

Studying Quality and Safety in European Hospitals – QUASER:

**Understanding organisational and cultural
factors influencing the implementation of QI
systems**

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Background to the Research: EU Policy

Right of patients to seek healthcare in another Member State

Directive on safe, high quality and efficient cross-border healthcare (2008) – one of main goals:

“Patients should be confident that the quality and safety standards of the treatment they will receive in another Member State are regularly monitored and based on good medical practices”

Background: EU 7th Framework Programme Call on Quality and Safety

“Study the relationship of organisational quality management and culture, professionals' involvement, and patient empowerment with the quality of hospital care, including clinical effectiveness, patient safety and patient involvement.

Identify **organisational and cultural characteristics of hospitals** and professional- and patient-related tools that are associated with better quality of care.

This research should serve to **guide hospitals to develop their own effective safety and quality improvement programmes** and provide the basis for assessing hospital quality of care by purchasers and national and local governments.”

Research aims –

To explore relationships between organisational and cultural characteristics of hospitals and how these impact on clinical effectiveness, patient safety and patient experience in European countries

Research objectives -

To design and disseminate the Quality and Safety Guide for Hospitals – to assist hospitals to implement quality and safety programmes

To design and disseminate the Framework for Assessing Hospital Quality – to assist purchasers of hospital services and governments to assess quality of hospital care

QUASER project funded April 2010 – March 2013

Partners/Countries

5 Countries

- England
- Netherlands
- Norway
- Portugal
- Sweden

7 Partners

1. University College London, UK
2. Erasmus University, Netherlands
3. Jönköping County Council, Sweden
4. Centre for Patient Safety and Service Quality, Imperial College London, UK
5. King's College London, UK
6. ISCTE, Portugal
7. University of Stavanger, Norway

Translational stakeholder group

- Spain
- Romania
- Turkey
- Denmark
- Poland
- Estonia
- Norway
- Netherlands
- Sweden
- Taiwan

Background

- ❖ Good understanding of types of quality improvement strategies – such as:
 - ✓ Lean, Six Sigma, Clinical governance, Risk management
 - ✓ Specific tools and strategies
 - PDSA cycles
 - Surgery checklist
 - Standardised care pathways

- ❖ Less understanding of
 - ✓ The factors that increase effectiveness of implementation
 - ✓ The longitudinal factors – the quality journey and building capacity

Background

Quality is not just technical, it has human and social components

Leadership

Organisational culture

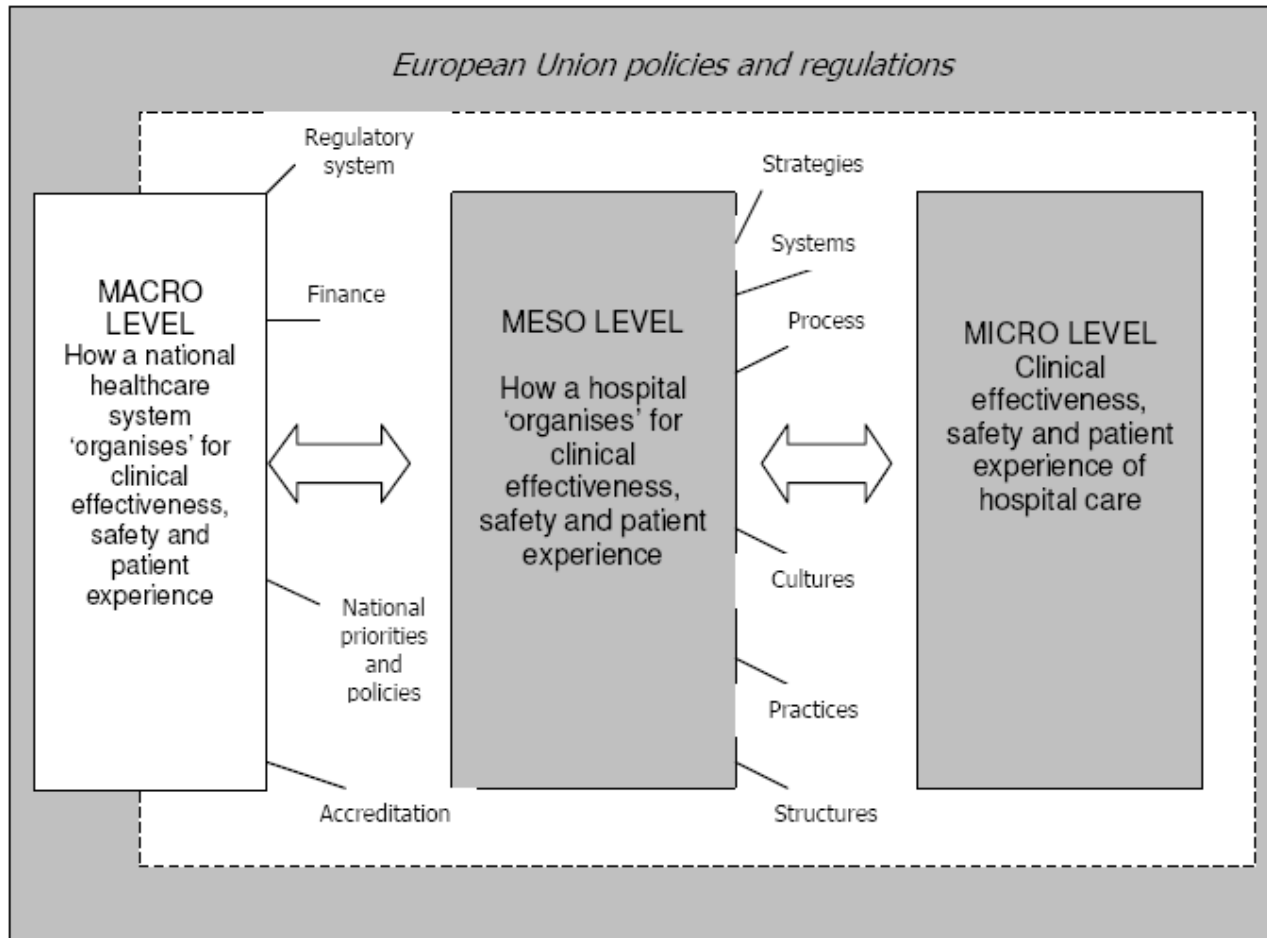
Team based structures

Organisational structures and processes

Increasing interest in this field see e.g. Curry et al, What distinguishes top-performing hospitals in acute MI mortality rates. *Ann Int Medicine*, 2011

Key features of QUASER

- Quality as a human and social accomplishment, not just technical
- Working definition of quality: clinical effectiveness, patient safety, patient experience
- Multi level, longitudinal study – focus on the interactions between the macro, meso and micro levels and their effect on quality
- Translational research – translate research into outputs with relevance, utility and value

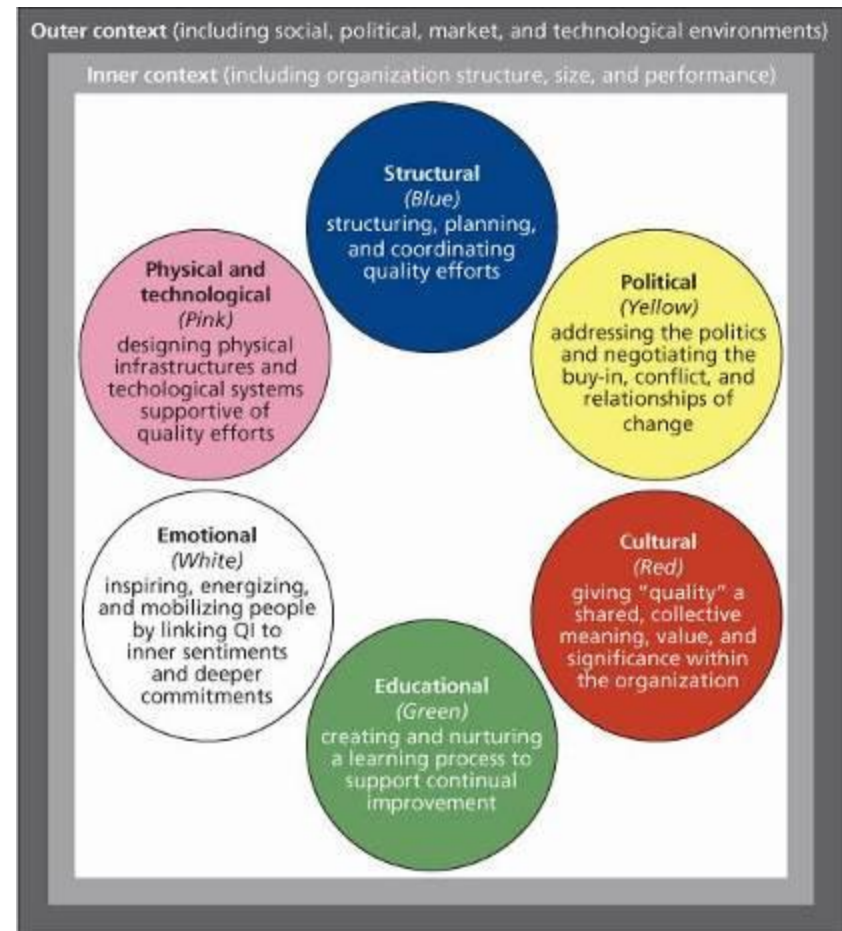


Conceptual Approach

- Start with the practice
- What are people doing, or not doing in terms of quality improvement at the hospital level and at the bedside?
- What are the rationales that drive day-to-day practice?

Building on ‘Organising for Quality’ (Bate et al)

- Despite huge variety similar sets of challenges:
 - **Structural**
 - **Political**
 - **Cultural**
 - **Educational**
 - **Emotional**
 - **Physical and technical**
- **... NOW ADAPTED AND IMPROVED!**
- **Leadership added**



Key questions

- how is QI structured, planned and co-ordinated? how is 'quality' built into the hospital? (**structural**)
- how is QI led in the hospital? (**leadership**)
- how are the politics of change negotiated? (**political**)
- how are shared understandings & commitment to quality built? (**cultural**)
- how do staff learn about quality and quality improvement? (**educational**)
- how are individual and collective enthusiasm for quality and quality improvement engendered and supported? (**emotional**)
- how is the physical, informational and technological infrastructure used to support quality and quality improvement? (**physical & technological**)

what the respective roles of the macro-, meso- and micro-system levels are in terms of (a) the successful implementation and spread of quality improvement, and (b) sustained quality? How do the levels inter-relate?

Methods

- Identification of indicators of hospital quality and safety; identification of organisational and cultural characteristics related to hospital quality (**literature reviews**).
- Determine the best methods and mechanisms for developing, designing and disseminating the practical guide and framework (**literature review and interviews with key actors**)

Methods - fieldwork

- *macro-level*: describe national context and how influences organisational management of quality in hospitals (5 countries)
- *meso-level*: analyse structures and processes for managing quality in 2 hospitals in each country (10)
- *micro-level*: examine in one of the two hospitals how quality is organised in two clinical services (maternity services plus one other)
- study the *interactions* between the 3 levels

Robert et al (2011)

Methods – selection of hospitals

- 2 hospitals in each country that appear from available indicators to be at different stages of the quality journey:
- 1 ‘high performing’; 1 ‘developing’
- Selection also informed by using national accreditation or regulation measures, where available
- Other criteria for selection include:
 - General hospitals (emergency and planned care)
 - Mix of teaching and non-teaching across the sample
 - Provide maternity services

Burnett et al (2012)

Methods – macro framework

- Health care context
- Funding and access
- Regulatory framework
- Accreditation and monitoring
- Information availability
- Resources available
- Patient rights

Methods – meso fieldwork

Hospitals 1 and 2 – over 12 month period

- 10-15 senior staff interviews (x2)
- Longitudinal study of QI ‘tracer’ (one HCAI, one other e.g. patient experience, clinical effectiveness)
- Non-participant observation of key meetings
- Semi-structured interviews, shadowing, focus groups with all levels of staff
- Quality and performance data
- Documentary analysis

Methods – micro fieldwork

Hospital 1 (‘high performing’) only

- 2 clinical micro systems: maternity and one other
- Non-participant observation of key meetings
- 15 semi-structured interviews – staff
- Shadowing of staff, and/or focus groups
- Routine data
- Documentary analysis

Findings: Quality and safety indicators available

Indicator	England	Portugal	Netherlands	Sweden	Norway	All
C-diff or MRSA rates	Yes	Yes	Not available at the hospital level.	Yes	Not available at the hospital level.	
Surgical site infection rates	Yes	Yes	Yes	Yes	Yes	*
Composite mortality rate	Yes	Yes	Yes	For some hospitals not all	No	
Specific mortality rates (AMI, Stroke, CABG, AAA)	Yes	Yes	Yes	Yes (AMI, Stroke, CABG)	Not available at the time of this project	
Emergency readmission rates	Within a set period	Yes	Only for heart failure	Some diagnoses not all	No	
3 rd and 4 th degree perineal trauma rate	Yes	No	Yes but not available at the hospital level (voluntary data collection by obstetricians)	Yes	Not available in time for this process	
Caesarean section rate	Yes	Yes	Percentage of caesarean sections in proportion to the expected	Yes	Yes	*
Primary angioplasty rates	Yes	Yes	Yes	Yes	No	
Hip fractures treated in 48 hours	Yes	Yes	Yes	Yes	Yes	*
24 hr scan rate for stroke	Yes	Yes	No	No	No	

Burnett et al (2012)

Findings from ‘Guiding quality work in European hospitals’

Use of guides varies by health care system context

- Guides play more prominent role in *top-down* systems – many designed at national level e.g. England
- In *bottom-up* systems, guides are available but focus more on quality improvement goals rather than specific tools and methods – many designed at local level e.g. Sweden, Portugal, Norway

From ‘guides’ to ‘guiding’

- the 'guide' needs to be much more than a passive piece of paper or a website, but an interactive, social process that 'guides' hospital leaders

Emerging themes from fieldwork

- How is QI defined?
- What role do national inspectorates play at meso/micro levels?
- Is QI a core or peripheral issue at macro, meso and micro levels?
- How does the current financial crisis impact upon QI in hospitals?
- Is QI management-led or clinically-led?
- How is information about quality shared? What information is on the table?
- How is QI negotiated and enacted in hospitals?
- Where are the learning/reflective spaces in hospitals relating to QI?

Emerging findings from fieldwork

2 examples of interactions between levels

(i) Meso-micro

- Managing the ‘disconnected hierarchy’ (Mintzberg)
- Use of ‘issue sellers’ to bridge gap between senior leadership level and clinical micro systems (cultural)

(ii) Meso-macro

- How senior hospital leadership enact their external environment (intermediary organisations, media etc.) – active or passive?

Next steps

- 5 country reports comparing findings from 2 hospitals in each country
- Cross-case analysis
- Development of ‘guide’ and ‘framework for payers’ – test with stakeholder group