



QUASER | The Hospital Guide

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

Funding

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Foreword

We are delighted to present the QUASER Guide for hospitals to health care leaders throughout Europe. The guide is based on extensive research in five European countries funded by the European Commission's Framework 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 help health care organisations, wherever they are on the 'quality journey', to reflect on, develop, and implement organisation-wide quality improvement strategies.

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 eight challenges for quality improvement, and provides strategies and examples from our data as a focus of discussion for health care organisations to develop their own way forward.

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

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QUASER | Introduction

What is it for?

The purpose of this Guide is to help hospitals in Europe reflect upon and implement organisation-wide quality improvement programmes. This is to ensure that patients across Europe receive high quality health care. Based on extensive research in hospitals in five European countries, 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 tools and techniques, but research shows they are crucial to the success of quality improvement efforts.

The Guide has been designed to be used flexibly by hospitals to guide the organisation on the quality journey and to provide a focus for discussions within the organisation about quality improvement. It can be used at all stages of the quality journey – by hospitals which already have a quality strategy and wish to improve, and those which 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 examples that are provided might be used to guide discussions at all stages of using the Guide, or only at the last stage when deciding on strategies. We encourage people to use it in the way that makes most sense for their hospital or organisation.

Who should use it?

The Guide can be used by different people within health care organisations. For example:

1. **Senior hospital leaders** can use it to formulate, implement and monitor their organisation-wide quality improvement strategies. It can be used by a team of senior leaders jointly to discuss and formulate their strategy and to review their progress in quality improvement.
2. **Leaders of units or teams** who wish to improve the quality of their frontline services can also use the Guide. For example, it could be used by a team of people who work together to discuss and implement quality improvement using the Guide as a focus.
3. The Guide could also be used as a tool for structuring discussions about quality improvement between **senior hospital leaders and local managers, clinical directorates, site managers and others** who are implementing quality improvement projects.
4. A range of **health care organisations** can use the Guide. Although the research was carried out in acute care hospitals, we envisage that the Guide could also be used in mental health organisations, care homes, diagnostic centres and other types of health care organisations wishing to improve the quality of care.
5. The Guide can be used by **groups of staff within health care organisations** on their own, or with external facilitation.

Overview of content

This QUASER guide takes the form of a research-based tool that your hospital can use to identify where the strengths and possible weaknesses in your organisation's quality improvement efforts are, and what you may need to do to improve. It is intended as a reflective tool which prompts your senior leadership teams and others to collectively think about:

- The progress your hospital has already made on the journey to providing high quality health care
- Which **challenges** commonly faced by hospitals in Europe your organisation has focused on to date, and which need more attention
- How your actions as a team can help improve the quality of the health care provided by your hospital

Having helped you to answer these questions the guide provides some suggested strategies for how your hospital could meet the challenge to deliver high quality services. It then provides examples from hospitals that have already implemented these strategies elsewhere in Europe.

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



Overview of content (continued)

Each individual hospital may not need to implement each and every one of the suggested strategies. Rather, the list of strategies and examples illustrates the whole range of responses made by senior leadership teams to the eight common challenges. Your teams will need to find strategies that will work for your hospital in your particular local context. If they do not do so then the quality of care delivered by your hospital will not be as good as it could be. The eight challenges are:

- **Leadership** – providing clear, strategic direction
- **Political** – addressing the internal organisational politics and negotiating the conflicts and relationships 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

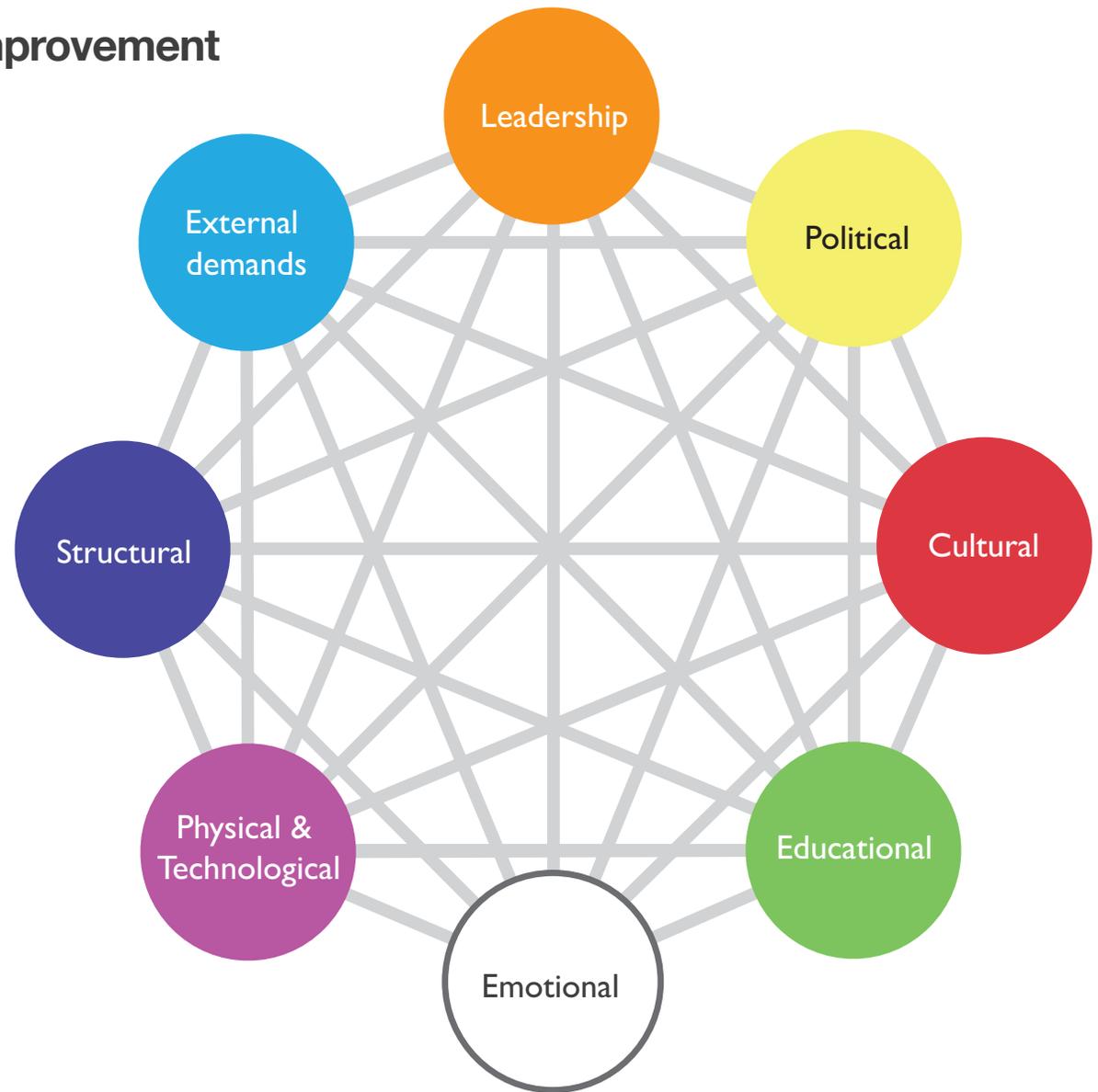
- **Structural** – structuring, planning and coordinating quality efforts
- **External demands** – responding to broader social, political and contextual factors

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

The possible combinations of strategies to these common challenges are innumerable. Furthermore, what works for one hospital may not work for another. Our overall advice to senior leadership teams and others seeking to learn from the strategies and examples we have studied is to:

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

The eight challenges of quality improvement



How to use this QUASER 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 their current quality improvement journey, remembering that discussion and dialogue are the keys to effective use of the Guide at all stages.

Stage 1. Challenges: As a team, collectively discuss how your hospital (or directorate, unit, ward) is currently responding to the eight common challenges and assess how much progress you have already made in each challenge. Reviewing your overall responses across the eight challenges can help identify current gaps and opportunities in your overall approach and help prioritise the areas you need to focus on for the hospital's future quality improvement efforts. You can approach this diagnostic step in different ways. For example, team members could jointly discuss and agree on the ratings or they could complete it individually and then come together to discuss points of agreement or difference.

Stage 2. Strategies: Discuss how well your hospital (directorate, unit or ward) is doing in terms of the suggested strategies within each challenge. For example, does your organisation have 'a lot of work to

do' on most or all of the cultural 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 can be used to generate ideas about what might or might not work for your particular organisation. Discussion and dialogue about different perceptions and experiences will inform this stage and lead to some plans for how you might address the areas that you have identified as important.

Stage 3. Your strategy for quality improvement: Drawing on the examples provided, formulate and document a quality improvement strategy, including an action plan that shows actions to be taken, timeframe, resources and key responsibilities.

Teams need to take into consideration the interactions between the challenges and the planned strategies. Therefore, after the initial questions listed above relating to the eight challenges (stage 1) and consideration of the range of strategies available to meet these challenges (stage 2), plan your strategy by thinking about:

continued overleaf

How to use this QUASER guide (continued)

- how are the potential strategies you identified in response to each of the challenges best related or joined together?
- what are the processes by which these different combinations of strategies burst into life or not?
- which resulting set of organisational processes are most likely to have the biggest impact in your particular hospital?

In developing your strategy for quality improvement draw on the examples provided showing how other European hospitals have addressed the challenges. You might want to consider whether any of these approaches would work in your context, or could be adapted to your context. To help you do this we have provided prompts for each example.

Stage 4. Review: 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 ongoing 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 teams carry out an intelligent and reflective search for appropriate strategies that fit their local context by:

- providing a checklist of the areas and topics any hospital effort will need to cover (a 'map')
- giving teams a way of charting their progress on their improvement journey, and a method for identifying any 'gaps' in their own activities that need to be addressed in the future (a self-administered diagnostic tool)
- allowing assumptions about the practice of how to organise hospitals for high quality care to be surfaced, and to be thought about, perhaps for the first time (a reflective model)
- providing senior leaders and others with a framework and language for talking about and debating the issues (a dialogical tool)

Scope

This Guide has been designed for supporting organisational dialogues about quality improvement. It provides a structure for people to talk about their progress on the quality improvement journey, to plan and prioritise what they should do next and to develop strategies encompassing all the important aspects of quality improvement. Users should be aware of the following limitations of the Guide 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 teams a definitive 'answer' to the question of how to improve quality – leaders have to find these themselves, using the Guide as a framework to guide their discussions and thinking
- 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)

- 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 in the QUASER Guide

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.

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.

Terms (continued)

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



How are you doing on the Challenges?

Here you can begin to explore how well your own hospital is doing in terms of the eight common quality improvement challenges that we identified in our research. You can indicate in the table on page 17 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 18. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your 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 your hospital has responded well to and which will require further attention.



Challenges (continued)

By reviewing the table and/or spider diagram you can now decide which of the eight challenges you would like to work on further and begin to consider which strategies you should use to address these gaps in your current approach.

- **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.

Continued overleaf



Challenges (continued)

- **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.

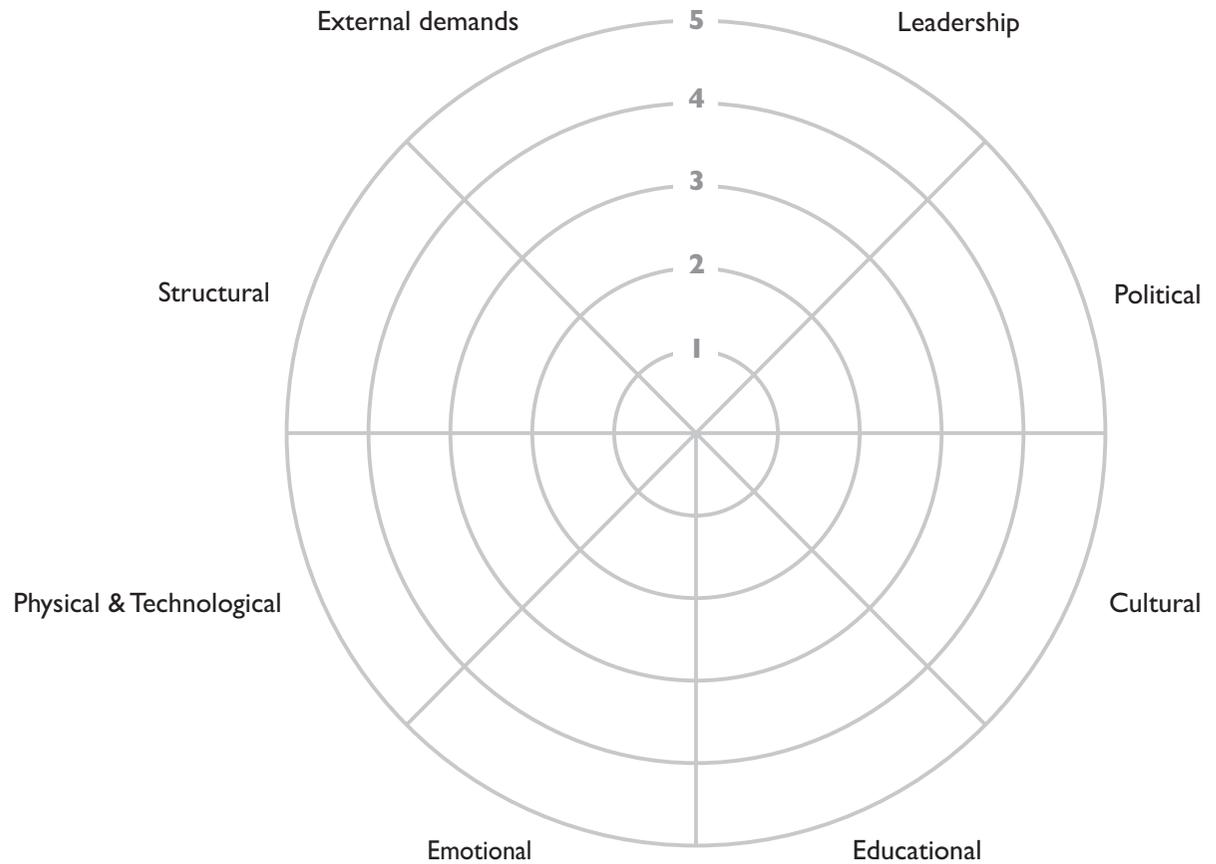


Diagnostic Step – Challenges

Challenge	We 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 challenge, 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.



Leadership

QUASER | Leadership



Introduction to the Leadership challenge

Here you can begin to explore how well your own 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 24 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 25. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your hospital is currently addressing the Leadership challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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 p81–142

Strategies

1. Translating national targets into local quality improvement initiatives pp 82, 86, 90, 120, 128 *
2. Aligning quality improvement work that (a) your 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 82, 123
3. Securing commitment to quality improvement in your hospital with all staff pp 86, 93, 94, 97, 111, 126
4. Developing your staff for quality improvement pp 98, 102, 105, 107, 131
5. Implementing long-term quality improvement strategies pp 131
6. Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement pp 82, 86, 98, 140

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

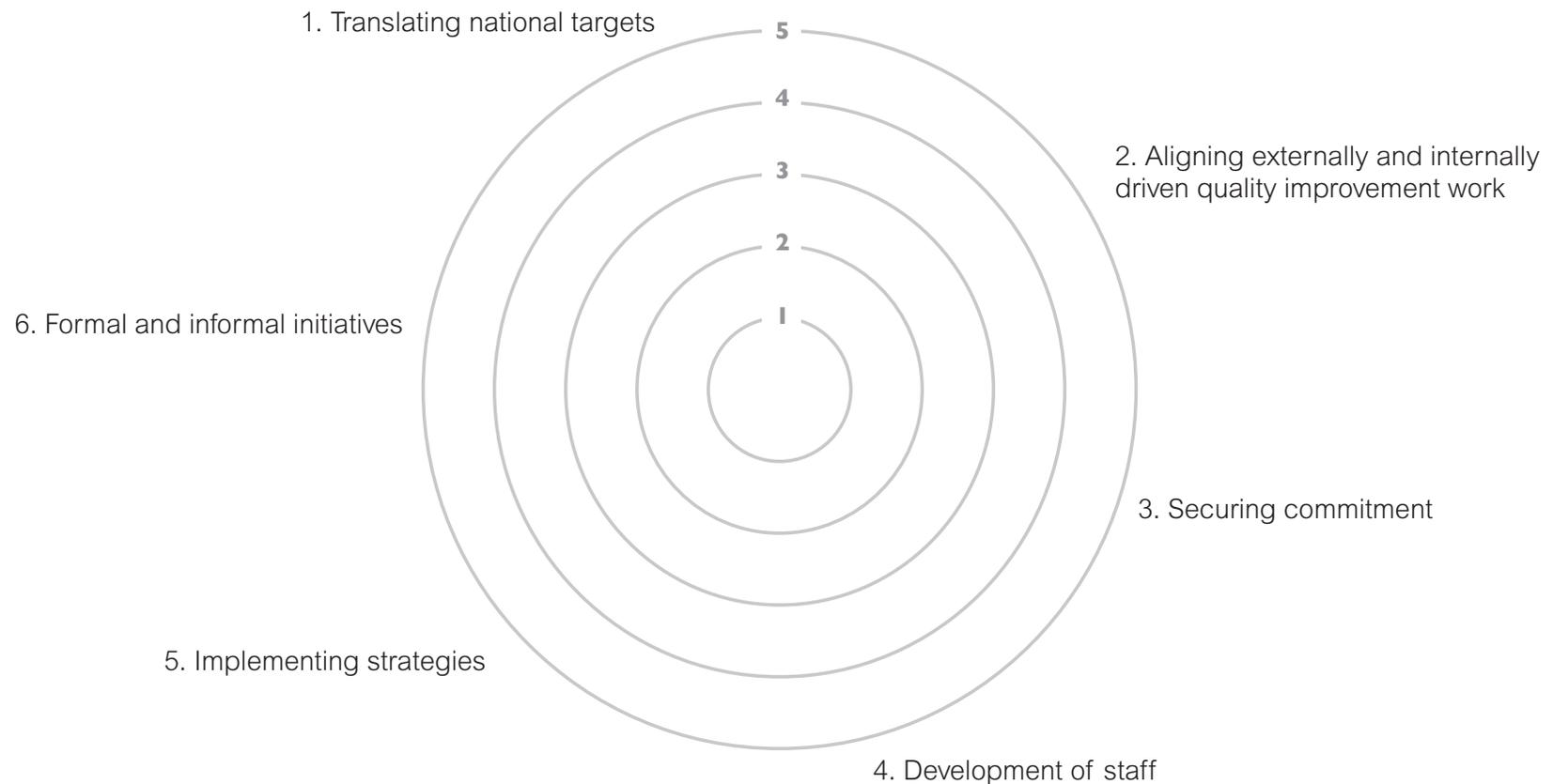


Diagnostic Step – Leadership

Strategies	We 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. Translating national targets into local quality improvement initiatives						
2. Aligning quality improvement work that (a) your 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 your hospital with all staff						
4. Developing your 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:
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 | Political



Introduction to the Political challenge

Here you can begin to explore how well your own 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 30 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 31. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your hospital is currently addressing the Political challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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 p81–142

Strategies

1. Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning) pp 82, 86, 90, 111, 120, 123, 128 *
2. Establishing a shared understanding of quality improvement in your hospital pp 94, 126, 131, 140
3. Identifying quality improvement priorities with your patients pp 134
4. Identifying quality improvement priorities with your staff pp 134
5. Managing tensions and the politics of change pp 86, 94, 114, 126, 128
6. Enabling multi-professional working pp 94, 114, 131

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

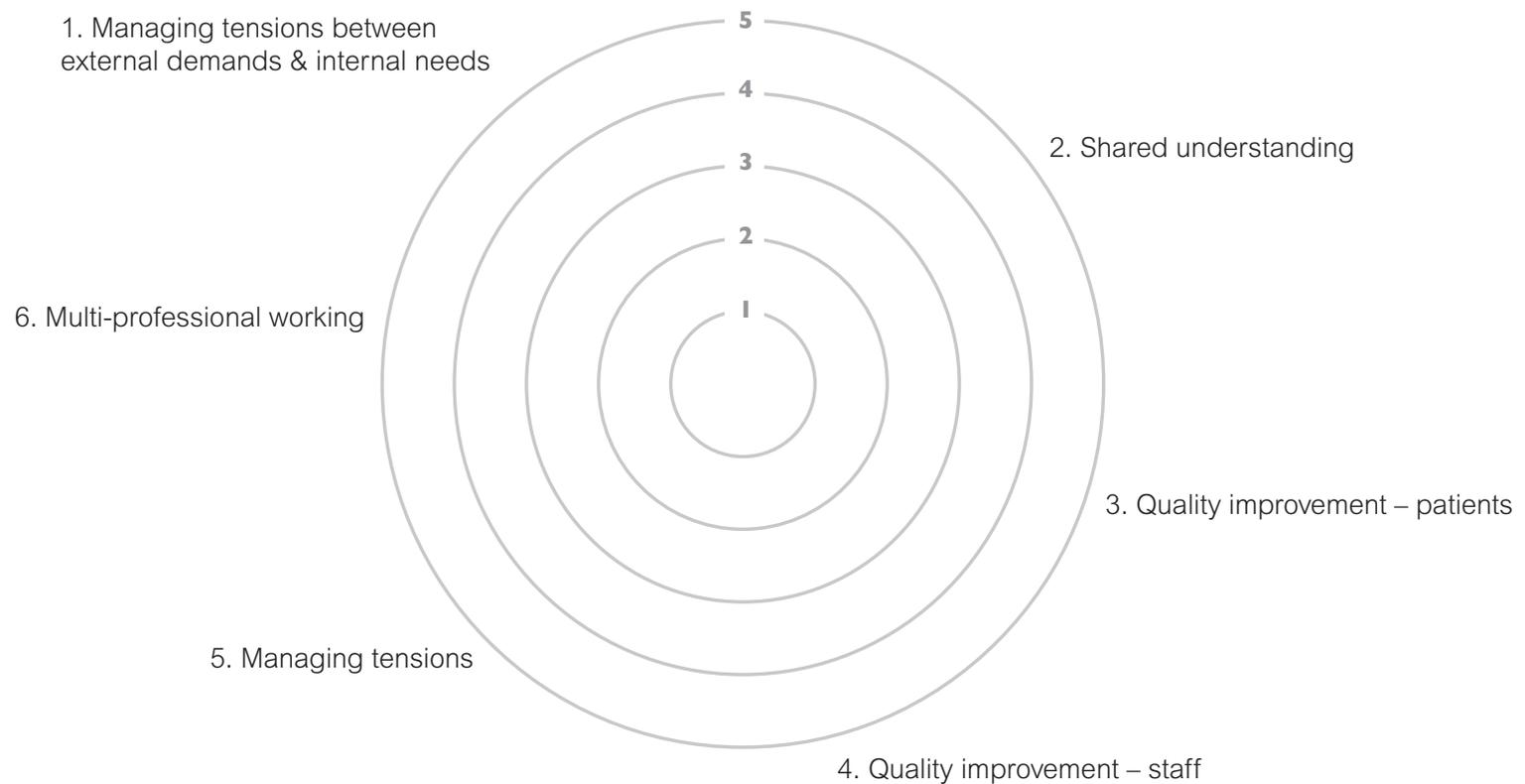


Diagnostic Step – Political

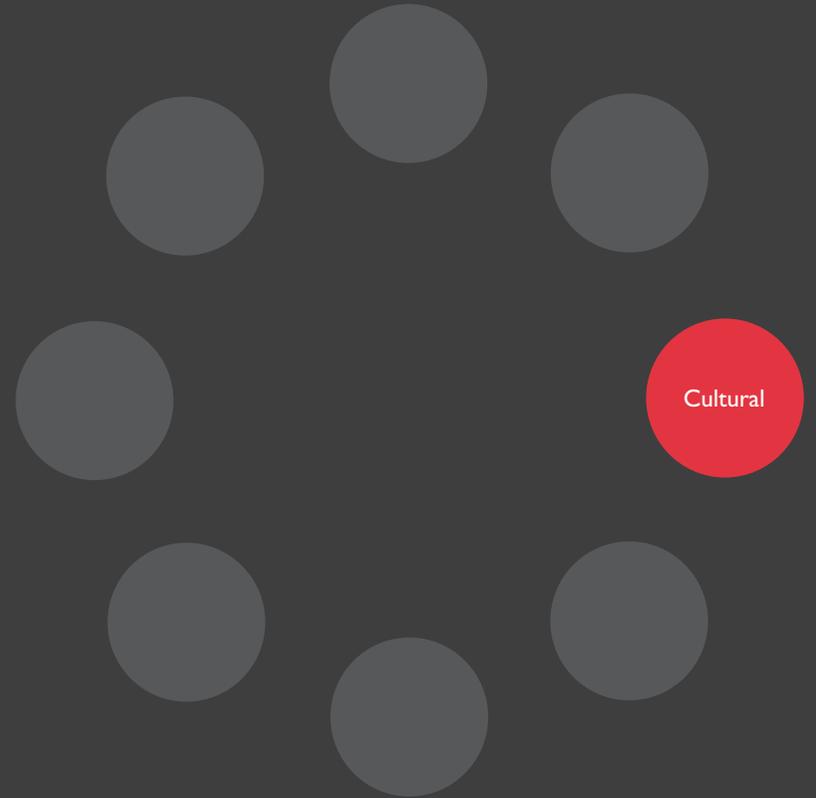
Strategies	We have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Managing tensions between external demands (e.g. for performance and accountability) and internal needs (e.g. for staff development and organisational learning)						
2. Establishing a shared understanding of quality improvement in your hospital						
3. Identifying quality improvement priorities with your patients						
4. Identifying quality improvement priorities with your 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:
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 | Cultural



Introduction to the Cultural challenge

Here you can begin to explore how well your own 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 36 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 37. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your hospital is currently addressing the Cultural challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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 p81–142

Strategies

1. Establishing a broad, shared understanding of quality and quality improvement in your hospital which encourages 'buy in' from all professional groups pp 82, 94, 126, 128 *
 2. Allowing local adaptation of initiatives within a broader strategic framework pp 86, 111
 3. Embedding quality improvement in the way we do things around here pp 90, 120, 126
 4. Establishing the relevance and importance of change pp 93, 97, 111, 126, 140
 5. Reflecting on quality in your hospital and your quality improvement journey pp 94, 102, 105, 126, 131
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* Page numbers refer to examples to assist with your strategy development

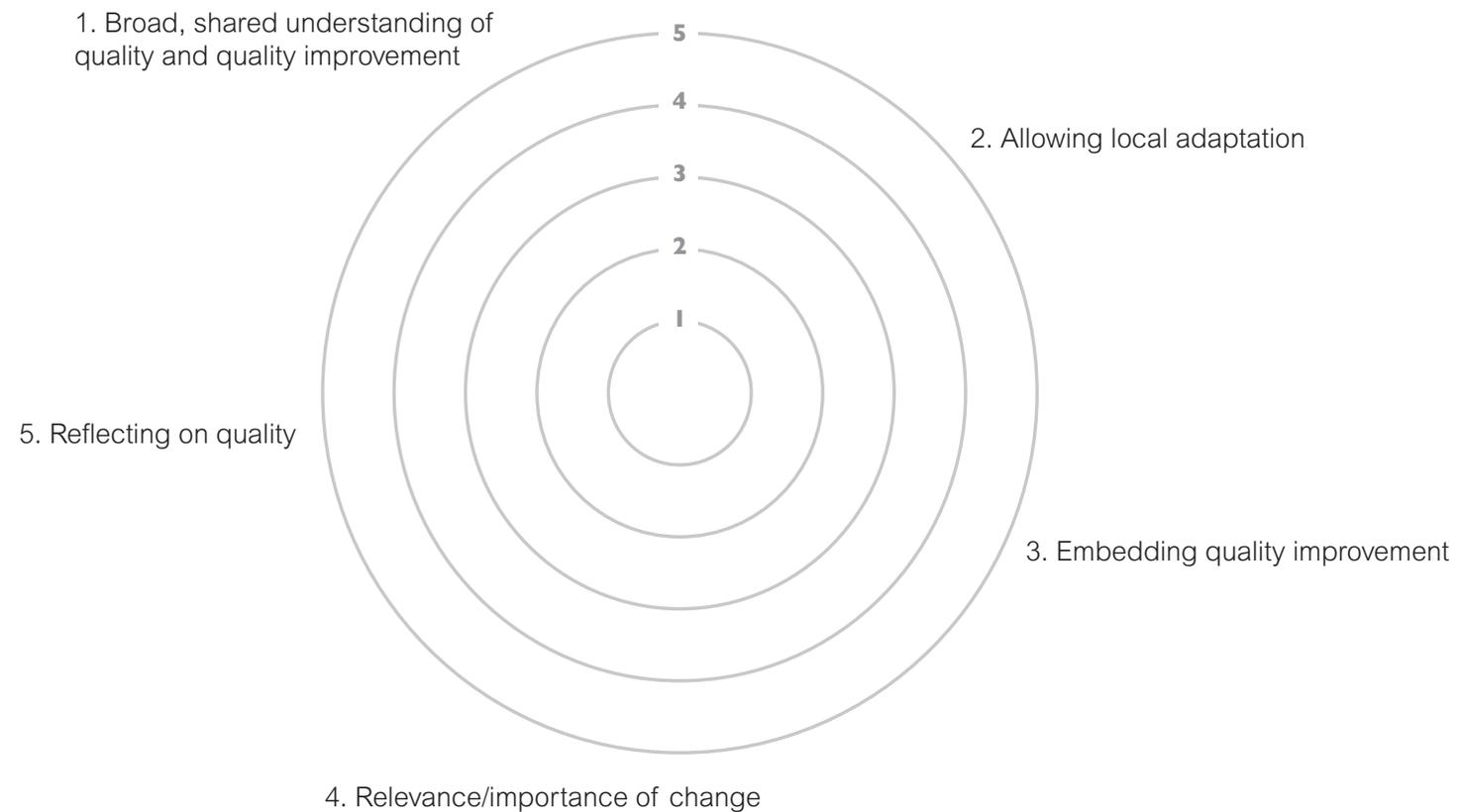


Diagnostic Step – Cultural

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?
1. Establishing a broad, shared understanding of quality and quality improvement in your 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 we do things around here						
4. Establishing the relevance and importance of change						
5. Reflecting on quality in your hospital and your quality improvement journey						



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 | Educational



Introduction to the Educational challenge

Here you can begin to explore how well your own 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 42 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 43. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your current approach with regard to the Educational challenge.

Whichever option you choose for completing the table and/or the spider diagram, the purpose is to begin new conversations about how your hospital is currently addressing the Educational challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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. These examples may help with your own thinking and identify actions that your hospital should take.



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 p81–142

Strategies

1. Encouraging spaces for reflection for staff to think about and discuss quality improvement within your hospital pp 94, 102, 105, 107, 127, 131 *
2. Learning continually from your patients pp 134
3. Integrating quality improvement into educational activities pp 102, 107
4. Importing and adapting strategies from other hospitals nationally and internationally pp 98, 111
5. Enabling staff to learn about quality improvement from outside your hospital pp 98, 102, 105, 111, 131
6. Linking the learning from different quality improvement projects pp 82, 114
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 131, 140
8. Using a range of data sources and tools to understand quality pp 94, 120, 123, 128, 140
9. Encouraging multi-professional learning and sharing about quality improvement pp 102, 105, 107, 114, 131

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

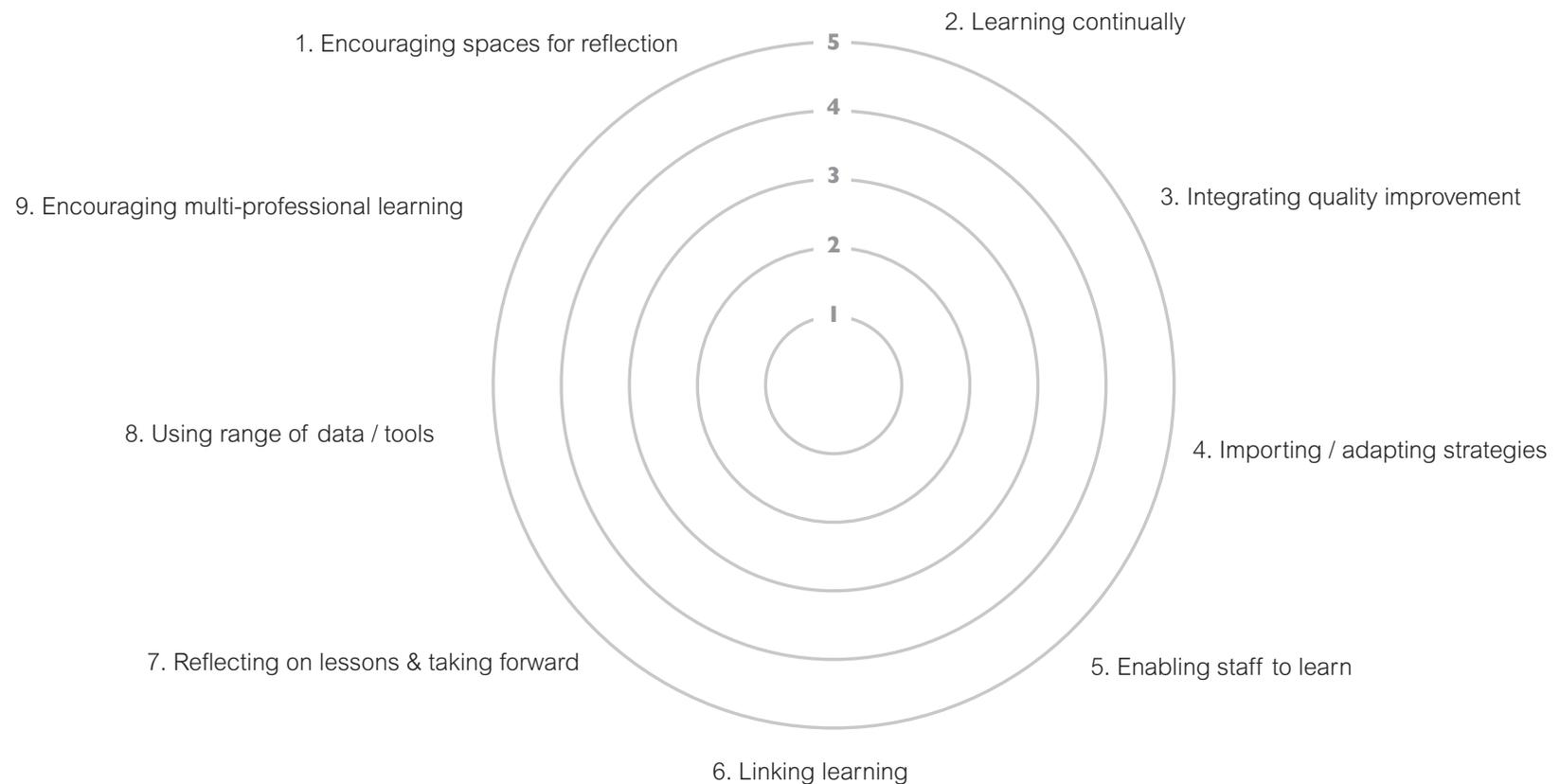


Diagnostic Step – Educational

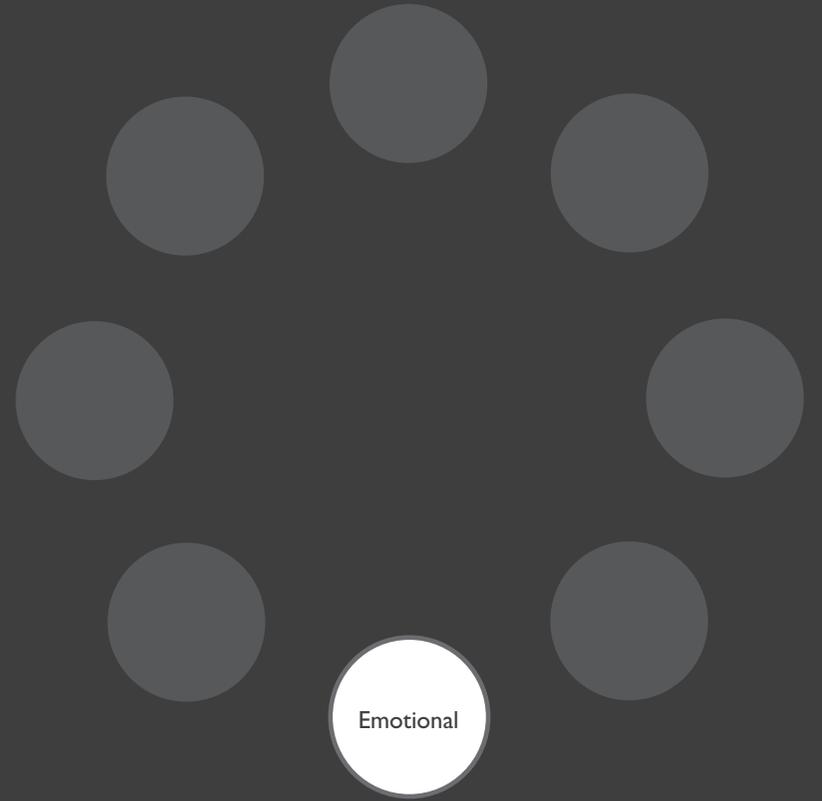
Strategies	We have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Encouraging spaces for reflection for staff to think about and discuss quality improvement within your hospital						
2. Learning continually from your 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 your 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:
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 | Emotional



Introduction to the Emotional challenge

Here you can begin to explore how well your own 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 48 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 49. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your hospital is currently addressing the Emotional challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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 p81–142

Strategies

1. Making the most of all the potential resources for quality improvement in your hospital by framing quality in different ways to different audiences pp 93, 94, 98, 111, 127, 134 *
2. Establishing quality and quality improvement as the goal of clinical work pp 90, 97, 120, 131, 134
3. Paying attention to the social as well as the technical aspects of quality improvement pp 105, 123
4. Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values pp 93, 97, 111, 127, 140
5. Listening to your staff and patients pp 134
6. Making quality improvement visible pp 93, 94, 97, 128, 140

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

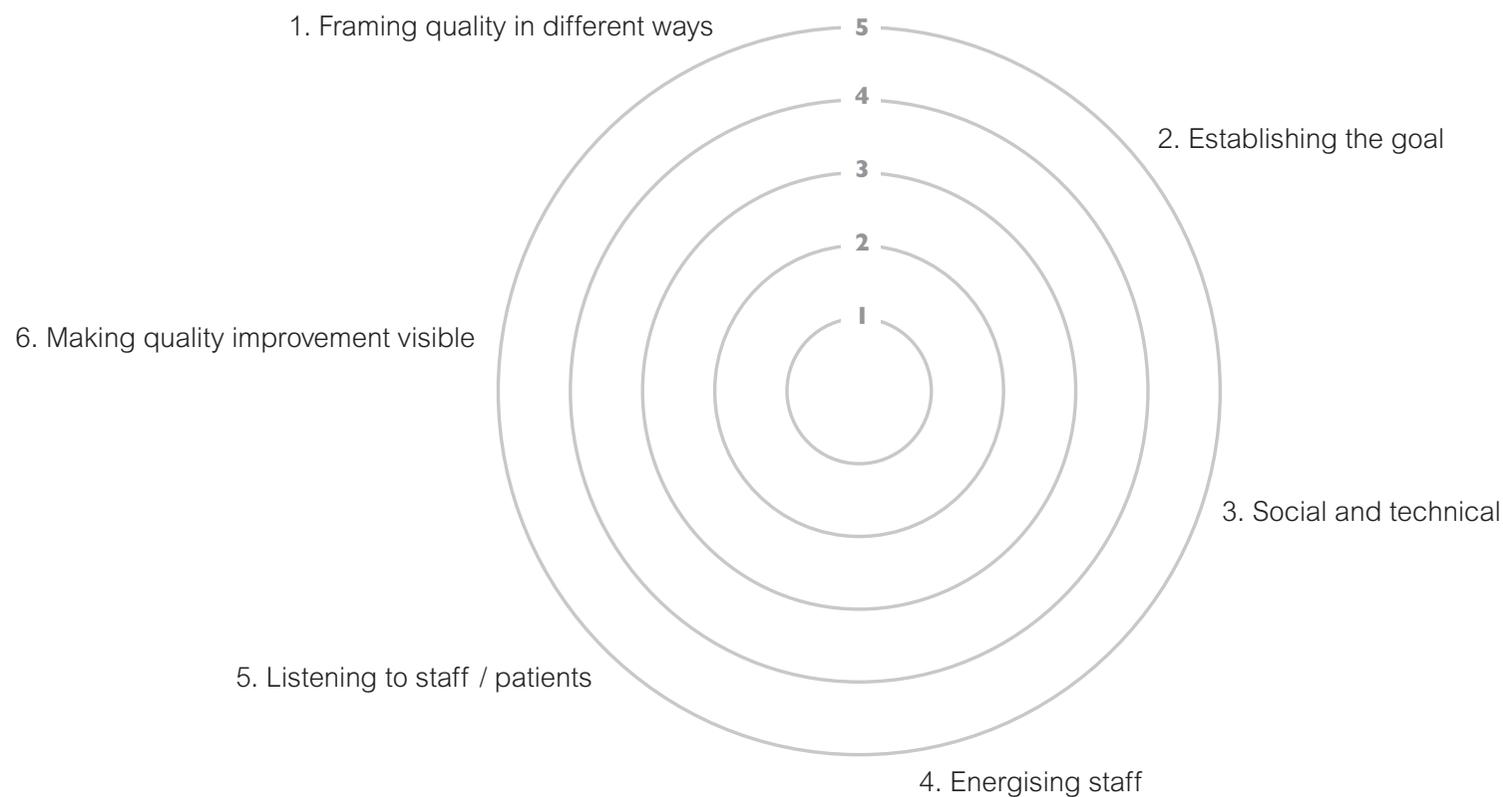


Diagnostic Step – Emotional

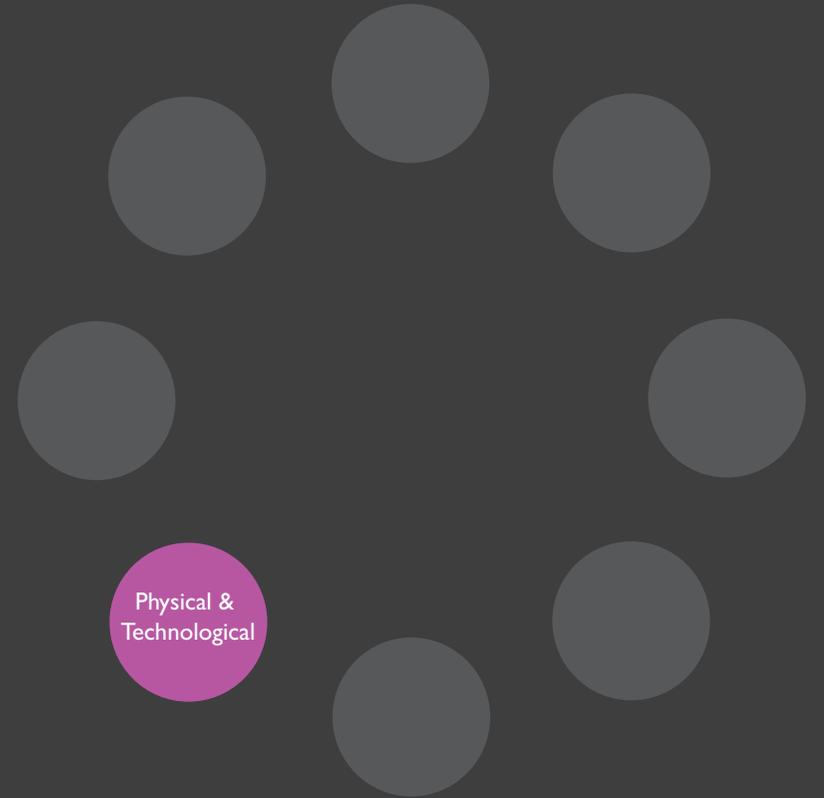
Strategies	We have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Making the most of all the potential resources for quality improvement in your hospital by framing quality in different ways to different 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 your 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:
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 | Physical & Technological



Introduction to the Physical & Technological challenge

Here you can begin to explore how well your own 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 54 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 55. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 your 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 your hospital is currently addressing the Physical & Technological challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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.

See prompts at the
end of each example
in section p81–142

Strategies

1. Measuring & monitoring your hospital's performance over time pp 90, 120, 123, 128 *
2. Designing the physical environment in support of quality improvement pp 140
3. Benchmarking and checking how your hospital is doing compared to others pp 90, 98, 111, 123, 128
4. Sharing information about quality improvement amongst your staff pp 93, 97, 98, 120, 140

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

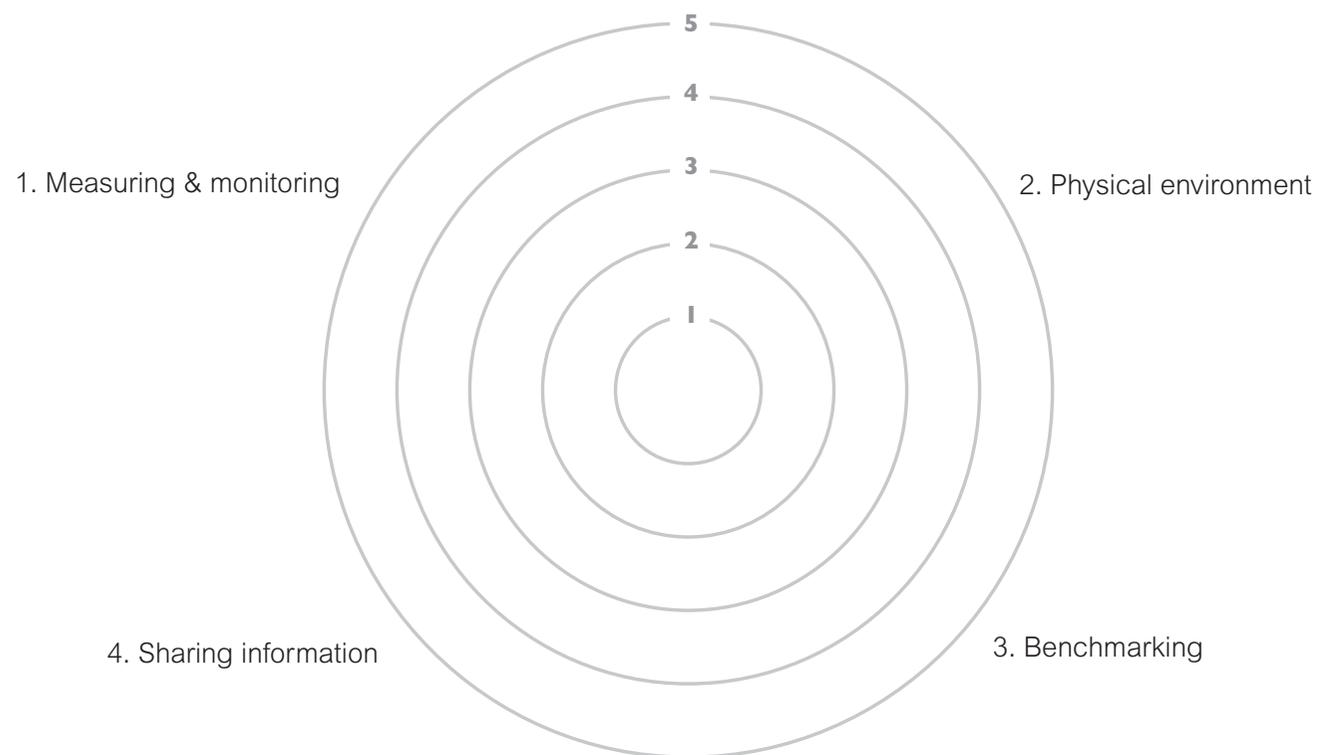


Diagnostic Step – Physical & Technological

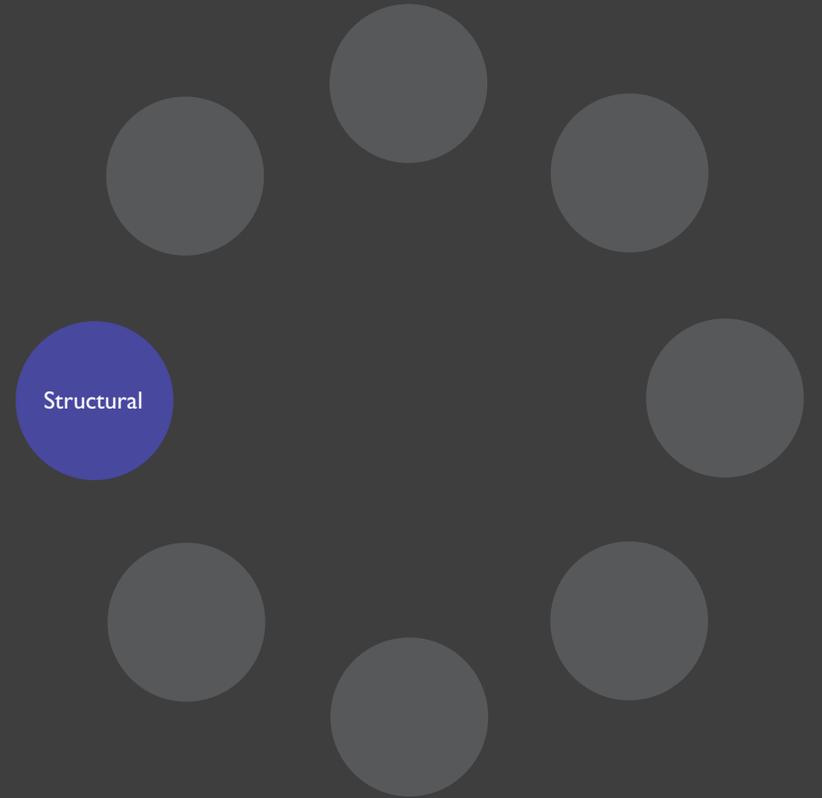
Strategies	We have already made a lot of progress in this area					
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Why did you choose this?
1. Measuring & monitoring your hospital's performance over time						
2. Designing the physical environment in support of quality improvement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



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 | **Structural**



Introduction to the Structural challenge

Here you can begin to explore how well your own 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 60 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 61. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your hospital is currently addressing the Structural challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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 p81–142

Strategies

1. Integrating quality improvement into the daily routines of your staff
pp 90, 97, 102, 120, 141 *
2. Building quality improvement capacity within your hospital
pp 98, 102, 105, 107, 114
3. Coordinating quality improvement efforts in your hospital
pp 82, 86, 94, 114, 120, 123, 128, 134
4. Capturing and embedding the learning from quality improvement
pp 102, 105, 107
5. Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in your hospital
pp 83, 97, 98, 102, 114, 132, 134

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

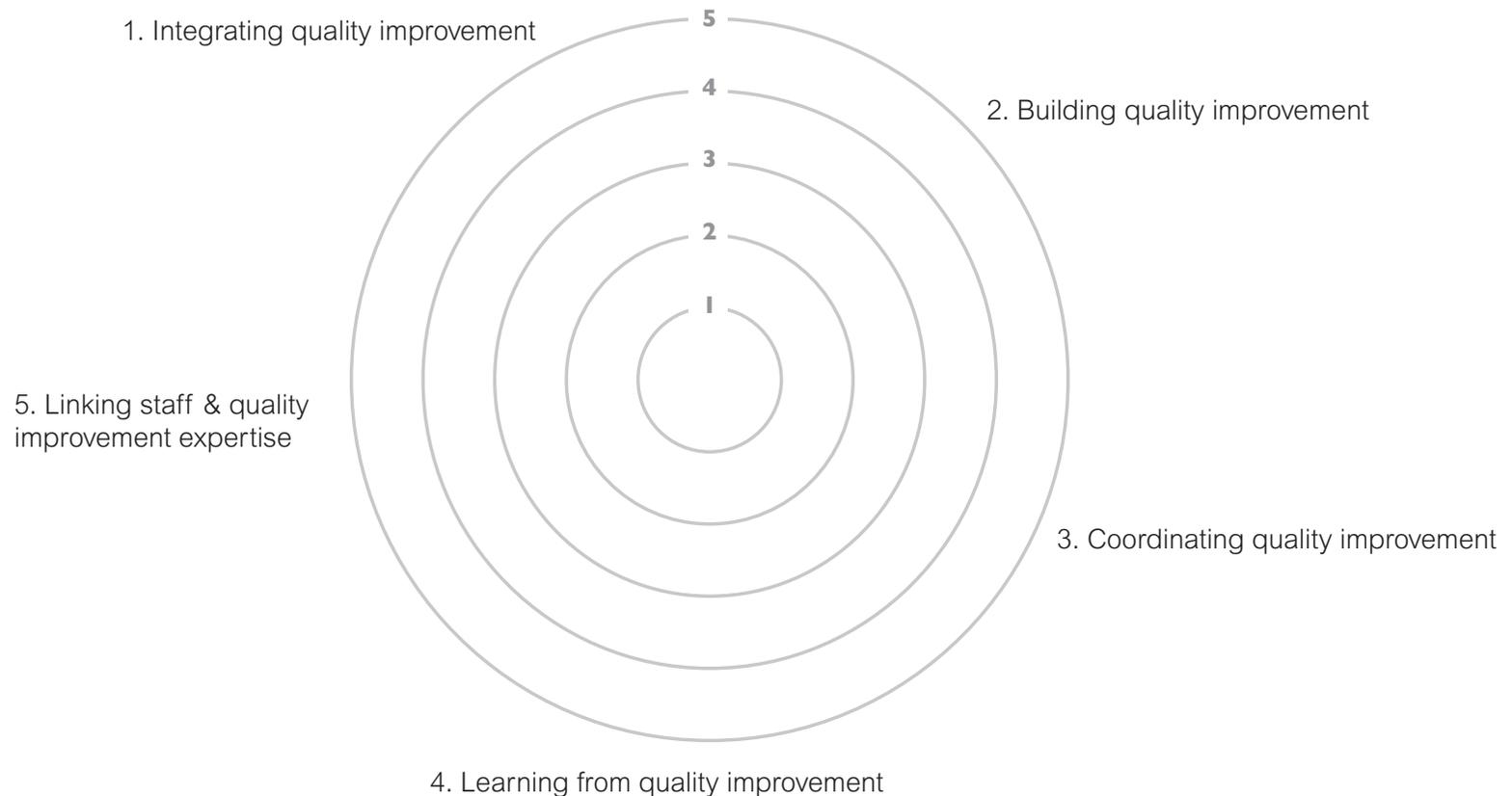


Diagnostic Step – Structural

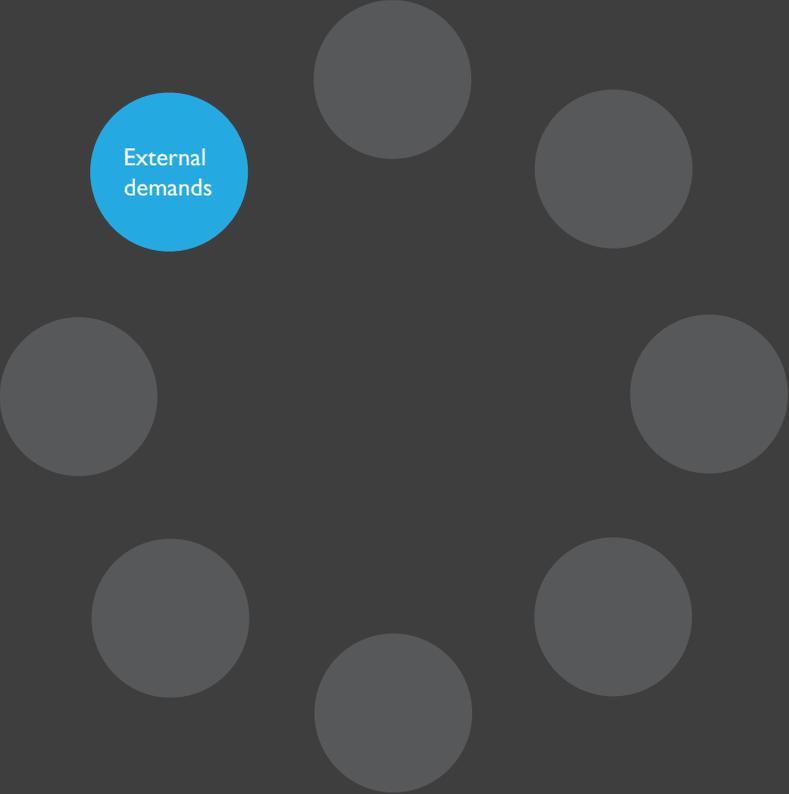
Strategies	We have already made a lot of progress in this area					Why did you choose this?
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	
1. Integrating quality improvement into the daily routines of your staff						
2. Building quality improvement capacity within your hospital						
3. Coordinating quality improvement efforts in your 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 your hospital						



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.

A cluster of ten circles arranged in a roughly circular pattern. One circle at the top-left of the cluster is highlighted in a bright blue color and contains the text "External demands". The other nine circles are a dark gray color and are empty.

External
demands

QUASER | External demands



Introduction to the External demands challenges

Here you can begin to explore how well your own 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 66 the extent to which you feel your 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 hospital 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
- The senior leadership team could complete the table collectively as part of a facilitated group discussion
- Staff members at different levels of your hospital – or within different departments – could complete the table and the results could be compared to inform wider discussions about how quality improvement is implemented and experienced throughout your hospital

Another option is to complete the spider diagram on page 67. Again, this could be done individually or collectively amongst the senior leadership team or by staff at various levels – or within different departments – within your 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 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 your 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 your hospital is currently addressing the External demands challenge 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 section is provided for capturing these.

Having considered which strategies you should use to address these gaps in your 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 with your own thinking and identify actions that your 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.

See prompts at the
end of each example
in section p81–142

Strategies

1. Actively managing the demands of your external environment
pp 82, 123 *
 2. Using external demands as a means of increasing focus on, and supporting, quality improvement within your hospital
pp 93, 99
 3. Establishing a positive, working relationship with payers and regulators pp 114, 127
-

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

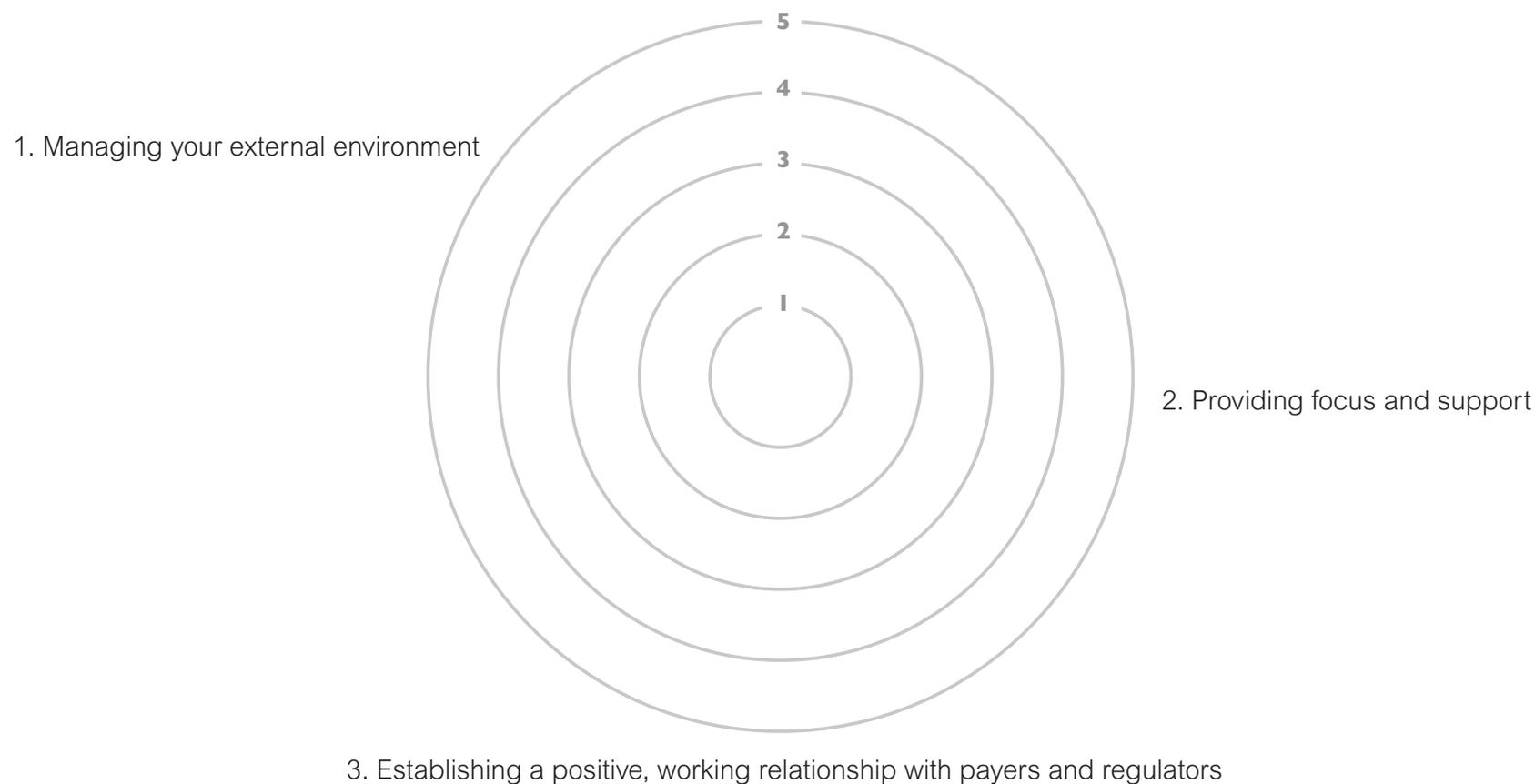


Diagnostic Step – External demands

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?
1. Actively managing the demands of your external environment						
2. Using external demands as a means of increasing focus on, and supporting, quality improvement within your 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:
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 strategy. This may build on your existing strategy or may be a new strategy 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. 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.

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 82, 86, 90, 120, 128
2. Aligning quality improvement work that (a) your 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 82, 123
3. Securing commitment to quality improvement in your hospital with all staff						pp 86, 93, 94, 97, 111, 126
4. Developing your staff for quality improvement						pp 98, 102, 105, 107, 131
5. Implementing long-term quality improvement strategies						pp 131
6. Encouraging both 'top-down' (formal, planned) and 'bottom-up' (informal, emergent) approaches to quality improvement						pp 82, 86, 98, 140

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. for staff development and organisational learning)						pp 82, 86, 90, 111, 120, 123, 128
2. Establishing a shared understanding of quality improvement in your hospital						pp 94, 126, 131, 140
3. Identifying quality improvement priorities with your patients						pp 134
4. Identifying quality improvement priorities with your staff						pp 134
5. Managing tensions and the politics of change						pp 86, 94, 114, 126, 128
6. Enabling multi-professional working						pp 94, 114, 131

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 your hospital which encourages 'buy in' from all professional groups						pp 82, 94, 126, 128
2. Allowing local adaptation of initiatives within a broader strategic framework						pp 86, 111
3. Embedding quality improvement in the way we do things around here						pp 90, 120, 126
4. Establishing the relevance and importance of change						pp 93, 97, 111, 126, 140
5. Reflecting on quality in your hospital and your quality improvement journey						pp 94, 102, 105, 126, 131

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 your hospital						pp 94, 102, 105, 107, 127, 131
2. Learning continually from your patients						pp 134
3. Integrating quality improvement into educational activities						pp 102, 107
4. Importing and adapting strategies from other hospitals nationally and internationally						pp 98, 111
5. Enabling staff to learn about quality improvement from outside your hospital						pp 98, 102, 105, 111, 131
6. Linking the learning from different quality improvement projects						pp 82, 114
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 131, 140
8. Using a range of data sources and tools to understand quality						pp 94, 120, 123, 128, 140
9. Encouraging multi-professional learning and sharing about quality improvement						pp 102, 105, 107, 114, 131

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 your hospital by framing quality in different ways to different audiences						pp 93, 94, 98, 111, 127, 134
2. Establishing quality and quality improvement as the goal of clinical work						pp 90, 97, 120, 131, 134
3. Paying attention to the social as well as the technical aspects of quality improvement						pp 105, 123
4. Energise staff over the course of quality improvement initiatives by understanding and responding to their beliefs and values						pp 93, 97, 111, 127, 140
5. Listening to your staff and patients						pp 134
6. Making quality improvement visible						pp 93, 94, 97, 128, 140

Physical & Technological

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Measuring & monitoring your hospital's performance over time						pp 90, 120, 123, 128
2. Designing the physical environment in support of quality improvement						pp 140
3. Benchmarking and checking how your hospital is doing compared to others						pp 90, 98, 111, 123, 128
4. Sharing information about quality improvement amongst your staff						pp 93, 97, 98, 120, 140

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 your staff						pp 90, 97, 102, 120, 141
2. Building quality improvement capacity within your hospital						98, 102, 105, 107, 114
3. Coordinating quality improvement efforts in your hospital						pp 82, 86, 94, 114, 120, 123, 128, 134
4. Capturing and embedding the learning from quality improvement						pp 102, 105, 107
5. Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in your hospital						pp 83, 97, 98, 102, 114, 132, 134

External demands

Strategies	Actions	Person responsible	Timeline	Resources	Which other challenges does this link to?	Refer to examples
1. Actively managing the demands of your external environment						pp 82, 123, 127
2. Using external demands as a means of increasing focus on, and supporting, quality improvement within your hospital						pp 93, 99
3. Establishing a positive, working relationship with payers and regulators						pp 114

QUASER | Examples 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:

- Translating national targets into local quality improvement initiatives (Leadership ●)
- Aligning quality improvement work that (a) your 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 your hospital (Structural ●)

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

- Translating national targets into local quality improvement initiatives (Leadership ●)
- Securing commitment to quality improvement in your 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 your 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.

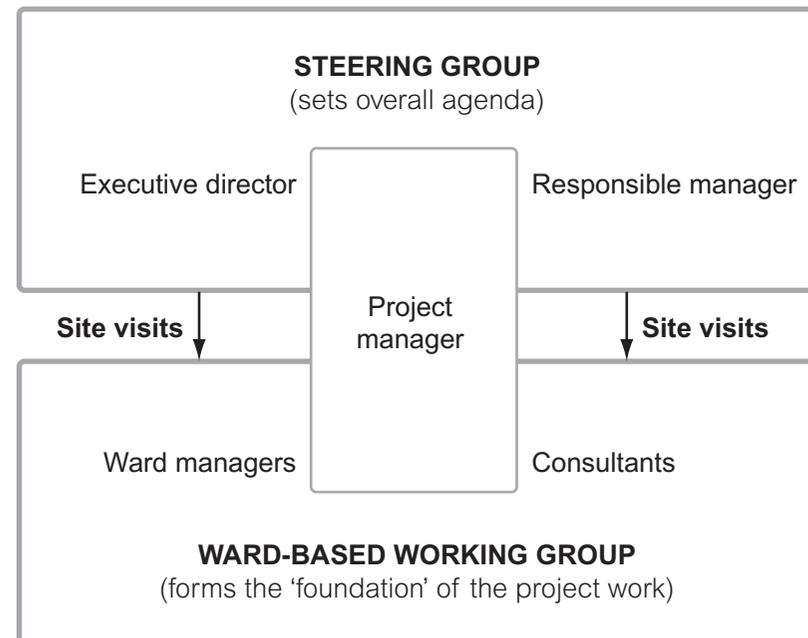


Figure (top right): Bottom-up participation is balanced by top-down managing in the ‘Productive Ward’

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:

- 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 we do things around here (Cultural ●)
- Establishing quality and quality improvement as the goal of clinical work (Emotional ●)
- Measuring and monitoring your hospital’s performance over time (Physical & Technological ●)
- Benchmarking and checking how your hospital is doing compared to others (Physical & Technological ●)
- Integrating quality improvement into the daily routines of your 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:

- Securing commitment to quality improvement in your 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 your 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 your staff (Physical & Technological ●)
- Using external demands as a means of increasing focus on, and supporting, quality improvement within your 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 your hospital with all staff (Leadership ●)
- Establishing a shared understanding of quality improvement in your 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 your hospital which encourages ‘buy in’ from all professional groups (Cultural ●)
- Reflecting on quality in your hospital and your 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 your hospital (Educational ●)
- Making quality improvement visible (Emotional ●)
- Making the most of all the potential resources for quality improvement in your hospital by framing quality in different ways to different audiences (Emotional ●)
- Coordinating quality improvement efforts in your 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:

- Securing commitment to quality improvement in your 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 your staff (Physical & Technological ●)
- Integrating quality improvement into the daily routines of your 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:

- Developing your 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 your hospital (Educational ●)
- Making the most of all the potential resources for quality improvement in your hospital by framing quality in different ways to different audiences (Emotional ●)
- Sharing information about quality improvement amongst your staff (Physical & Technological ●)
- Benchmarking and checking how your hospital is doing compared to others (Physical & Technological ●)
- Building quality improvement capacity within your hospital (Structural ●)
- Linking staff at all levels who are interested in getting involved with quality improvement with relevant expertise and resources in your hospital (Structural ●)

- Using external demands as a means of increasing focus on, and supporting, quality improvement within your 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.**

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.

- 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.

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:

- Developing your staff for quality improvement (Leadership ●)
- Reflecting on quality in your hospital and your quality improvement journey (Cultural ●)
- Encouraging spaces for reflection for staff to think about and discuss quality improvement within your hospital (Educational ●)
- Integrating quality improvement into educational activities (Educational ●)
- Enabling staff to learn about quality improvement from outside your hospital (Educational ●)
- Encouraging multi-professional learning and sharing about quality improvement (Educational ●)
- Integrating quality improvement into the daily routines of your staff (Structural ●)
- Building quality improvement capacity within your 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 your 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:

- Developing your staff for quality improvement (Leadership ●)
- Reflecting on quality in your hospital and your quality improvement journey (Cultural ●)
- Encouraging spaces for reflection for staff to think about and discuss quality improvement within your hospital (Educational ●)
- Enabling staff to learn about quality improvement from outside your 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 your 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:

- Developing your 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 your hospital (Educational ●)
- Building quality improvement capacity within your 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:

- Securing commitment to quality improvement in your 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 your hospital (Educational ●)
- Making the most of all the potential resources for quality improvement in your 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 your 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:

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

- 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 we do things around here (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 your hospital's performance over time (Physical & Technological ●)
- Sharing information about quality improvement amongst your staff (Physical & Technological ●)
- Coordinating quality improvement efforts in your hospital (Structural ●)
- Integrating quality improvement into the daily routines of your 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:

- Aligning quality improvement work that (a) your 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 your hospital's performance over time (Physical & Technological ●)
- Benchmarking and checking how your hospital is doing compared to others (Physical & Technological ●)
- Coordinating quality improvement efforts in your hospital (Structural ●)
- Actively managing the demands of your 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** 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 bi-annually).
- 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, which 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 your hospital with all staff (Leadership ●)
- Establishing a shared understanding of quality improvement in your hospital (Political ●)
- Managing tensions and the politics of change (Political ●)
- Establishing a broad, shared understanding of quality and quality improvement in your hospital which encourages 'buy in' from all professional groups (Cultural ●)
- Embedding quality improvement in the way we do things around here (Cultural ●)
- Establishing the relevance and importance of change (Cultural ●)
- Reflecting on quality in your hospital and your quality improvement journey (Cultural ●)

- Encouraging spaces for reflection for staff to think about and discuss quality improvement within your hospital (Educational ●)
- Making the most of all the potential resources for quality improvement in your 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:

- 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 your 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 your hospital is doing compared to others (Physical & Technological ●)
- Measuring and monitoring your hospital's performance over time (Physical & Technological ●)
- Coordinating quality improvement efforts in your 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:

- Implementing long-term quality improvement strategies (Leadership ●)
- Developing your staff for quality improvement (Leadership ●)
- Establishing a shared understanding of quality improvement in your hospital (Political ●)
- Enabling multi-professional working (Political ●)
- Reflecting on quality in your hospital and your 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 your hospital (Educational ●)
- Encouraging spaces for reflection for staff to think about and discuss quality improvement within your 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 your 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:

- Identifying quality improvement priorities with your staff (Political ●)
- Identifying quality improvement priorities with your patients (Political ●)
- Learning continually from your patients (Educational ●)
- Listening to your staff and patients (Emotional ●)
- Making the most of all the potential resources for quality improvement in your 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 your hospital (Structural ●)
- Coordinating quality improvement efforts in your 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:

- Encouraging both ‘top-down’ (formal, planned) and ‘bottom-up’ (informal, emergent) approaches to quality improvement (Leadership ●)
- Establishing a shared understanding of quality improvement in your 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 your staff (Physical & Technological ●)

- Integrating quality improvement into the daily routines of your 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 | 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

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, Gjesten 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

AHRQ guide – **www.ahrq.gov/**

Australian Institute of Health Innovation (AIHI) – **www.aihi.unsw.edu.au**

Australian Patient Safety Foundation, contains quality improvement tools – **www.apsf.net.au/**

Centre for evidence based medicine – **www.cebm.net**

Cochrane Collaboration – **www.cochrane.org**

Deepening our understanding of quality improvement in Europe –

DUQuE – **www.duque.eu**

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

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

Health Foundation, patient experience, measurement –

www.health.org.uk/publications/measuring-patient-experience

Health Foundation, patient safety, tools –

www.patientsafety.health.org.uk

Hospitals in Pursuit of Excellence with free downloadable information based on several quality – improvement case studies – **www.hpoe.org**

Institute for Healthcare Improvement website – **www.ihp.org**

Institute for Healthcare Optimization (mainly focusing on logistic and variability) – **www.ihoptimize.org**

Institute of Medicine – **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/**

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

National Association for Healthcare Quality (NAHQ) – **www.nahq.org**

National Institute for Health and Care Excellence (NICE) –

www.nice.org.uk

Other Resources (continued)

National Quality Measures Clearinghouse –

www.qualitymeasures.ahrq.gov

NHS Change Model – **www.changemodel.nhs.uk/pg/dashboard**

Online learning modules for quality improvement –

www.improvementskills.org

OpenSafety.org, patient safety – **www.opensafety.org**

Planetree, patient experience – **www.planetree.org**

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

Website of Paul Plsek with quality improvement tools –

www.directedcreativity.com/pages/ToolKitFrameset.html

In Dutch:

Dutch Institute for Healthcare Improvement CBO with information about quality improvement – **www.cbo.nl**

Dutch national patient safety campaign website – **www.vmszorg.nl/**

Dutch website about innovation in healthcare –

www.zorgvoorinnoveren.nl

In Swedish:

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

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

Patient involvement in quality and safety (SALAR) –

www.skl.se/vi_arbetar_med/halsaochvard/patientsakerhet/patientmedverkan

Patient safety – tools and films (SALAR) – **www.skl.se/vi_arbetar_med/halsaochvard/patientsakerhet/publikationer**

Swedish quality registries, background and data (SALAR) -

www.kvalitetsregister.se/om_kvalitetsregister

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