropriate
- be aware that hospitals need to build them into ongoing organisational and quality improvement processes

The challenge for payers is then to reflect how their actions/behaviours may support or inhibit the development and implementation of quality improvement strategies in hospitals.



## The nine challenges of quality improvement



## How to use this QUASER payer Guide

The following stages are one suggestion for how you might use the Guide, but we encourage people to use it in ways that suit their priorities and needs, remembering that discussion and dialogue are the keys to effective use of the Guide at all stages. For example, you may wish to focus first on how your own actions/behaviours can facilitate quality improvement in hospitals (stage 4).

**Stage 1:** Assess the hospital against the eight common challenges by checking how close you think it is to meeting each (you might wish to do this jointly with the hospital). Reviewing your overall responses across the eight challenges can help identify current gaps and opportunities in the hospital's overall approach, and help facilitate discussions on the necessary direction of travel of the hospital's future quality improvement efforts.

**Stage 2:** Then assess how well the hospital is doing in terms of the suggested strategies within each challenge. For example, does the organisation have 'a lot of work to do' on most or all of the structural strategies? Does it already 'do well' in terms of the majority of the political strategies? Once you have identified these gaps and opportunities the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to each

of the challenges. These ideas can form the basis of discussions about how to address the gaps identified.

**Stage 3:** If you haven't engaged the hospital in previous stages, we suggest that at this point, payers engage in a dialogue with the hospital to discuss the results and facilitate reflection on necessary actions.

**Stage 4 (the payers' challenge):** Reflect on how your own actions/behaviours can facilitate quality improvement in hospitals by working through the payer-specific strategies (p.67) and examples (p147). Again, you might wish to discuss this jointly with the hospitals you fund/contract with.

**Stage 5:** Formulate and document a quality improvement strategy for your organisation, including an action plan that shows actions to be taken, timeframe, resources and key responsibilities.

**Stage 6:** Use the Guide to review progress at regular, agreed times. On the basis of the review, revise the action plan as necessary. Review progress on an on-going basis, reformulate the plan and revise action plans as necessary.

You may want to consider how patients could be involved in the process of using the Guide. For example, how could you involve patients in each of these stages?

## How can the Guide help?

The Guide can help payers carry out an intelligent review of a hospital's approach to quality improvement, and help you reflect on how payers can, through your own actions, facilitate quality improvement. Although payers have different roles in different health care systems, we suggest that the Guide can be used to:

- provide a checklist of the areas and topics any hospital effort will need to cover (a 'map')
- give payers a way of charting a hospital's progress on their improvement journey, and a method for identifying any 'gaps' in a hospital's activities that need to be addressed in the future
- allow assumptions about the practice of how to organise hospitals for high quality care to be surfaced in discussion with the hospital's senior leadership team, and to be thought about, perhaps for the first time
- provide payers with a Guide and language for talking about and debating the issues

## Scope

This Guide has been designed for supporting organisational dialogues about quality improvement. It provides a structure for people to talk about progress on the quality improvement journey, to plan and prioritise what should happen next and to develop strategies encompassing all the important aspects of quality improvement.

Users should be aware what this Guide has been designed to help with, and ensure that it is not used for a purpose for which it was not designed.

- It has not been designed to give an overall measure of the quality of a hospital
- It was not designed for comparing the quality of care in different hospitals or units
- It cannot give a definitive 'answer' to the question of how to improve quality
- It does not offer already formulated solutions that will work in any context – teams need to devise their own solutions that fit their own health care context (cultural, structural or economic)

## Scope (continued)

- It was not designed for quality assurance – that is, for checking the level of care currently being delivered. It is designed to be used as a reflective tool to guide dialogue about improvement. It would not be helpful to complete it without reflecting on the issues it raises. Avoid ticking boxes.
- It was not designed as an accreditation requirement, although it may be helpful as a tool for reaching required standards.

## Definitions of terms used

### **Frontline teams**

Frontline teams are responsible for delivering direct care and are comprised of professionals of different professional backgrounds and levels of seniority. They are often managed by a senior team of clinicians such as senior nurses, ward managers and Unit Directors.

### **Macro**

The macro level refers to the institutions, policies, and requirements that govern how health care is organised. The macro level differs across countries in terms of the structures and mechanisms for funding, delivering and regulating health care.

### **Meso**

The meso level is the organisational level. A hospital is a meso level organisation with particular structures and functions such as departments, committees and roles.

### **Micro**

The micro level refers to the individual and encompasses behaviour and actions. In QUASER, we studied clinical microsystems, which are small units of people who regularly work together to deliver care to patients, such as a ward or specialist centre.

## Terms (continued)

### **Payer**

The term payer refers to organisations such as insurers and commissioners which pay for health care. In many countries, government organisations pay for health care. They enter into contracts with providers to deliver care. The term generally does not refer to patients even though patients ultimately fund health care through taxes or direct payments.

### **Quality**

The QUASER definition of quality is care that is clinically effective, safe and patient centred. The term patient centred is related to the concept of patient experience – patient centred care will lead to a high quality experience of care for patients. These are three of the six components of quality identified by the Institute Of Medicine. The Guide focuses on these three components because they have received the most research attention and because there is some overlap between these three dimensions and the others, especially efficiency and timeliness.

### **Quality Assurance**

The aim of quality assurance is to ensure that minimum standards are being met and to deal with poor performance. It includes mechanisms such as quality monitoring and reporting, national standards, guidelines and targets.

### **Quality Improvement**

Quality improvement is the use of systematic methods and tools to improve outcomes for patients on a continuous basis. This includes outcomes in each of the three areas of quality contained in the QUASER definition: clinical effectiveness, patient safety and patient experience.

### **Senior Leadership Team**

The senior leadership team comprises those who are responsible for developing and implementing hospital-wide strategies. It can include, for example, the Chief Executive Officer, the Medical Director, Director of Nursing, Risk Manager and other senior clinicians.





# QUASER | Challenges



## Introduction to the Challenges

Here you can begin to explore how well the hospital you are assessing is doing in terms of the eight common quality improvement challenges that we identified in our research. You will also consider the role that payers have later in the guide (see page 67). You can indicate in the table on page 16 the extent to which you feel the hospital has already made a lot of progress in addressing each of the challenges. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 17. Again, this could be done individually or collectively amongst the senior leadership team in your organisation or jointly with the senior

leadership team of the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the eight challenges using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the hospital's current approach.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how quality improvement in the hospital is currently organised and to prompt thinking about how your approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes page is provided for capturing these.

Having completed this first stage of considering the eight challenges you should now have a better sense of which of the challenges the hospital has responded well to and which will require further attention. By reviewing the table and/or spider diagram you can now decide which of the eight challenges need to be worked on further, and begin to consider which strategies will need to be used to address these gaps in your current approach.



## Challenges (continued)

**Leadership** – Leadership for quality improvement involves providing clear, strategic direction for the organisation to meet the quality improvement challenges and developing quality improvement leaders throughout the organisation.

**Political** – To be successful, quality improvement efforts require the support of all stakeholders and key occupational groups. This challenge requires addressing the internal organisational politics, engaging people effectively, ensuring they have a shared understanding of quality and obtaining their support for quality improvement efforts. This will enable people to work productively together to improve quality.

**Cultural** – This challenge involves creating an organisational culture in which quality is a shared value that is central to clinical work and underlies all aspects of the organisation's activities. This is particularly important in sustaining quality improvement efforts over time.

**Educational** – Successful implementation of quality improvement requires a continuous learning process that should be supported and nurtured by the organisation. Identification of the skills and knowledge required for quality improvement and the development of structures and processes to train staff are required. Formal and informal learning and individual and organisational learning should be fostered.

**Emotional** – The emotional challenge involves inspiring people about quality improvement, engaging their emotions and building a passion and excitement for quality improvement. This will enable the organisation to effectively mobilise ideas, resources and energy for quality improvement.

**Physical & Technological** – Quality improvement should be supported by effective information systems and IT systems to enable monitoring and benchmarking. The physical environment should also be conducive to quality improvement efforts.

**Structural** – Structuring, planning and coordinating quality improvement involves deciding on how to organise quality improvement work. Organisational structures should support ongoing improvement work and include, for example, roles and responsibilities, committees, lines of authority and reporting, incentives and rewards, and the development of organisation-wide quality strategies.

**External demands** – This challenge involves responding to broader social, political, economic and contextual factors. Managers need to be aware of the broader contextual factors that influence their hospital, and devise strategies to proactively manage them.

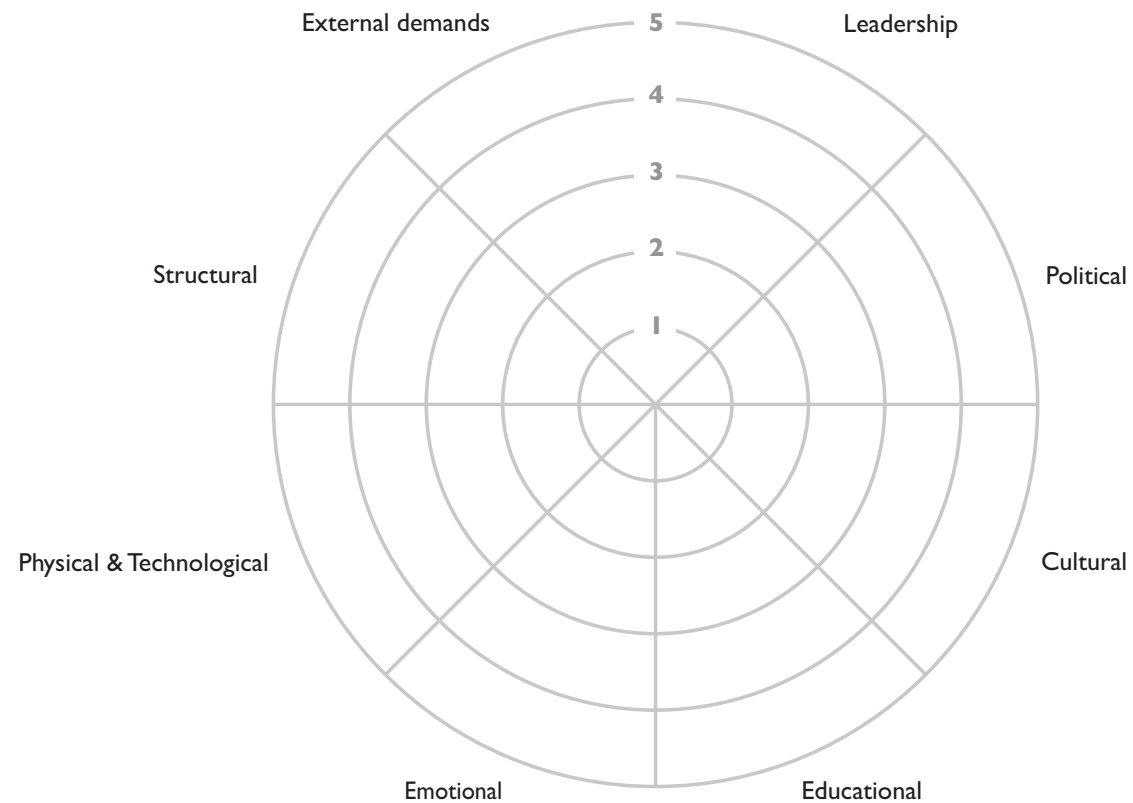
**Role of payers** – How can you facilitate quality improvement in hospitals through your actions/behaviours? (see page 67).



## Diagnostic Step – Challenges

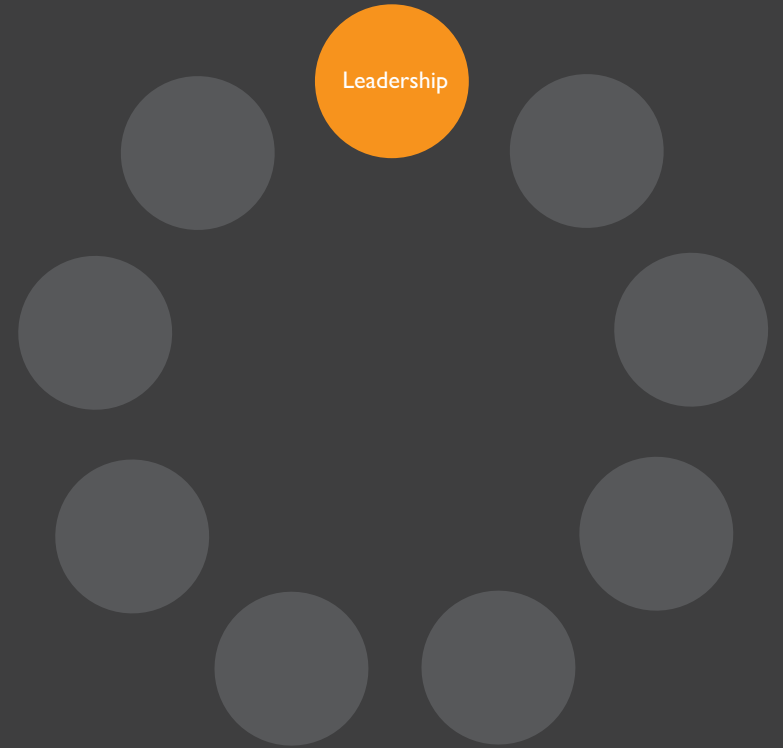
Challenge	They have already made a lot of progress in this area					Why did you choose this?
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
Leadership						
Political						
Cultural						
Educational						
Emotional						
Physical & Technological						
Structural						
External demands						

## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
 They have made a lot of progress in this area **5 = strongly agree** **4 = agree** **3 = neither agree or disagree** **2 = disagree** **1 = strongly disagree**  
 Join the points together for a visual representation of progress.





QUASER | Leadership



## Introduction to the Leadership challenge

Here you can begin to explore how well the hospital is doing in terms of the six suggested strategies that we identified in our research for addressing the Leadership challenge. You can indicate in the table on page 22 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 23. Again, this could be done by your organisation alone, or together with senior

leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the six strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Leadership challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Leadership challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Leadership challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.



## Leadership

Leadership for quality improvement involves providing clear, strategic direction for the organisation to meet the quality improvement challenges and developing quality improvement leaders throughout the organisation.

See prompts at the  
end of each example  
in section p85–163

## Strategies

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1. Translating national targets into local quality improvement initiatives pp 86, 90, 94, 124, 132 \*
2. Aligning quality improvement work that (a) the hospital has to do (e.g. in response to external regulators or national policies) with (b) priorities for quality improvement that emerge locally, in ways that combine to have the greatest overall impact pp 86, 127
3. Securing commitment to quality improvement in the hospital with all staff pp 90, 97, 98, 101, 115, 130
4. Development of staff for quality improvement pp 102, 106, 109, 111, 135
5. Implementing long-term quality improvement strategies pp 135
6. Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement pp 86, 90, 102, 144

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\* Page numbers refer to examples to assist with your strategy development

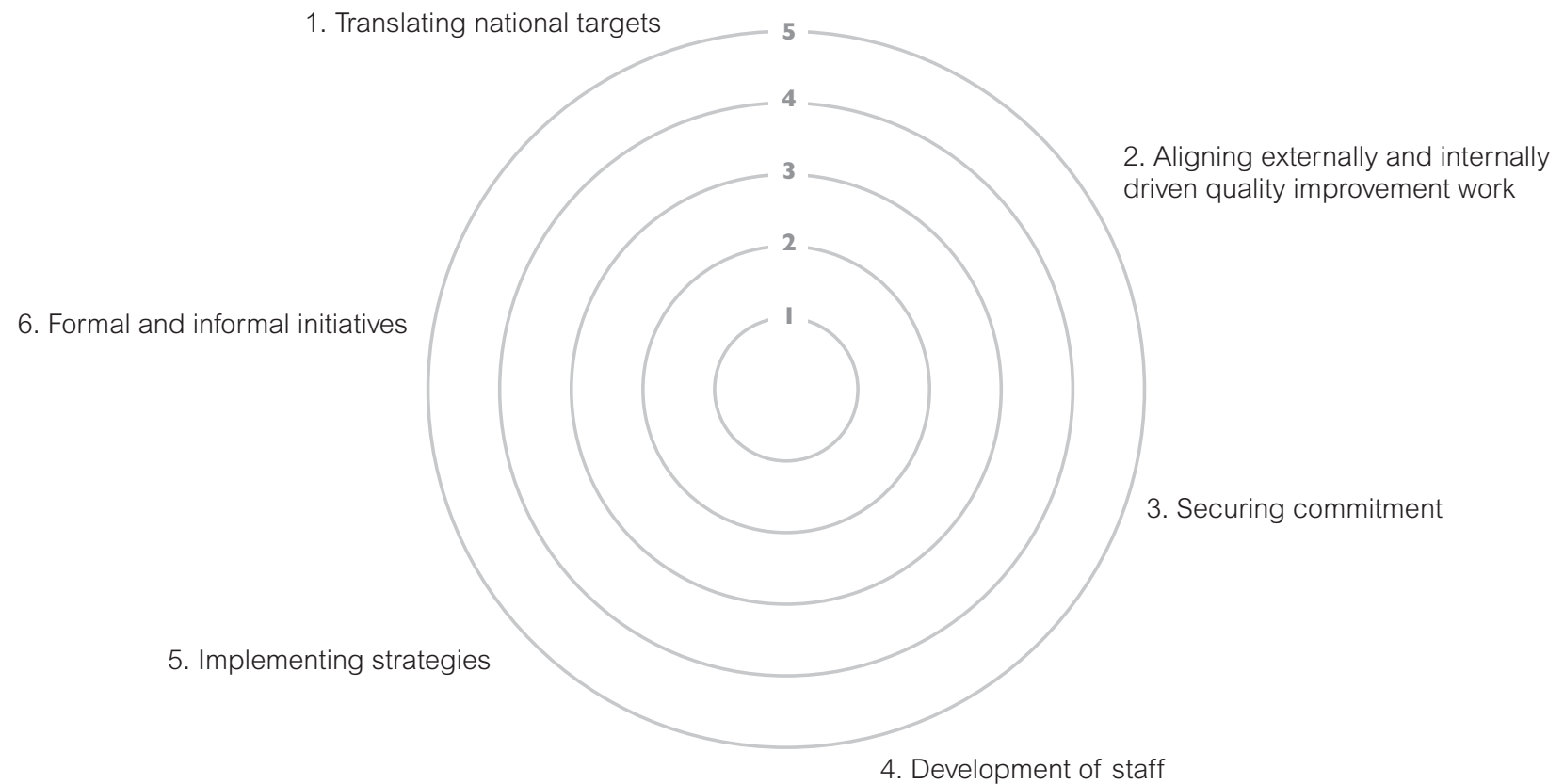


## Diagnostic Step – Leadership

Strategies	They have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Translating national targets into local quality improvement initiatives						
2. Aligning quality improvement work that (a) the hospital has to do (e.g. in response to external regulators or national policies) with (b) priorities for quality improvement that emerge locally, in ways that combine to have the greatest overall impact						
3. Securing commitment to quality improvement in the hospital with all staff						
4. Development of staff for quality improvement						
5. Implementing long-term quality improvement strategies						
6. Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement						

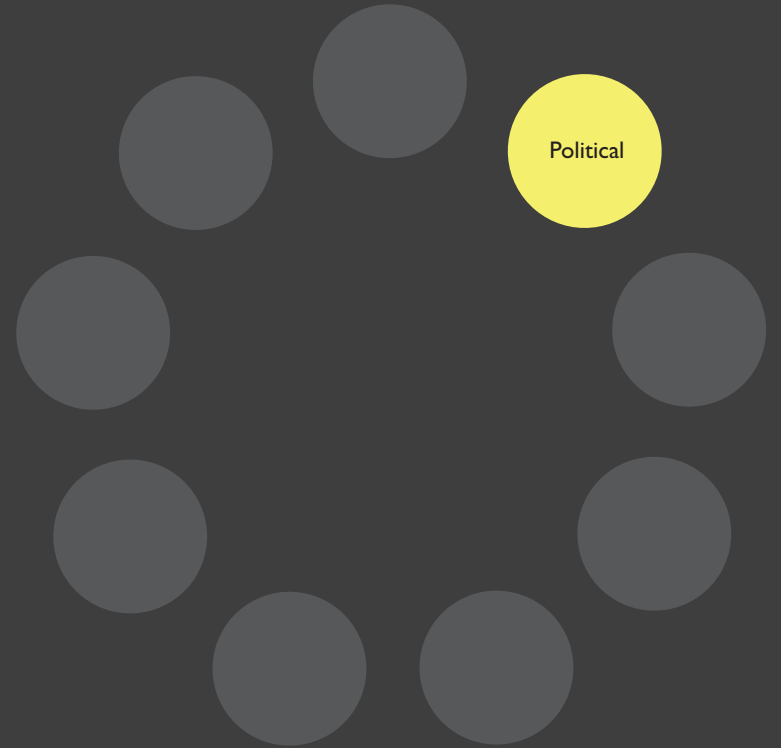


## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
 They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
 Join the points together for a visual representation of progress in this challenge.





QUASER | Political



## Introduction to the Political challenge

Here you can begin to explore how well the hospital is doing in terms of the six suggested strategies that we identified in our research for addressing the Political challenge. You can indicate in the table on page 28 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 29. Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the six strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Political challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Political challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Political challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.



## Political

To be successful, quality improvement efforts require the support of all stakeholders and key occupational groups. This challenge requires addressing the internal organisational politics, engaging people effectively, ensuring they have a shared understanding of quality and obtaining their support for quality improvement efforts. This will enable people to work productively together to improve quality.

See prompts at the  
end of each example  
in section p85–163

## Strategies

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1. Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. staff development and organisational learning) pp 86, 90, 94, 115, 124, 127, 132 \*
2. Establishing a shared understanding of quality improvement in the hospital pp 98, 130, 135, 144
3. Identifying quality improvement priorities with patients pp 138
4. Identifying quality improvement priorities with staff pp 138
5. Managing tensions and the politics of change pp 90, 98, 118, 130, 132
6. Enabling multi-professional working pp 98, 118, 135

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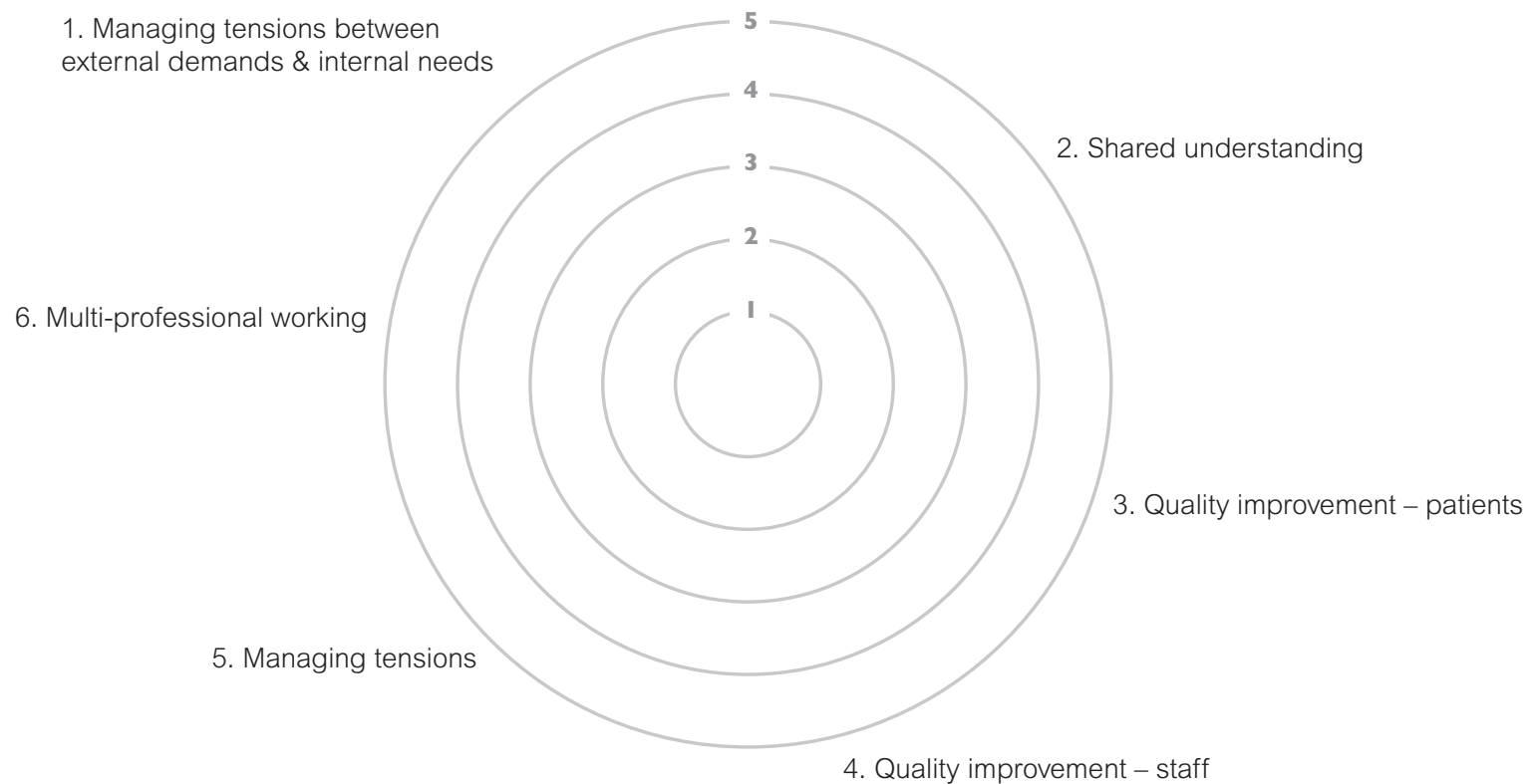
\* Page numbers refer to examples to assist with your strategy development



## Diagnostic Step – Political

Strategies	They have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. staff development and organisational learning)						
2. Establishing a shared understanding of quality improvement in the hospital						
3. Identifying quality improvement priorities with patients						
4. Identifying quality improvement priorities with staff						
5. Managing tensions and the politics of change						
6. Enabling multi-professional working						

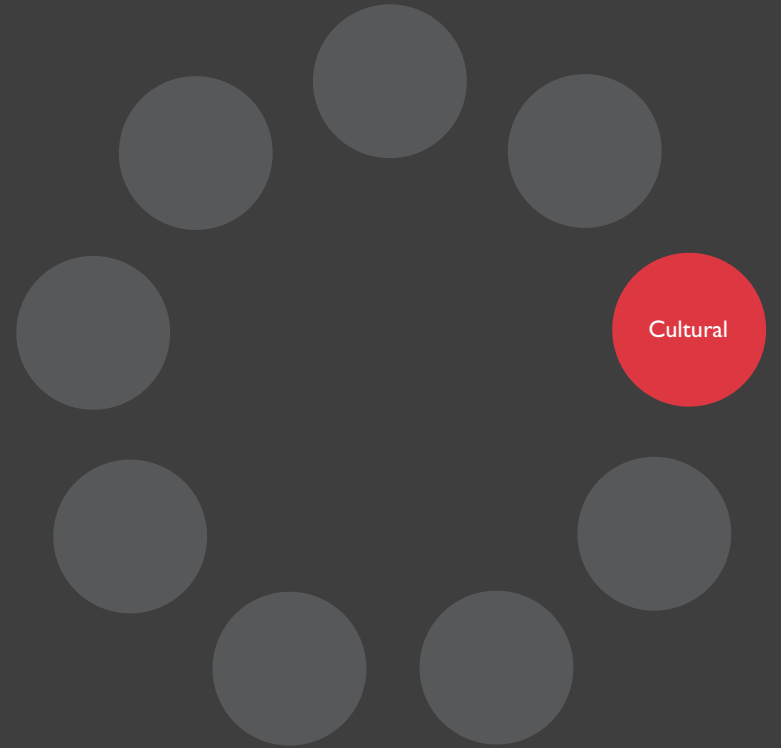
## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
 They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
 Join the points together for a visual representation of progress in this challenge.







QUASER | Cultural



## Introduction to the Cultural challenge

Here you can begin to explore how well the hospital is doing in terms of the five suggested strategies that we identified in our research for addressing the Cultural challenge. You can indicate in the table on page 34 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 35.

Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the five strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree).

The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Cultural challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Cultural challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Cultural challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.



## Cultural

This challenge involves creating an organisational culture in which quality is a shared value that is central to clinical work and underlies all aspects of the organisation's activities.

This is particularly important in sustaining quality improvement efforts over time.

See prompts at the  
end of each example  
in section p85–163

## Strategies

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1. Establishing a broad, shared understanding of quality and quality improvement in the hospital which encourages 'buy in' from all professional groups pp 86, 98, 130, 132 \*
  2. Allowing local adaptation of initiatives within a broader strategic framework pp 90, 115
  3. Embedding quality improvement in the way they do things pp 94, 124, 130
  4. Establishing the relevance and importance of change pp 97, 101, 115, 130, 144
  5. Reflecting on quality in the hospital and the quality improvement journey pp 98, 106, 109, 130, 135
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\* Page numbers refer to examples to assist with your strategy development

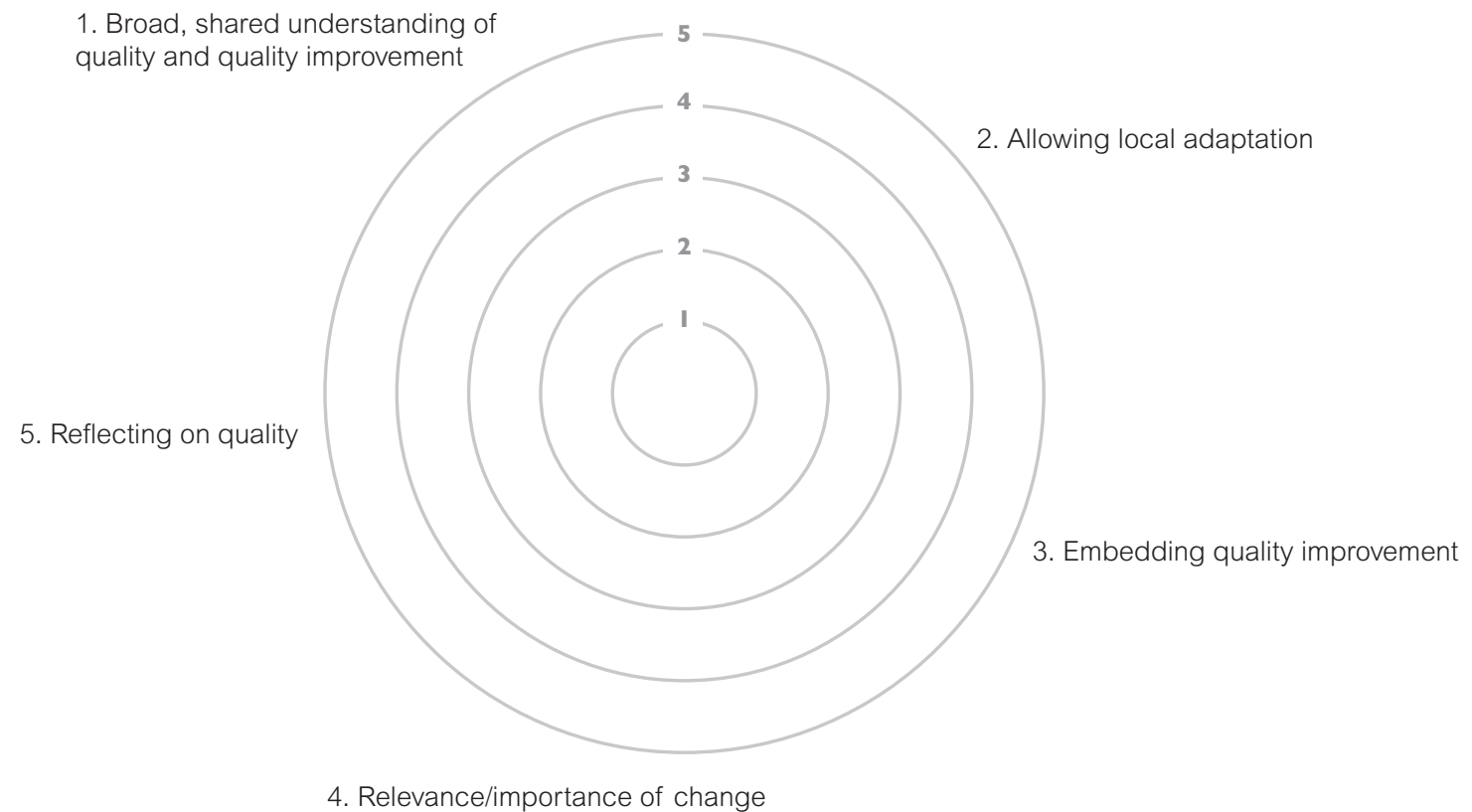


## Diagnostic Step – Cultural

Strategies	They have already made a lot of progress in this area					Why did you choose this?
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
1. Establishing a broad, shared understanding of quality and quality improvement in the hospital which encourages 'buy in' from all professional groups						
2. Allowing local adaptation of initiatives within a broader strategic framework						
3. Embedding quality improvement in the way they do things						
4. Establishing the relevance and importance of change						
5. Reflecting on quality in the hospital and the quality improvement journey						



## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
Join the points together for a visual representation of progress in this challenge.





QUASER | Educational



## Introduction to the Educational challenge

Here you can begin to explore how well the hospital is doing in terms of the nine suggested strategies that we identified in our research for addressing the Educational challenge. You can indicate in the table on page 40 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another, option is to complete the spider diagram on page 41. Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the nine strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Cultural challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Educational challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Educational challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge.





## Educational

Successful implementation of quality improvement requires a continuous learning process that should be supported and nurtured by the organisation. Identification of the skills and knowledge required for quality improvement and the development of structures and processes to train staff are required. Formal and informal learning and individual and organisational learning should be fostered.

See prompts at the end of each example in section p85–163

## Strategies

1. Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital pp 98, 106, 109, 111, 131, 135 \*
2. Learning continually from the patients pp 138
3. Integrating quality improvement into educational activities pp 106, 111
4. Importing and adapting strategies from other hospitals nationally and internationally pp 102, 115
5. Enabling staff to learn about quality improvement from outside the hospital pp 102, 106, 109, 115, 135
6. Linking the learning from different quality improvement projects pp 86, 118
7. Embedding processes for capturing and reflecting on lessons learnt at the end of all quality improvement projects, and taking those lessons forward to future quality improvement projects pp 135, 144
8. Using a range of data sources and tools to understand quality pp 98, 124, 127, 132, 144
9. Encouraging multi-professional learning and sharing about quality improvement pp 106, 109, 111, 118, 135

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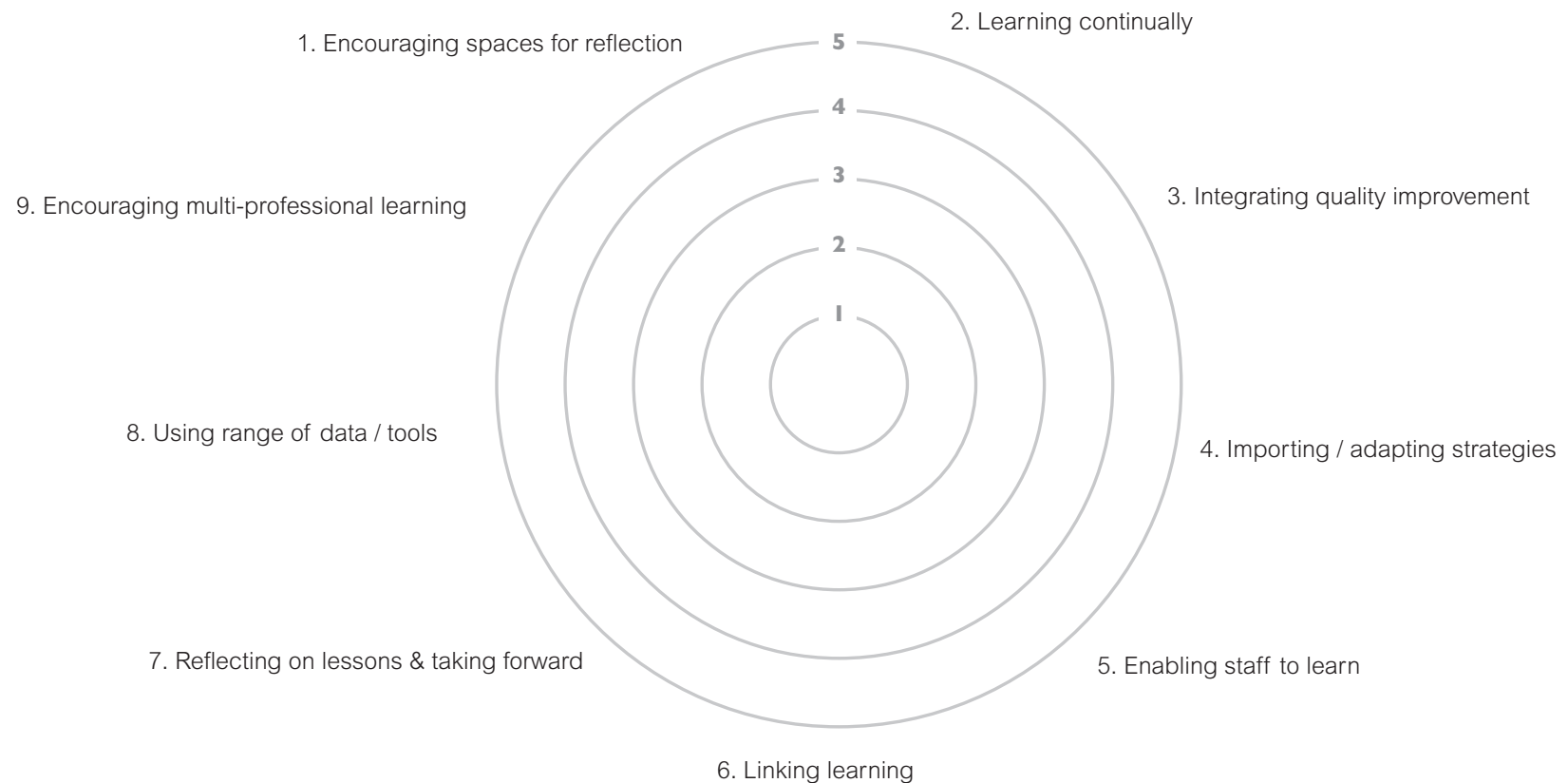
\* Page numbers refer to examples to assist with your strategy development



## Diagnostic Step – Educational

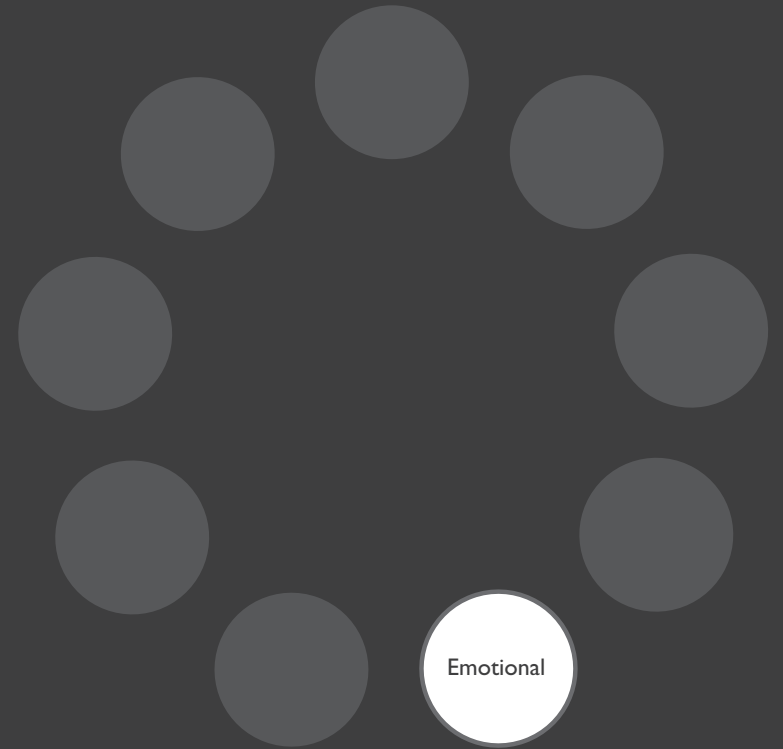
Strategies	They have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital						
2. Learning continually from the patients						
3. Integrating quality improvement into educational activities						
4. Importing and adapting strategies from other hospitals nationally and internationally						
5. Enabling staff to learn about quality improvement from outside the hospital						
6. Linking the learning from different quality improvement projects						
7. Embedding processes for capturing and reflecting on lessons learnt at the end of all quality improvement projects, and taking those lessons forward to future quality improvement projects						
8. Using a range of data sources and tools to understand quality						
9. Encouraging multi-professional learning and sharing about quality improvement						

## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
 They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
 Join the points together for a visual representation of progress in this challenge.





QUASER | Emotional



## Introduction to the Emotional challenge

Here you can begin to explore how well the hospital is doing in terms of the six suggested strategies that we identified in our research for addressing the Emotional challenge. You can indicate in the table on page 46 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 47. Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the six strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Emotional challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Emotional challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Emotional challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.



## Emotional

The emotional challenge involves inspiring people about quality improvement, engaging their emotions and building a passion and excitement for quality improvement. This will enable the organisation to effectively mobilise ideas, resources and energy for quality improvement.

See prompts at the  
end of each example  
in section p85–163

## Strategies

---

1. Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences pp 97, 98, 102, 115, 131, 138 \*
2. Establishing quality and quality improvement as the goal of clinical work pp 94, 101, 124, 135, 138
3. Paying attention to the social as well as the technical aspects of quality improvement pp 109, 127
4. Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values pp 97, 101, 115, 131, 144
5. Listening to the staff and patients pp 138
6. Making quality improvement visible pp 97, 98, 101, 132, 144

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\* Page numbers refer to examples to assist with your strategy development



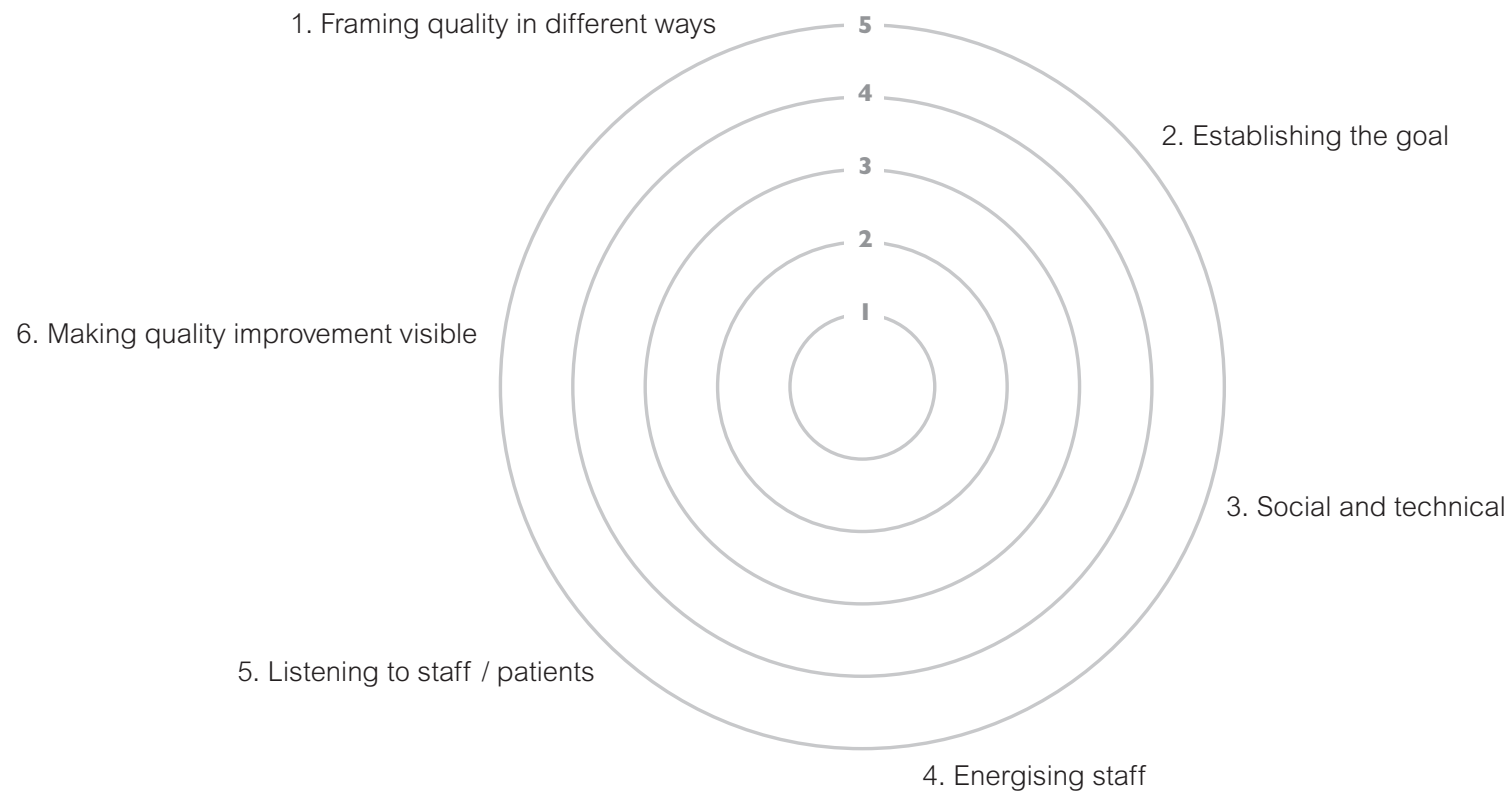
## Diagnostic Step – Emotional

Strategies	They have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences						
2. Establishing quality and quality improvement as the goal of clinical work						
3. Paying attention to the social as well as the technical aspects of quality improvement						
4. Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values						
5. Listening to the staff and patients						
6. Making quality improvement visible						



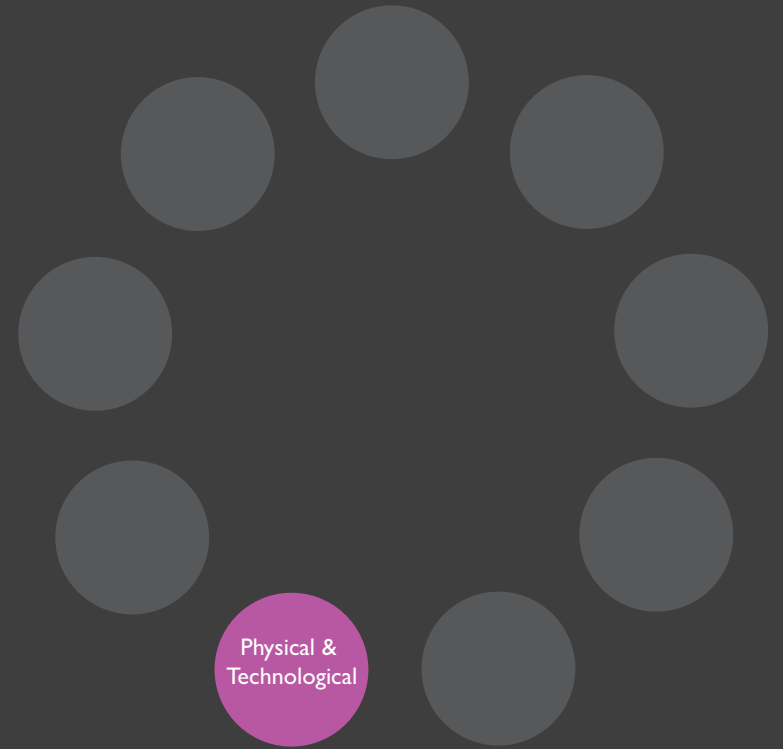


## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
Join the points together for a visual representation of progress in this challenge.





QUASER | Physical & Technological



## Introduction to the Physical & Technological challenge

Here you can begin to explore how well the hospital is doing in terms of the four suggested strategies that we identified in our research for addressing the Physical & Technological challenge. You can indicate in the table on page 52 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 53. Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that your hospital has made a lot of progress with regard to each of the four strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Physical & Technological challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Physical & Technological challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Physical & Technological challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.



## Physical & Technological

Quality improvement should be supported by effective information systems and IT systems to enable monitoring and benchmarking. The physical environment should also be conducive to quality improvement efforts.

## Strategies

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1. Measuring and monitoring the hospital's performance over time pp 94, 124, 127, 132 \*
  2. Designing the physical environment in support of quality improvement pp 144
  3. Benchmarking and checking how the hospital is doing compared to others pp 94, 102, 115, 127, 132
  4. Sharing information about quality improvement amongst staff pp 97, 101, 102, 124, 144
- 

\* Page numbers refer to examples to assist with your strategy development

See prompts at the end of each example in section p85–163

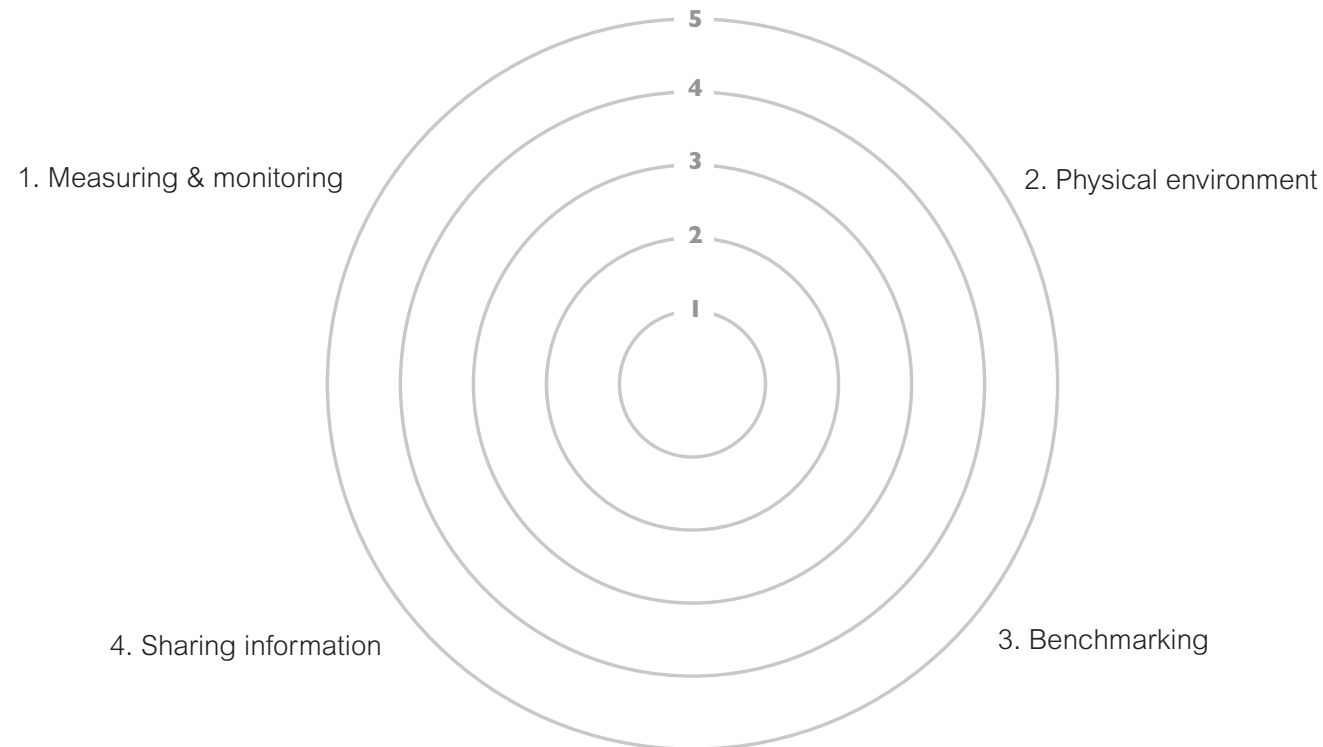


## Diagnostic Step – Physical & Technological

Strategies	They have already made a lot of progress in this area					Why did you choose this?
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
1. Measuring and monitoring the hospital's performance over time						
2. Designing the physical environment in support of quality improvement						
3. Benchmarking and checking how the hospital is doing compared to others						
4. Sharing information about quality improvement amongst staff						



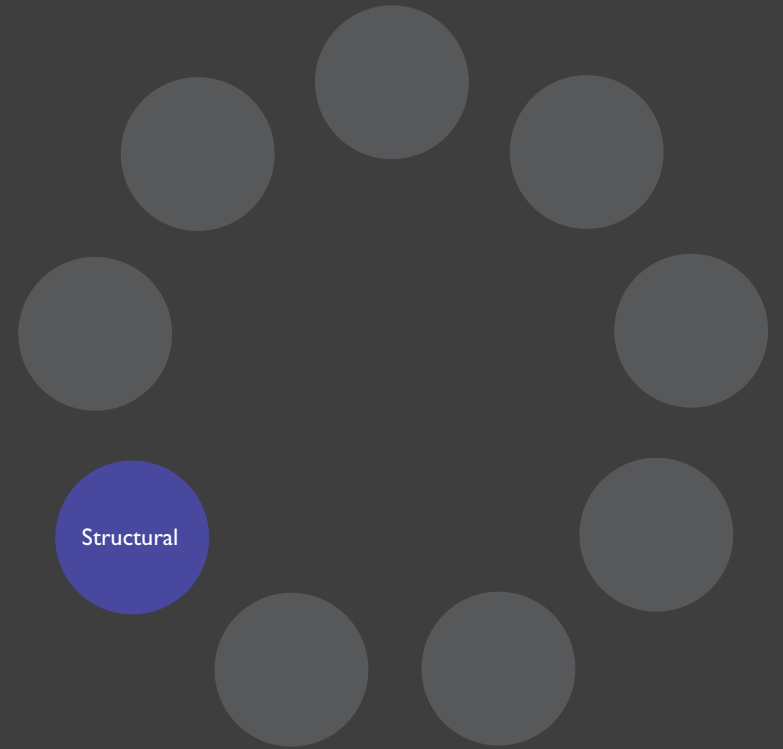
## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
Join the points together for a visual representation of progress in this challenge.







QUASER | **Structural**



## Introduction to the Structural challenge

Here you can begin to explore how well the hospital is doing in terms of the five suggested strategies that we identified in our research for addressing the Structural challenge. You can indicate in the table on page 58 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 59. Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the five strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the Structural challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the Structural challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the Structural challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.



## Structural

Structuring, planning and coordinating quality improvement involves deciding on how to organise quality improvement work. Organisational structures should support ongoing improvement work and include, for example, roles and responsibilities, committees, lines of authority and reporting, incentives and rewards, and the development of organisation wide quality strategies.

See prompts at the  
end of each example  
in section p85–163

## Strategies

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1. Integrating quality improvement into the daily routines of staff  
pp 94, 101, 106, 124, 145 \*
2. Building quality improvement capacity within the hospital  
pp 102, 106, 109, 111, 118
3. Coordinating quality improvement efforts in the hospital  
pp 86, 90, 98, 118, 124, 27, 132, 138
4. Capturing and embedding the learning from quality  
improvement pp 106, 109, 111
5. Linking staff at all levels who are interested in getting  
involved with quality improvement with relevant expertise  
and resources in the hospital pp 87, 101, 102, 106, 118, 136, 138

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\* Page numbers refer to examples to assist with your strategy development

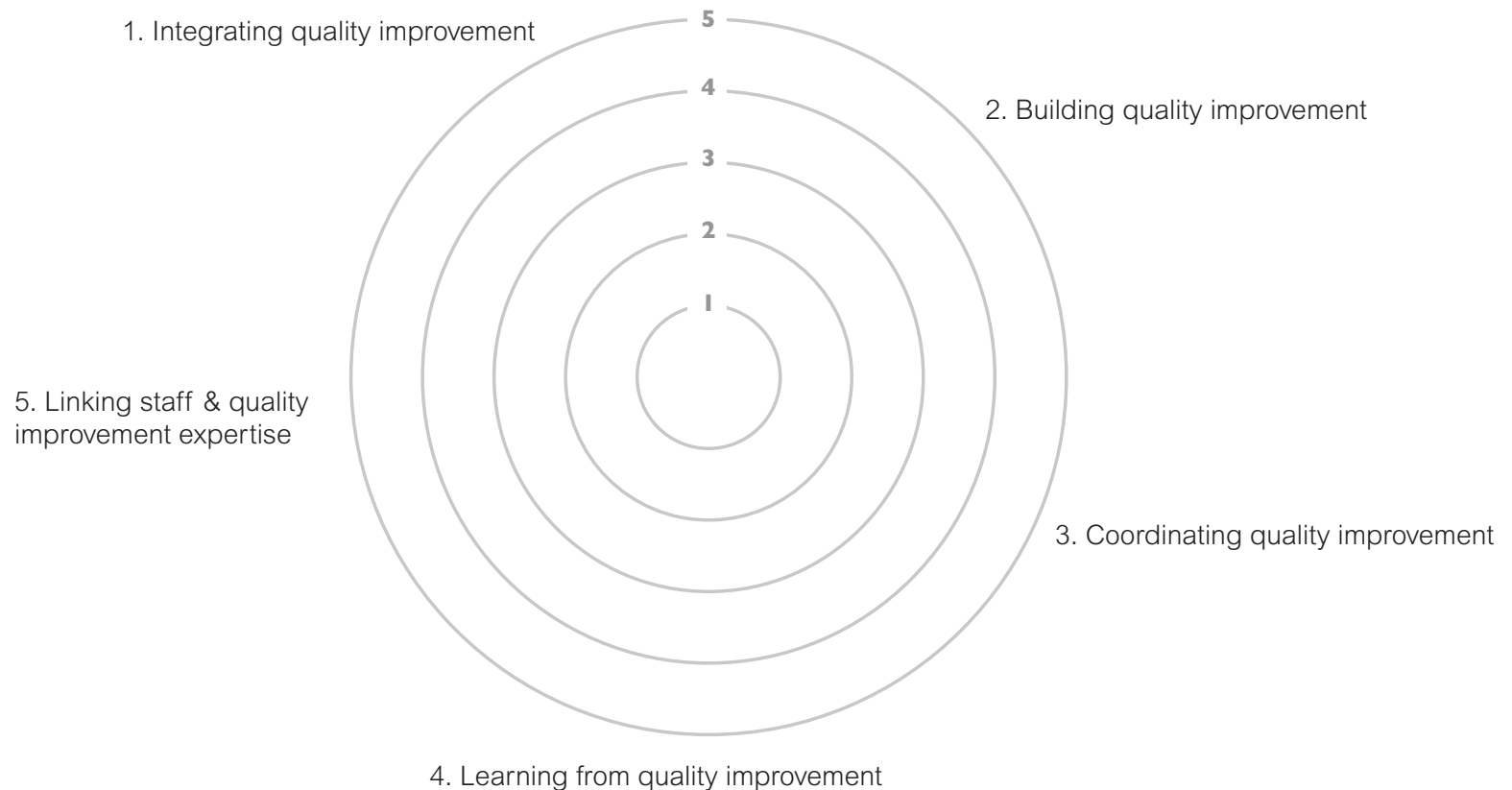


## Diagnostic Step – Structural

Strategies	They have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Integrating quality improvement into the daily routines of staff						
2. Building quality improvement capacity within the hospital						
3. Coordinating quality improvement efforts in the hospital						
4. Capturing and embedding the learning from quality improvement						
5. Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital						

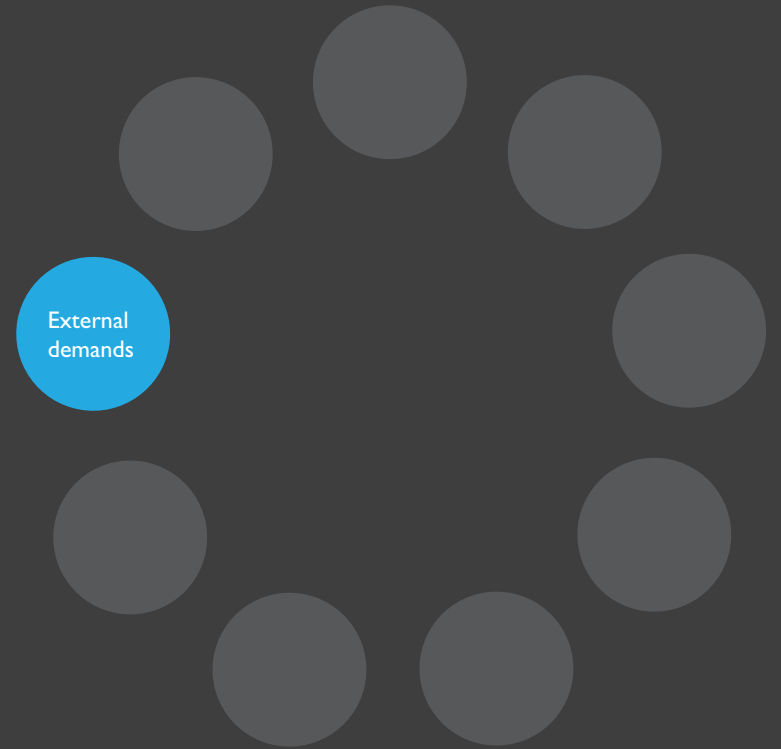


## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
Join the points together for a visual representation of progress in this challenge.





# QUASER | External demands



## Introduction to the External demands challenge

Here you can begin to explore how well the hospital is doing in terms of the three suggested strategies that we identified in our research for addressing the External demands challenge. You can indicate in the table on page 64 the extent to which you feel the hospital has already made a lot of progress in implementing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 65. Again, this could be done by your organisation alone, or together with senior leaders from the hospital. Respondents can simply mark on the

diagram the extent to which they agree that the hospital has made a lot of progress with regard to each of the three strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the current approach with regard to the External demands challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how the hospital is currently addressing the External demands challenge and to prompt thinking about how that approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes section is provided for capturing these.

Having considered which strategies you should use to address these gaps in the hospital's current approach to the External demands challenge, the QUASER Guide provides examples of how senior leadership teams in other hospitals in Europe have responded to this challenge. These examples may help identify actions that the hospital should take.





## External demands

This challenge involves responding to broader social, political, economic and contextual factors. Managers need to be aware of the broader contextual factors that influence their hospital, and devise strategies to proactively manage them.

## Strategies

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1. Actively managing the demands of the external environment  
pp 87, 127 \*
  2. Using external demands as a means of increasing focus on, and supporting, quality improvement within the hospital  
pp 97, 103
  3. Establishing a positive, working relationship with payers and regulators pp 118, 131
- 

\* Page numbers refer to examples to assist with your strategy development

See prompts at the  
end of each example  
in section p85–163

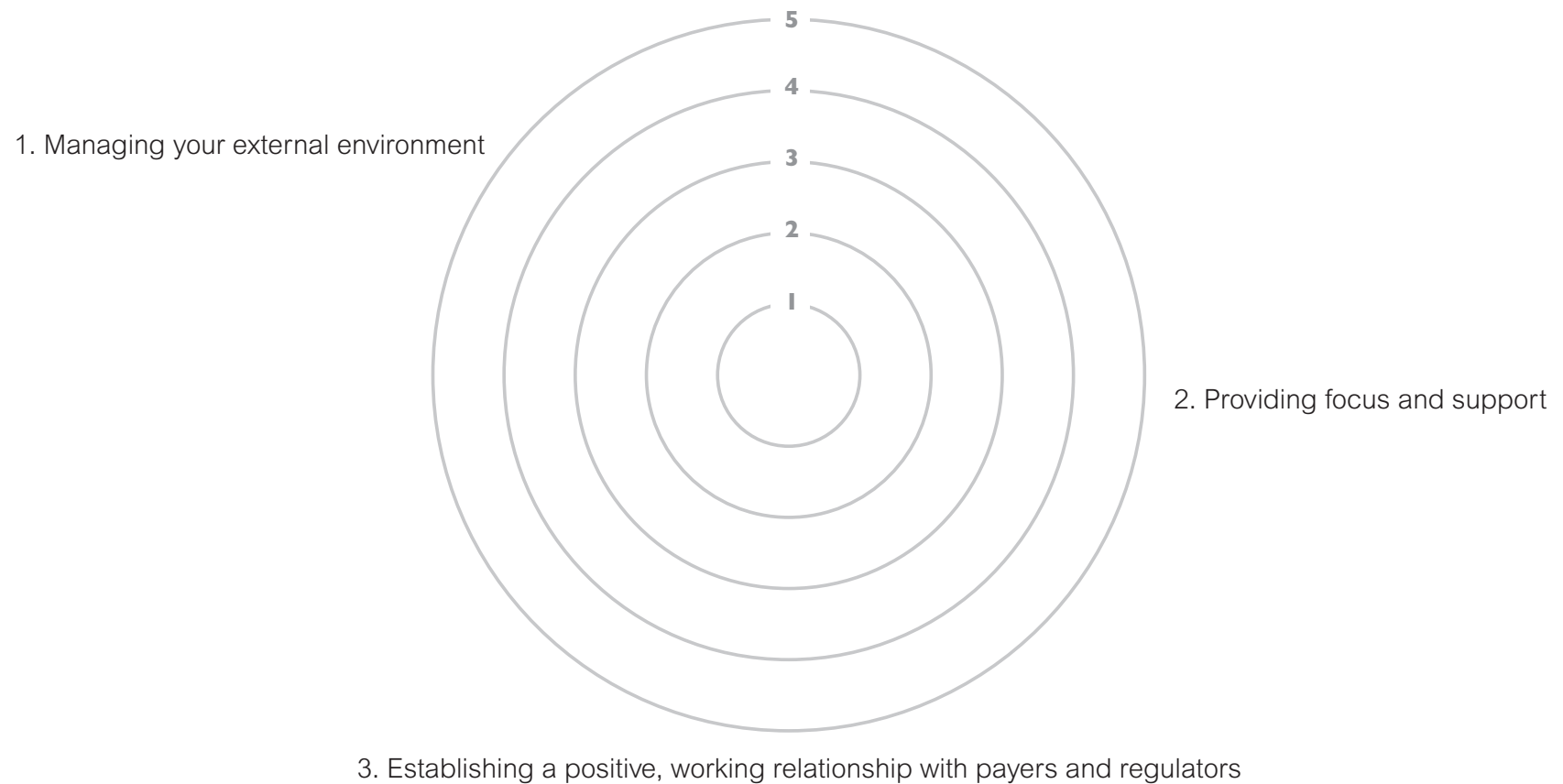


## Diagnostic Step – External demands

Strategies	They have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Actively managing the demands of the external environment						
2. Using external demands as a means of increasing focus on, and supporting, quality improvement within the hospital						
3. Establishing a positive, working relationship with payers and regulators						



## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
They have made a lot of progress in this area **5 = strongly agree 4 = agree 3 = neither agree or disagree 2 = disagree 1 = strongly disagree**  
Join the points together for a visual representation of progress in this challenge.





QUASER | The role of payers in quality improvement



## Introduction to the role of payers in quality improvement

Here you can begin to explore how you can facilitate quality improvement in hospitals through your actions and behaviours in terms of the nine strategies that we have identified in our research. You can indicate in the table on page 70 the extent to which you feel your organisation has already made a lot of progress in addressing each of these strategies. There are several options for completing the table:

- Members of the senior leadership team in your organisation could complete the table individually and then compare and discuss their answers as a group, focusing particularly on significant differences in responses and exploring the reasons for these
- Members of the senior leadership team in your organisation could complete the table together with the senior leadership team of the hospital
- Whether you do this within your organisation or together with the senior leadership team of the hospital, you could complete the table collectively as part of a facilitated group discussion

Another option is to complete the spider diagram on page 71. Again, this could be done individually or collectively amongst the senior leadership team in your organisation or jointly with the senior leadership team of the hospital. Respondents can simply mark on the diagram the extent to which they agree that your organisation has made a lot of progress with regard to each of the nine strategies using the 5 point scale (1 = strongly disagree to 5 = strongly agree). The results will provide a visual representation of the perceived strengths and weaknesses of the payer's current approach.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how your organisation is currently facilitating quality improvement in hospitals and to prompt thinking about how the approach could be enhanced. The process of completing the table and/or spider diagram may prompt further thoughts and action points. A notes page is provided for capturing these.

Having considered which strategies you should use to address these gaps, the QUASER Guide provides examples of how payers might address these strategies drawn from our research. These examples may help identify actions that you should take.

## The role of payers in quality improvement

How you can facilitate quality improvement in hospitals through your actions/behaviours?

See prompts at the  
end of each example  
in section p85–163

## Strategies

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1. Enabling quality improvement and quality assurance within hospitals pp 148 \*
2. Encouraging hospitals to learn from each other pp 151
3. Engaging hospital staff in quality improvement initiatives pp 152
4. Facilitating whole-system approaches to quality improvement pp 154
5. Helping hospitals to manage competing external demands pp 155
6. Providing a clear strategic direction to help hospital leaders plan for quality improvement work pp 158
7. Providing clear incentives by linking quality improvement to funding pp 159
8. Directly funding quality improvement work in hospitals pp 160
9. Prioritising requirements in light of hospital resources pp 161

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\* Page numbers refer to examples to assist with your strategy development

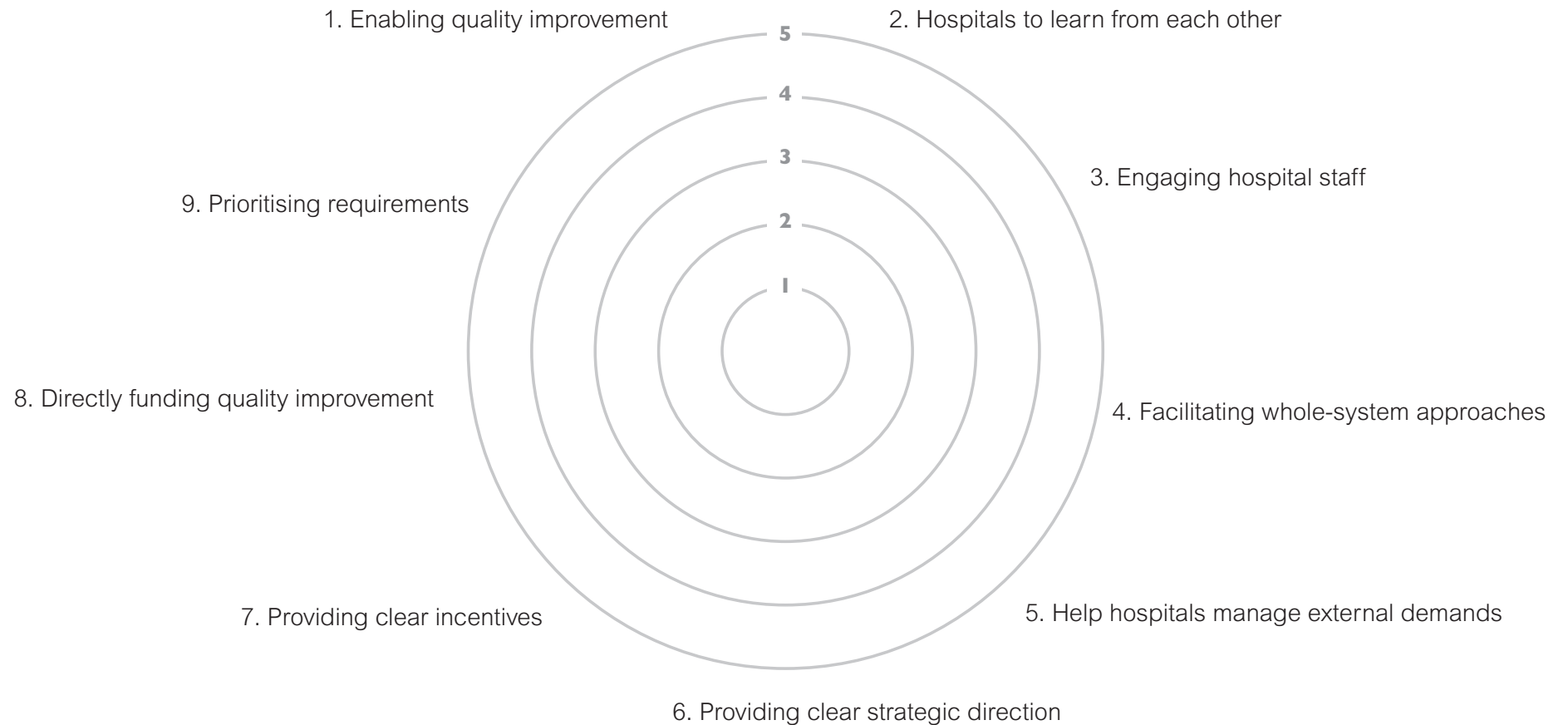


## Diagnostic Step – The role of payers in quality improvement

Strategies	We have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this score?
1. Enabling quality improvement and quality assurance within hospitals						
2. Encouraging hospitals to learn from each other						
3. Engaging hospital staff in quality improvement initiatives						
4. Facilitating whole-system approaches to quality improvement						
5. Helping hospitals to manage competing external demands						
6. Providing a clear strategic direction to help hospital leaders plan for quality improvement work						
7. Providing clear incentives by linking quality improvement to funding						
8. Directly funding quality improvement work in hospitals						
9. Prioritising requirements in light of hospital resources						



## Spider diagram



For each strategy, indicate your agreement with the following statement by marking the appropriate point on the diagram:  
 We have made a lot of progress in this area **5 = strongly agree** **4 = agree** **3 = neither agree or disagree** **2 = disagree** **1 = strongly disagree**  
 Join the points together for a visual representation of your progress in this challenge.



QUASER | Developing your quality improvement strategies

## Developing your quality improvement strategies

This section builds on the work you have done in the previous sections and is designed to help you develop your quality improvement strategies. This may build on your existing strategies or may be new for your organisation.

Start by reviewing the diagnostic steps in the previous sections and consider which areas are a priority for action; those where you think you need to focus most attention. Now take a look at the examples provided. Here you will find case studies from our research including areas of good practice and things to avoid. Some of these examples relate to strategies hospitals can implement (pp85–146); others relate to strategies payers can implement (pp147–163). The examples also provide information about the interactions between the challenges, for example, how work to address the educational challenge can also help to address the cultural and political challenges. We also suggest you seek out best practice within your organisation and talk to others in your networks to find out how they are addressing these challenges.

The tables in the following sections are provided as a planning tool to help you document the areas to work on; use the tables in the way that suits your team best.

There is a table for each challenge that lists each strategy and for each strategy the examples are cross-referenced. You may wish to focus specifically on the challenges for payers (see p67) or you may also wish to focus on how you can facilitate hospitals to meet their challenges (pp19-66).

We suggest you start by discussing the areas for action then agree the specific actions you intend to take and who will lead these and when they should report back. Other factors to consider are the resources required and, most importantly, what difference you expect to see from these actions and when the actions should be reviewed.

## Leadership

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Translating national targets into local quality improvement initiatives						pp 86, 90, 94, 124, 132
2. Aligning quality improvement work that (a) the hospital has to do (e.g. in response to external regulators or national policies) with (b) priorities for quality improvement that emerge locally, in ways that combine to have the greatest overall impact						pp 86, 127
3. Securing commitment to quality improvement in the hospital with all staff						pp 90, 97, 98, 101, 115, 130
4. Development of staff for quality improvement						pp 102, 106, 109, 111, 135
5. Implementing long-term quality improvement strategies						pp 135
6. Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement						pp 86, 90, 102, 144

## Political

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. staff development and organisational learning)						pp 86, 90, 94, 115, 124, 127, 132
2. Establishing a shared understanding of quality improvement in the hospital						pp 98, 130, 135, 144
3. Identifying quality improvement priorities with patients						pp 138
4. Identifying quality improvement priorities with staff						pp 138
5. Managing tensions and the politics of change						pp 90, 98, 118, 130, 132
6. Enabling multi-professional working						pp 98, 118, 135

## Cultural

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Establishing a broad, shared understanding of quality and quality improvement in the hospital which encourages 'buy in' from all professional groups						pp 86, 98, 130, 132
2. Allowing local adaptation of initiatives within a broader strategic framework						pp 90, 115
3. Embedding quality improvement in the way they do things						pp 94, 124, 130
4. Establishing the relevance and importance of change						pp 97, 101, 115, 130, 144
5. Reflecting on quality in the hospital and the quality improvement journey						pp 98, 106, 109, 130, 135

## Educational

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital						pp 98, 106, 109, 111, 131, 135
2. Learning continually from the patients						pp 138
3. Integrating quality improvement into educational activities						pp 106, 111
4. Importing and adapting strategies from other hospitals nationally and internationally						pp 102, 115
5. Enabling staff to learn about quality improvement from outside the hospital						pp 102,106, 109, 115, 135
6. Linking the learning from different quality improvement projects						pp 86, 118
7. Embedding processes for capturing and reflecting on lessons learnt at the end of all quality improvement projects, and taking those lessons forward to future quality improvement projects						pp 135, 144
8. Using a range of data sources and tools to understand quality						pp 98, 124, 127, 132, 144
9. Encouraging multi-professional learning and sharing about quality improvement						pp 106, 109, 111, 118, 135



## Emotional

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences						pp 97, 98, 102, 115, 131, 138
2. Establishing quality and quality improvement as the goal of clinical work						pp 94, 101, 124, 135, 138
3. Paying attention to the social as well as the technical aspects of quality improvement						pp 109, 127
4. Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values						pp 97, 101, 115, 131, 144
5. Listening to the staff and patients						pp 138
6. Making quality improvement visible						pp 97, 98, 101, 132, 144

## Physical & Technological

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Measuring and monitoring the hospital's performance over time						pp 94, 124, 127, 132
2. Designing the physical environment in support of quality improvement						pp 144
3. Benchmarking and checking how the hospital is doing compared to others						pp 94, 102, 115, 127, 132
4. Sharing information about quality improvement amongst staff						pp 97, 101, 102, 124, 144

## Structural

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Integrating quality improvement into the daily routines of staff						pp 94, 101, 106, 124, 145
2. Building quality improvement capacity within the hospital						pp 102, 106, 109, 111, 118
3. Coordinating quality improvement efforts in the hospital						pp 86, 90, 98, 118, 124, 27, 132, 138
4. Capturing and embedding the learning from quality improvement						pp 106, 109, 111
5. Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital						pp 87, 101, 102, 106, 118, 136, 138

## External demands

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Actively managing the demands of the external environment						pp 87, 127
2. Using external demands as a means of increasing focus on, and supporting, quality improvement within the hospital						pp 97, 103
3. Establishing a positive, working relationship with payers and regulators						pp 118, 131

## The role of payers

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Enabling quality improvement and quality assurance within hospitals						pp 148
2. Encouraging hospitals to learn from each other						pp 151
3. Engaging hospital staff in quality improvement initiatives						pp 152
4. Facilitating whole-system approaches to quality improvement						pp 154
5. Helping hospitals to manage competing external demands						pp 155
6. Providing a clear strategic direction to help hospital leaders plan for quality improvement work						pp 158
7. Providing clear incentives by linking quality improvement to funding						pp 159
8. Directly funding quality improvement work in hospitals						pp 160
9. Prioritising requirements in light of hospital resources						pp 161



QUASER | Examples from hospitals to assist your strategy development

## Examples to assist your planning

Aligning quality improvement efforts

Balancing bottom-up and top-down

'Care Guarantees'

Celebrating success

Defining what quality means in this hospital

External and internal competition

Using external perspectives and resources

External knowledge & learning centres

Formal and informal learning

Formal quality improvement programmes and campaigns

In-house training in quality improvement

Intermediaries, boundary spanners and 'linking pins'

Management IT systems

National reporting systems

Organisational and professional identities

Quality dashboards

Reflexive and creative spaces

Using patient experiences/stories

Visualising quality improvement

## Aligning quality improvement efforts

Links to the following strategies in the Guide:

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- Translating national targets into local quality improvement initiatives (Leadership ●)
- Aligning quality improvement work that (a) the hospital has to do (e.g. in response to external regulators or national policies) with (b) priorities for quality improvement that emerge locally, in ways that combine to have the greatest overall impact (Leadership ●)
- Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement (Leadership ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Establishing a broad, shared understanding of quality and quality improvement in your hospital which encourages 'buy in' from all professional groups (Cultural ●)
- Linking the learning from different quality improvement projects (Educational ●)
- Coordinating quality improvement efforts in the hospital (Structural ●)



- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital (Structural ●)
- Actively managing the demands of the external environment (External demands ●)

When dealing with the numerous quality improvement-related demands from both outside the hospital (macro level demands) and internal processes it is easy for quality improvement efforts to become fragmented. Several of the main quality improvement challenges facing senior leadership teams in our hospital case studies related to aligning:

- internal and external quality improvement agendas
- different understandings of quality and quality improvement
- individuals and groups
- formal and informal quality improvement work.

The following examples describe ways to help leaders align their quality improvement efforts and also show the detrimental effects of a lack of alignment.

### **Examples designed to help leaders align their quality improvement efforts**

In **Netherlands B** we found several examples of how quality improvement activities could be successfully aligned. Within the hospital, committees were given responsibility for tailoring national guidelines and embedding them within local quality standards. For example, a work group at ward level was established to address infection rates. The group consisted of different healthcare professionals and managers, and such collaborations helped staff to get to know each other and to understand each other's expertise and perspectives. The meetings provided a forum where they brainstormed about quality improvement activities to reduce infections.

Also at **Netherlands B** certain individuals performed formal linking roles across various boundaries within the hospital. These 'linking pins', which included medical doctors and nurses with special areas of focus, served as a channel for transferring expert knowledge into daily routines. They also played an important role in keeping quality improvement topics high on the agenda of their colleagues (see also 'Intermediaries, boundary spanners, 'linking pins' example).

In **Sweden A** the hospital CEO believes that quality improvement is an integral part of clinical activities and department heads find it odd

to distinguish between quality improvement and clinical work as they regard the two as different sides of the same coin, and thus impossible to separate. For example, in the maternity clinic micro-system, which has worked with quality improvement and patient safety since the mid-1990s, each staff member has 10% of his/her time allocated for improvement work. All staff members are expected to – and most did – conduct quality improvement projects each year. Staff also rotated membership of different improvement groups, thereby improving their understanding of different quality improvement issues.

In **Netherlands A** there was an interesting example of how the manager of the Quality and Safety department aligned the external needs of the Healthcare Inspectorate with the on-going quality improvement work in the hospital. The Healthcare Inspectorate had introduced a new form of supervision requiring hospitals to conduct audits. The manager invited the Inspectorate to pilot the new supervision method in the hospital. In this way the hospital could influence the Inspectorate on how to design the new supervision method, and test whether it was in accordance with the Inspectorate's expectations. For the quality manager, this was a way to align new external demands with the hospitals' internal quality management system, and to put quality on the agenda of internal stakeholders, including medical staff and the hospital board.

**Norway A** has launched an improvement programme as a strategic mechanism to promote organisational development, learning, empowerment and a holistic approach to quality – including clinical effectiveness, patient safety, patient experiences, and cost efficiency. The programme is structured around patient treatment and pathways, and emphasises how these depend on internal factors (e.g. Human Resources, leadership, organisation, economy) and external factors (e.g. geography, Information and Communication Technology (ICT), politics, professional knowledge). The senior managers have put enormous effort into involving all staff in the projects, as well as patients (see also Using patient experiences and stories examples), and as such have generated enthusiasm for improving care. A key strategy behind the success of this improvement programme has been the use of employees as 'strategic consultants' in the quality improvement work i.e. multidisciplinary project teams were involved in defining and identifying quality problems, and finding solutions. It is founded on staff empowerment, anchoring among local managers, and is a structured way of developing and running quality improvement projects. In addition, there are quality champions at the executive level; the CEO and the director of development have played a vital role in the quality journey, promoting a systematic approach to quality improvement and integrating it into the routine of the hospital. These quality champions helped to turn what could have been perceived purely as economic cost saving projects into positive processes where employees were empowered to take part in the improvement programme.

### Examples of detrimental effects of a lack of alignment

In **Netherlands B** quality improvement is mainly organised in projects and committees, which are often established in response to external demands. However, the multiplicity of external and internal demands and the number of projects and committees often leads to diverging quality improvement agendas within the hospital, resulting in insufficiently aligned quality improvement initiatives. Ward managers spoke about the multiplicity and amount of quality work and a lack of alignment. Quality improvement committees tended to focus mostly on embedding structures for quality assurance or governance (due to national demands) rather than supporting professionals in quality improvement work with tools, advice and/or methods. There was a lack of alignment between senior managers, who were responsible for quality improvement ‘control’ and policies, and healthcare professionals – especially medical specialists as they are self-employed in the Netherlands – who were held accountable for quality improvement work.

In **England A** interviewees spoke of the need to see beyond collecting data and meeting targets, and rather to focus on improving quality as the real ‘end’: ‘[There is an] endless stream of targets to try and achieve which...are there for quality; but... almost the analysis is the means to an end and I think we’re trying to do these things to ensure quality – not just to ensure that we’ve met the targets – and there seems to be a focus on that [the targets]. And how do you get the balance when people have scorecards and they measure quality. I’m not sure the balance is right.’

### Prompts:

- Does your hospital have an overall quality improvement strategy, which brings a clear coherence to all its quality improvement efforts and aligns with internal and external demands? Think about how this has been achieved and how it can be improved.
- What structures (committees, roles etc.) does your hospital have for disseminating quality improvement goals and methods, so professionals can be involved? Are they successful?
- Which key individuals in your hospital have the best overview of everything that is going on with regard to quality improvement? How do you draw on their expertise to connect up different quality improvement activities and spot new priorities? How do key individuals contribute to the alignment of quality improvement themes and initiatives?
- Where in your hospital are external requirements (from regulators, inspectors etc.) discussed in terms of internal quality improvement priorities and activities? How does it lead to prioritisation?
- Do your staff know what to do if they have an idea for quality improvement and want to take it forward? How are they encouraged to do so?

## Balancing bottom-up and top-down

Links to the following strategies in the Guide:

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- Translating national targets into local quality improvement initiatives (Leadership ●)
- Securing commitment to quality improvement in the hospital with all staff (Leadership ●)
- Encouraging both ‘top-down’ (formal, planned) and ‘bottom-up’ (informal, emergent) approaches to quality improvement (Leadership ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Managing tensions and the politics of change (Political ●)
- Allowing local adaptation of initiatives within a broader strategic framework (Cultural ●)
- Coordinating quality improvement efforts in the hospital (Structural ●)

Data from our 10 hospitals suggest that approaches to quality improvement that combine bottom-up and top-down are implemented more successfully. Here we give some examples of particular quality improvement initiatives that have combined top-down with bottom-up in different ways.

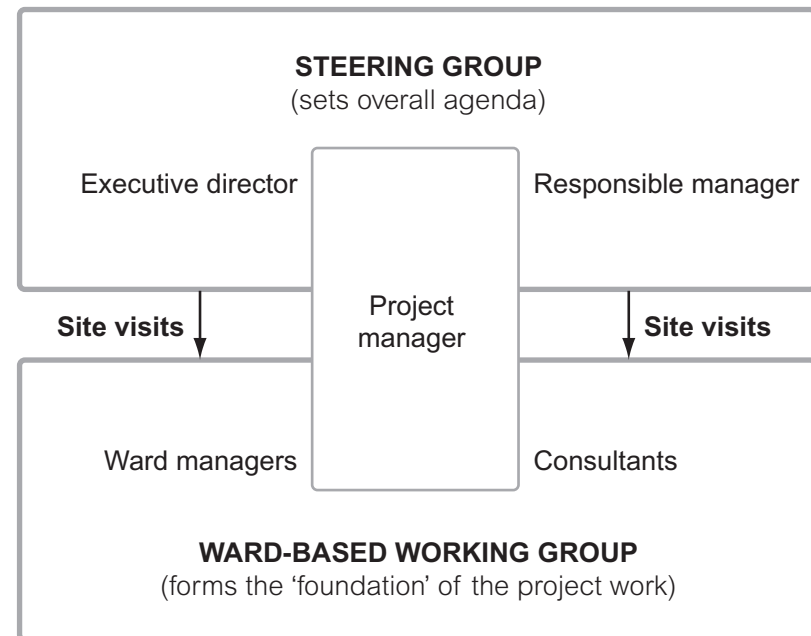
**Netherlands A** has been implementing the ‘Productive Ward’ – a theme-based toolbox that builds on ‘Lean thinking’, with the aim of increasing the experience of staff, efficiency and direct time available for patient care (see also ‘Formal quality improvement programmes and campaigns’ example). This quality and efficiency improvement intervention allows ward teams to select the areas they wish to focus on and offers a range of ‘Lean’ tools to address these. This was described as very motivating by the teams, the team leaders and the project leaders. Many ward staff participated because they felt it gave them an opportunity to regain control over their work and allowed them to be involved with quality improvement work that went beyond externally driven indicators. As an orthopaedic nurse commented ‘we are do-ers’, explaining his motivation to participate.

The figure below shows how this bottom-up participation is balanced by top-down managing of the project, as recommended by the Productive Ward approach.

**Netherlands A** also faces challenges associated with implementing initiatives like the Productive Ward, for example:

- Bottom-up projects that get implemented in a top-down fashion run the risk of eventually being forced into compliance with organisational agendas.

- A critical observer questioned how local change could be sustained in large organisations: ‘Giving people a bike to ride is not enough,’ he argues. Large hospitals should clearly communicate the ‘underlying destination of the ride’, that is, organisational aims and agendas. Otherwise, those participating in the project might ‘ride into walls’ in the end and be ‘again forced to comply’ with organisational agendas.
- Generating tension with regards to nurses’ expectations and project deliverables.
  - The project runs the danger that nurses might feel disappointed at some time or another because they could not satisfy an important expectation.
- Tension created by projectification
  - Nurses participating in the project repeatedly describe cross-disciplinary collaboration with doctors as one of their main challenges in quality work; however cross-disciplinary aspects of change are not explicitly addressed in project-based improvement work.



**Figure (top right): Bottom-up participation is balanced by top-down managing in the ‘Productive Ward’**

The steering group sets the overall agenda and comprises one of the executive directors, the responsible middle manager and the project

manager. Communication between senior management and ward managers is mainly through the project manager, who disseminates important outcomes of the steering group to the working groups, in which the project manager, the consultant, and the ward managers participate. Ward managers supervise the ward-based working groups, whose work is structured in three prescribed modules, which together form the ‘foundation’ of the project, and then allows the project team to pick from a series of themes (ward rounds, turnover, meals etc.). The executive director and the middle manager maintain contact with the ward-based work through site visits, when they hear

about developments and bottlenecks. These visits are designed to demonstrate the relevance of the project work and also serve as 'mini-evaluations'. This quality improvement project combines building on bottom-up motivations with top-down management of the overall agenda, although linking the two was not always easy and was reliant on the informal linking work of the project leader.

In **Netherlands A and B** risk management is conducted in a top-down and bottom-up manner. At ward level, incidents are reported in a safe incident reporting system. These incident reports are then analysed by a Ward Committee on Underlying Causes. The goal is to analyse these incident reports so that measures can be taken to prevent comparable incidents from occurring again. In recent years, staff are seeing more incidents and are taking the trouble to report these in the ICT system, which is seen as a breakthrough in safety culture by the hospital. At the same time, there is a hospital Safety Committee reviewing the total volume of incidents and looking for patterns in reports at hospital level. Finally, for some serious incidents in the hospital, the Committee can ask for more in-depth, independent assessments, like root-cause analyses. These investigations are done by doctors, nurses and ward managers, who have received training for this. In this case both bottom-up ward analysis and an investigation at hospital level leads to recommendations for quality improvement to be made to the Board of Directors.

In **Portugal B**, the hospital-wide Clinical Risk Group identified that one of the main safety problems in the hospital related to patients' falls. Following evidence-based actions in identifying the appropriate scales for risk of falls and implementing these into wards, together with collaboration between the Clinical Risk Group, the Quality Committee and the hospital Board, a computerised system that allows falls to be reported across the hospital into one system was introduced. The Clinical Risk Group analyses data from different services and disseminates the results throughout the hospital.

In **Norway B**, the Department for Patient Safety was established to promote a systems approach to patient safety within the hospital. For example, following the launch of Norway's first national patient safety campaign in 2011, the Women's Clinic in Hospital B took part in one of the campaign's pilot projects – 'Safer Surgery' – implementing the WHO safe surgery checklist. The specialist Department for Patient Safety supported the Women's Clinic quality improvement processes during this pilot project to implement and evaluate the use of the checklist, and provide feedback to department leaders. Being part of a national pilot project was a motivating factor for staff in the Women's Clinic; the department manager said: 'We were very proud to be asked to be a pilot in the campaign.'

**Sweden A** employs a range of strategies to support the co-ordination and sustainability of quality improvement using a combination

of top-down, bottom-up and middle-out inspired initiatives. For example, HCAI (healthcare associated infections) prevention and control was established with a long-term focus that was integrated with national, regional and local work practices. Within the hospital, a multi-professional commission was established which brought together a range of expertise available at national level. In addition, this commission set up a network of groups from all over the country to work together on this issue. Two chief physicians played a regional linking role, visiting heads of clinics in other hospitals in the county to ensure the screening of infections had started, and to spread learning among the hospitals. Within the hospital, the project manager and urology nurse instructed coaches (physicians and nurses) so they could bring relevant knowledge back to the different wards, thereby enabling synchronisation of activities throughout the hospital.

In addition, **Sweden A** uses a county-wide clinical incident reporting system, as described in the National reporting systems examples.

A final example from **Norway B** focuses on how leaders became aware that reconfiguration and rationalisation processes can cause ethical dilemmas for micro-level staff and how they need to build trust and a common understanding of change by integrating professionals into the reconfiguration processes. This hospital systematically communicated and consulted with staff concerning a reconfiguration of services.

Leaders set about selling and initiating change in a pedagogical way within the organisation. This involved assessing patient pathways and revising them to meet priority guidelines and best practices, leading to major pathway changes. However, the changes resulted in downsizing in some departments. It was noted that this entire process was very emotionally draining for all staff. Although downsizing was achieved, leaders later recognised that they had been too focused on downsizing and they had failed to leave any kind of buffer for emerging tasks. They realised that there was not any slack or redundancy in the system as processes were tightly coupled and, importantly, they had stripped out physician time that had been allocated for patient contact. This exemplar highlights that tackling downsizing in this systematic and rational way can be successful but it may lead to de-energising emotional challenges for staff and patients, and may cause future structural challenges as additional practices emerge.

*Prompts follow overleaf.*



## Prompts:

- Which quality improvement initiatives in your hospital would you classify as either ‘top-down’ or ‘bottom-up’? What proportion of each do you have? Is this the right balance? How might you encourage more of one or the other?
- How are bottom-up initiatives and top-down policy aligned in your hospital? Which of these alignment efforts happen in formal settings, which in informal surroundings? What is the consequence of this (formal/informal) setup?
- How do you encourage both bottom-up and top-down quality improvement initiatives and what processes do you have in place to align these? Think also of the cultural processes involved, e.g. formal tools like root cause analyses can have cultural effects if you broaden the scope of people engaged.

## ‘Care guarantees’

Links to the following strategies in the Guide:

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- Translating national targets into local quality improvement initiatives (Leadership ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Embedding quality improvement in the way they do things (Cultural ●)
- Establishing quality and quality improvement as the goal of clinical work (Emotional ●)
- Measuring and monitoring the hospital’s performance over time (Physical & Technological ●)
- Benchmarking and checking how the hospital is doing compared to others (Physical & Technological ●)
- Integrating quality improvement into the daily routines of staff (Structural ●)

All hospitals are faced with the challenge of meeting financial and performance targets and, in the face of this pressure, quality can sometimes slip off the agenda. Here we present some examples of how hospitals in our study group integrated quality with finance and



performance bringing it into the routine management of the hospital, and we highlight some of the problems that may arise.

Since 2009 **Netherlands A** has been pioneering the concept of care guarantees. Based on ‘user’ (i.e. patients, and their carers and families) expectations, the care process is adapted and translated into explicit promises about specific aspects of quality for patients that can be measured and sustained. For example, the care guarantee for lung diseases explains how outpatient visits are organised, the waiting times for treatment and results, and privacy policies. New care guarantees are signed annually in the context of the hospital’s ‘Contract with Society’. To date, care guarantees have been developed for larger relevant user groups (e.g. elderly people in a rapidly ageing region) in the regional care market. The hospital aims to adapt 80% of its care processes into care guarantees, to make care more transparent for patients and sustain quality of care through patient intervention. In addition, care guarantees are strategies for tailoring hospital care to specific user groups, generating greater volumes of patients and market share alike. However, such patient-led interventions can be time-consuming and expensive and consequently guarantees are prioritised according to the relative size of the patient groups.

In Sweden, care guarantees are part of government policy supported by the Swedish Association of Local Authorities and the Regions.

Initially, these guarantees were established to eradicate waiting times for initial consultations in outpatient clinics/day care offices. Managers in Sweden B devolved the responsibility for delivering the required waiting times to the departments and in 2012 introduced economic sanctions on these departments if they missed the waiting times targets. In order to support the departments, a project group was subsequently set up and four central values were agreed alongside that of access to services:

- 1) improved service quality
- 2) improved quality of working life for the staff
- 3) doing things right first time so reducing repeat visits
- 4) balancing between patient consultations and other ways of achieving a good patient outcome.

The project was managed as follows:

- Each department could add locally decided goals and were given some discretion as to when to engage each clinic in the project if there were multiple clinics in the department.
- Funding was set aside to provide the economic incentives for departments to achieve the required improvements.
- Departments each set up a project management team and these were supported by an experienced consultancy company that had

worked with the hospital before and conformed to the hospital's culture and ways of working, with an emphasis on lean production and mutual dialogue between professionals and managers.

The following challenges have been encountered:

- The departments had local freedom over how to implement the improvements, which required some difficult decisions such as introducing new roles for certain staff and changing the management arrangements in clinics, leading to some staff being moved.
  - The department heads were vital in managing the resistance to change that arose in some areas (see leadership and political challenges).
- Managers in **Sweden A** also added quality goals to the waiting times targets with financial incentives. Each year 2% of each clinic's budget is top-sliced. This money is returned if they reach the quality and waiting times targets.
  - In the interviews, the staff in the hospital expressed concern about the risk of focussing only on those things that need doing to gain more money and hence losing sight of the needs of the patient. They described economic incentives for quality improvement as two sides of the same coin.

### Prompts:

- How would a system of care guarantees to patients work in your hospital, for example in some specialties?
- Think about whether there are ways that economic incentives could be integrated into your quality improvement work rather than finances and quality being seen as separate.
- How and where are strategic choices made in terms of deciding which quality improvement priorities to focus on and how to balance competing quality improvement agendas?

## Celebrating success

Links to the following strategies in the Guide:

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- Securing commitment to quality improvement in the hospital with all staff (Leadership ●)
- Establishing the relevance and importance of change (Cultural ●)
- Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences (Emotional ●)
- Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values (Emotional ●)
- Making quality improvement visible (Emotional ●)
- Sharing information about quality improvement amongst staff (Physical & Technological ●)
- Using external demands as a means of increasing focus on, and supporting, quality improvement within the hospital (External demands ●)

Celebrating success can be a way of thanking very busy and hard pressed staff, and a way of letting the community know about the good work going on in the hospital. Here are some examples from our study sites of how this has been done.

In **Portugal B** the Quality Committee members recognise the importance of celebration as a way to harness energy and harmonise the different interests and players in the quality improvement process. ‘We released the date on which we obtained accreditation to the community and to all our regional partners who work directly with us in the continuity of care, including health centres in our sphere of influence’. The hospital held an event where they invited all their external partners and stakeholders and presented the very positive results including those of the hospitals they work with. In this way, the hospital shared their success with their partners to reach as many as possible, including other hospitals where their patients have shared care, and organisations such as Civil Protection, the Municipal Council, and charities.

In **Netherlands A** they held a re-accreditation ceremony, intentionally designed to demonstrate the hospital’s effort to improve quality to interested outsiders (e.g. insurers, patients, the national hospital inspectorate) and staff. They also hold an annual Quality Day where frontline staff present their improvement projects and compete for a prize, a much-wanted trophy designed by a local artist. Nurses largely find the improvement day inspiring and a nice reward for work ‘that is otherwise invisible’. Visibility and recognition is seen here as a way to help drive the improvement work. These quality celebrations are intended to maintain interest in quality improvement and to stimulate

staff to continue to improve the quality of health care.

In **Netherlands B** they celebrated with staff using ‘treats’ at the coffee break when the formal supervision of the Healthcare Inspectorate was lifted. They also issued a press release to the media about this and celebrated with the public, thereby combining external public relations and internal celebration. During a hospital-wide ‘patient safety week’ the goals achieved in the preceding year were also celebrated.

**Prompts:**

- Do you celebrate the success of your staff in improving quality in your hospital? How can you best use such ‘celebrations’ to maintain staff enthusiasm and motivation for quality improvement over time?
- How do you show the local community and your stakeholders all the good work on quality that is happening in your organisation?
- In what ways could you celebrate success with your staff, community and stakeholders more than you currently do?

**Defining what quality means in this hospital**

Links to the following strategies in the Guide:

- 
- Securing commitment to quality improvement in the hospital with all staff (Leadership ●)
  - Establishing a shared understanding of quality improvement in the hospital (Political ●)
  - Managing tensions and the politics of change (Political ●)
  - Enabling multi-professional working (Political ●)
  - Establishing a broad, shared understanding of quality and quality improvement in the hospital which encourages ‘buy in’ from all professional groups (Cultural ●)
  - Reflecting on quality in the hospital and the quality improvement journey (Cultural ●)
  - Using a range of data sources and tools to understand quality (Educational ●)
  - Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital (Educational ●)
  - Making quality improvement visible (Emotional ●)
  - Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences (Emotional ●)
  - Coordinating quality improvement efforts in the hospital (Structural ●)

In recent years, the concept of quality improvement has become more widely accepted, however, as demonstrated in the examples here, quality improvement remains a complex notion, which can mean different things to different healthcare professionals. Having a clear message about what quality improvement means to the hospital, together with providing appropriate resources and training, is an important step in integrating quality improvement into every day healthcare practises.

In **England B** there was a clear disconnect – or at least tension – between the publicly celebrated concept of quality and the implicit operational definition. The public narrative (i.e. hospital website, hospital publications, as well as the language used by senior leaders in conversations with the public and the media) stresses that quality is at the forefront of the organisation. However, staff reported how the quality issue quickly slipped off the agenda in the face of financial crisis, despite pressure from the external regulator to make immediate improvements. Staff describe how tens of thousands of pounds are spent using external consultants to assist the organisation in making financial savings, whereas, in contrast, only one external consultant was recruited to help the organisation improve upon its quality. Whilst the trust invested substantial resources into external aides and weekly meetings related to activity and meeting financial targets, similar effort was lacking in relation to quality improvement.

Conceptualisation of quality differs between system levels, professional groups, and the type of services provided. Quality is regarded as part of being a healthcare professional at **Norway A**. When employees are asked about their roles and responsibilities related to quality and quality improvement, their answers show that the conceptualisation of quality is often related to the provision of care and treatment according to specified procedures, professional guidelines/national guidelines, and sound professional practice. Quality is part of being a healthcare professional at the micro level, by updating professional skills, complying with procedures, and doing the best for the patient. At the meso level there is more emphasis on the systematic and holistic approach to quality, including quality systems and procedures, the use of indicators to measure quality, and fostering a quality culture.

A senior manager responsible for coordinating the quality and patient safety work within the trust said: ‘I think part of the reason for where we are today is the major focus from the CEO. The CEO put quality on the agenda and it is obvious that this is exercised down the organisational levels. In addition,...the professionals in the lower level of the organisation are very preoccupied with providing high quality healthcare service. A lot of good work is carried out without thinking in terms of quality or quality improvement. That’s because when the patient arrives and something is not working at the ward level, they take action and do something about it and implement a change. That is an important explanation for where we are today’.

This ethos was further demonstrated by an experienced midwife: ‘it feels like I don’t have so much to say when you ask about quality and quality improvement. To me quality is the individuals’ professional knowledge. Here many employees have a lot of competence and that’s the most important thing’.

In Norway A and B, departmental meetings are used to discuss problems and ethical dilemmas in the care and treatment of their patients. These meetings represent an arena to consider the best treatment options, how to deal with complex tasks and ethical dilemmas, and to build shared conceptualisation of clinical effectiveness and patient experience. The ‘Formal and informal learning’ example provides more detail about such meetings.

### Prompts:

- How explicit is your hospital about what it means by ‘quality’? Think about whether you have a clear quality strategy that defines the components of quality. How should each of these be measured and improved?
- How can you provide your staff with the opportunity to reflect on what ‘quality’ means, share their different understandings and increase awareness of different professionals?
- Do you encourage multi-professional working on quality improvement projects to enable sharing of different perspectives? How can this be achieved successfully to motivate and energise staff at all levels and to help remove hierarchical boundaries and tensions?
- How does your hospital make its ‘quality’ mission visible to your staff and patients? How can you make your hospital’s ‘quality’ message more apparent?
- Are the different components of quality managed through different organisational processes and structures or are they part of an integrated approach throughout the organisation? How does your hospital’s approach to quality improvement effect how staff and patients perceive quality improvement?

## External and internal competition

Links to the following strategies in the Guide:

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- Securing commitment to quality improvement in the hospital with all staff (Leadership ●)
- Establishing the relevance and importance of change (Cultural ●)
- Establishing quality and quality improvement as the goal of clinical work (Emotional ●)
- Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values (Emotional ●)
- Making quality improvement visible (Emotional ●)
- Sharing information about quality improvement amongst staff (Physical & Technological ●)
- Integrating quality improvement into the daily routines of staff (Structural ●)
- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in your hospital (Structural ●)

Taking into account that quality improvement initiatives are often in project form, the role of emotion is crucial in two situations: in mobilising staff to sign up to initiatives and in the celebration of

success or the achievement of results stemming from quality efforts. The management of emotion can be associated with the personalised consideration of achievement and the capacity of leaders to inspire members of the organisation, playing an essential role in mobilising and consolidating the enthusiasm of organisational members involved in quality improvement efforts. The specific forms that these activities take vary. The intervention of leaders should be personalised and inspiring, particularly in the initial stages of projects and the celebration of results. Engaging staff in competition and the visualisation of achievements are ways of inspiring and involving staff in quality improvement, as demonstrated in the case study from England A.

In **England A** the Director of Nursing developed a method that presented visually to staff results of audited performance metrics achieved per month for each ward. Using technology and a traffic light system of red, amber and green colours these performance metrics created healthy competition between ward sisters and ward staff. These metrics clarified specific areas where wards needed to improve and gave focus to staff. It also motivated the staff; they were amazed by their rate of improvement and they eagerly anticipated their score every month.

A nurse remarked, 'I mean I think when they first came in we all thought oh we'll never get 100% in this, we'll never get 100% in that.'

And we started probably about nine months ago and we were getting scores like 20% and 30%. But we're now scoring nearly at 100% in everything. So if you'd have asked me nine months ago you'll be getting 100% I'd say no never. So I think they are worthwhile because...it does make you think gosh we need to do this, and I think without them we'd never have increased our performance'.

This demonstrates how the Director of Nursing considered emotional, political and technological challenges in attempting to improve ward performance, using competition between wards and technology to energise staff in mobilising quality improvement.

### Prompts:

- How can we identify areas in which to encourage healthy competition between wards and professionals? Think about cultural challenges.
- How can we mobilise competition and energise staff interest in quality improvement? Think about the political challenge and vested interests of different wards; think about the emotional challenge around how to energise staff.

### Using external perspectives and resources

Links to the following strategies in the Guide:

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- Development of staff for quality improvement (Leadership ●)
- Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement (Leadership ●)
- Importing and adapting strategies from other hospitals nationally and internationally (Educational ●)
- Enabling staff to learn about quality improvement from outside the hospital (Educational ●)
- Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences (Emotional ●)
- Sharing information about quality improvement amongst staff (Physical & Technological ●)
- Benchmarking and checking how the hospital is doing compared to others (Physical & Technological ●)
- Building quality improvement capacity within the hospital (Structural ●)
- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital (Structural ●)



- Using external demands as a means of increasing focus on, and supporting, quality improvement within the hospital (External demands ●)

A number of our hospitals used external resources to facilitate quality improvement, such as participating in national projects and campaigns, participating in external peer review visits, and the use of external advisors from outside healthcare.

**Netherlands A** uses a range of external resources in their quality improvement processes, as described here.

For example, **medical professionals** are essential to the learning and improvement infrastructure. They:

- communicate about quality at conferences and symposia.
- collaborate with regard to quality and safety in their national associations.
- adhere to external visitation schemes that are organised by professional associations and direct internal visitation formats.
  - These are internal, specialism-specific group tours of inspection attended by internal medical auditors. Usually, internal visitations precede external visitations ‘to prepare doctors well.’ The visitation results are compiled in a report, which professionals use to set out improvement activities that

are checked by the auditors a year later. The report is shared with the audited professional group.

- Doctors perceive that these visitations help them to ‘benchmark and position the quality of their work’.
- However, this learning was reported as not being shared beyond the medical community.

The management team, particularly the head of the Department for Quality and Safety, invest in **external consultancy**.

- For example, the director of safety, health and the environment of a large chemical company serves as an external advisor on the Quality and Safety Commission, and another consultant ‘is sometimes part of [calamity] investigation committees that are busy in-house, and sometimes ... asked to support wards that are in trouble.’ (Quality manager).
- The input of an external consultant was particularly important for an initiative called the Patient Safety Round, as described in the ‘Formal and informal learning’ example.
- External consultants are also engaged to provide expertise in the implementation of the Productive Ward. Expertise is then transferred to staff who spread and sustain the project.

- The Quality and Safety manager co-initiated a research project with an external research consultancy. The ‘Origine’ project generated interview-based insights into how elderly people experience care in the hospital. The findings were presented to staff from the Department for Quality and Safety and the Patient Service Office. At that meeting there was a productive discussion of how these insights might help the actual improvement of quality and project outcomes were used by the divisional director to develop new care guarantees.
  - **One of the key messages here is the need to have a balance between internal and external sources of expertise and tacit knowledge.**
- Clinical champions and senior management were involved in building networks providing access to new knowledge and learning as well as supporting problem solving.
  - Associations with universities and educational institutions were used to integrate quality improvement into professional training.
  - Centralised IT systems that aligned macro priorities (regulatory; financial priorities; quality priorities; safety requirements and priorities; patient involvement; and professional accreditation) with measurement and monitoring of patient safety and quality performance were important in developing quality improvement. Hospital performance information could be accessed in ‘real time’ and used more effectively for decision-making.
  - Resourcing of specialist quality improvement teams and training in the use of quality improvement techniques that could be deployed across the hospital was also deemed useful.

**England A and B** were seen as working well in terms of quality improvement. Hospitals used **external perspectives and resources** in the following ways:

- They used external expertise, training, ‘best practice’ and were networked with a host of organisations (research centres, centres of excellence, professional bodies and national organisations supporting quality improvement and research institutions).
  - These external sources of knowledge and expertise were often integrated into hospital initiatives to support their efforts to implement quality improvement.

Conversely, hospitals that suffered from **insufficient internal resources** (staffing and hospital infrastructure) were unable to effectively mobilise quality improvement. For example:

- One hospital experienced difficulties because staff became demoralised when sufficient resources were not provided to enable them to deliver high quality care.
- Staff, already under pressure, struggled to cope when patient

numbers increased greatly and felt distressed that they had to compromise on the care delivered.

- One senior nurse commented that she was held accountable for quality and safety but given no control over staffing numbers and the means to ensure quality and safety.
- These conditions had a strong de-energising effect on staff and strongly illustrate that organisational commitment to quality needs to be backed up with sufficient resources to attain it.

**Netherlands B** is collaborating with six other hospitals in a learning network group on the ten themes of the national hospital patient safety campaign. They share among each other good examples and best practices. Also, the patient council provides hospital B advice on quality improvement topics or feedback on relevant patient topics.

**Norway A** uses the Department for Patient Safety as a resource for quality improvement as described in the Balancing bottom-up and top-down examples. Portugal A was encouraged by the Portuguese Directorate of Health (DGS) to adopt the WHO Global Patient Safety Challenge to prevent healthcare associated infections, as described in the Formal quality improvement programmes and campaigns examples. Further examples of using external perspectives and resources are described below in the External knowledge and learning centres examples.

### Prompts:

- Which external resources do you draw on currently to inform your approach to quality improvement? How do you determine which ones to use? How strategic are these choices in relation to your own quality improvement priorities?
- What processes do you use to decide which external resources and perspectives to draw on?
- How do you ensure that you capture and transfer the skills and learning from external agencies to your own staff? How can you improve the sharing of information about quality improvement amongst your staff?
- Think about whether you have an internal resource with the skills and expertise to determine the value of the range of external resources and adapt them to your local context.

## External knowledge and learning centres

Links to the following strategies in the Guide:

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- Development of staff for quality improvement (Leadership ●)
- Reflecting on quality in the hospital and the quality improvement journey (Cultural ●)
- Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital (Educational ●)
- Integrating quality improvement into educational activities (Educational ●)
- Enabling staff to learn about quality improvement from outside the hospital (Educational ●)
- Encouraging multi-professional learning and sharing about quality improvement (Educational ●)
- Integrating quality improvement into the daily routines of staff (Structural ●)
- Building quality improvement capacity within the hospital (Structural ●)
- Capturing and embedding the learning from quality improvement (Structural ●)
- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital (Structural ●)

Using external knowledge and learning centres can be an important resource for facilitating quality improvement initiatives and training, as described in the examples here.

**Sweden A** is proactive in using external knowledge and learning centres in the following way:

- Staff from all levels focus on creating links with external specialist knowledge and learning centres to source quality improvement training courses and training to support professional education.
- Managers encourage clinics and departments to request and communicate training needs to external knowledge and learning centres.
- Resources for accessing external knowledge and learning are routinely made available by the commissioner of hospital services.
- External demands and priorities set by the commissioner and hospital leaders are made transparent in the 'Diamond', a structural tool that departmental and clinic staff can use to identify where they should focus their attention. This tool also highlights crossovers and connections that help staff to efficiently and effectively tackle these priorities.

Examples of this approach are:

- One hospital clinic has worked with an external knowledge centre to develop hospital tailored solutions for quality improvement implementation.
  - It has a drama project with a forum theatre focused on improving understanding and education.
  - There are also regular meetings, mainly within professions, in which learning is shared between experienced and less experienced professionals, which were started because of worries about knowledge loss.
  - The clinic has sustained improvement education since 1998 and also maintains continuous dialogue with the external knowledge centre to gain ideas and inspiration for improvement education as well as sourcing courses in risk analysis and leadership training courses.
- The hospital leadership visibly demonstrated their support and commitment for improvement work by sending an entire department to an external knowledge centre for a training course in a different city. The staff recognised that these training days were expensive both in terms of cost and staff time. In signalling this level of commitment, leaders also identified that quality improvement training needs to be multidisciplinary and completed by staff in their multidisciplinary teams.

- In engaging with these external entities, the hospital draws on external learning of best practice for quality improvement. It customises and uses this knowledge to develop a system for hospital centred quality improvement training.

In Norway, the Regional Health Authority (RHA) has established a quality strategy and offers courses related to quality improvement. Norway B is a large university hospital and has a considerable research portfolio, a Section for Patient Safety, and internal special competence in several areas. Hence, Norway B does not depend on the RHA resources in terms of the RHA competence. Norway A, on the other hand, takes large advantage of the RHA as a resource and competence partner in the quality improvement work. The educational activities offered by the RHA in relation to the patient safety campaign, the quality improvement strategy and web pages are especially important for small sized hospitals compared to large university hospitals.

Also in **Norway B** a Department for Patient Safety has been set up as an internal 'knowledge centre' to help in planning, implementing and continuously following up quality improvement work, as described in the Balancing bottom-up and top-down examples.

**Netherlands B** offers employees the opportunity to take external courses. Every employee has an annual personal development

discussion in which agreements are made about necessary and desirable competences. It is possible to take a training course that is appropriate for the development of the employees and the knowledge needed in the hospital. It is the responsibility of the division manager to weigh up the wishes of employees for further education and training and the goals of the organisation. According to the managers this is sometimes a tricky assessment procedure, particularly if there are limited resources. Moreover, information from the individual 'personal development discussion' is not centralised in the hospital to make a wider hospital training plan. This means that there is no organisation-wide approach to quality improvement, although some internally organised team- or ward-related courses have been set up, for example the hospitality course for reception desk employees or the feedback training in the nursing ward.

**Prompts:**

- Who is responsible in your hospital for identifying external knowledge and learning resources or centres for quality improvement?
- How do nationally promoted quality improvement interventions and campaigns link with the development of quality improvement and professional development in hospital departments and wards?
- How do you identify hospital-wide quality improvement training needs?
- How is external knowledge disseminated throughout the hospital? How can you enhance this sharing of information?

## Formal and informal learning

Links to following strategies in the Guide:

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- Development of staff for quality improvement (Leadership ●)
- Reflecting on quality in the hospital and the quality improvement journey (Cultural ●)
- Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital (Educational ●)
- Enabling staff to learn about quality improvement from outside the hospital (Educational ●)
- Encouraging multi-professional learning and sharing about quality improvement (Educational ●)
- Paying attention to the social as well as the technical aspects of quality improvement (Emotional ●)
- Capturing and embedding the learning from quality improvement (Structural ●)
- Building quality improvement capacity within the hospital (Structural ●)

Professional training in quality improvement is vital, with both formal and informal learning processes being used.

In **Netherlands A** learning from existing local expertise is considered important to create a shared understanding of quality and safety. For example, the intensive care unit (ICU) traditionally takes on the role of expertise guidance in the hospital. In addition to existing protocols, ICU nurses are often asked to demonstrate high-tech machines to other nursing staff, when these machines have to be used on wards. The nurses traditionally consider themselves as advisors outside the standard learning system. This function was recently formalised and now ICUs host speed intervention teams (SIT) nationally that, based on a patient's emergency score, can be asked for advice on clinically effective treatment for high-risk patients.

In addition, in **Netherlands A**, internal evaluation is an important means of learning about quality and safety. The Department for Quality and Safety invests in annual evaluations of its own quality and safety tools by using external consultants. The Patient Safety Round is one example. It was originally constructed as a series of quarterly ward rounds, where ward managers, together with an independent guest (preferably from middle management) discussed a pre-structured safety checklist, with additional self-checks performed in the months between the quarterly rounds. The invited external evaluator, who amongst others conducted interviews with users, found that the ward rounds were largely considered bureaucratic and the self-checks were not conducted. Consequently, the system was revised and now the

ward rounds focus on semi-structured conversations on safety instead of checklists. It has reduced the number of intervening rounds and their function has been changed from self-evaluation to conversations between nurses and ward managers. However, the element of control remains built into the rounds and ward managers have to deliver the number of checks performed to the Department of Quality and Safety, and in the case of the ward rounds, they also have to report planned improvement activities.

**Netherlands B** used internal audits as a way to learn about quality of care in each organisational department. In these internal audits they used the Dutch audit checklist (based on the INK model, the Dutch version of the Baldrige award ) to interview staff and management about quality improvement. The internal audits were done by staff, accompanied by an organisation consultant who helped with the administrative tasks. All staff are trained to perform an audit. Audits were seen as reflexive spaces for staff to discuss quality of care and as a means to disseminate best practices. Other informal educational 'structures' include professionals with an area of special interest sharing their knowledge during daily practice.

In **Norway A** inter-professional working was highlighted in the Oncology Department through the use of a weekly de-briefing and guidance meeting. This group is led by a psychiatrist from the

Palliative Care team. It is open to all staff in the Oncology Department, regardless of grade. These sessions are used to help staff to deal with the very emotional situations they face and by sharing and learning together they can help each other, which in turn helps inter-professional working and breaking down the hierarchies.

In **Sweden A** hospital leaders actively encourage using external knowledge and learning centres (see the External knowledge and learning centres examples). In addition, there are links with a wide range of universities which collaborate in developing quality improvement courses that integrate into and support professional training. For example, there is a Masters programme in quality improvement and Leadership of Health and Welfare at the School of Health Sciences led in collaboration with an 'Academy for Improvement of Health and Welfare' – a collaborative centre for practice-based research and education in the field of quality improvement and leadership. Close collaboration with centres of learning is promoted by employing hospital staff with hybrid responsibilities covering clinical and university lecturing responsibilities.

Hospital leaders also promote and resource internal training and benchmarking that spreads local learning and expertise. A practical training centre has been set up, where nurses and doctors receive training, for example in how to insert a urinary catheter, doing



tracheotomy etc. There is benchmarking between departments in the hospital and also, by networking, with departments at other hospitals. Furthermore, training and research findings are disseminated through the intranet and through conferences. Training conferences such as ‘Management Force’, ‘Innovation Force’ and the ‘Micro-system Festival’ are other examples of development and training run by the hospital.

### Prompts:

- How can leaders show their commitment to quality improvement? Think about the cultural challenge around making quality improvement an integral part of the culture of your hospital.
- How can leaders identify key goals and priorities for staff training in quality improvement?
- How can leaders identify areas of expertise and transmit this learning across the hospital?
- How can your hospital locate and build networks and collaboration with external knowledge and learning centres for quality improvement? Think about the educational challenge of resourcing quality improvement learning.
- How can you enable staff to access external support for quality improvement? Do they have the resources and permissions for this activity?

### In-house training in quality improvement

Links to the following strategies in the Guide:

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- Development of staff for quality improvement (Leadership ●)
  - Integrating quality improvement into educational activities (Educational ●)
  - Encouraging multi-professional learning and sharing about quality improvement (Educational ●)
  - Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital (Educational ●)
  - Building quality improvement capacity within the hospital (Structural ●)
  - Capturing and embedding the learning from quality improvement (Structural ●)

All hospital organisations are faced with the challenge of how to keep staff up-to-date and informed as well as training them in how to improve quality. Here are some examples of what was found to work in our study sites, and also some examples of difficulties that can be encountered.

**Netherlands A** is a teaching hospital. They have developed a ‘Learning House’ to coordinate the learning needs across the hospital. They

offer introduction days for new employees; facilitate the mandatory training courses; organise training for new protocols and procedures; develop e-learning modules; run skills laboratories; and offer project management training for those leading key projects in the hospital. The Learning House also coordinates the curriculum for nursing and medical students enabling them to bring all the learning requirements together. Through the Learning House, courses are offered to staff in safety and quality, including how to develop an open and fair culture to enable people to speak up and report incidents and how to analyse risks and incidents. Often, external experts are brought in from other high-risk industries to help address local safety problems via the formal committee structure – which can be another important means for ‘transporting’ quality improvement knowledge.

**Netherlands B** has a broad range of training and development courses on quality improvement, especially on project management, auditing and safety analysis methods (several root-cause analysis tools and prospective risk assessment). However, the hospital management has been asking for more courses on change management and improvement methods as they felt there was a lot of effort given to teaching problem analysis and too little attention on problem solving. Sweden A is an organisation with the responsibility to provide healthcare and medical and dental treatment to the population of their county. The education and continuous development of their staff is

central to their quality improvement work. They have established a centre for learning and innovation (including leading and leadership), referred to here as Q. In parallel they have also set up F, an academy focussed on the development of new knowledge, enabling staff locally to participate in and learn from this. The mission of the organisation’s learning and innovation work is:

- Both Q and F work closely with their academic partners in the local School of Health Sciences to provide opportunities for staff to undertake postgraduate study, for example, Masters programmes.
- Department heads are trained in leadership and quality improvement internally through courses arranged by Q and through other internal and external arrangements. The training in quality improvement is provided for all staff members and the aim is to train staff together in multidisciplinary teams. Q also ensures that the training provided to staff is consistent and builds on the patient safety concept ‘Safe Health Care – every time, all the time’. There is a very deliberate strategy in spreading the organisation’s drive to improve patient safety by promoting a shared understanding amongst all their staff.
- Clinics and departments also have the opportunity to request specific training or help on quality improvement projects according to their needs, and Q will arrange this. An example might be how to conduct a survey and analyse the data or more practical clinical

skills. This has led to a practical training centre being established where staff can be trained in, for example, placing urinary catheters or inserting tracheotomies.

Collaboration between the professions – through inter-professional learning (see Emotional and Cultural challenges) – can also be valuable. The following are examples of where this has been successful and also where this has been unsuccessful.

In **England B**, an organisation with two district hospitals and a range of community services, the infection control team have set up a network of Link Nurses, one for each ward or department. These Link Nurses come together regularly for training and are then able to spread this learning to their colleagues back in their work places, making it specific to the work that they are doing.

In **Portugal A**, a teaching hospital, there is very little inter-professional learning. The doctors training and development generally happens separately to the nurses so there is limited sharing and access to knowledge across the different professions. The doctors are allocated time off for training but the nurses are expected to update their knowledge during their free time. The nurses described feeling sidelined by this approach and they believe that it underlines the hierarchical imbalance between professions (see emotional challenge).

This in turn stops nurses speaking up (see cultural challenge). One nurse said that ‘if the work was done together, the presentation of an issue among doctors and nurses, we would all be mobilised, but that doesn’t happen, everyone does their own thing.’

Similarly, in **Netherlands A** nurses described how there was limited collaboration between nurses and doctors, which made things difficult. For example, they had seen how poor collaboration had led to medication errors. The nurses felt that as a result of poor collaboration between the professions there was a hierarchical distance – a power distance – between doctors and nurses, which hampered open communication on quality and safety.

In contrast, in **Sweden A** networking across departments, in a variety of different groups and settings, is seen as a key factor in building change relationships and commitment for quality improvement work in the hospital. All staff are given the opportunity to participate and the opportunity to influence and take the initiative in quality improvement work and this is regarded as important for empowerment.

A senior consultant said, ‘You should sell in the ideas in different places in the organisation; you can never steer from the top down.’

The quality strategy is supported by: regular quality improvement follow-up dialogues and meetings at different levels in the organisation; quality improvement education programmes; a wide range of quality

improvement-projects; the visualisation of results through displays on notice boards and in newsletters; and an IT-based management system to coordinate all this.

**Prompts:**

- Do you have a good system for coordinating training in your hospital and making sure it is comprehensive?
- If you wanted to train all your staff in quality improvement methods relating to clinical effectiveness, patient safety and patient experience, how would you do this? Do you have the systems in place to enable this to happen?
- How do you spread knowledge to frontline clinical staff about important clinical issues such as methods to improve infection control or the use of complex equipment for critically ill patients? Could your current systems be improved?
- Do you have good inter-professional training? Could this training be improved to foster a culture of empowerment where everyone feels able to speak up?
- Might individual managers be stopping or reducing staff training in order to reduce costs? Are there other, more cost-effective ways of providing staff training in your organisation that would help improve patient care?
- Could you develop more e-learning modules for mandatory training and, if so, how would you keep these modules up-to-date and of interest to staff?

## Formal quality improvement programmes and campaigns

Links to the following strategies in the Guide:

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- Securing commitment to quality improvement in the hospital with all staff (Leadership ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Allowing local adaptation of initiatives within a broader strategic framework (Cultural ●)
- Establishing the relevance and importance of change (Cultural ●)
- Importing and adapting strategies from other hospitals nationally and internationally (Educational ●)
- Enabling staff to learn about quality improvement from outside the hospital (Educational ●)
- Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences (Emotional ●)
- Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values (Emotional ●)
- Benchmarking and checking how the hospital is doing compared to others (Physical & Technological ●)

## Formal quality improvement programmes

Two of our 10 hospitals were implementing the Productive Ward at the time of our fieldwork. ‘The Productive Ward: Releasing Time to Care™’ was developed in England by the National Health Service Institute for Innovation and Improvement (NHS Institute). The programme has three aims, namely to:

- increase the proportion of time nurses spend on direct patient care
- improve experiences for staff and patients
- make structural changes to the use of ward spaces to improve efficiency.

The programme provides guidance and tools to help nurses make changes to their physical environment and working processes in order to improve the quality of care and raise safety standards. There are three foundation modules (Knowing How we are Doing, Well Organised Ward, and Patient Status at a Glance) and eight process modules, which focus on specific areas of practice such as medicines, shift handover and patient hygiene. Since 2006, the Productive Ward has been rapidly and widely adopted across the English NHS and the programme has also spread internationally to healthcare organisations in the USA, Canada, Australia, New Zealand, Denmark, Belgium and the Netherlands.

**Netherlands A** have recently been implementing the Productive Ward as described in the Balancing bottom-up and top-down examples.

### **National quality improvement campaigns**

In the **Netherlands B** one of the quality improvement consultants in the Patient Safety & Quality Unit supports the hospital's improvement efforts by working solely on the goals of the national hospital safety programme, which consist of ten improvement themes. Her role included organising a 'Patient Safety Week', which incorporated activities to keep the topic of patient safety on the hospital's agenda. Specific days of the week were devoted to particular patient safety issues (such as hand hygiene) and these motivating events were organised to enthuse professionals for quality improvement work.

In **Sweden A** a national campaign entitled 'Safe Deliveries' was organised by the insurance company of the County Council (as each time there is an unsuccessful delivery the cost implications for the company are significant). The campaign included participative roadshows and a development forum delivered by the maternity clinic in the hospital to provide support to students and method development for clinical teaching. Any staff working with deliveries were expected to work towards a CTG 'drivers licence', a certificate showing that the individual has developed the skills needed.

In **Portugal A** the national campaign to improve hand hygiene is part of an initiative led by the World Health Organisation in order to ensure patient safety. Portugal took up this challenge in 2008 with the public launch of the national strategy to improve hand hygiene. The following support was provided:

- The Ministry of Health promoted this strategy and was responsible for issuing and translating the essentials, such as implementation guides, an observation manual and a description of hand hygiene procedures for healthcare workers.
- In addition to specific training support for the implementation and monitoring of the strategy, the Portuguese Directorate of Health (DGS) equipped the participating units with a technical kit comprising educative and promotional material to be used in the services, a catalogue of further material and documents translated and adapted for Portugal with technical orientation concerning hand hygiene measures.
- The DGS also provided a computer program that allows the coordinators to digitalise the received data and create reports (both at a hospital and service level). This also enabled the DGS to collate all the data and analyse them on a national level before making recommendations to hospitals on how to improve.

Both **Norway A and B** have been influenced by the national patient safety campaign – ‘In Safe Hands’– launched in 2011, in forms of pilot projects, focussed themes, and overall increased attention towards patient safety. Norway B participated in a campaign pilot project and the head of the Section of Patient Safety explained: ‘There has been great enthusiasm about the project. I was really surprised in a positive way. There have been a low degree of resistance, of course a bit of resistance, but the key success factor has been the enthusiasm among the leaders and their strong signals of ‘yes we are doing it’, and the leading professionals who have incorporated it in their practice.’ This demonstrates how national campaigns can motivate staff in quality improvement.

### Prompts:

- Does your hospital regularly participate in formal quality improvement programmes and campaigns? Think about the national/regional programmes that you have participated in, or could participate in, to facilitate quality improvement and motivate staff.
- How do you prioritise which programmes and campaigns to participate in?
- How do you seek to maintain local momentum for quality improvement once programmes and campaigns are formally over? And how do you ensure the sustainability of improvements?
- Does your hospital access external resources provided by national programmes and campaigns and adapt them to your local context? Have there been any challenges in accessing these external resources, which could be improved?
- Does your hospital have an internal quality improvement team with the resource and expertise to help implement national programmes and campaigns? Have there been any challenges in using internal resources, which could be improved?
- How do your staff hear about and learn from your hospital’s participation in formal programmes and campaigns? How can you best use and advertise formal programmes to maintain staff enthusiasm and motivation for quality improvement?

## Intermediaries, boundary spanners, 'linking pins'

Links to the following strategies in the Guide:

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- Managing tensions and politics of change (Political ●)
- Enabling multi-professional working (Political ●)
- Linking the learning from different quality improvement projects (Educational ●)
- Encouraging multi-professional learning and sharing about quality improvement (Educational ●)
- Coordinating quality improvement efforts in the hospital (Structural ●)
- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital (Structural ●)
- Building quality improvement capacity within the hospital (Structural ●)
- Establishing a positive, working relationship with payers and regulators (External demands ●)

Here we describe a number of strategies used for bridging professional and departmental boundaries to facilitate quality improvement.

## Boundary spanning roles

In **England A**, although many staff refer to difficulties in embedding an organisational culture for quality improvement, a new strategy devised by management to mobilise collaboration and engagement of clinical staff appears successful. The publishing of the HSMR (hospital standardised mortality ratios) data by Dr Foster, showing the hospital to have a high rate, together with poor performance on other clinical indicators, led the CEO to appoint into a new role of Director of Clinical Performance, a senior doctor who enjoys a challenge and who is more than prepared to argue about the quality of clinical care with his colleagues: 'I can make it so hot for them that they get on and do it'.

This doctor spans the organisation in his work, conducting case note reviews and directly challenging any consultant to prove they are delivering safe, high quality care.

He describes his role as follows: 'the job description was such that basically if there was an operational performance issue anywhere in the organisation I was able to go in and troubleshoot it, and it put me above the Divisional Directors'.

The pugnacious, tenacious approach of this individual has had success in a number of areas of quality including: improved communication



between the pathologist conducting post mortems and the consultants who were in charge of the patient in hospital, to learn about the findings relating to deaths in hospital; improved the management of patients who are receiving palliative care and are on the Liverpool Care Pathway; the provision of a second CT scanner and improved diagnostic services in both hospitals; improved clinical coding; and the development of a quality dashboard for divisions directly related to clinical care.

The following is an example of the approach taken with consultant colleagues when asking them to make changes to their working practices: ‘people talk about being professional ... but the response is always, well management needs to do it. And you say, well who is management? You are, you’re not a staff grade, you’re the professional lead for your department, you tell me what good looks like and how do we get to good?’

The hospital has instituted further boundary spanning roles such as the Director of Infection Prevention and Control who is a consultant anaesthetist appointed to the role to engage consultants across the trust in complying with infection control policies and procedures. The consultant lead in the organisation for clinical audit was also described as spanning the organisation with success in encouraging clinical audit, and this is reported in the Trust’s quality accounts.

In addition, middle managers operate as boundary spanners spreading knowledge and learning for quality improvement. They have a number of hybrid roles and responsibilities and access to a range of professional groups and organisational levels providing them with a broader awareness and depth of understanding of how processes and systems of care and quality improvement link together. This is important as it helps them to identify and investigate patterns and weak spots in the system.

A middle manager refers to these capabilities and hybrid roles in the management of complaints, safety and patient experience: ‘I have a broad responsibility in terms of how I coordinate and manage a quality and safety team. I see a large part of my role as ensuring quality and safety and that’s through the leadership of my nursing team, through the lead nurses and the matrons and the ward sisters and I focus a lot of my time in essence around quality and safety. It may not always appear like that but always at the back of my mind is around the quality of care and the safety of patients. I sign off all the complaints and you’ve heard us talk about how we’re trying to reduce complaints and so forth, get better responses, manage all of that. I sign off a lot of safety reports so I then ensure that the reports reach an appropriate standard, and that we’re learning from those things. Infection prevention is a key part of safety and patient experience. So, I’ve a large part in ensuring that the workplace are delivering around standards and then I’m looking at the outcomes’.

In **Norway A** all managers are formally responsible for quality improvement and patient safety. Senior executive managers are also represented in the hospital's key committees, the Quality Committee, the Patient Safety Committee, and the Quality Forum. Hence, they have a visible role related to quality improvement and patient safety. A key micro-level role is performed by the professional development/educational nurse who has responsibility for professional development, updating quality procedures, and being a front-runner in the quality work. The professional development/educational nurse plays a key role as a boundary spanner between the micro level staff and the managers, as they are involved in activities across levels and professions and can translate it into micro level language.

### **'Link-centred' strategies**

In **Portugal A** chief doctors and nurses of the services were responsible for appointing personnel to act as links in the service i.e. 'service links' or 'linking nurses'. The development of the 'link-centred' strategy to support infection control was based on the need to overcome the lack of support among the different levels. The service links are involved in coordinating structures and services and are focused on bringing the intermediate links closer together.

A local coordinator highlights how: 'Everything is a reason to quit (...) too much work, too many patients, the lack of professionals; these

are common to all situations. (...) I think that our constant presence, our insistence and our way of finding a pretext to remind people and to motivate them is crucial. It's rather exhausting for us, but if we don't keep this up, people will give up more easily. Until this becomes automatic, we'll have to keep giving out information and keep on insisting so that people will also become concerned about this [hand hygiene]'.

Taking into account that the link network is mainly made up of nurses, the development of this strategy led to professionals from this group being more easily mobilised, and this professional group showed greater involvement in the project.

In addition, without mass training in hospital A, the question of how to organise the training of the colleagues was mostly left to the links in the different services involved.

In **Netherlands B** certain individuals perform formal linking roles across various boundaries within the hospital. For example, one quality improvement consultant within the Patient Safety & Quality Unit focused specifically on patient safety, organising activities such as the Patient Safety week. Hygienists performed a similar role, moving between wards to inform staff about aspects such as hand hygiene, whilst transferring knowledge from one ward to another. Also, for

several quality issues linking pins were active at ward level. These included medical doctors and nurses with special areas of focus (e.g. pressure ulcers, pain, malnutrition and materials management), who served as a channel for transferring expert knowledge into daily routines; they also played an important role in keeping quality improvement topics high on the agenda of their colleagues. These nurses and doctors had a number of extra hours to spend on their area of focus. Hospital experts (for example, wound and pressure ulcer nurse practitioners) organised meetings in order to train other nurses, so that they in turn give other nurses instruction or refresher courses (on the basis of the teach-the-teacher principle).

### **Cross-organisational and occupational networks and groups**

In **England A** the Director of Nursing has set up a system to work with wards and departments to monitor and improve care services. Here the importance of having information about quality to use as part of the accountability process is seen as part of the toolkit needed to change the culture, combined with devolved responsibility and clarity of roles and accountability.

A senior executive describes this role: ‘...I want the ward sister to feel autonomous in decision-making, but they also need to own their data. ...and they’ll be expected to talk about their data to me or my deputy

to say what does that tell us? So they’ve got to own the data and understand it. They also do their own auditing. They come back and report what the compliance is. They talk about what they’re doing to improve when they come back and then what we’re looking at. So for me we’re just encouraging that culture at the moment’.

**Sweden A** uses a number of arenas and meeting constellations that are important for implementing and sustaining quality improvement in hospital A.

- All department heads along with the hospital managers are part of the Healthcare Management Team, where they have joint meetings and together set the goals for quality.
  - One of the department heads says: ‘There, we put together our targets for quality, a case example is that we shall cut our healthcare associated infections with 50 per cent.’
- Another example is developing measurements for improving patient safety ‘where we also have a strategy that one should go through their own [clinical] results, look at some issues that are bad and have an action plan for how to work with those issues’.
  - In this way the hospital at the meso level interacts with the micro level in applying quality improvement tools e.g. the PDCA (plan-do-check-act) wheel to learn from bad experiences in order to provide quality improvement.

- The hospital also formally designates roles across organisational levels with responsibilities for initiating, supporting and sustaining quality improvement. The CEO regards these positions as glue in the organisation as they facilitate quality improvement processes and perform networking within the organisation.
  - For example, most of the 24 departments/clinics have a Department Care Developer who supports the heads of the departments. Staff drawn from differing levels include: the Chief Medical Officer, the Care Development Coordinator and a Care Controller who work closely together with the Care Development Coordinator and first line managers to strengthen dialogue and leadership for quality improvement work. In the maternity clinic the Care Developer runs a course that trains staff in quality improvement. The hospital has invested resources in buying an accredited course designed by staff from a range of professions. It is mandatory for all staff to attend this course and it is repeatedly taught to mixed groups of professionals.
- There is a small quality department that provides support to staff at all levels.
- Overall, quality improvement interventions are led by task forces that deal with implementation issues that arise across several departments. Leadership of quality improvement is the responsibility of the CEO, the Care Development Coordinator, the

Chief Medical Officer, the Heads of the Administrative Departments and the Heads of the Departments. The hospital's quality strategy is both knowledge and budget oriented.

In **Norway A** professional organisations play a useful part in communicating best practices across the hospital. Most employees are members of professional organisations and the professional organisations are highly acknowledged. Quality improvement based on professional guidelines established by professional communities, and national guidelines within the specific professions are conveyed in professional training courses, guidelines, conferences and journals produced by professional bodies. This role of professional organisations is especially critical in hospitals that lack departments and staff with specialist knowledge of best practice.

### **Negative examples where boundaries were not being successfully bridged**

In **Netherlands A**, sharing of knowledge and learning between medical communities at daily routine meetings appears inconsistent. For example, a communications manager draws attention to how ward staff and ward managers are largely isolated from each other and refers to the limited transfer of learning as follows: 'Well, I find it scandalous, how little we learn from each other. I'm trying to break down the walls,

so that we can learn from each other. I want to be honest here, it's crazy when you look at the wards. They don't look any further than their own ward...because...sometimes, they might have thought up a good solution to a disturbing problem. If they shared that, everyone could do something with it.'

**England B** has experienced major difficulties in developing structures that facilitate engagement and collaboration of staff and service users in determining how quality improvements are achieved. For example:

- Failure in developing consultation committees and meetings with service users regarding the centralisation and re-configuration of services has led to clashes with service user protest groups.
  - Similarly, there appears to be a tension between the nationally-set definition of quality in standards set by the regulator and how hospital staff view how quality may be achieved.
- Some staff described the standards set by the national inspectorate as rigid, inflexible and with limited understanding of the reality of hospital life.
  - A proactive approach to quality seems to be lacking, and interviewees experience an organisation that acts on a short-term quality perspective that has lost focus on the patient experience.
- A short-term focus is demonstrated by the employment of external improvement consultants on various projects. For example, one company has been brought in to help with the financial turnaround, another for organisational development to support the management restructuring and another to make recommendations for new governance structures and processes.
- This has been widely criticised by staff and in the press, with headlines such as, 'The cash-strapped NHS Trust which runs [hospital] has spent more than £4million on outside consultants in the last year' and one campaigner quoted as saying: 'This is an absolute disgrace. How many doctors' and nurses' salaries would that have paid for?'
- In contrast, some staff accept that external consultants employed to aid financial transformation 'have really got things motoring'.
- Overall, the high financial expenditure on external consultants has de-energised staff.
- Staff appear de-motivated and frustrated by the failure of senior management to make use of many people in the organisation who have studied and have developed their skills in areas such as service improvement but who are currently not brought in to the overall organisational effort to improve the quality of care in the hospital.

## Prompts:

- Think about whether (and how) your hospital uses employees to bridge professional and departmental boundaries in pursuit of quality improvement.
- What are the key positions in your hospital in terms of managing quality both up and down the organisation? Are these a key part of implementing your quality strategy?
- As well as such formal roles do you know who are the key informal opinion leaders in your hospital with regard to quality improvement? How might you make the most of their contributions to your overall quality improvement effort?
- How do you spread learning from successful quality improvement projects in different departments and teams in your hospital? How do you share the learning more widely?
- In which meetings and how often do multi-professional groups come together to discuss quality improvement?
- Who in your hospital is responsible for looking externally for new ideas and approaches to quality improvement and adapting them into your local context?

## Management IT systems

Links to the following strategies in the Guide:

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- Translating national targets into local quality improvement initiatives (Leadership ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Embedding quality improvement in the way they do things (Cultural ●)
- Using a range of data sources and tools to understand quality (Educational ●)
- Establishing quality and quality improvement as the goal of clinical work (Emotional ●)
- Measuring and monitoring the hospital's performance over time (Physical & Technological ●)
- Sharing information about quality improvement amongst staff (Physical & Technological ●)
- Coordinating quality improvement efforts in the hospital (Structural ●)
- Integrating quality improvement into the daily routines of staff (Structural ●)

**Sweden A** has an IT management system available to all staff on the intranet. The system provides a means for ensuring that all quality improvement initiatives comply with regulatory requirements in the areas of quality, safety, personnel, finances, health, and the environment, and with the organisation's core mission and values. The system is continuously updated, including new macro level requirements and initiatives. An integral part is the balanced scorecard (BSC), which is used to operationalise clinical goals, measurements, monitoring and improvement (see the Quality Dashboards examples).

There are other tools contained in the system; for example, a diagram showing the components of the overall quality strategy, including learning, innovation, access, prevention, cooperation, clinical improvement, patient safety, medication and good finances. It also shows the 14 quality issues that are important in all clinical care as shown in the figure below.

**Figure: 'Safe Health Care – every time, all the time' - a concept for quality improvement and patient safety†.**

† By clicking on any of these 14 issues it is possible to find out about work in different clinical areas relating to that issue.

Senior managers' views are that the system is effective because it provides a means to highlight the importance of quality, empower clinicians, adequately resource quality improvement and align initiatives with external priorities. The system is used in the following ways:



- The annual meetings between care unit managers and hospital management are structured around the system and ensure that all initiatives are coordinated with external and internal requirements.
- The BSC is reviewed and discussed regularly by senior leaders.
- The system ensures that quality is an integral part of the daily work with patients.
- The system, therefore, provides quality improvement leadership, ensures quality improvement is incorporated into all activities, and aligns external and internal goals. This is an example of how



a hospital has met the physical and technological challenge, but it has also enabled them to meet other challenges – leadership, external demands, cultural, structural and emotional.

**Norway A** has emphasised the systemising of data to prevent a culture of assumptions. Part of the quality journey was initiated by the CEO due to the observation of a culture of assumptions i.e. where staff assumed they performed well, but had no data for this. The CEO hired a data analyst to extract information from available data sources and to visualise the data in a simple and user-friendly way. This information was used strategically for improving quality. For example, in relation to one of the national quality indicators which asks for a summary of the ‘time for discharge’ the hospital visualised these numbers and established demands for leaders to report their numbers according to these targets: ‘If I go back in time and read the reports from 2006-2007 and look at the times for discharge summary before we established the new way of reporting, we see numbers of 40%, 20% and 60%. Current numbers show 80% and some departments report 100% long-term. I don’t think we would have achieved this target without the new way of using and reporting quality data’ (CEO).

In addition, administrative staff support and facilitate the process of accessing quality information and reports from different data sources and IT systems. They make sure that reports are available, they screen reports going to the Patient Safety Committee and reports going to the

Board of Health, and search for trends and how they can be managed. Several of the interviewees at the meso level argue that this hospital stands out compared to other hospitals, in its effort in systematically using available quality information for managing quality improvement.

**Prompts:**

- How does your hospital make use of IT as part of its overall quality strategy? Could this be enhanced?
- Does your IT system provide you with regular and reliable information upon which to establish quality improvement priorities and measure performance over time? Think about whether the use of IT systems could help you better meet and integrate all your quality improvement demands.
- Do you invest in IT systems that can help leaders make decisions based on data from clinical processes? Think about whether you need further investment.
- Do you have and use IT systems that can improve access to up-to-date data on the quality of care?
- Think about whether there is an infrastructure for the flow of data.
- Do your employees have the necessary skills to use IT systems for quality improvement? What IT training do your staff undergo?
- Do your IT systems enable inter-professional information sharing about the quality of patient care? Can this be improved?



## National reporting systems

Links to the following strategies in the Guide:

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- Aligning quality improvement work that (a) the hospital has to do (e.g. in response to external regulators or national policies) with (b) priorities for quality improvement that emerge locally, in ways that combine to have the greatest overall impact (Leadership ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Using a range of data sources and tools to understand quality (Educational ●)
- Paying attention to the social as well as the technical aspects of quality improvement (Emotional ●)
- Measuring and monitoring the hospital's performance over time (Physical & Technological ●)
- Benchmarking and checking how the hospital is doing compared to others (Physical & Technological ●)
- Coordinating quality improvement efforts in the hospital (Structural ●)
- Actively managing the demands of the external environment (External demands ●)

Hospital managers often have to meet multiple targets and standards, some incentivised with money and others not. How to choose what to focus on and how to deliver these external requirements can be a challenge. Here we present some examples of this from different countries.

As with most countries, the hospitals in Sweden are required to monitor and manage numerous different quality indicators. In **Sweden B**, the County Council governs quality improvement efforts through performance-based contracts with care providers, private and public, for acute hospitals through the 22 indicators. However, the hospital management is critical of the use of remuneration for all these quality indicators since there are many other indicators of quality available to the managers in Sweden. For example, medical specialties nationally have 'quality registries' that are used by the National Board of Health to provide recommendations to hospitals about quality of care.

There is also a web site called 'open comparisons' that the Swedish Association of Local Authorities and Regions publishes, where the performances of individual departments can be compared. Hospitals also have to take note of and implement the recommendations from several external organisations. As is evident from this list, knowledge-based governance is increasingly being integrated into economic governance. Those negotiating contracts and paying for hospital

care should be aware of the multiple requirements and demands on hospitals relating to quality and quality indicators.

The following is an example of a new demand to monitor quality that was seen by managers as having the potential to upset other local quality improvement work and how this was overcome. In **Netherlands A** the Healthcare Inspectorate is currently piloting a new form of checking against their standards required for a quality service. They asked two hospitals to conduct their own audits of critically functioning processes according to a given framework and to report their findings back to the Inspectorate. The Quality and Safety Manager argued that this would be difficult since it would make him the 'long arm of the inspectorate' and would force him to 'play the game' which could endanger the good working relationships he had with the professional staff he worked with on quality and safety (see political challenge). Instead, the Quality and Safety Manager stimulated the development of regional audit teams including professionals that would perform the audits in other participating hospitals. In this way professionals were able to learn about how others had introduced quality improvements at the same time as delivering the required audits to the Inspectorate. Taking the initiative, the manager had generated new structures to mitigate the potential detrimental effect of the new external demands that he considered would damage his working relationships that were important for 'informal' quality improvement work.

Here are examples of organisation-wide systems to manage patient safety that also helps to manage improvements in care processes.

In **Sweden A** there is a computer system which captures and helps staff to manage adverse events, incidents, risks, risk analyses and the recommendations for improvements following investigations. The system is available through the hospital's intranet and supports the County Council's main and supporting processes in healthcare, administration, culture and education regarding reporting, measuring and tracking deviations and by identifying suggestions for continually improving services and processes. It provides patients, families, customers and staff the opportunity to influence the quality of county services, and meet governmental requirements.

In **Portugal B** hospital managers are keen to have information systems that enable the professionals to obtain indicators about their clinical performance. Thus, the hospital has a wide range of information systems, which enables departments and the hospital to monitor the quality of clinical care. These include hospital-wide data collection systems for nursing and other clinical indicators and also specific clinical systems, for example in obstetrics and in cardiology (the variety of individual clinical specialty information systems (about 16) does raise problems; for example the 16 information systems do not 'communicate' with each other). Examples of how this system is used are as follows:

- The information systems produce data that are then compared with the existing indicators for each department, and also with indicators for the accreditation process, or indicators of the national bodies (Professional Orders, Colleges, Ministry of Health) or international organisations (WHO, UNICEF).
- Professionals can track one indicator to the next and see developments over time.
- Hospital staff have access to their own departmental indicators and general hospital ones (usually), but by asking they can have access to other departments' indicators too.
- The indicators are compared with the previous years (quarterly and biannually).
- Access is via the intranet, and there are also meetings.
  - There is usually a biannual meeting with the hospital administration for the dissemination of data. Heads of services usually attend, but the meetings are open to anyone who wants to go.
- The hospital is also a partner in the 'IASIST' information system, where the data for the entire hospital is entered onto a system and this data is then compared with an average standard from other hospitals in the Iberian Peninsula who have joined this system. This allows managers and clinicians to understand the position of the hospital in relation to other partners.
- A very important aspect of the existing electronic records system in the hospital is the fact that it helps clinical procedures to be carried out in a more appropriate way with warnings given to the professionals.
  - One doctor explained: 'In the computer system there are alerts. One thing that was recorded and is part of the certification system of the hospital is checking patient allergies. All patients must have cases of allergy identified, which is not to say that during hospitalisation they cannot acquire an allergy, but if the patient has an allergy situation, it must be properly recorded and that is flagged up as an alert in the electronic system.'

In **Portugal A** the creation, collection, analysis and dissemination of performance indicators is a practice geared towards learning. The hospital regularly publishes global indicators for productivity (number of visits, tests undertaken), accessibility (waiting list by specialty, percentage of first appointments compared to total number of appointments, waiting time by type of appointment) and user satisfaction (number of complaints, positive feedback, suggestions). These indicators have been increasingly disseminated internally. The directors of departments and head nurses receive the respective data, updated every quarter, and are free to examine and use the data the way they see fit. In some areas, such as in the case of infection control, there is the belief that producing indicators should not be the focus of

concern, but rather how they are interpreted, taking into account the specific nature of the hospital. As the same data can always be subject to different interpretations, the most important thing seems to be the ability of the hospital to create conditions for a general debate on these possible interpretations and drawing of respective conclusions and corrective measures – a learning process.

In **Netherlands A and B** the hospitals have a decentralised electronic database that enables staff to report local incidents, which is described in the Reflexive and creative spaces examples.

### Prompts:

- How do you deal with multiple external demands to document your hospital's performance? How do you address contradictory demands?
- How could you design one coherent data collection system that is also meaningful to staff and patients?
- Are your clinical and service indicators used for learning at a local level? If not, how might you work with frontline clinical staff to help them use their performance data to improve quality?
- How good are your information systems at capturing good quality information for quality improvement? Is this information available to, and understood by, different stakeholders (management, professionals)? Are there ways that you can use the information available to help frontline staff learn and improve?

- How do you use your incident reporting system for learning? How much time do staff have to reflect and learn from incidents and to plan improvements? What facilities are there available for this?

### Organisational and professional identities

Links to the following strategies in the Guide:

- Securing commitment to quality improvement in the hospital with all staff (Leadership ●)
- Establishing a shared understanding of quality improvement in the hospital (Political ●)
- Managing tensions and the politics of change (Political ●)
- Establishing a broad, shared understanding of quality and quality improvement in the hospital which encourages 'buy in' from all professional groups (Cultural ●)
- Embedding quality improvement in the way they do things (Cultural ●)
- Establishing the relevance and importance of change (Cultural ●)
- Reflecting on quality in the hospital and the quality improvement journey (Cultural ●)

- Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital (Educational ●)
- Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences (Emotional ●)
- Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values (Emotional ●)
- Establishing a positive, working relationship with payers and regulators (External demands ●)

An understanding of quality can be built through a strong organisational or professional identity with a focus on clinical effectiveness.

**Portugal A**, for example, has a strong identity rooted in its long history and the role it plays in the NHS. As a top hospital in terms of training, an end-of-line hospital and one that should be able to deal with a wide variety of cases whose complexity or rarity has meant that other hospitals were unable to help, clinical effectiveness is core to its identity. This identity, whether at the level of service, or the hospital as a whole, is used as the framework for all quality initiatives. There is an awareness in the hospital of the importance of making staff

enthusiastic for quality improvement. Medical doctors functioned as change champions within their specialty and working in particular clinical services (including both the micro-systems we studied) maintained high levels of self-esteem due to its inherent characteristics and reputation in the hospital. In the other clinical micro-system, formal leaders used successes in day-to-day care and treatment, as well as underlining the unit's already high levels of quality according to performance data. The leaders also repeatedly mentioned that the unit receives the most difficult and complex cases in the country, comparing their practices with international standards and services in high-ranking countries to argue in favour of their high performance. This cultural attribute is responsible for the constant search for knowledge and technological upgrading, but also for the major difference in status between doctors and nurses, groups that differ in how they value the various dimensions of the concept of quality used in the QUASER project: doctors are more concerned with clinical effectiveness and nurses are more focused on patient experience, and to a lesser degree, on patient safety.

*Continued overleaf*

## Prompts:

- How strong an identity does your hospital have with your local community and staff? How does this identity relate to your quality strategy?
- How does your hospital promote its values and expected behaviours to your staff?
- What opportunities do staff have to reflect on their role in the wider hospital (beyond the boundaries of their team and service)?
- How does your communication strategy systematically link quality improvement projects (from start to finish) to professional, departmental and hospital identities (as appropriate)?

## Quality Dashboards

Links to the following strategies in the Guide:

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- Translating national targets into local quality improvement initiatives (Leadership ●)
- Managing tensions and the politics of change (Political ●)
- Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) (Political ●)
- Establishing a broad, shared understanding of quality and quality improvement in the hospital which encourages ‘buy in’ from all professional groups (Cultural ●)
- Using a range of data sources and tools to understand quality (Educational ●)
- Making quality improvement visible (Emotional ●)
- Benchmarking and checking how the hospital is doing compared to others (Physical & Technological ●)
- Measuring and monitoring the hospital’s performance over time (Physical & Technological ●)
- Co-ordinating quality improvement efforts in the hospital (Structural ●)

Developing structures that present qualitative and quantitative performance data that is easily accessible and scientifically robust and that supports executive decision making and also appeals to organisational cultural norms represents an effective quality improvement strategy, as described in these examples. As an example of a quality dashboard, we describe the use of the balanced scorecard (BSC) – a tool that can be used for creating a shared understanding among decision makers.

In **England A** the Director of Nursing, recognising the hospital's cultural norm that scientific and robust evidence would influence members of the executive team in their decision making, formulated a method that presented both qualitative data covering the evaluation of patient experience of care and quantitative performance data. 'Quality Experience Dashboards' encompassed all hospital data on patient experience and data recording, for example, the number of falls, pressure ulcers, the number of admissions and environmental scores such as staffing levels. In this way, the Director of Nursing moved patient experience operationally onto the board agenda and successfully managed internal politics by appealing to the senior leaders' appreciation of hard data. The Director of Nursing recognised the cultural challenge of appealing to the scientific mindset of senior leaders and clinicians and addressed the political challenge of gaining support for a greater emphasis on patient experience of care and service user involvement in quality improvement.

### Balanced scorecard (BSC)

**Sweden B** uses a BSC to help improve efficiency and quality, and reduce costs. Some of the indicators on the BSC are hospital-wide, as part of the contract with the County Council (the payer), for example, the County Council has set a target that no patient should have to wait more than four hours in accident & emergency to receive appropriate specialist treatment. Other indicators are across a number of departments within the hospital, whilst others are specific to certain departments. The BSC was described by a senior leader as having 'a central role in structuring quality improvement work' in the hospital as it, 'links to remuneration of quality improvement practices and aids in identifying clinical problems for further scrutiny'.

Within the Department of Internal Medicine, for example, there are 30 indicators, grouped into four categories as follows:

1. *Patient. Strategic goal: High quality patient experience.*
2. *Process. Strategic goal: Well-functioning care processes.*
3. *Employees. Strategic goal: Competent and engaged employees who thrive at their work.*
4. *Economy. Strategic goal: Economy in balance.*

The BSC is a vital tool in meetings between hospital and clinical leadership (part of the 'steering dialogue', an essential part of the system of developing responsible accountable behaviour). The meeting



was structured around the department's BSC, as follows:

- The BSC is represented as an excel file on a projector image, with outcome figures for the different indicators coloured as green (indicator met), yellow (partially met) and red (not met).
- For each of the indicators, the BSC also shows activities undertaken to meet the indicator, the start and end time of the activities, last year's outcome, the forecasted outcome by each reporting time and for the end of the current year, as well as the status (green, yellow and red).
- Discussion of the BSC tends to focus on a few topics.
  - For example, the hospital-wide indicator 'Share of patients with door-to-door time at the emergency ward four hours or less' was set at 83% for the current year. The actual outcome was 55% for the first quarter and 54% for the first half-year. The department had not set out any specific measures to achieve this indicator. The chief medical officer of the hospital and department heads discussed and brainstormed ways of improving waiting times at the emergency ward e.g. changing the triage process in an acute ward, increasing discharge from the acute ward (a short-time care unit), having continuous rounds and a changed working schedule for the physicians in order to increase the number of doctors on duty when demand is highest.

- Overall, the BSC can be used to optimise care process flow.

In **Netherlands B** an ICT tool based on the BSC is used for senior management. Three perspectives – financial, business processes and patient experiences – are translated into indicators. The financial department and sometimes the electronic patient record provide data for the BSC. The results on the indicators are presented as a traffic light; red meaning below the target threshold, yellow meaning on the target threshold and green above.

For some managers it was hard to understand why the traffic light was turning from one colour to another and, more importantly, to understand what they could do to improve and get better results for specific indicators. For example, when there were a lot of temporary hired staff – as a result of absence due to illness – the indicators for pressure ulcers, pain and productivity were turning red. The ward manager had not understood the correlation between hired staff, production and basic standards in nursing care, and therefore further analysis and discussion of the BSC may be required to determine courses of action for improvement.



**Prompts:**

- Is there an emphasis on the collection of quantitative data for measuring performance? Think about cultural norms and challenges.
- How can patient experience data be presented to inform executive decision-making? Think about technological challenges.
- How can leaders motivate staff to support the evaluation of patient experience? Think about emotional and cultural challenges of energising engagement.
- Do staff (e.g. department leaders) who are able to make changes based on the data meet regularly to discuss implications? If not, how might you improve the systems and processes through which data collection relating to quality can feed through to actual improvements on the ground?

**Reflexive and creative spaces**

Links to the following strategies in the Guide:

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- Implementing long-term quality improvement strategies (Leadership ●)
- Development of staff for quality improvement (Leadership ●)
- Establishing a shared understanding of quality improvement in the hospital (Political ●)
- Enabling multi-professional working (Political ●)
- Reflecting on quality in the hospital and the quality improvement journey (Cultural ●)
- Encouraging multi-professional learning and sharing about quality improvement (Educational ●)
- Embedding processes for capturing and reflecting on lessons learnt at the end of all quality improvement projects and taking those lessons forward to future quality improvement projects (Educational ●)
- Enabling staff to learn about quality improvement from outside the hospital (Educational ●)
- Encouraging spaces for reflection for staff to think about and discuss quality improvement within the hospital (Educational ●)
- Establishing quality and quality improvement as the goal of clinical work (Emotional ●) *continued overleaf*

- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital (Structural ●)

**Netherlands A** recognises that performance measurement is counterintuitive to double-loop learning and tries hard to generate reflexive spaces that enable open and safe investigation, and builds on tools such as the decentralised blame-free IT enabled incident reporting system. The system is intended to enhance mutual communication so that managers and nurses can analyse and learn from local mistakes. It is not designed to distribute responsibilities or blame individuals, which is why reporting is anonymous. This is shown as follows:

- Incident reports are stored locally in the ICT environment and analysed by a team of nurses and the ward manager.
- An element of control is built into the function of the ICT system. The ward manager is responsible for initiating improvement actions based on retrospective analysis, and if the plans are not entered into the database on time, the middle manager receives an automated warning after 10 weeks and the executive director after 16 weeks. In the case of the ward rounds, the Department for Quality and Safety, amongst others, monitor how many reports are written.
- The system can flag up problems, which can result in changes to clinical practice. An oncology nurse provided an example as follows: ‘There was a time when we had new needles. It seems that these new needles often injected through [not into] the vein. So we contacted the provider, and it turned out there was a special way [of injecting these needles] and we had to teach people how to do it.’
- The system is used on the ward to learn from repetitive errors (even though originally it was designed to report any error or possible incident). However, difficulties arise in preventing this system being used as a means to enforce local norms rather than encourage learning. While some nurses use the incident reporting system as a tool for deliberating on an error and its cause, others describe it as a governance tool to enforce local norms and compliance with guidelines and mandatory requirements.
- Some staff articulate that the incident reporting system is ‘another coercive means managers use to control us and they tend not to rely on it as a source of learning’. A nurse articulates this as follows: ‘If I see a colleague not carrying out the medication double check, I’ll tell him. I’ll tell him twice but the third time it happens, I will report this failure in the reporting system’.
- Staff at lower levels find it difficult to communicate openly with staff higher in the organisational hierarchy. For example,

an oncology nurse articulated that she found it difficult to communicate about medication errors with doctors and other nurses.

- In tackling this educational and learning challenge, the hospital needs to be aware that if a culture of blame is embedded then staff will not volunteer information that will incriminate them in poor practice. This hospital aims to tackle these challenges by creating reflexive spaces for all the professions in order to better deal with diverging interests and communication challenges, and to allow staff to feel safe in reporting errors.

**Netherlands B** uses creative techniques to foster learning about quality improvement and especially safety issues. For example, one of the consultants in the Patient Safety and Quality Unit, dedicated to the national hospital safety programme, organised the Patient Safety Week – a week full of engaging and motivating activities, designed especially to keep the topic of patient safety on the agenda. In this week the hospital played a game called ‘Who is the mole’, based on a TV reality show where a team competes for prize money i.e. one person is the ‘mole’ (whose secret job is to sabotage everyone else’s attempts at winning) who has to play along without blowing his cover; the others (and viewers at home) have to uncover the mole to stop the sabotage and win the game. In this case, the mole was a colleague (doctor,

nurse, laboratory employee, care assistant) who deliberately ignored the hygiene rules. Whoever caught a mole in the act collected a ticket. The person who caught the most moles (collected the most tickets) won a prize. Every day several moles were active, to keep the game exciting. The idea was to watch out for colleagues who were not complying with hygiene guidelines, and when you recognised a mole, to speak up and let them know what they were doing wrong. The purpose of ‘Who is the mole’ is to be aware of (un)hygienic behaviour and to learn to speak up and give feedback to one another in order to reveal the blind spots. However, the doctors weren’t pleased with how the game was played because it called for the moles to practice bad hygiene on purpose, and they felt that hygiene is not something to be toyed with.

In addition, there are examples of where hospitals were failing to spread learning especially between departments and across professions, which are described in the ‘In-house training in quality improvement’ and the ‘Intermediaries, boundary spanners, ‘linking pins’” (negative examples where boundaries were not being successfully bridged) examples.

### Prompts:

- What social spaces are available in your hospital that could support learning?
- How can these spaces be used to support organisational learning? How can this be resourced?
- Could senior staff be allocated roles to locate and manage these social spaces? Think about the structural challenge of allocating staff roles and tasks.
- Can you identify permission behaviours that senior staff can use to encourage junior staff to participate openly in incident reporting? Think about the cultural challenge of embedding knowledge and learning.
- Can the incident reporting system protect the anonymity of staff? Think about the technological challenge.
- How can senior staff support junior staff who feel responsible for errors? Think about the emotional challenge.
- How can senior staff understand that they are intimidating to junior staff? Think about the cultural challenge.
- How are responsibilities for training allocated? Are they dictated by professional roles and can you prevent tensions arising from political challenges?
- How can you prevent junior staff from feeling sidelined? Think about the emotional challenge and staff feeling de-motivated.

- How do structural challenges related to the allocation of roles and time limit staff engagement in learning activities?

### Using patient experiences and stories

Links to the following strategies in the Guide:

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- Identifying quality improvement priorities with staff (Political ●)
- Identifying quality improvement priorities with patients (Political ●)
- Learning continually from the patients (Educational ●)
- Listening to the staff and patients (Emotional ●)
- Making the most of all the potential resources for quality improvement in the hospital by framing quality in different ways to different audiences (Emotional ●)
- Establishing quality and quality improvement as the goal of clinical work (Emotional ●)
- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in the hospital (Structural ●)
- Coordinating quality improvement efforts in the hospital (Structural ●)

As well as the regular use of patient surveys, which were commonplace in our 10 hospitals, we found several examples of other ways of using patient experiences to identify quality improvement priorities and inform quality improvement work. Hospitals try to engage with ‘service users’ (i.e. patients and their carers and families) using different forums, and use patient representatives on committees. Complaints and feedback from service users can be used to improve the quality of care. In addition, the patient experience can be used in quality improvement training for healthcare professionals. Challenges associated with using patient experiences are also described.

### Engaging with service users

In **Portugal A** the hospital has created three distinct structures each specifically tasked with giving service users information about their rights and obligations and gathering their complaints and suggestions:

- The End-user Department was created by ministerial decree, and aims to improve service effectiveness and quality by giving users information about their rights and obligations and gathering their complaints and suggestions. This department plays a key role as a vehicle for patients or their relatives to voice their opinions, with the benefit of flagging situations that management may need to resolve.

- The Friends of the Hospital Association is a non-profit organisation operating with 400 volunteers who, working on a part-time basis under the nursing teams, assist in the areas of information, guidance and assistance for patients and their families or giving patients help with meals and hygiene.
- The Religious and Spiritual Aid Service, which is Catholic, organises daily masses and provides individual help if requested by patients or family members. In addition to this, it facilitates contact with representatives of other religions when asked.

In **England A** a department tasked with ‘Patient Advice and Liaison’ engages with patients, relatives and wider service user groups and hospital staff. This department gathers feedback from patients using surveys and face-to-face contact. They liaise with senior ward staff to investigate complaints. In dealing with complaints they aid in diffusing difficult confrontations between patients and staff.

In **Sweden A** there are a number of strategies and forums for involving patients in quality improvement efforts. These include involving patients in decisions regarding the purchase of new equipment, ‘learning cafes’ where patients and their carers are supported to meet and discuss their illness experiences with other patients and relatives, and representatives from patient associations participating in formal

quality and safety meetings. Staff training uses patient stories to create staff commitment. In addition, a patient ‘ombudsman’ works as part of a small quality improvement department. This department also coordinates monthly discussions with the medical director, ombudsman and patient groups, and reports this patient feedback to hospital departmental staff (care developers) specifically tasked with improvement in each hospital department.

### **Patient representatives**

In **Norway A** service users are represented in an overall user panel at the hospital, in the overall Quality Committee, and in the steering committee of the quality improvement programme. Ideally, patient representatives are also expected to be included at each step of the quality improvement projects. In addition, there are patient surveys (at irregular intervals) and a mailbox to collect patient experiences on the wards. However, there have been difficulties regarding incorporating patient experiences in quality improvement in practice. As a senior manager said: ‘It is difficult to involve users [in quality improvement] because the projects are so detailed, and the users often don’t have the qualifications to go into these details. They almost turn into a hostage left on the sideline and they have no possibility of going into details and give advice. We have 100,000 users, but the users involved in the projects are always the same people. We have no experience of

users taking an active part and telling us how to do [the work]. They are pacified and it is difficult’.

In **England A** service users were engaged to assess and feedback on the quality of care, and were able to influence the ‘Annual Plan’. Patient advisors spanned organisational boundaries and were acquiring deep awareness of quality and safety issues and best practices across the hospital: ‘the idea is that each patient advisor is attached firstly to a division and more specifically to a CBU within that division ... We [patient advisor] will be consulted on all the aspects that are significant and the day-to-day running of the hospital. We won’t be required to offer a strategic view but in terms of the operational side we get requested quite often to put in some input in specific terms when it amounts to something that has to do with patient experience.’

However, this hospital also demonstrated how resourcing for such intermediaries needs to be sustained even when resources are constrained; for example, the number of advisors was not maintained after two of the advisors left.

In addition, a patient advisor reflected on how the senior management team had brought them under strict control, so that they had little impact, but were rather used as mediators between the hospital and the public and referred to this as follows: ‘Previously we could give an

external view, an outsider's view to the inside of here; now the change is that there is a temptation to ask us to reflect to the outside as the internal view, in other words we are more likely to be required to see things the hospital way than the patient way so I think this is actually a weakness of the system now'.

**Netherlands A** uses patient involvement instrumentality as a frontline narrative that enables it to align quality and financial values. A Client Council advise the team of executive directors. The Client Councils consist of representatives drawn from the local community who work with the hospital's executive team and inform decision-making regarding the allocation of hospital resources. They enable service users to contribute to decision-making regarding future service demand, feedback on services and future service changes.

### **Using service user feedback for quality improvement**

In **England A**, the complaints process is embedded in formal governance structures throughout the Trust. However, from executive management to frontline staff, there were simultaneously ambiguous ideas about how information deriving from complaints should be used. Leaders at the divisional level were generally committed to using complaints as valuable feedback in order to tackle the problems within their area. At the same time, they were concerned about

high numbers of complaints, as this was used by their superiors to indicate poor performance, for which they were held accountable. More senior leaders predominantly used complaints as a measure for patient experience in the divisions and they also used the figures to benchmark their hospital against others.

During a Governance and Risk Management meeting, one senior leader expressed concern about the number of complaints and the image this gave of their hospital in the media, stressing the importance of bringing the numbers down. On the other hand, a colleague argued that complaints were valuable feedback that can help improve services saying: 'we shouldn't worry too much about high numbers of complaints, but focus on how we handle them and further encourage people to complain!' This discourse is reflected in pressures from outside, such as requirements imposed by commissioners, the Care Quality Commission (CQC) and the representation of their hospital in the media. The committee members were in agreement about the importance of using the complaint process as a tool for improving quality. At the same time, all accepted that reducing the numbers of complaints was a requirement. They finally agreed to compare their complaint process with the processes of other hospitals and to then 'tweak our process a bit' so that the numbers could be brought down.

Despite their concerns, they use complaints to improve services. For example, they got groups of nurses, healthcare assistants and ward staff together in order to agree ten key issues to focus on. One of the targets is, for example, reducing noise at night, on which they have had good feedback from patients so far.

**Netherlands A** has a Patient Service Office which is responsible for claims, patient opinion research, care guarantees and public debates; it employs complaint managers and relation managers who help wards to formulate communication strategies, set up patient folders or organise patient talks. It also employs a staff member for patient opinion research who advises wards and outpatient clinics on how to interpret information and de-escalate complaints. Also, it has developed an innovative hospital-based ICT system which assembles external quality improvement demands and which translates these into specific tasks for healthcare professionals, in order to increase the alignment of trans-local demands locally; as some indicators are about patient experience or even set up by patient organisations it indirectly refers to patient experience issues.

However, there are concerns that using purely quantitative data on complaints could be detrimental to quality improvement efforts: ‘I am afraid that it will just end up as counting the complaints filed for which ward, for which doctor and for which nurse. Then we’d get quantitative

measures of ‘Doctor x had six complaints’ for example, you wouldn’t look at what kind of complaints there are, what kind of patients are behind them, how the ward is structured and what kind of ward it is ... We’d lose incredibly important information this way because you’d only see x number of complaints.’

Using complaints also highlights the difficulty of juggling the agenda of learning with the demand to keep (or restore) public trust. For example, in response to Family F’s complaint the manager accompanying the nurses reflected that the meeting went well because the nurses managed to ‘put the client at the centre stage’ and also managed to ‘put on a compliant face that helped pour oil on troubled waters’. Putting on a compliant face seems to mean two things; firstly, appreciating the complaint and secondly, indicating that improvements will follow based on the insight. This case also shows that complaints are highly stressful situations to learn from. The difficulty of trying to satisfy the complainant and restore their confidence in the hospital during a very stressful meeting was described by the manager concerned as not a good way to learn. In addition, complaint management attaches much importance to restoring the patient’s trust in the hospital’s image. Balancing clients’ preferences and maintaining a trustworthy public image seems to be a challenge for healthcare professionals and does not always put learning in the drivers seat.



## The patient experience and training

In **Netherlands B** filming situations is another instrument that the hospital uses for assessing and improving quality. Once every 5 years all medical specialists are given 'video feedback' i.e. are filmed while working in contact with patients in the outpatient clinic. Instructive parts of the discussion are evaluated and alternative ways to have a dialogue are reviewed with a psychologist. For example, the transfer of patients from the nursing ward to the operating room was filmed and afterwards it was discussed with the employees concerned. Being able to watch a film of yourself, appraising yourself and getting feedback and tips from a colleague add up to a powerful tool for improving because it connects to emotional layers in employees: 'It's a powerful tool because you're confronted with your own actions. Afterwards, everyone had the image that transfer moments are very messy. Everyone's talking at once, it's not clear whether you're talking to me. While you're talking I'm connecting up a patient and therefore I can't listen properly. And you don't realise it until you watch it all on film.' A compilation of the notable moments is made from the filming and then discussed in a plenary session with all employees.

**Netherlands A** is also investing in ward-based culture sessions during which clinical teams watch a video about the widow of a man who has died after a severe disease. The widow reflects on the care process

and how particular therapeutic choices did not go well, on personal encounters between healthcare professionals and her husband, and how and when she felt his safety was at risk. The video is used to open a discussion on how the teams act according to the hospital's core values, which are patient-centred, professionalism, effectiveness and patient safety. The culture sessions are intended to stimulate wards to flesh out the core values locally and formulate what is needed to better comply with these. The sessions also allow teams to estimate their position on the quality journey. To date the culture sessions have not resulted in tangible improvement activities but the hospital wants to bundle local findings to facilitate quality improvement work.

### Prompts:

- How do you currently capture and use patient experiences to inform your quality improvement efforts?
- How can you involve patients and carers closely in your quality improvement projects, working alongside staff as partners in the improvement process?
- How are patients' views represented on key committees and decision-making bodies in your hospital?
- How is the quality of patient experience reported to your hospital leadership team? And how much attention does the team pay to these metrics and data? *Continued overleaf*

- How are metrics relating to patient experiences turned into quality improvement priorities and changes then implemented?
- Is there a senior role in your hospital with responsibility for improving patient experience?
- Does your hospital have a clearly defined budget for capturing and improving patient experiences?
- How do you work with partner healthcare organisations on improving the experiences of your patients as they transfer between you?

## Visualising quality improvement

Links to the following strategies in the Guide:

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- Encouraging both ‘top-down’ (formal, planned) and ‘bottom-up’ (informal, emergent) approaches to quality improvement (Leadership ●)
- Establishing a shared understanding of quality improvement in the hospital (Political ●)
- Establishing the relevance and importance of change (Cultural ●)
- Using a range of data sources and tools to understand quality (Educational ●)
- Embedding processes for capturing and reflecting on lessons learnt at the end of all quality improvement projects and taking those lessons forward to future quality improvement projects (Educational ●)
- Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values (Emotional ●)
- Making quality improvement visible (Emotional ●)
- Designing the physical environment in support of quality improvement (Physical & Technological ●)
- Sharing information about quality improvement amongst staff (Physical & Technological ●)

- Integrating quality improvement into the daily routines of staff (Structural ●)

A number of hospitals in our study are using visualisation of quality data or processes as facilitators of quality improvement. This is a particularly important method to convince professionals to work on the subject of healthcare associated infections (HCAI). HCAI are caused by bacteria invisible to the naked eye and the consequences of bad hygiene only become apparent in the following hours or days when the patient is getting ill. In the case of antibiotic resistance caused by the overuse of antibiotics the consequences are invisible as well. This lack of feedback leads to professionals not relating the appearance and consequences of HCAI to their own behaviour.

It has been described that: ‘Problems are like elephants, and these infections are like invisible elephants. For doctors the problem is if you can’t see it, it does not exist.’

To remedy this problem, hospitals use a number of visualisation methods to get HCAI on the radar of the professionals, such as: making photos of risky places; using screen savers, posters and intranet messages to get attention; organising information and education weeks; and checking the hands of staff under blue fluorescent light.

In addition, performance data with graphs (bars, spreadsheets, funny images) can be used to visualise the problem and the goals for improvement – tools to steer quality improvement work. Most hospitals build technological infrastructures to collect, analyse and present performance data.

For example, in **Sweden B** an ‘E-portal’ gathers different information from the data log system which will then pop up in tables and bar charts so that the clinics can use the data in their continuous improvement work and see that ‘now the prescription of Ciproxin has gone down and we want it to do so, and now it has gone up and we do not want it to; now we have more Clostridium and we do not want that.’ (Sweden Strama coordinator). By getting more frequent data you can control the business better.

In **Netherlands B** the staff were aware of the difficulty in changing behaviours relating to hand hygiene in a context where it is very difficult to give instant feedback to staff on their hand hygiene. One method used during a Patient Safety Week was to get staff to put their hands under a blue fluorescent light after they had scrubbed them, revealing how much dirt remained. This helped staff realise that they were not washing their hands properly, even if they thought they were. In **England B**, where rates of MRSA and c-diff were low, the hospital publicised these rates both internally and externally in newsletters and on their website to draw attention to these.

In **Norway B**, a ‘mini-audit’ was used as part of a wider programme to prevent and control HCAs. These audits did not use quantitative data, but rather made particular problems or improvements qualitatively visible. For example, they demonstrated that certain improvements were not taken up by all staff. The mini-audit gives feedback without making judgements of individuals as they feedback observations in real-time, also allowing for quick intervention. A quality improvement project member states: ‘We pay a visit to staff on the wards and systematically conduct short interviews to reveal what happens in practice. Instead of the traditional approach where you conduct the analysis and suggest improvement measures, we just hand over the status of our study to the managers and leave the process of finding and implementing improvement measures up to them’.

In implementing the Productive Ward (see also ‘Balancing bottom-up and top-down’ and ‘Formal quality improvement programmes and campaigns’ examples) in **Netherlands A**, the use of a white board was important in making the project visible to staff. A nurse involved in the project says that he can see what ‘really happens’ far better because he can compare last week’s medication errors [one of the chosen indicators on the ward] with the ones made this week. This lets him see both the quantity and reasons for the errors. Now he can communicate ‘these facts’ to others – ‘even doctors’. During the weekly review meeting on the ward, a nurse remarked that the crosses [indicating medication errors, coloured red on days when errors occur] had been

red ever since they were introduced and asked what the value of this exercise is. Another nurse in Productive Ward replied that this shows how much improvement is still required, and, as a result, they had made a list of where and how medication errors occur, which made clear how many communication problems had yet to be resolved, including with the medical doctors.

Complaints from patients and their families are a source of information for hospital managers to find out about quality problems in their hospitals. Examples are described in the Using patient experiences and stories examples (Using service user feedback for quality improvement).

#### Prompts:

- How do staff find out about quality improvement in your hospital? Through notice boards, events, newsletters? What are the most effective ways of disseminating information about quality improvement in your hospital?
- How can we help staff visualise their collective level of performance? Think about the technological challenge around visualising performance.
- Does your hospital use the information in complaints to best effect in terms of deeper learning about quality of care in the organisation or do you just count the numbers?

QUASER | Examples on the role of payers to assist your strategy development

## Examples to assist your planning: The role of payers

Enabling quality improvement and quality assurance within hospitals

Encouraging hospitals to learn from each other

Engaging hospital staff in quality improvement initiatives

Facilitating whole-system approaches to quality improvement

Helping hospitals to manage competing external demands

Providing a clear strategic direction to help hospital leaders plan for quality improvement work

Providing clear incentives by linking quality improvement to funding

Directly funding quality improvement work in hospitals

Prioritising requirements in light of hospital resources

## Enabling quality improvement and quality assurance within hospitals

Links to the following challenges:

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- Cultural (●)
- Physical & Technological (●)
- Structural (●)
- External demands (●)

Payers should consider how they assess whether the hospital's internal processes for ensuring compliance with national regulations are adequate, not only in terms of quality assurance but also for quality improvement purposes. The examples here describe some of the challenges faced by hospitals in dealing with quality improvement and ensuring compliance, while facing multiple external pressures and a lack of resources. In addition, the examples from Netherlands A and England B shows how bureaucracy can hinder the development of new quality improvement projects.

At the macro level in England, each NHS body is required by national regulations to have a process for handling complaints. Where they do not do this or they lack effective systems for learning from complaints, the Care Quality Commission (CQC) can use enforcement powers. In

**England A**, the complaints process is embedded in formal governance structures throughout the trust in the following manner:

- Quality and Safety Teams within each division (micro level groupings) review complaints and an action plan is prepared for each.
- The themes from complaints are clustered in order to identify trends, which are then highlighted at divisional risk meetings.
- Senior midwives and nurses talk these themes through with ward-managers, who then feed the data back to the frontline staff. Examples of changes at this level include a programme to reduce noise at night and work to improve communication with patients and families.
- The Heads of the Divisional Quality and Safety Teams report their data to the Director of Patient Safety (meso level), who oversees the hospital's complaint process and undertakes the triaging of complaints to identify the main themes at an organisational level.
- The Director of Patient Safety presents updates on numbers and processes related to complaints to the Governance and Risk Management Committee, a subcommittee of the trust board, for assurance. At meetings of this subcommittee, the Director of Patient Safety also shares information about benchmarking the number of complaints with other hospitals. This subcommittee drives activities around complaints through setting organisational targets for the complaint process and reviewing the progress of actions taken in the divisions.

However, from executive management to frontline-staff, we found simultaneously ambiguous ideas about how information deriving from complaints should be used. Leaders at the divisional level were generally committed to using complaints as valuable feedback in order to tackle the problems within their area. At the same time, they were concerned about high numbers as this was used by their superiors to indicate poor performance, for which they were held accountable. More senior leaders predominantly used complaints as a measure for patient experience in the divisions and they also used the figures to benchmark their hospital against others. During a Governance and Risk Management meeting, one senior leader expressed concern about the number of complaints and the image this gave of their hospital in the media, stressing the importance of bringing the numbers down. On the other hand, a colleague argued that complaints were valuable feedback that can help improve services saying: 'we shouldn't worry too much about high numbers of complaints, but focus on how we handle them and further encourage people to complain!'. This discourse is reflected in pressures from outside, such as requirements imposed by commissioners, the CQC and the representation of their hospital in the media. The committee members were in agreement about the importance of using the complaint process as a tool for improving quality.

Similarly in **Netherlands A** – in relation to external targets for reducing pressure ulcers, an interviewee commented: ‘I just wish maybe at the top they’d be a bit more supportive practically. [When] I’ve got a bit of a rise in pressure ulcers, which is distressing... because we’ve done a lot of work around that, but it will be directly related to the pressures of staffing, so instead of...each of us on the wards helping with staffing, no, it’s all about doing a report and telling us about it and then me chasing the matrons... to get some forms filled. Again it’s all about this paper thrown in to the process’.

In the **Netherlands B** the most important payers (healthcare insurers) support innovations in the quality of care through a scheme whereby division managers can submit a plan to the Board of Directors for larger improvement projects [LTP projects], and where they can then receive a financial contribution for innovations from the healthcare insurer. Standard forms have been made for these projects that are aimed to support and further professionalise the project management process. Examples include a project proposal form, the format for drawing up a plan of attack, quarterly reporting forms, an evaluation protocol and a completion checklist. A course on project-based working methods is also offered to the project leaders. Because the organisation has to account for the use of the resources, an individual in the organisation is employed to support project leaders in completing the necessary paperwork and to monitor the project

schedule and targets. However, it is striking that the division managers think that the forms and the individual are troublesome, bureaucratic and of little help: ‘You wouldn’t believe all the paperwork that goes with it. I get thoroughly sick of it. It’s almost impossible for me to get my people motivated again to put so much time into it... There are dozens of pages where you often see the same questions but in all sorts of different places. It goes well beyond my irritation threshold.’

In **England B** interviewees spoke about long processes to get permission to act to improve quality: ‘All these sorts of committees and stages... it’s paralysing slow. So that actually the people who really want to do things generally just do them and then someone goes oh we can’t afford this and we [say], okay well if you don’t want to afford it that’s fine, tell the patients they can’t have it, and they go what me? ... whereas the people who do their business plan and... submit it to their general manager, and ... he goes off and speaks to the PCT, and... the commissioning directors, and then ...it has to go to this board, and then it has to go to that board, and everyone else gets nervous, so nobody makes the decision, but it’s okay, because it’s all locked into a process. And as long as there’s a process everybody feels really safe, but nobody actually does anything’



**Prompts:**

- How can you help hospitals ensure compliance with national regulations without stifling innovation?
- How can payers assure the quality of the services they fund as well as simultaneously encourage and enable quality improvement?

**Encouraging hospitals to learn from each other**

Links to the following challenges:

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- Political (●)
- Educational (●)
- Emotional (●)

Payers can play an important role in brokering discussion about quality with hospital leaders that enable knowledge exchange and peer-to-peer learning. The example of Sweden B shows how a county council network meeting allows space for regular discussions with representatives from hospitals in order to construct a shared understanding through negotiating priorities, goals and plans.

In **Sweden B**, indicators are decided by county council officials. However, before they are decided they are referred to a county council network of chief medical officers and patient safety experts from all the major hospitals in the county. At the first meeting, the participants discussed how suggested indicators and initiatives from the Swedish Association of Local Authorities and Regions as well as from county council officials might affect care. They tried to negotiate how the indicators were designed so that they would stimulate quality

improvements, to get them accepted by the medical community, rather than solely serving as symbols of political ambitions. At the second meeting they also discussed their hospitals' respective relative performance: whether poor outcome measures represented real practice or were due to specific acceptable circumstances. Thus, they went to considerable efforts to ensure that indicators, goal levels and outcome figures should be seen as both reliable and valid as well as both realistic and enthusing.

### Prompts

- How can you enable and facilitate wider discussions amongst leaders of different hospitals about quality improvement priorities and strategies?

### Engaging hospital staff in quality improvement initiatives

Links to the following challenges:

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- Political (●)
- Cultural (●)
- Educational (●)
- External demands (●)

Payers can play an important role in encouraging and supporting hospital staff to lead and participate in quality improvement work. The following examples show how Portugal B and Norway B embraced new national quality improvement initiatives, resulting in positive changes in their hospitals. In Portugal the following national healthcare strategies were initiated:

- In 1996, the Portuguese Ministry of Health (MS) devised a strategy aimed at improving access to hospitals and health centres as well as enhancing the quality of services provided by the Portuguese National Health System (SNS).
- In 1998, the Ministry of Health drew up a document entitled 'Health in Portugal – A strategy for the turn of the century' which sets out the need for an internationally recognised quality system in health.

- To this end, an agreement was signed with the King's Fund Health Quality Service (KFHQS) for the implementation of a National Quality Accreditation Programme for Portuguese hospitals. The Ministry of Health invited all hospitals to join this process of accreditation with the KFHQS.

**Hospital B** formed part of the group of early adopters, along with six other hospitals. The establishment of this protocol led to the development of quality programmes that guaranteed a continuous improvement in care, including internal and external audits and the establishment of indicators for monitoring healthcare provision. Committees were also appointed to implement KFHQS standards of quality. The Head Nurse commented, 'We were a new hospital, we had only been going for 9-10 years and this hospital has always had very bold initiatives. At the time it had a staff of recently qualified professionals, new and young people from various fields and specialisations, and so the hospital was very dynamic in embracing projects and initiatives of this kind. And at the time the people on the board were already open to these methods and interested in them.' A member of the quality committee commented, 'Our hospital was part of the first pilot study in Portugal. Only seven hospitals joined the Hospital Quality Accreditation Program.' Overall, the professional culture of the hospital formed the basis for joining the Ministry of Health initiative.

Similarly, **Norway B** participated in the National Patient Safety Campaign. The director of the Women's Clinic commented: 'I think the Minister of Health launched the National Patient Safety Campaign at the correct point in time in Norway. It was really important that she initiated that campaign. All health trusts need to pay extra attention to patient safety. Our job is to provide safe healthcare. So, the campaign has been really important for us, and it gives you credit for discussing these topics. And now it is unacceptable to not participate in the patient safety work. That is indisputable. We are focusing on patient safety now, that's the CEO's focus, and the Patient Safety Department's focus, and it is opportune for us to focus on patient safety. It is a very positive approach to systematically implement change. We are collaborating with the CEO, the level 2 managers in which I am included, and the Regional Health Authority. This contributes to an open atmosphere.'

#### Prompts:

- What role can you play in encouraging hospitals and their staff to engage with national/regional quality improvement priorities?
- How can payers support hospitals to draw on external resources?

## Facilitating whole-system approaches to quality improvement

Links to following challenges:

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- Political (●)
- Cultural (●)
- Educational (●)
- Structural (●)

Payers can design and promote initiatives to improve communication and exchange between different levels of a healthcare system. The example of Portugal B shows how a lack of communication across different levels hampered the implementation of a quality improvement strategy on improving hand hygiene.

In Portugal, the objective of the first Global Patient Safety Challenge is to prevent healthcare-associated infections, and it advocates, among other practices, hand hygiene as one of the measures with the greatest impact on the reduction of such infections, as well as on the decrease in antimicrobial resistance and the reduction in costs associated to this issue. Portugal took up this challenge in 2008 with the public launch of the national strategy to improve hand hygiene. The Direcção-Geral da Saúde (DGS – General Directorate of Health, GDH) promoted

this programme, and was responsible for issuing and translating the norms essential for carrying it out. Although the DGS advocated the involvement of the hospital's top management and the appointment of a Local Coordinator initially, the development of this programme depended solely on the Infection Control Committee (ICC). The ICC's performance was based on a limited support network, composed of professionals who were on the Committee and their intermediate links with the services involved. The greatest problem pointed out by the participants themselves was the limited interaction among the different players of the meso- and macro-levels on the one hand, and top management's limited involvement on the other. It should be noted that this admission is viewed as a generalised attitude, and not just a stance that affects this project in particular. Improving communication and exchange between different levels of a healthcare system could therefore lead to more effective and efficient implementation of quality improvement.

### Prompts:

- How can payers encourage national, regional and local levels of healthcare systems to exchange knowledge and implement quality improvements in a collaborative way?

## Helping hospitals to manage competing external demands

Links to following challenges:

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- Political (●)
- Cultural (●)
- Structural (●)
- External demands (●)

Payers have an important role to play in helping hospitals to manage a variety of external demands and regulations. The example from **Netherlands A** demonstrates the challenges hospitals face because of fragmented healthcare systems. The example from **England A** describes a scheme used to combine various quality measurements into one system, thereby overcoming challenges associated with fragmentation.

In **Netherlands A** quality is firstly expressed by compliance with national quality indicators, which come from the Healthcare Inspectorate, insurers and the national programme on 'Visible Care'. The multitude of indicators hospital A has to comply with is increasing steadily. The hospital is also actively involved in various certification and accreditation schemes. Besides compliance with diverging national and international norms, and the guidelines of

scientific associations, the hospital holds a range of certifications for components, such as laboratories (ISO, NTA, CCKL) and the hospital quality and safety system (NIAZ, VMS). Medical professionals, who are obliged to comply with a hospital's quality management system, additionally rely on their national bodies for professional standards and guidelines. Various independent committees focus on quality improvement issues, such as the committee for quality and safety, the nursing professionals' committee, the calamity report committee, the complaints committee, or ward-based incident-reporting committees.

Also in **Netherlands A** the challenge is to deliver both efficient and high-quality care. According to middle managers, the marketisation of Dutch healthcare and its inherent focus on cost containment generates challenges to deliver both efficient and high-quality care simultaneously. In 2009, the hospital underwent a reorganisation to obtain 'a better link with the market and the capacity to react [to changes] more quickly'. Division directors are responsible for negotiating price and volume with health insurers. However, they have limited power as they lack both internal contracts on care and price with the care groups and financial budgets to negotiate with the internal medical communities (for resources of the informal kind see same section below). This lack of financial means of exchange, they argue, not only weakens their negotiating power with care managers (responsible for care processes), but importantly, with

medical managers (responsible for clinical care) as well. In addition, most medical communities operate on a freelance basis in the Netherlands and traditionally have a powerful standing in Dutch hospitals. A management team meeting highlights this: ‘A division director announced to the executive director that he has problems making specialists comply with the registration of some national indicators. Taking the case of cataract surgery, the director argued that because national medical bodies are currently debating the usefulness of the quality indicator (wait 28 days between operations to the left and right eye), some specialists would not comply with the protocol. The executive director scribbled in his note book, and said that professionals are free to continue leading their evidence debate in their national bodies and that he actually welcomes such discursive engagement. Yet, they still have to comply with the rules and agreements set in the hospital. Later, he called in the medical managers, after the board meeting, and reminded them of their professional responsibility, which according to him also included ‘the willingness to stick to agreements’ (research diary, 29.08.11).

In **England A**, the nursing metrics are displayed on spider graphs that combine process measures for nursing care (such as infection rates, thrombosis rates, falls and pressure ulcers) with staff information (such as staffing levels and sickness absence) together with information about the patient experience. Every month nurses use this tool to

monitor half the patients on every ward for all measures. The Chief Nurse was part of the team that developed the nursing metrics. About 8 months ago, she introduced the use of this tool in the service for the elderly, from where they were spread throughout all wards of hospital A. Although the measures are process orientated, senior nurses see that they have helped to improve care (e.g. significantly reduce falls, improve tissue viability, and drug administration errors).

The Chief Nurse explained this success as follows: ‘They give us the granular detail of where the problems are before they happen. [...] which is yes you had 15 falls in a month, which part of the patient journey did we not do to understand where the improvement needs to be. Did we risk assess the patient? If they were high risk was there a care plan? [...], did [the patient] have a bedrail assessment? Did we inform the specialist falls nurse? Did they get their review on time? Was the patient reassessed? Was there medication or other interventions that were making that patient fall actually? What was their mobility status?’

Nationally there are many measures that are either recommended or required to be collected for different initiatives such as the ‘Essence of Care’; ‘Energising for Excellence’; ‘Safety Express’ with the ‘Safety Thermometer’; CQUIN; QIPP; and a number of Dept. of Health specific quality measures such as VTE risk assessments. The nursing metrics

now collected in hospital A combine the requirements from all these initiatives, removing overlap and stopping things being collected ‘in splendid isolation’. The Chief Nurse sees them as not just a measurement of how much and what happened when, but as a tool that provides information on how did it happen, what generated it, and what was the root cause.

The micro level staff also find the nursing metrics helpful as the following quote of a nurse illustrates: ‘oh we’ll never get 100% in this, we’ll never get 100% in that. And we started probably about nine months ago and we were getting scores like 20% and 30%. But we’re now scoring, the last one I just looked at we’re nearly at 100% in everything. So if you’d have asked me nine months ago you’ll be getting 100% I’d say no never. So I think they are worthwhile because actually, it does make you think gosh we need to do this...’.

There is recognition at the meso and micro level that, under the old system of measuring so many things separately, too many different initiatives to improve quality were underway without understanding the root cause, and this was diluting the impact of any one of them. The Chief Nurse is convinced that, for example, fractures due to patients falling and drug errors that are expensive for the NHS could be significantly reduced if the different national agencies could get together and agree on one measure to be used nationwide.

She therefore started promoting the nursing metrics by talking to the Royal College of Nursing and the CQC. This example shows how senior leaders at meso level try to improve care provided in the micro systems of their hospital. At the same time, this vignette illustrates that they share knowledge with other organisations so that patients in other hospitals can benefit from their insights. This exemplar also demonstrates how senior leaders try to influence the macro context in order to create an environment that is more geared to the needs of their hospital.

#### **Prompts:**

- How can you work with other payers and regulators in the healthcare system to ensure competing and conflicting demands are not being made of hospitals in terms of monitoring and improving quality?
- How can you best engage with hospital leaders to co-design measurement and reporting systems?

## Providing a clear strategic direction to help hospital leaders plan for quality improvement work

Links to following challenges:

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- Political (●)
- Structural (●)
- External demands (●)

Payers have a responsibility to hospitals to provide a clear strategic direction that enables – rather than impedes – quality improvement work. The example of **England B** shows how the changes to the healthcare system in England resulted in uncertainty and a lack of a focus of direction.

In **England B**, changes in commissioning arrangements<sup>1</sup> instituted by policymakers lack direction – ‘a vacuum’. Trust senior management have taken proactive steps to forge new agenda: the national policy changes on commissioning, which are leading to a reorganisation of commissioning and primary care locally, was described as causing a disconnect with the trust. These changes have come at a time when the trust is developing its clinical services strategy; in an ideal world it would have had clear commissioning intentions set out by the new local GP cluster commissioners prior to their official start

date, however the lack of this, together with an absence of a previous commissioning strategy, led to the trust taking the lead in developing the local strategy, described as ‘push rather than pull’. This has been a clear choice by the trust to drive the development of a clinical services strategy rather than waiting for the commissioning process to settle down. The trust nevertheless recognises the risk in this approach in that the commissioners, once established, might decide on a different route.

Commissioning was described as one of the challenges for the trust both in terms of local relationships and the perceived lack of direction for services from the trusts commissioners. The frustrations caused by the lack of a constructive relationship were described by one interviewee: ‘But we’ve always been struggling against commissioners saying you run an inefficient service, you’ve got too many doctors, you’ve got too many nurses, you’re not seeing enough patients, you’re spending too much money, we’re not going to commission the amount of work that you’re doing. So for example we’re going to demand limit the need for secondary care and then I mean it’s a repeating cycle each year ... where the commissioners say we think you’re going to do this amount of activity, because we are going to demand limit and at the end of each year as long as I can remember they’ve spectacularly failed to demand limit, we have over performed, the money is late in coming in, there’s arguments about the money. How do you develop services in that sort of climate?’.



**Prompts:**

- Are you providing a clear and consistent context in which hospital leaders are able to plan and implement long-term strategies for quality improvement?

<sup>1</sup> The NHS in England is currently undergoing major changes. Prior to April 2013, 152 bodies called primary care trusts (PCTs) controlled local spending on dentists, hospital operations and tests, and medicines – accounting for 80% of NHS spending. They were mostly made up of health managers. From April 2013, PCTs are being replaced by more than 200 GP-led organisations called Clinical Commissioning Groups (CCGs), which are responsible for closer to 60% of the NHS budget. Every GP surgery has to belong to a CCG; the government believes CCGs will be better placed to decide on local priorities because more doctors and nurses will be involved.

**Providing clear incentives by linking quality improvement to funding**

Links to following challenges:

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- Cultural (●)
- Emotional (●)
- Structural (●)

Payers can set clear incentives for particular forms of quality improvement work. In both **Portugal A and B**, funding and commissioning is allocated according to diagnosis related group information and is not linked to quality improvement priorities or performance: public health units are allocated global budgets based on contracts (contratos programa) signed by the Ministry of Health. This budget is based on diagnosis-related group (DRG) information, as well as on non-adjusted hospital outpatient volume. Because budgets are covered by supplementary allocations, the activity-based system has limited incentives to encourage cost-containment or efficient practices. The contracts do not take into account any quality indicators.

**Prompts:**

- Are you providing specific incentives relating to particular forms of quality improvement work in hospitals? If not, how might you?

## Directly funding quality improvement work in hospitals

Links to following challenges:

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- Educational (●)
- Physical & Technological (●)

Payers can play an important role in supporting and enabling quality improvement activities particularly with regards to providing access to external resources.

In **Norway A** the Regional Health Authority (RHA) plays an active role in the region with regards to quality and safety in healthcare. There is an annual quality conference with a prize for the best quality improvement project. The quality prize can be for a quality improvement project, but can also be given to individuals or a team who has provided an outstanding effort for quality improvement for a long time. Furthermore there is a fund available for the local health trusts, where bottom-up quality improvement projects are encouraged to apply for funding.

The patient safety campaign plays an important role in spreading/initiating quality improvement activities at the meso level. In the letter of assignment, the RHA requested the hospital to take part in the national campaign activities. The letter of assignment from the Ministry

included measurement targets/indicators for the RHAs on establishing the use of the Global Trigger Tool to measure harm to patients, and on conducting a patient safety culture survey according to national patient safety campaign expectations. However, there was frustration from administrative staff actively involved in executing the campaign activities, mainly directed at to the lack of knowledge and response from the National Knowledge Centre, which acts as the secretary for the campaign. Meso level managers expressed very positive attitudes towards the patient safety campaign and argued that the campaign helped to legitimise the quality improvement work and attention. The patient safety campaign and the up-coming patient safety report to the parliament are important symbolic steps for directing attention and demands for patient safety in the Norwegian healthcare system, and it is therefore important to get it right.

In **Sweden B** the financial crisis has no specific impact on the hospital: the contract with the county extends for three years with a two percent pay reduction each year, i.e. the same production volume is required for each year but there is a reduction in the remuneration with two percent each year. There is thus an implicit assumption that the hospital will be able to improve productivity by two percent each year (a very common measure in Swedish public policy). Other demands such as accessibility might cause even further reduction if not adhered to. The hospital has no exact figures for quality improvement work since it is considered to be part of everyone's responsibility.

The outpatient clinic project was budgeted to 0.65 million Euros, and financed by the hospital as a means to re-organise patient flows and working patterns due to the demands from the governmental Care Guarantee Scheme. There are a few other projects that also get special funding from the government, such as the patient safety culture survey. Apart from the quality department, every department has a care developer.

#### Prompts:

- Where payers are actively trying to support quality improvement work in hospitals are they doing so in a collaborative and informed way?

#### Prioritising requirements in light of hospital resources

Links to following challenges:

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- Political (●)
- Emotional (●)
- External demands (●)

Payers need to take account of staffing levels and other factors when considering new indicators or measurement requirements. The example of **England A** shows the challenges hospitals face in dealing with insufficient staffing levels and the impact this has on the quality of care.

In **England A**, a senior nurse identified regional and trust-internal politics that made the quality of care uncertain, particularly in the context of getting extra staff from agencies: 'XX is a very close proximity hospital bunch and the agency staff are now being stretched to all the hospitals that are under pressure, we're not getting any fill, so then it stretches our own internal staff. When I was a major in ED [the emergency department] sometimes you snap your fingers and you can get staff quick because the immediate urgency can be seen, if I said to you, resus is full, I've got two red calls coming in, there's been a pile up on the xxxx Road'.

In addition, the demand for care has increased throughout the last few years. A doctor explained to us: 'Again, it's lack of resources, lack of

nursing ... lack of frontline staff to deal with an increasingly dependent population. I think the general public and politicians are just not recognising that the population is growing older – everyone knows that, but they're not realising what that means in terms of dependency. Ten years ago you could go on to the ward and there would only be a few people who needed two nurses to move and handle them. Now the vast majority of our ward needs two nurses to move and handle, double dependencies'. He then continued: 'People will revert to what's their primitive reflex, which may be can't be bothered, don't want to take much time over that, when they are put under pressure, and there's a lot of pressure in the system. Lack of time, lack of resources, demoralisation because of poor staffing levels, high demand, high expectation'. In a time of scarce resources and high clinical pressure, hospital staff face significant challenges regarding quality standards in their everyday work. This is despite the existence of a culture of mindfulness that keeps staff awake to quality and safety concerns. One nurse sighed as she said: 'Sometimes it's very difficult to keep going on about quality in the times we're in, because you keep getting battered down.'

Every day practices of staff in Hospital A appeared to involve the need to compromise on quality in that they knew what they ideally should be doing, but felt that they were unable to do it due to staffing levels or other workload pressures. For example, with regards to hourly

rounds, a nurse explained: 'For instance now staffing, because we've got the extra areas open and staffing isn't as good as it is, I think it's very difficult to achieve a good hourly round where you ask the five questions and you have time to reassure the patient, talk to the relative. I think if there's only three staff on or four staff on a late shift, that's almost impossible. And I think until we manage to close the extra capacity and get the staffing levels back to what they should be, it will be difficult to do that. But I think once staffing is back it is realistic and I've seen it work, and the staff have seen it work and they want it to work'.

Compromises made as a result of an increasing workload were also the biggest concern of a patient representative: 'The problem is because of the financial constraints the number of staff is being restricted. The workload is not really well used so you don't have to be a mathematician to know that it means that those who remain have to work harder to do the required number of tasks. Now this inevitably means one, there's a risk of a demoralisation of the staff and two, that there's not the physical capacity to do everything that's needed so this is a big concern of mine'. Furthermore, priorities for quality such as the strong focus on efficiency and quantifiable outcome measures set by the Trust board were not necessarily shared by all staff members in hospital A. Clinical staff at all levels felt forced to compromise on quality on the basis of priorities that they often disagreed with.

## Prompts

- How do payers prioritise which indicators need to be measured?
- How often are these reviewed to ensure they are still all relevant and necessary?
- How do payers take account of competing demands and pressures on hospital staff when considering their reporting requirements?



QUASER | References and Resources

## References

The original research into leading US and European hospitals which informed the development and design of the QUASER study was published in the following book:

Bate *et al.* Organizing for Quality: The Improvement Journeys of Leading Hospitals in Europe and the United States. Radcliffe Publishing, 2008: <http://www.radcliffehealth.com/shop/organizing-quality-improvement-journeys-leading-hospitals-europe-and-united-states>

A summary of the book can be found here: [http://www.rand.org/pubs/research\\_briefs/RB9329/index1.html](http://www.rand.org/pubs/research_briefs/RB9329/index1.html)

### **The QUASER study protocol is free to access:**

Robert *et al.* A longitudinal, multi-level comparative study of quality and safety in European hospitals: the QUASER study protocol. *BMC Health Services Research* 2011, 11:285. <http://www.biomedcentral.com/1472-6963/11/285>

This paper examines the feasibility of using common process and outcome indicators to compare quality and safety in hospitals in the five QUASER countries:

Burnett S, Renz A, Wiig S, Fernandes A, Weggelaar A, Calltorp J, Anderson J, Robert G, Vincent C, Fulop N. Prospects for comparing European hospitals in terms of quality and safety: lessons from a comparative study in five countries. *Int J Qual Health Care* 2013; doi: 10.1093/intqhc/mzs079. <http://intqhc.oxfordjournals.org/content/early/2013/01/04/intqhc.mzs079.full>

The involvement of patients in quality improvement in Norway is free to access here:

Wiig S, Storm M, Aase K, Gjestsen MT, Solheim M, Harthug S, Robert G, Fulop N and QUASER team. Investigating the use of patient involvement and patient experience in quality improvement in Norway: rhetoric or reality? *BMC Health Services Research* 2013, 13:206. <http://www.biomedcentral.com/1472-6963/13/206>



## Other Resources

Academy4Healthcare Improvement: Educational resources –

**[www.a4hi.org/Education/educase.cfm](http://www.a4hi.org/Education/educase.cfm)**

AHRQ guide – **[www.ahrq.gov/](http://www.ahrq.gov/)**

Australian Institute of Health Innovation (AIHI) – **[www.aihi.unsw.edu.au](http://www.aihi.unsw.edu.au)**

Australian Patient Safety Foundation, contains quality improvement tools – **[www.apsf.net.au/](http://www.apsf.net.au/)**

Centre for evidence based medicine – **[www.cebm.net](http://www.cebm.net)**

Cochrane Collaboration – **[www.cochrane.org](http://www.cochrane.org)**

Deepening our understanding of quality improvement in Europe –

DUQuE – **[www.duque.eu](http://www.duque.eu)**

Experience-based Co-design toolkit (Kings Fund) –

**[www.kingsfund.org.uk/projects/point-care/ebcd](http://www.kingsfund.org.uk/projects/point-care/ebcd)**

Health Foundation, measuring patient experience article –

**[www.health.org.uk/public/cms/75/76/313/4300/Measuring%20patient%20experience.pdf?realName=xJseSs.pdf](http://www.health.org.uk/public/cms/75/76/313/4300/Measuring%20patient%20experience.pdf?realName=xJseSs.pdf)**

Health Foundation, patient experience, measurement –

**[www.health.org.uk/publications/measuring-patient-experience](http://www.health.org.uk/publications/measuring-patient-experience)**

Health Foundation, patient safety, tools –

**[www.patientsafety.health.org.uk](http://www.patientsafety.health.org.uk)**

Hospitals in Pursuit of Excellence with free downloadable information based on several quality – improvement case studies – **[www.hpoe.org](http://www.hpoe.org)**

Institute for Healthcare Improvement website – **[www.ihl.org](http://www.ihl.org)**

Institute for Healthcare Optimization (mainly focusing on logistic and variability) – **[www.ihoptimize.org](http://www.ihoptimize.org)**

Institute of Medicine – **[www.iom.edu](http://www.iom.edu)**

The Measurement and Monitoring of Safety. Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring. Burnett S; Carthey J; Vincent C. The Health Foundation (24 Apr 2013) ISBN 978-1-906461-44-7 - **[www.health.org.uk/publications/the-measurement-and-monitoring-of-safety/](http://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety/)**

Medicare Quality Improvement Community (qualitynet.org) – with tools and guidance on quality improvement –

**[www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs)**

National Association for Healthcare Quality (NAHQ) – **[www.nahq.org](http://www.nahq.org)**

National Institute for Health and Care Excellence (NICE) -

**[www.nice.org.uk](http://www.nice.org.uk)**

## Other Resources (continued)

National Quality Measures Clearinghouse –

**[www.qualitymeasures.ahrq.gov](http://www.qualitymeasures.ahrq.gov)**

NHS Change Model – **[www.changemodel.nhs.uk/pg/dashboard](http://www.changemodel.nhs.uk/pg/dashboard)**

Online learning modules for quality improvement –

**[www.improvementskills.org](http://www.improvementskills.org)**

OpenSafety.org, patient safety – **[www.opensafety.org](http://www.opensafety.org)**

Planetree, patient experience – **[www.planetree.org](http://www.planetree.org)**

Tools to implement World Health Organization (WHO) safety (especially surgical safety) – **[www.who.int/patientsafety](http://www.who.int/patientsafety)**

Website of Paul Plsek with quality improvement tools –

**[www.directedcreativity.com/pages/ToolKitFrameset.html](http://www.directedcreativity.com/pages/ToolKitFrameset.html)**

### **In Dutch:**

Dutch Institute for Healthcare Improvement CBO with information about quality improvement – **[www.cbo.nl](http://www.cbo.nl)**

Dutch national patient safety campaign website – **[www.vmszorg.nl/](http://www.vmszorg.nl/)**

Dutch website about innovation in healthcare –

**[www.zorgvoorinnoveren.nl](http://www.zorgvoorinnoveren.nl)**

### **In Swedish:**

Breakthrough series, method and QI-tools (SALAR) –

**[www.skl.se/vi\\_arbetar\\_med/halsaochvard/genombrott](http://www.skl.se/vi_arbetar_med/halsaochvard/genombrott)**

Improvement knowledge, background, courses and tools

(Qulturum, Jönköping County Council) –

**[www.lj.se/infopage.jsf?childId=12112&nodeId=38344](http://www.lj.se/infopage.jsf?childId=12112&nodeId=38344)**

Patient involvement in quality and safety (SALAR) –

**[www.skl.se/vi\\_arbetar\\_med/halsaochvard/patientsakerhet/patientmedverkan](http://www.skl.se/vi_arbetar_med/halsaochvard/patientsakerhet/patientmedverkan)**

Patient safety – tools and films (SALAR) – **[www.skl.se/vi\\_arbetar\\_med/halsaochvard/patientsakerhet/publikationer](http://www.skl.se/vi_arbetar_med/halsaochvard/patientsakerhet/publikationer)**

Swedish quality registries, background and data (SALAR) -

**[www.kvalitetsregister.se/om\\_kvalitetsregister](http://www.kvalitetsregister.se/om_kvalitetsregister)**

# QUASER | Acknowledgements

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