# Improving the role of NHS boards in quality improvement

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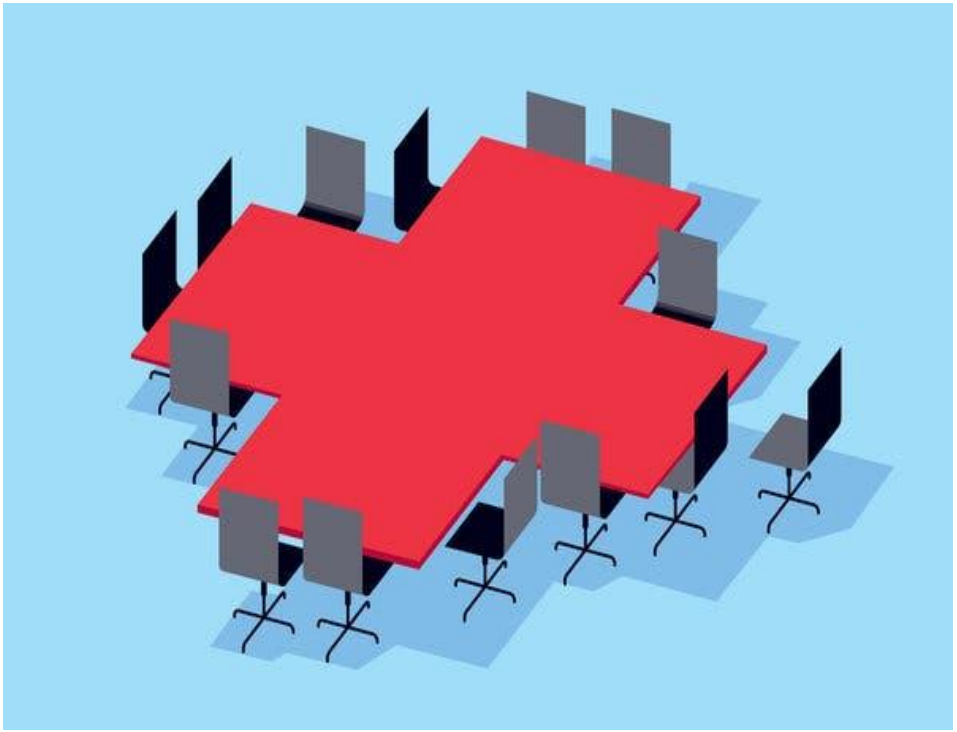
**UCL Department of Applied Health Research**

**Zoom call, organised by 'Q Connectors' network, 2nd December 2019**

# What I'm going to cover

- Policy and research background
- Programme of research on role of boards in QI
- Lessons for boards and regulators
- Further information….



# Background (1)

- Growing *policy* attention internationally on the role of boards in supporting high-quality care
- Concerns that boards focus on finance and external performance standards at the expense of quality
- In English NHS, the Francis inquiry (2013) into serious failings of care at Mid Staffordshire NHS Foundation Trust found that the board

  *'failed to tackle an insidious negative culture involving a tolerance of poor standards and disengagement from management and leadership responsibilities'.*

- Regulatory bodies in NHS attempting to strengthen board-level governance of quality

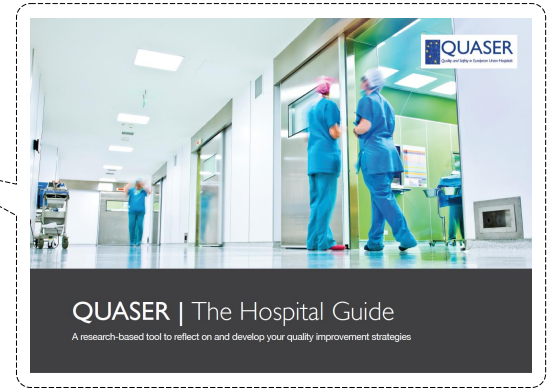
# Background (2)

- Increasing *research* attention on role of boards (Millar et al, 2013)
- Differences between high and low performing boards wrt board composition and processes (Jha & Epstein, 2010)
- Effective hospital Boards associated with specific management practices seen as helpful to improving the quality of care (Tsai et al, 2015)
- Five years post Francis: boards responded e.g. patient safety has higher priority, better policies on key policies, but current challenges risk threatening gains made (Chambers et al, 2018)

# Overview of research programme

QUASER study
[2010-2013]

QUASER guide



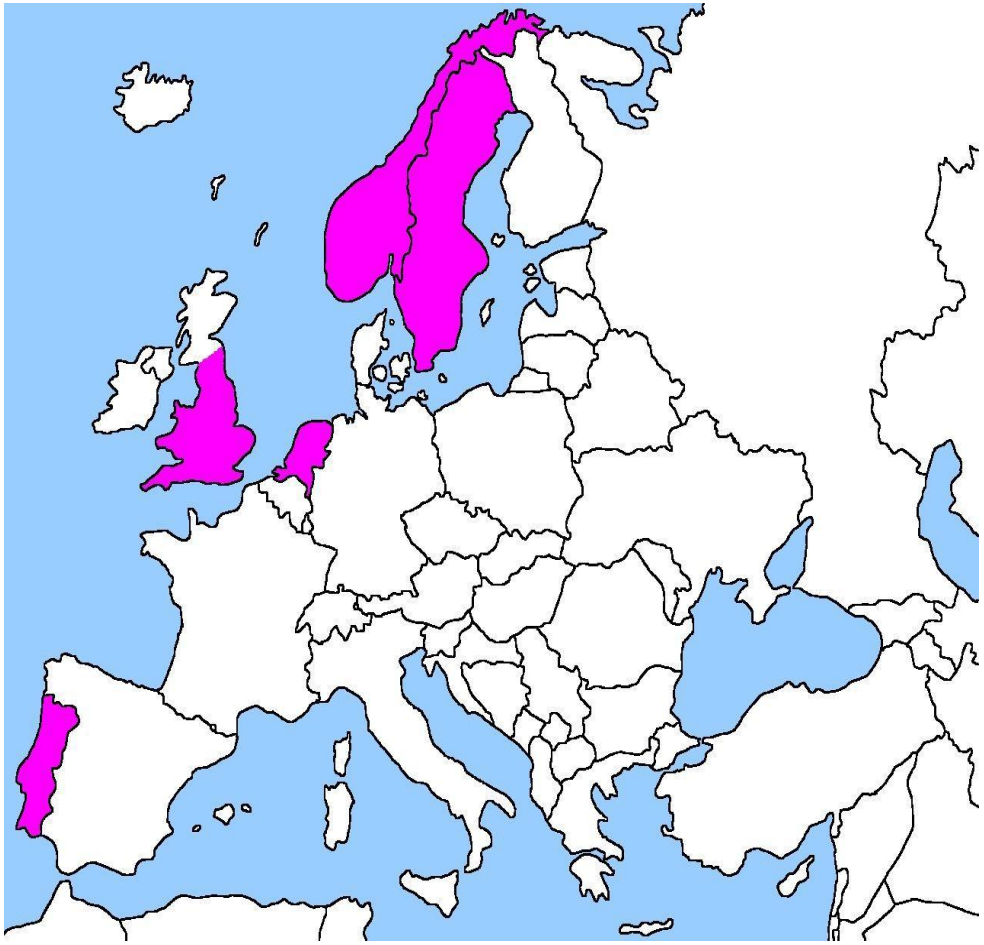

iQUASER study
[2014-2017]

Evaluation of implementation of QUASER Guide

How do Boards govern for QI?

QUASER
Quality and Safety in European Union Hospitals

# QUASER: 2010 - 2013



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

BMC Health Services Research

STUDY PROTOCOL Open Access

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

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

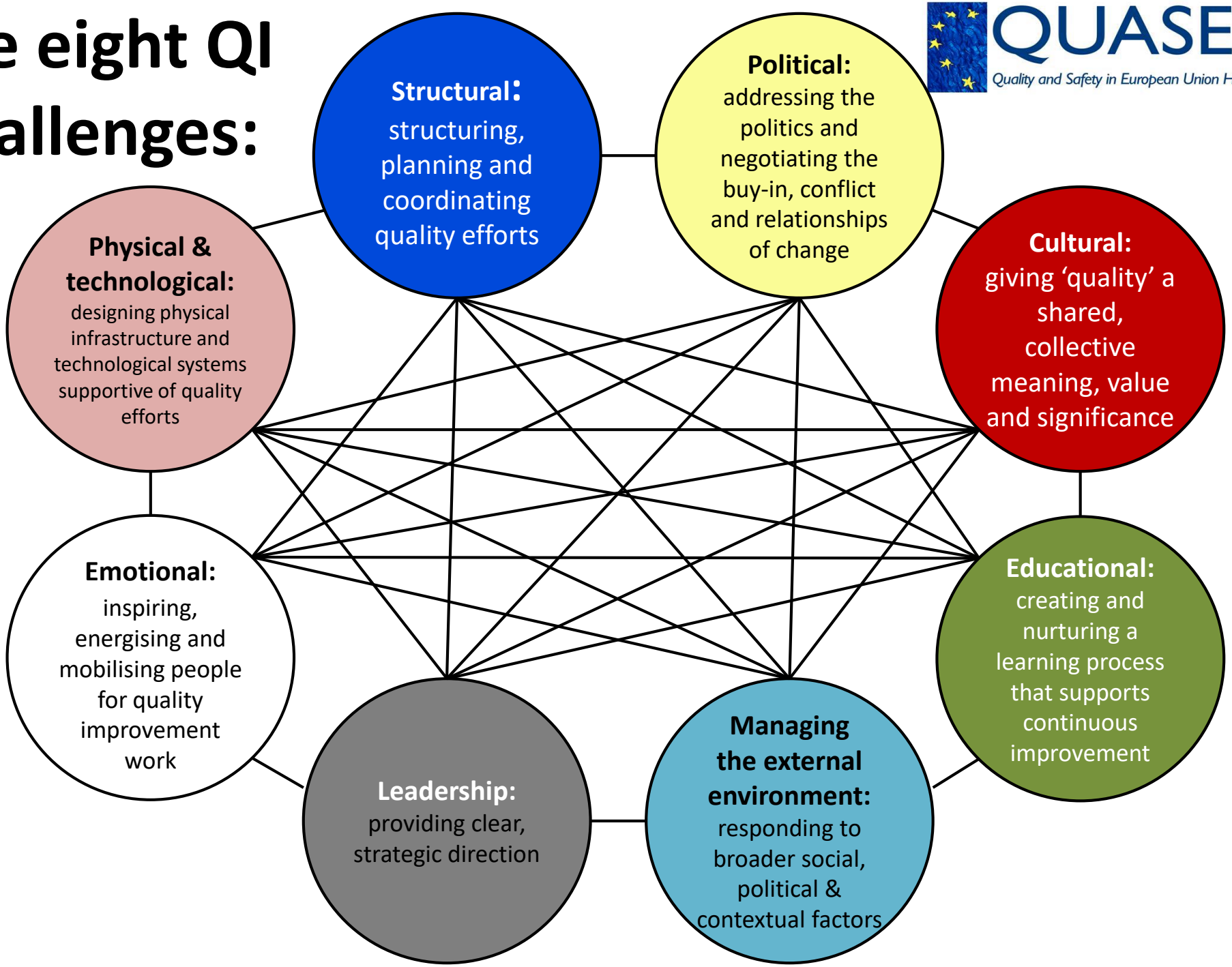
**Abstract**

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

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

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

# The eight QI challenges:

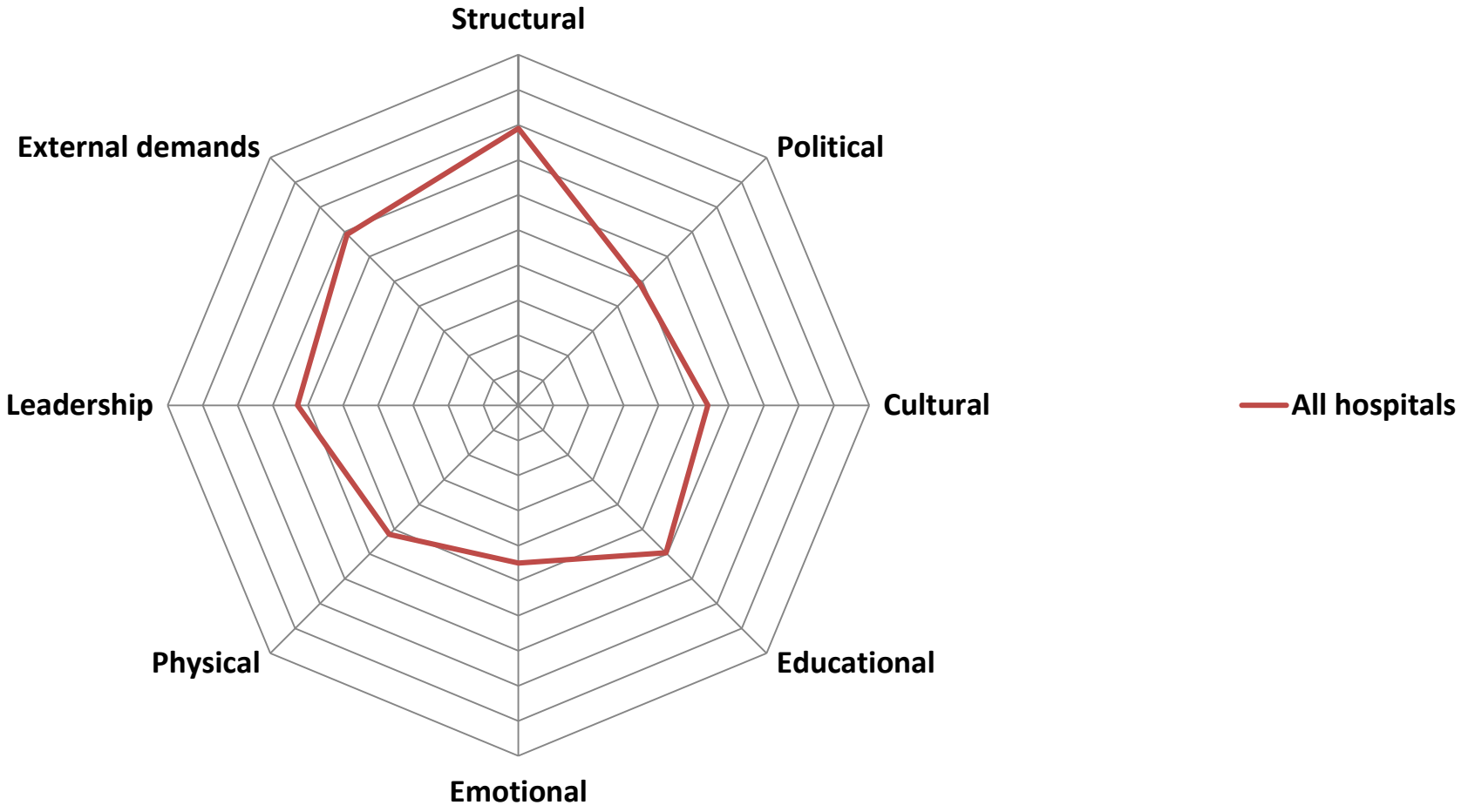



QUASER
Quality and Safety in European Union Hospitals

# Common features: the bad news….

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

# Attention paid to challenges - overall



QUASER
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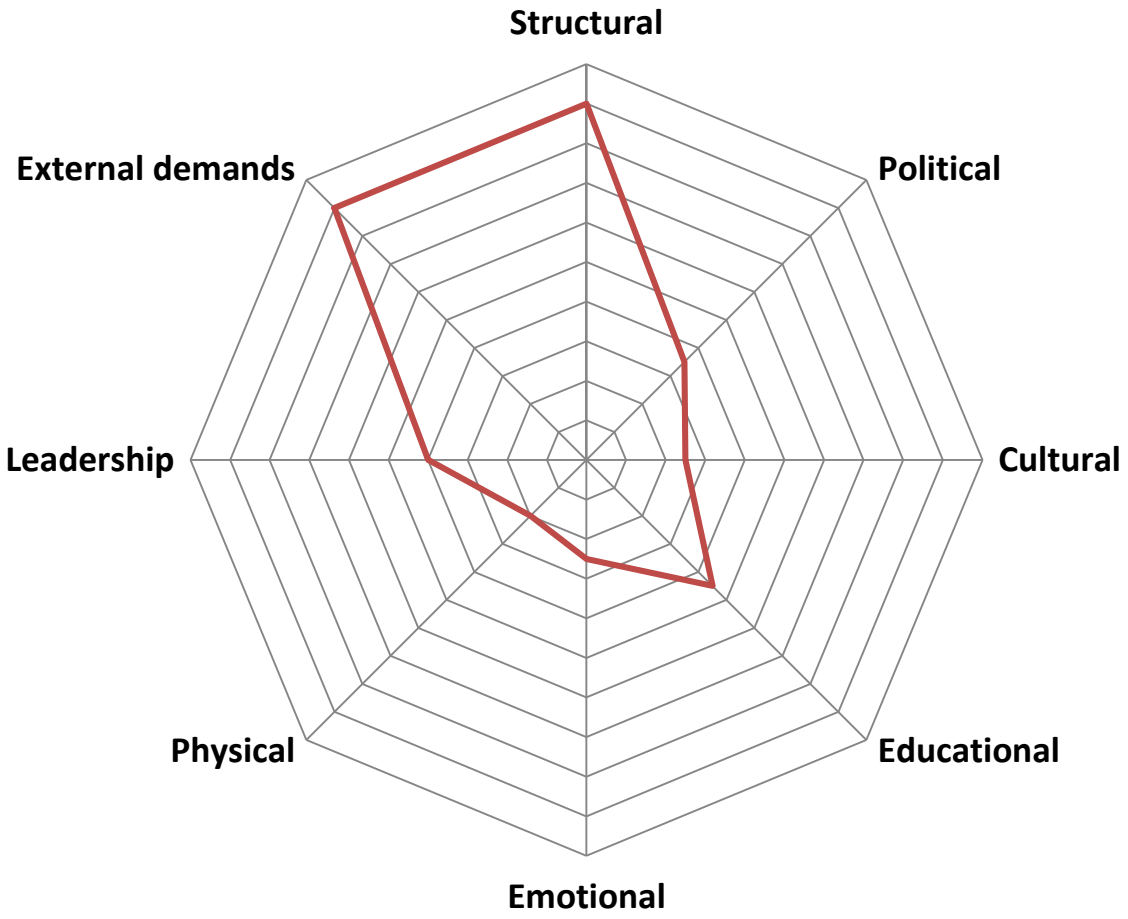
# Attention paid to challenges - England




Good News!

QUASER
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# ‘Good news’ examples relating to….

- Balancing external and internal demands (Burnett et al, 2015)
- Creating ‘boundary spanning’ roles
- Involving patients in QI

QUASER
Quality and Safety in European Union Hospitals

# What enabled these 'good news' examples?

- Long-term commitment to QI
- Stability of context and leadership
- Pockets of 'good news' even in 'challenged' organisations
  - Bottom up QI initiatives – led by clinical enthusiasts
  - But not harnessed effectively by senior/board leaders


# QUASER | The Hospital Guide

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

# Guide Structure

## Stage 1

**Diagnostic questions on the 8 QI challenges. "Which Challenge(s) should we focus on?"**

**Example: Educational Challenge**

| Strategies & Options | |
|---|---|
| | Provide QI knowledge through mandatory training… |
| | Develop links with Universities |
| | Learn from patients and staff |
| | Learn from evidence |
| | Support communities of practice |
| | Integrate continuous learning |
| | Engage and use external expertise |

## Stage 2a

**How well are we doing on the strategies? Prioritised list for targeted action. Key lessons and examples of solutions (linked to other challenges)**

## Stage 2b

**Consider how this challenge links with other challenges e.g. cultural**

## Stage 3

**Co-ordinated plan for QI implementation**

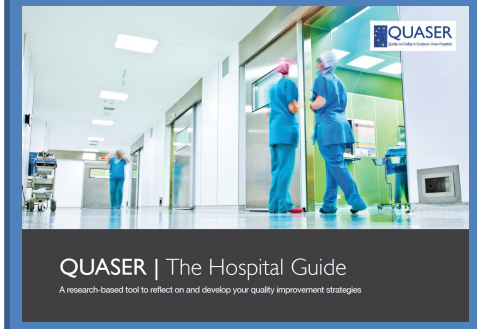
Anderson J E et al (2019)

# Implementing the QUASER Guide

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

- The research was funded by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care North Thames at Barts Health NHS Trust. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

# Study overview




+ OD

- Mixed method before and after study of the iQUASER intervention
- Cost consequence analysis

**How QI is governed at board level**

- Development of a QI 'maturity' framework
- Qualitative study applying the framework in 15 NHS Trusts

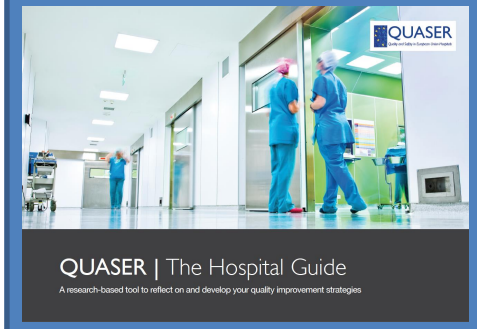
# Participants

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

# Summary of data collection

- April 2014-June 2016
- Observations of board meetings in 15 orgs (x3)
- Documentary analysis (15 orgs)
  - 3 sets of board meeting papers,
  - Quality Accounts and other relevant documents
- Interviews with up to 5 board members (8 org)
  - 2014 (n=37)
  - 2015/16 (n=29)

# Study overview

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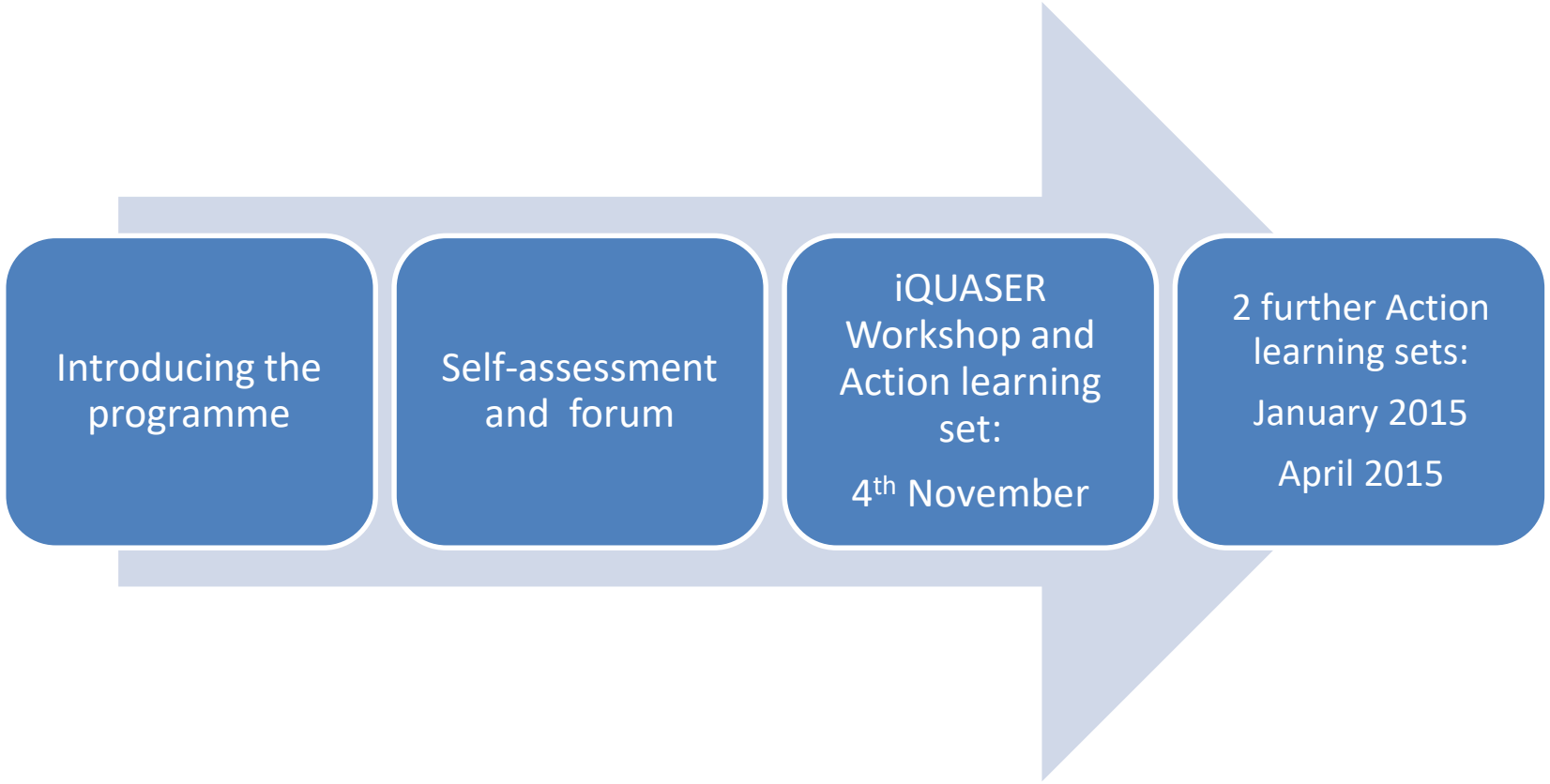
# iQUASER intervention

- The intervention consists of four phases over a 12 month period (July 2014 to July 2015)



## iQUASER self-assessment tool: organisational level

### SECTION 1: LEADERSHIP Challenge

* **Q 1.1 The LEADERSHIP challenge was identified as a key challenge in quality improvement by the QUASER study: Please indicate whether you have already made a lot of progress overall in this area.**

*Consider whether your organisation has made a lot of progress in providing clear strategic direction for quality improvement work and development of quality improvement leaders throughout your organisation.*

| 5 Strongly agree | 4 Agree | 3 Neither agree or disagree | 2 Disagree | 1 Strongly disagree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* **Q 1.2 The QUASER guide identifies the following strategies in relation to the LEADERSHIP challenge: Please indicate whether you have already made a lot of progress in this area:**

| | 5 Strongly agree | 4 Agree | 3 Neither agree or disagree | 2 Disagree | 1 Strongly disagree | N/A Don't know |
|---|---|---|---|---|---|---|
| A. Translating national targets into local quality improvement initiatives. | ○ | ○ | ○ | ○ | ○ | ○ |
| B. Aligning quality improvement work that balances national priorities/'must dos' with local quality priorities. | ○ | ○ | ○ | ○ | ○ | ○ |

| Org. | Engagement | QI strategy | QI Project | Implemented | Response | Effects |
|---|---|---|---|---|---|---|
| 1 | Strong | Improved | • QI facility | Large extent | Transformation | • Appointed a Director of Quality Improvement as part of the development of an organisation-wide QI facility<br>• Developed an organisation-wide QI strategy |
| 4 | Strong | Improved | • Diabetes project | Large extent | Transformation | • Appointed Director of Quality to implement the organisation-wide QI project and to take forward organisation-wide coordination of QI activity<br>• Developed an organisation-wide QI strategy. |
| 2 | Moderate | Improved | • Review of governance arrangements<br>• Non- smoking policy<br>• Improve bed management (eliminate external placements and non-clinical bed transfers). | Large extent | Customisation | • Used the intervention to reflect on, develop and accomplish local objectives. |
| 6 | Moderate | Improved | • Pre-existing initiatives 're-labelled' as the organisation-wide QI project | Moderate extent | Loose coupling | • Nothing new or different as a result of the intervention |
| 3 | Minimal | Not improved | • None selected | Not at all | Loose coupling | • Replaced by another initiative that was allocated by central government |
| 5 | Minimal | Not improved | • None selected | Not at all | Corruption | • Focus on external demands for quality assurance |

# Factors shaping organisational responses

## *'Slack'* (Bourgeois 1981)

- Thinking space & someone to 'do the doing'
- Shaped by compliance with national standards

## *'Readiness'* (Weiner 2009)

- Stable leadership
- Board members with expertise in QI
- Commitment of CEO and Chair

## *Need functioning & coherent board*

- 'nominal board'
- 'staged board'

**Jones et al (2019)**

# Study overview


+ OD

- Mixed method before and after study of the iQUASER intervention
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**How QI is governed at board level**

- Development of a QI 'maturity' framework
- Qualitative study applying the framework in 15 NHS Trusts

Jones et al, 2017

# Developing the Maturity Framework

| Dimension | Studies |
|---|---|
| 1. QI as Board priority | Jiang et al 2008, Jiang et al 2009, Jiang et al 2012, Jha and Epstein 2010, Joshi and Hines 2006, Bader 2006 |
| 2. Using data for improvement | Kroch et al 2006, Jiang et al 2008, 2009, Jiang, Lockee and Fraser 2011. |
| 3. Familiarity with current performance | Kroch et al 2006, Jha and Epstein 2010 |
| 4. Degree of staff involvement | Ramsay et al 2013 |
| 5. Degree of public/patient/carer involvement | Ramsay et al 2013 |
| 6. Clear, systematic approach (clear and well specified priorities, manageable number) | Kroch et al 2006, Jiang et al 2009, Jha and Epstein 2010, |
| 7. Balance between clinical effectiveness, patient experience and safety | Kroch et al 2006, Jiang et al 2009 |
| 8. Dynamics (how board members challenge/ask questions of each other) | Chambers et al 2013 |

# QI Maturity Framework: example

**QI as a board priority**

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

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

# Differences in QI maturity

| | CQC rating 2016 | QI Maturity Level | Framework Characteristics | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Organisation | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 1 | Outstanding | High | H | H | H | H | H | H | H | H |
| 2 | Good | High | M | M | H | H/M | H/M | H | H | H |
| 3 | Requires improvement | Medium | M | L/M | M | L/M | M | M | M | L |
| 4 | Requires improvement | Low/Medium | M/H | L/M | L/M | L/M | L/M | L/M | L | M |
| 5 | Requires Improvement | Low | M | L | M | L | L | M | L | L |
| 6 | Requires Improvement | Medium | M | M | L | M | M | M | M | M |
| 7 | Inadequate | Low | L | L | M | M | H | L | L | L |
| 8 | Inadequate | Medium | L | M | M | M/H | M/H | L | L | L |
| 9 | Requires improvement | Medium | L | M | M | M/H | M/H | L | M | M |
| 10 | Good | Medium/High | M/H | M | H | L/M | L | H | H | M |
| 11 | Outstanding | High | H | M | H | H | H | M | H | H |
| 12 | Requires improvement | Low/Medium | L/M | L/M | L | M/L | M | L | L | M |
| 13 | Good | Medium | M | M | M | L | L | M | M | H |
| 14 | Good | High | H/M | M | H | M/H | H/M | M | H | H |
| 15 | Good | High | M | M | H | M/L | L/M | H | H | H |

# Characteristics of organisations with a high QI maturity

1) Long term & short term focus on QI
2) Patient & staff engagement
3) Using data for improvement
4) A culture of continuous improvement
5) Clinical leadership

# Long term & short term focus on QI

- **QI Maturity: High**
- Combines long term and short term focus on QI
- Capacity to be able to create/consider long term QI and build it in to plans
- Articulate and enact values and expected behaviours and use these as the basis for recruitment and appointment

- **QI Maturity: Low**
- Short term focus on QI
- Limited capacity to be able to create/consider long term QI

# Patient & staff engagement

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

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

# Using data for QI

## QI Maturity: High

- Data used for QI not just QA
- Clear and readable
- Triangulation of data in discussions
- more ‘real time’ data
- ‘soft intelligence’ (walkarounds, patient complaints)
- Benchmarking

## QI Maturity: Low

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

# A culture of continuous improvement

## QI Maturity: High

- Constant questioning and self-examination
- 'Striving for excellence' part of the corporate identity
- Used external networks for learning,
  - proactively discussing particular issues with staff from regulatory agencies,
  - researching how other hospitals had responded to similar problems
  - visiting high performing organisations

## QI Maturity: Low

- appeared more complacent
- insufficient challenge from NEDs
- Overly optimistic

# Clinical leadership

- **QI Maturity: High**
  - Higher proportion of board members with a clinical background
  - Extended corporate roles
  - Positive board dynamics
  - Visible and vocal during meetings, providing knowledge of the external policy environment and helping to interpret data

- **QI Maturity: Low**
  - A lower proportion of board members with clinical backgrounds
  - Clinical leaders restrict their contribution to matters that fall within their clinical remit
  - Negative dynamics with other board members

# Learning for boards

- Characteristics of higher QI maturity indicate where boards might want to focus:
  - Balancing long and short term focus
  - Using data for QI, not just QA
  - Engaging staff and patients in QI
  - A culture of continuous improvement
  - Crucial role of clinical leaders

- 'Top of the shop' commitment imperative to improving role of board in QI

# Learning for external bodies

- Role for external bodies:
  - in enabling ‘slack’ e.g. reducing reporting burden
  - in facilitating ‘readiness’ and functioning/coherent boards
  - targeting of OD interventions to where organisations are on their quality journey

- What happened next: NHSI piloted board maturity framework
- UCLPartners facilitated iQUASER with 5 further Trust boards
- Now evaluating special measures for quality and challenged providers regimes

# Thank you!
# Questions? Comments?

Collaboration for Leadership in Applied Health Research and Care North Thames

NHS National Institute for Health Research

# More information

- More information about QUASER project:

https://www.ucl.ac.uk/dahr/news-events/events-publication/quaser

- QUASER Guide available here:

https://www.ucl.ac.uk/dahr/pdf/study_documents/iQUASER_Hospital_Guide_291014_press-ready_cs4.pdf

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Burnett S et al. Using Institutional Theory to Analyse Hospital Responses to External Demands for Finance and Quality in Five European Countries. *J Health Services Research & Policy* 2015. doi:10.1177/1355819615622655: http://journals.sagepub.com/doi/full/10.1177/1355819615622655

- iQUASER project page:

http://clahrc-norththames.nihr.ac.uk/systems_and_models_theme/iquaser/

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http://qualitysafety.bmj.com/content/26/12/978

Two page 'at a glance summary' of 'How do boards govern for quality improvement':
http://clahrc-norththames.nihr.ac.uk/wp-content/uploads/2017/07/CLAHRC_North_Thames_iQUASER_BITE_final.pdf

Jones L et al. Explaining organisational responses to a board-level quality improvement intervention: Findings from an evaluation in six providers in the English National Health Service. *BMJ Qual Saf* 2019;28:198-204. https://qualitysafety.bmj.com/content/28/3/198

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# iQUASER Team

***Intervention team***

- Foresight Centre for Governance:
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  - Sue Rubenstein, Director

***Evaluation team***

- Naomi Fulop, Lorelei Jones, Linda Pomeroy, Estela Capelas Barbosa, Steve Morris (UCL),
- Janet Anderson, Glenn Robert (KCL)
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