Collaboration for Leadership in Applied Health Research and Care
North Thames

NHS
National Institute for Health Research

Role of boards in quality improvement: emerging findings from the iQUASER study

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What I'm going to cover

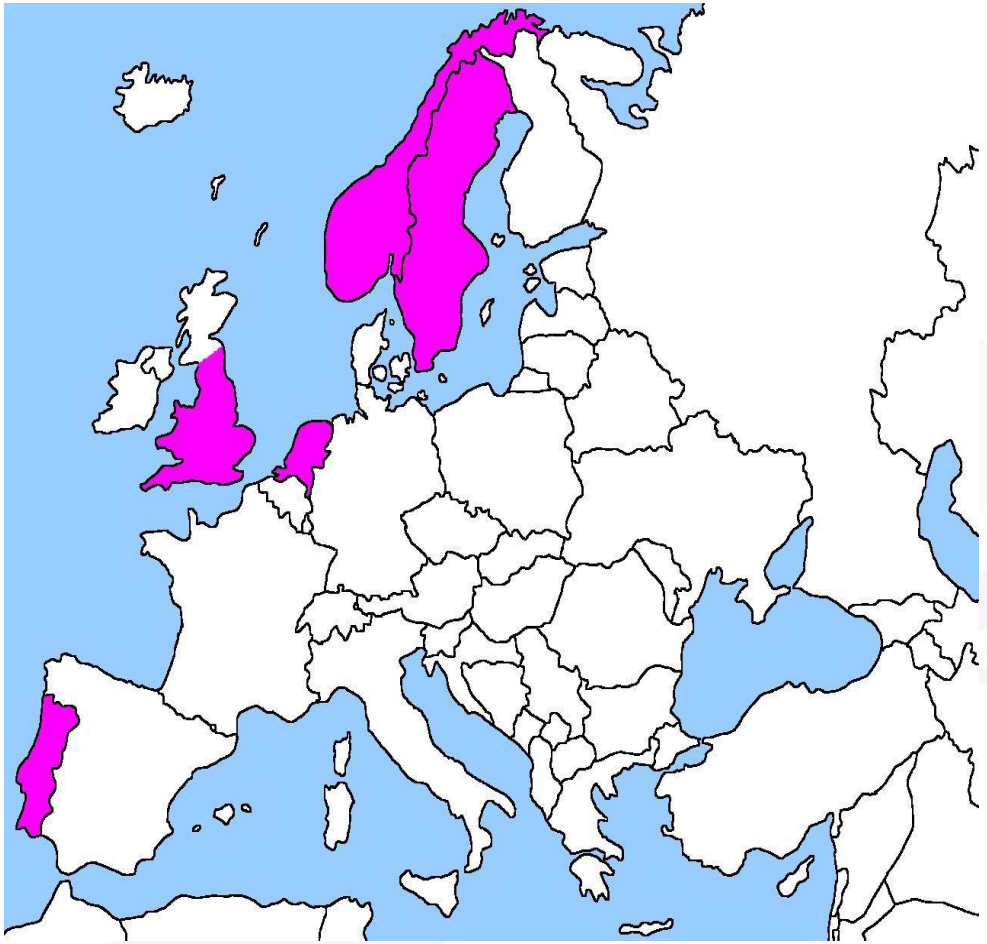
- Defining terms
- QUASER study – the Guide
- iQUASER study
  - Methods
  - Emerging findings
  - Emerging conclusions/questions

Defining terms

- **Quality:** provision of care that achieves highest possible **clinical effectiveness**, guarantees the highest possible standard of **patient safety** and ensures **patient experience** is as good as possible.
- **Quality improvement:** sustained, co-ordinated efforts by everyone involved in health care to achieve this
- **Quality assurance:** the maintenance of a desired level of quality in a service or product

QUASER
Quality and Safety in European Union Hospitals

QUASER: 2010 - 2013



Robert et al. BMC Health Services Research 2011, 11:285
http://www.biomedcentral.com/1472-6963/11/285

BMC Health Services Research

STUDY PROTOCOL Open Access

A longitudinal, multi-level comparative study of quality and safety in European hospitals: the QUASER study protocol

Glenn B Robert[1*], Janet E Anderson[2], Susan J Burnett[3], Karina Aase[4], Boel Andersson-Gare[5], Roland Bal[6], Johan Calltorp[7], Francisco Nunes[8], Anne-Marie Weggelaar[9], Charles A Vincent[3] and Naomi J Fulop[10], for QUASER team

Abstract

Background: although there is a wealth of information available about quality improvement tools and techniques in healthcare there is little understanding about overcoming the challenges of day-to-day implementation in complex organisations like hospitals. The 'Quality and Safety in Europe by Research' (QUASER) study will investigate how hospitals implement, spread and sustain quality improvement, including the difficulties they face and how they overcome them.
The overall aim of the study is to explore relationships between the organisational and cultural characteristics of hospitals and how these impact on the quality of health care; the findings will be designed to help policy makers, payers and hospital managers understand the factors and processes that enable hospitals in Europe to achieve-and sustain-high quality services for their patients.

Methods/design: in-depth multi-level (macro, meso and micro-system) analysis of healthcare quality policies and practices in 5 European countries, including longitudinal case studies in a purposive sample of 10 hospitals. The project design has three major features:
• a working definition of quality comprising three components: clinical effectiveness, patient safety and patient experience
• a conceptualisation of quality as a human, social, technical and organisational accomplishment
• an emphasis on translational research that is evidence-based and seeks to provide strategic and practical guidance for hospital practitioners and health care policy makers in the European Union.
Throughout the study we will adopt a mixed methods approach, including qualitative (in-depth, narrative-based, ethnographic case studies using interviews, and direct non-participant observation of organisational processes) and quantitative research (secondary analysis of safety and quality data, for example: adverse incident reporting; patient complaints and claims).

Discussion: the protocol is based on the premise that future research, policy and practice need to address the sociology of improvement in equal measure to the science and technique of improvement, or at least expand the discipline of improvement to include these critical organisational and cultural processes. We define the 'organisational and cultural characteristics associated with better quality of care' in a broad sense that encompasses all the features of a hospital that might be hypothesised to impact upon clinical effectiveness, patient safety and/or patient experience.

QUASER
Quality and Safety in European Union Hospitals

Findings: common features

- Focus on Quality **Assurance** rather than Quality **Improvement**
- Key drivers: governance, compliance, accountability cf learning and cultural change
- Focus on systems, tools and data cf changing attitudes, behaviours, cultures
- QI work resides largely at the margins of hospital priorities and routines in the face of financial pressures – finance takes precedence
- Dominated by a ‘project by project’ approach, not system-wide
- Focus on clinical effectiveness & patient safety – cf patient and public involvement in QI or even use of patient feedback on their experiences

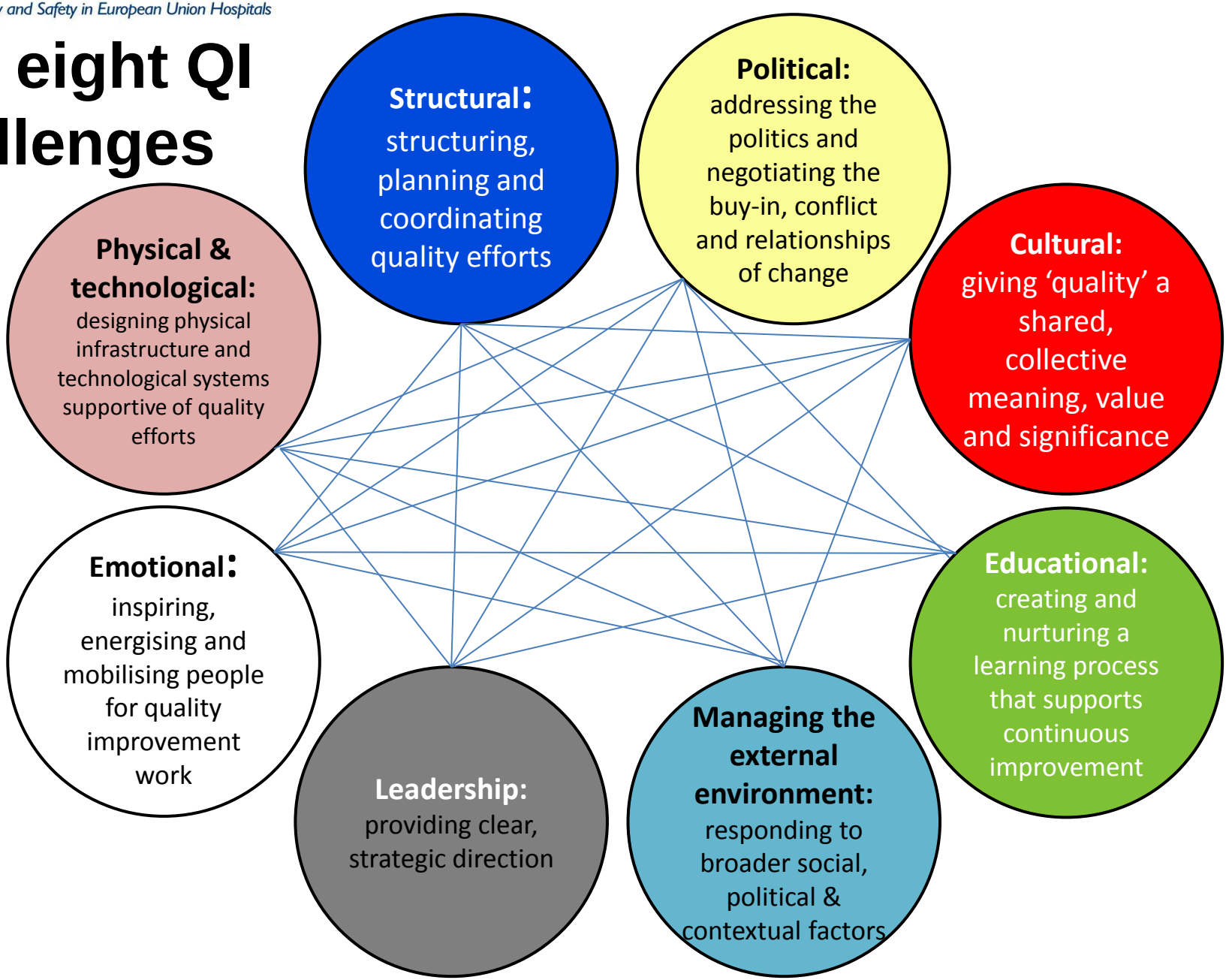
QUASER
Quality and Safety in European Union Hospitals

QUASER | The Hospital Guide

A research-based tool to reflect on and develop your quality improvement strategies

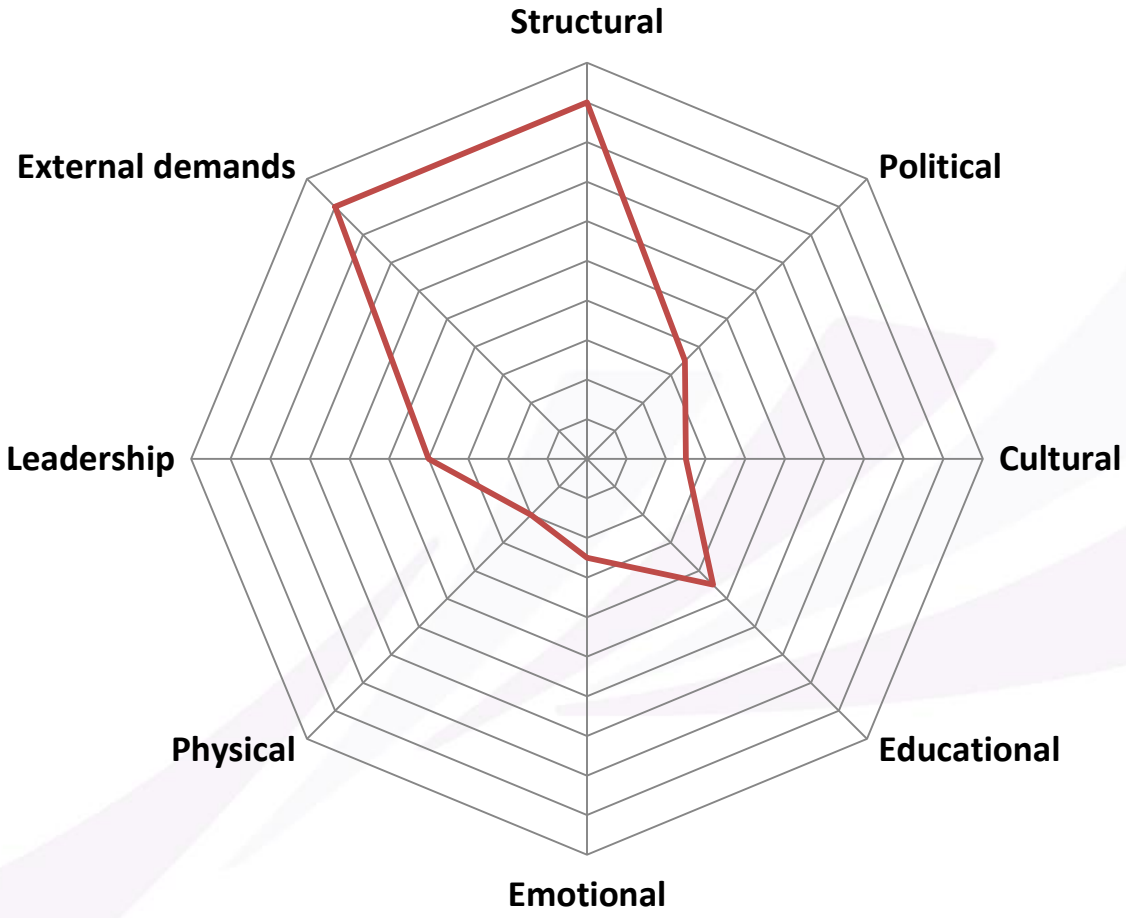
QUASER
Quality and Safety in European Union Hospitals

The eight QI challenges



QUASER
Quality and Safety in European Union Hospitals

Attention paid to challenges: England (2011-12)



Introduction to iQUASER

- iQUASER: programme of support for the *implementation* and *evaluation* of the QUASER guide for boards to develop their **organisation-wide quality improvement strategies**

- The evaluation is supported by the NIHR CLAHRC North Thames

Study Overview

- Mixed method, before and after study of iQUASER intervention
- Comparator and 'benchmarking' Trusts
- Qualitative study (interviews, observations of board meetings, analysis of documents)
- Cost-consequence analysis

3 main elements of study:

- impact of the iQUASER intervention (incl cost-consequences)
- **r'ship between board characteristics and QI maturity**
- **r'ship between QUASER 8 challenges and QI maturity**

Trusts involved in study

- 15 Trusts (12 acute, 2 mental health, 1 community):
  - 6 participating
  - 6 comparator (matched on type, FT status, CQC performance ratings, where available)
  - 3 'benchmarking':
    - 'high' (CQC 'outstanding')
    - 'medium' (CQC 'requires improvement')
    - 'low' (CQC 'inadequate')

Data collection

- Interviews with board members (8 Trusts)
- Observations of 3 board meetings (15 Trusts)
- Analysis of documents including Trust board minutes and Quality Accounts (15 Trusts)
- Data for cost consequence analysis (6 Trusts)

Data analysed for emerging findings

- For period: April 2014 – May 2015
- Data for all 15 Trusts:
  - Board minutes (not observed meeting) 2014
  - Board observation, 2014/2015
  - Quality Accounts, 2013/2014
- Data for 6 participating , 1 benchmarking Trust:
  - 36 interviews, 2014

Emerging Findings

1) The relationship between board characteristics and QI 'maturity'

2) QUASER 8 challenges: which ones are boards focussing on?

- Analysis of 8 QI challenges in 15 trusts (using Social Network Analysis)

QI Maturity framework

Developed framework consisting of 9 characteristics from combination of:

- review of literature

(incl these studies/reviews of role of board: Mannion et al, 2015 Millar et al, 2013 Ramsay et al, 2010 Jha and Epstein, 2013)

- early analysis of data

QI Maturity Framework

1) QI as board priority
2) Using data for improvement
3) Familiarity with current performance
4) Degree of staff involvement
5) Degree of public/patient involvement
6) Tone (how QI agenda items are reported to the board)
7) Clear, systematic approach (clear and well specified priorities, manageable number)
8) Balance between clinical effectiveness, patient safety and patient experience
9) Dynamics (how board members challenge/ask questions of each other)

QI Maturity Framework: example

QI as a board priority

- How much time is spent talking about QI? (at board meeting)
- Is time spent on QI elsewhere other than at the board meeting?
- Do the board members undergo any formal QI training?
- What is the proportion of the Quality discussions that relate to Quality Assurance vs Quality Improvement?

- **Overall QI maturity level**: high/medium/low

Differences in QI maturity

	CQC rating	QI Maturity Level	Framework Characteristics								
			1	2	3	4	5	6	7	8	9
Trust 1	Outstanding	High	H	H	H	H	H	H	H	H	H
Trust 2	Good	High	M	M	H	H/M	H/M	H	H	H	H
Trust 3	Requires improvement	Medium	M	L/M	M	L/M	M	L	M	M	L
Trust 4	Requires improvement	Low/Medium	M/H	L/M	L/M	L/M	L/M	M	L/M	L	M
Trust 5	Requires Improvement	Low	M	L	M	L	L	H	M	L	L
Trust 6	Requires Improvement	Medium	M	M	L	M	M	L	M	M	M
Trust 7	Inadequate	Low	L	L	M	M	H	M	L	L	L
Trust 8	Inadequate	Medium	L	M	M	M/H	M/H	M	L	L	L
Trust 9	Not assigned*	Medium	L	M	M	M/H	M/H	M	L	M	M
Trust 10	Not assigned*	Medium/High	M/H	M	H	L/M	L	M	H	H	M
Trust 11	Not assigned	High	H	M	H	H	H	M	M	H	H
Trust 12	Not assigned	Low/Medium	L/M	L/M	L	M/L	M	M	L	L	M
Trust 13	Not assigned	Medium	M	M	M	L	L	M	M	M	H
Trust 14	Not assigned	High	H/M	M	H	M/H	H/M	H	M	H	H
Trust 15	Not assigned	High	M	M	H	M/L	L/M	H	H	H	H

* CQC inspected, not rated

Emerging Findings: some characteristics related to QI maturity

1) Prioritising QI in work of board
2) Long term/short term focus on QI
3) Patient/staff engagement
4) Using data for improvement
5) Continuous improvement culture

Prioritising QI in work of board

QI Maturity: High

- Confidence in board sub-committee structures
- Qual cttee report taken ‘as read’ by board, with specific items escalated for attention & discussion

QI Maturity: Low

- Lack of confidence in board sub-cttee structures
- Qual committee report discussed in full at the board meeting. Not just items for escalation.

Long term/short term focus on QI

QI Maturity: High

- Combines long term and short term focus on QI
- Capacity to be able to create/consider long term QI and build it in to plans
- Quality Account priorities clear, well defined and internally driven

QI Maturity: Low

- Short term focus on QI
- Limited capacity to be able to create/consider long term QI
- Quality Account priorities large in number, not clearly defined and externally driven

Patient/staff engagement

QI Maturity: High

- Strong engagement of staff/patients in Quality Account priority setting
- Patients and/or staff: ‘a common thread’ through board agenda items

QI Maturity: Low

- Weak engagement of staff/patients in Quality Account priority setting
- Quality Account priorities strongly led by external requirements
- Limited linkage of board agenda items to patients and staff.

Using data for QI

QI Maturity: High

- Data predominantly used for Quality Assurance but…..
  - Data readable, clear
  - Triangulation of data in discussions
  - Linked to improvement actions and monitored
  - Awareness and effort to move toward more ‘real time’ data

QI Maturity: Low

- Data focused only on QA and……
  - Large volume of data, often not clearly presented
  - Reviewed in silos
  - Not linked to improvement actions
  - Focus on ensuring reactive data reliable

Continuous Improvement Culture

QI Maturity: High

Benchmarking used and….

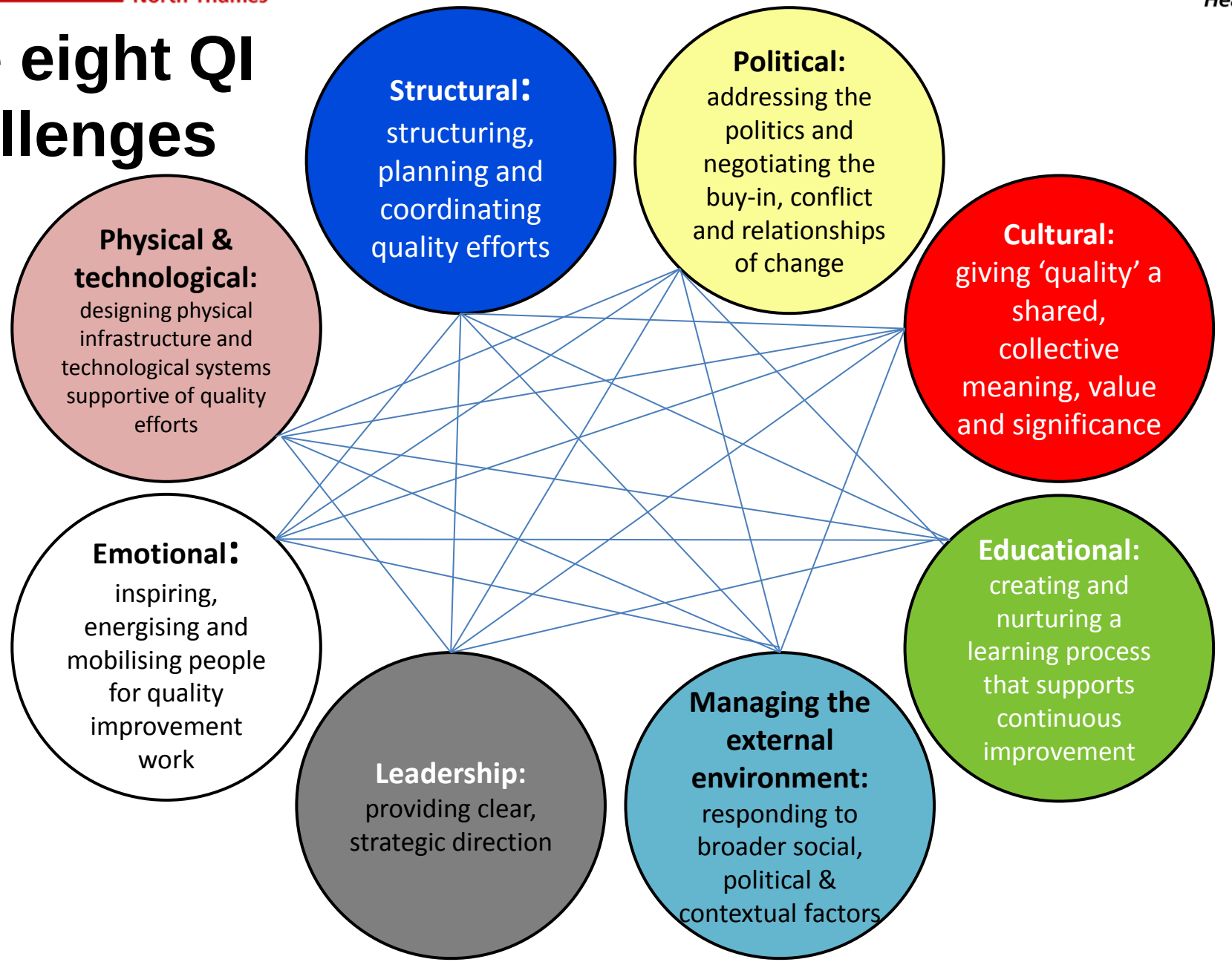
- Value benchmarking data
- Use benchmarking data for more than just rating itself against peers.
- Actively seek out other Trusts to visit or discuss a particular issue to see how can improve

QI Maturity: Low

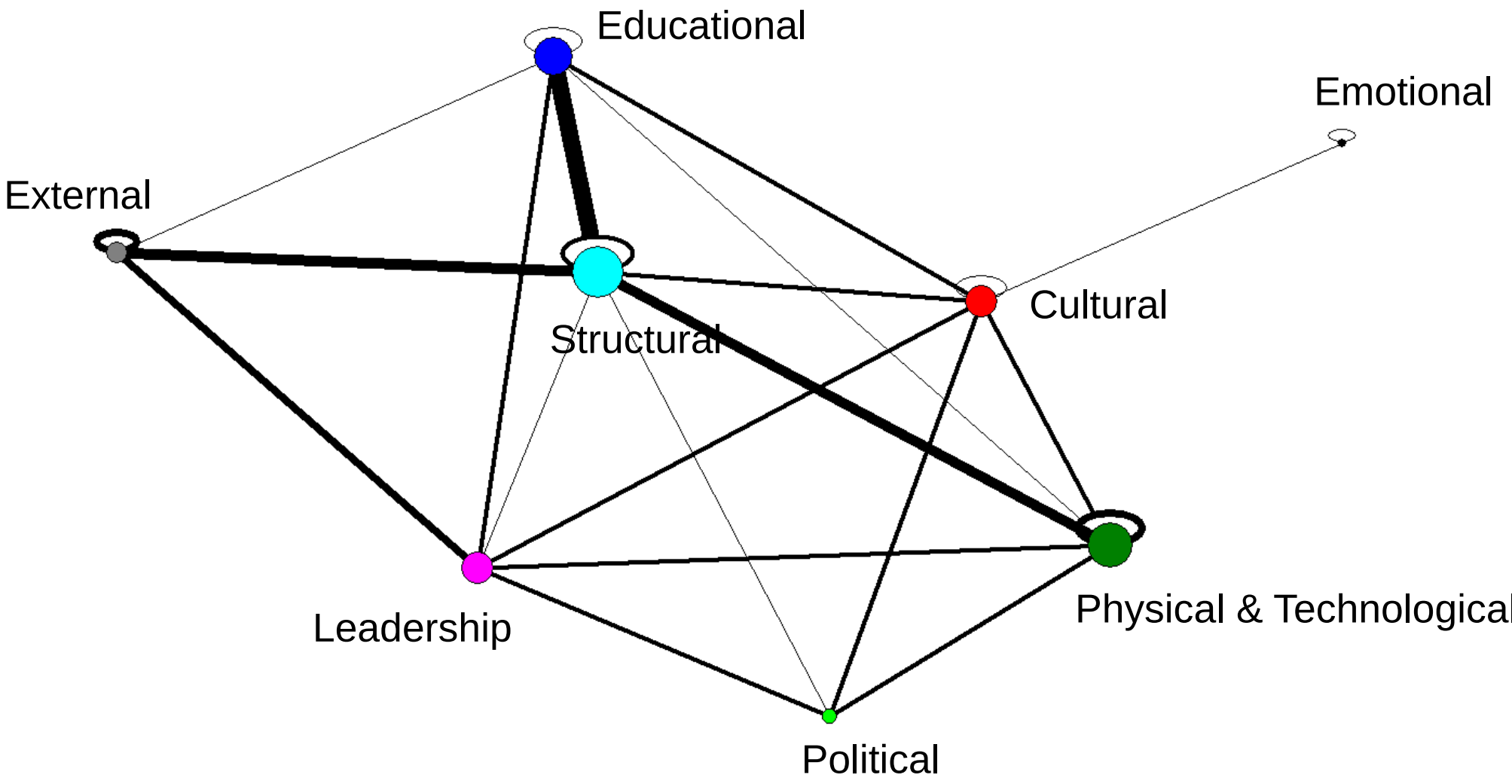
Benchmarking used but….

- Often unsure about the problem of comparisons where not comparing ‘like with like’
- Carried out in silos, mainly for external reporting measures

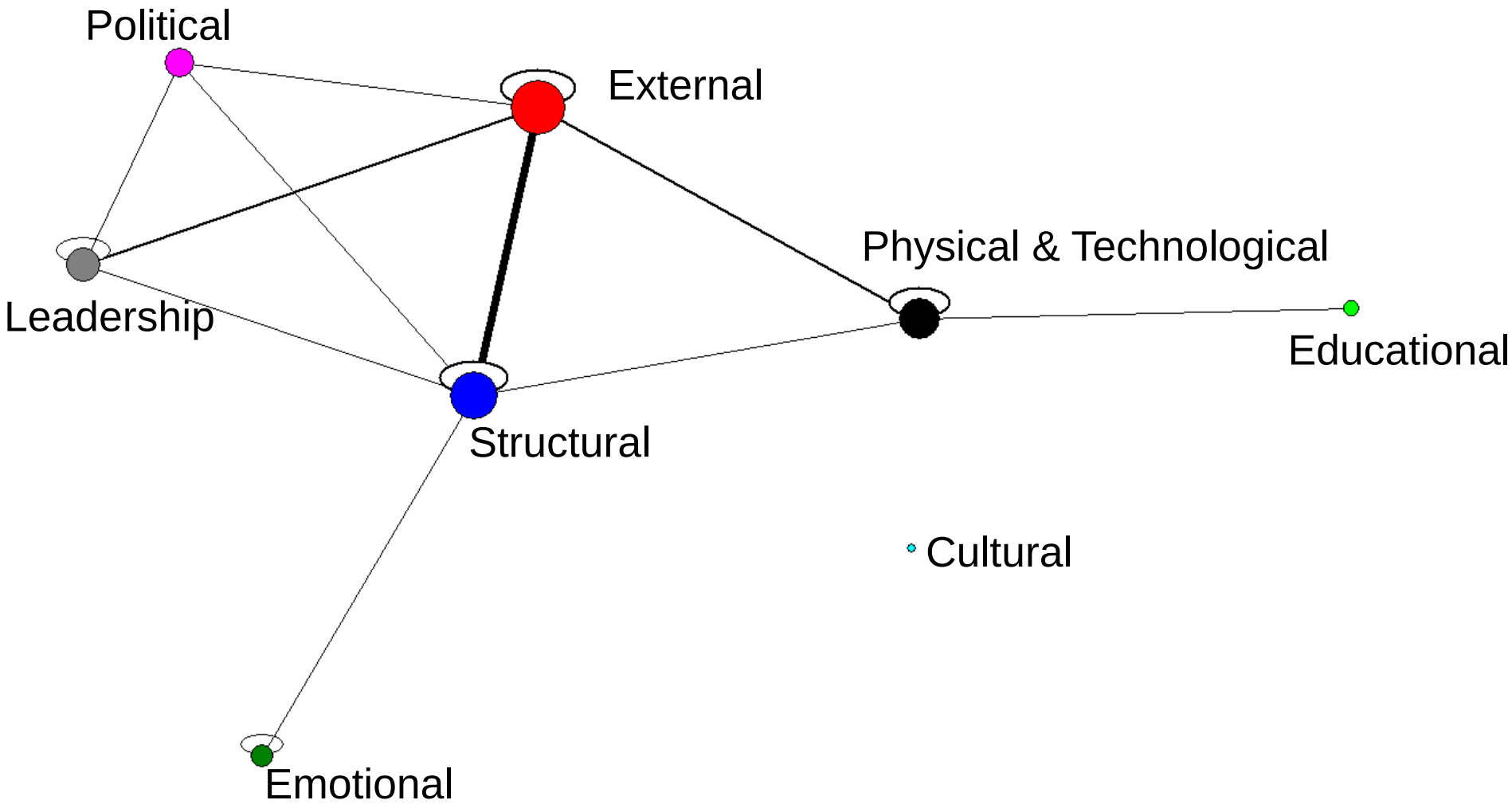
The eight QI challenges



8 challenges of QI: High QI maturity Trust



8 challenges of QI: Low QI maturity Trust



Emerging conclusion/questions

- Appears to be r'ship between Trust performance and QI maturity
- Higher performing/higher QI maturity (but which way round?)
- And ?r'ship between QI maturity and QUASER 8 challenges

Emerging conclusion/questions

- How have boards moved from focussing on quality assurance to QI?
- Characteristics of higher QI maturity indicate where boards might want to focus:
  - Actively prioritising QI in board work
  - Engaging staff/patients in QI
  - Balancing long and short term focus
  - Using data for QI, not just QA
  - Create continuous improvement culture
  - Balanced focus on 8 QUASER challenges?

THANK YOU!
ANY QUESTIONS?