



# Quality Framework for a Clinical Directorate

# Phase One: Mapping

*The Pursuit of Quality: A Clinical Directorate's Progress in Clinical Governance. A Case Study of the Women's and Children's Directorate, GUH*

*Stiofan de Burca, Peter Williams & Claire Armstrong*
*Health Systems Research Centre, UL*

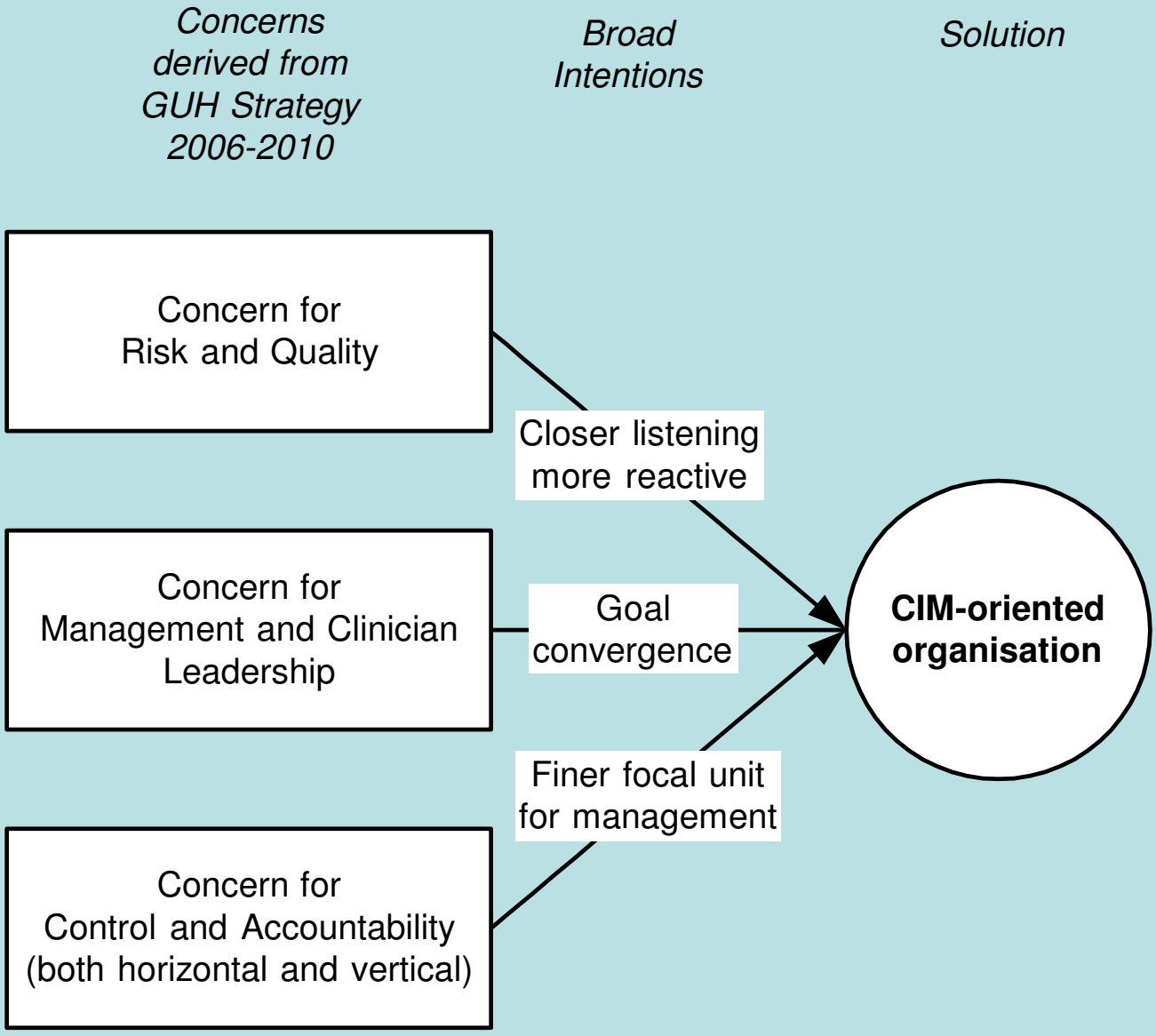
*Ref Report December 2008*


*21st April 2009*

Know Thyself !

*So What ?!*

# Motivation for Clinicians in Management (CIM) programme in GUH



# Access

- Introduction to GUH:
  - Prof Tim O'Brien: Request and introduction
  - General Management: Suggested collaboration with W&C CD
- Clinical Directorate:
  - Presentation and Discussions with Directorate Team
    - CD team consulted with Hospital and Directorate parties
  - Business Manager and Quality Coordinator facilitated Research Team
  - Preliminary meetings (with wide range of personnel as introduction)
    - Nursing: ADoN (UC); CNM & Ward staff stations, inc leaders at all levels Paeds (AM); Obs (SC); Gynae & others.
    - Medical staff (monthly CD medical meeting)
    - IT coordinator
    - Location of documents
- Hospital Functions:
  - Facilities: Deputy GM (PC)
  - Nursing: Director of Nursing (AM); Centre for Nurse Education: Head; practice coordinator
  - HR Dept: OB&D(COH); Training (JOS); Contracts (SB)
  - IT Dept: HOD (MM)
  - Quality & Risk: HOD (CH)
  - Medical Board: (JK)

# A Mixed Methods Approach

Document Analysis

Quantitative

Qualitative

# Documents

Requested: any documents used in hospital relevant to development of quality system – relating to the improved hospital performance and delivery of quality clinical outcomes, whose:

- Focus: on CD activity in Women's and Children's Directorate
- Shaping effect: that act as enablers or indicate constraints on capacity/capability
- Levels: at all hospital levels, inc HSE, hospital management, department, ward.

Access was facilitated to a wide range of documents

- Directorate Quality Coordinator played a lead role
- Context: Contemporaneous preparation for IHSAB accreditation

Document Analysis

- Goal-direction (intent): orientation, planning, execution, evaluation loop
- Action (realisation): structure, process, and outcomes

# Quantitative

As bridgehead to open up some key aspects

Survey instruments

- Clinical Governance Survey (Lugon & Secker-Walker, 1998)
- Clinical Governance Climate Questionnaire (Freeman)
- MARQuIS (Klazinga & al)
- Quality Cost Template (Lugon & Secker-Walker, 1998)

Statistical Analysis

# Qualitative

Informed by preliminary results of Quantitative surveys

Preliminary Interviews in the field

ad hoc; wide coverage; as informative background

Formal interviews (nominally one hour)

Representation sought for levels, role categories, and specialty

One-to-one (eight)

Focus Groups (two: Obs-Gynae; Paeds)

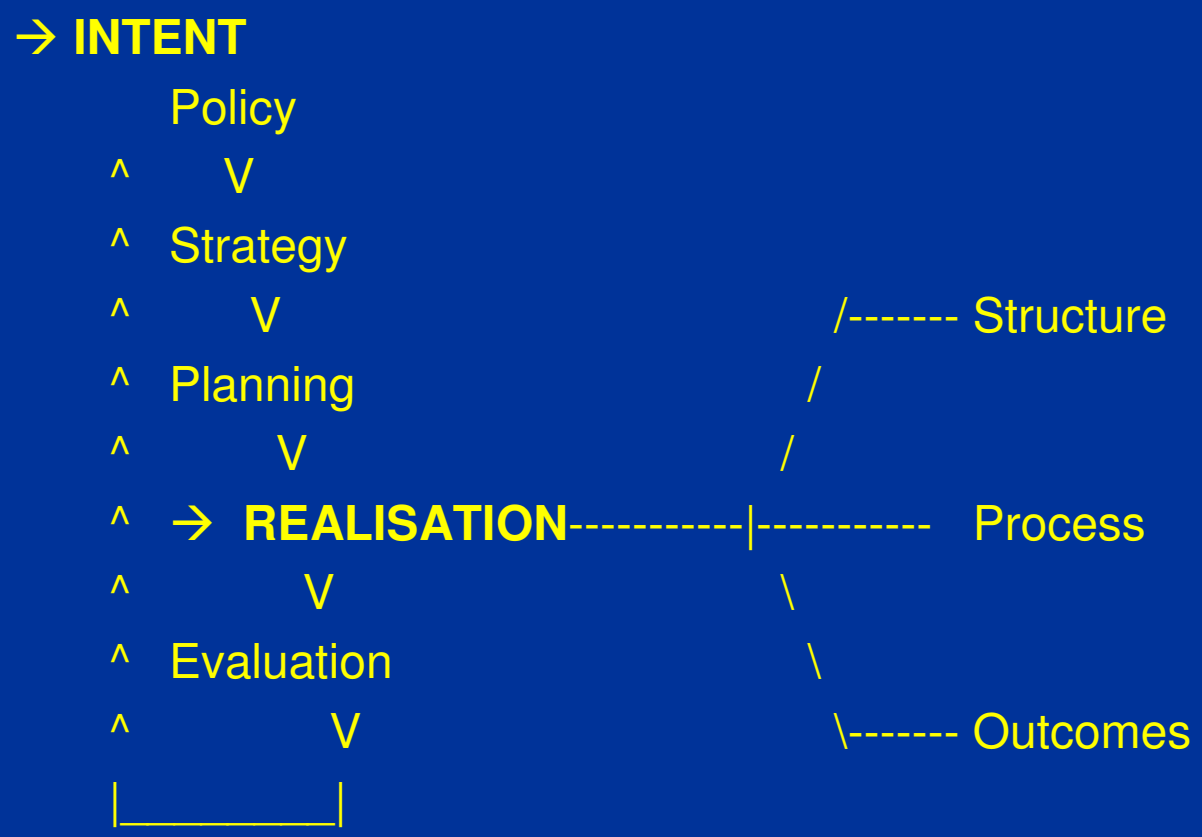
Formal data analysis: Template Analysis (*ref method of King*)

# RESULTS

Document Analysis
Qualitative Analysis
Quantitative Analysis

Triangulation

# Document Analysis:
## A Rich Documentation Base yields Intent and Realisation



# Document Presentation: Intent-Realisation

| Activity | Level | Ext to GUH | GUH Organisation | | Provider | | Patient | |
|---|---|---|---|---|---|---|---|---|
| | | HSE/DOHC/ OHM HIQA/ISO/ | Hosp/Functions | CD/Dept | Clinicians | Staff | Individuals | Community |
| *Intent* | Strategy | Quality & Fairness<br>HSE Corp Plan<br>Reform '03<br>Transformation | GUH Strategy<br>CQI Strategy<br>RM Strat & Pol<br>CA Pol | | Med Board<br>CQI Committee<br>RM Committee<br>CA Committee<br>workshops | DN(n/mw)<br>CQI Committee<br>RM Committee<br>workshops | | |
| *Intent* | Planning | HSE SP<br><br>16/97 | ISIT Workplan<br>Serv Plan '07<br>16/97 plan<br>Training Plan | CD SP<br><br>Shadow budget? | Training Needs assessment<br>Perf plan (form) | Training Needs assessment<br>Perf Plan (form) | | |
| *Intent* | Evaluation | Accred Reports<br>IHSAB/HIQA<br>OHM-CIM | HR: ISO (HR), HSE Best Employer?,<br>O2 Ability Award<br>Other (3rd) ISO? | What Works w/s<br>Baby Friendly Award<br>ISO (OG) | Perf assessment (form) | Perf assessmant (form) | Patient satisfaction<br>Comment card f/b | |
| *Realis -ation* | Structure | (Statutory and Professional Bodies) | Org Charts:<br>GUH (to CD level)<br>& Funct./Depts<br>EMT terms of ref<br>HMT terms of ref<br>RM Cttee &role<br>CA Cttee &role<br>ICT Tools | Job Spec CDir<br>Job Spec Busn Mgr<br>WTEs/Staff list<br>Refurbishment (Gyn)<br>6 beds Paeds<br>Baby security sys<br>... | ICPs<br>Assumed Prof Job specs | ICPs<br>Assumed Prof Job specs | DN as Complaints Officer/<br>Patient Representative | Outreach-<br>MidWife Clinic<br>Travellers Clinic |
| *Realis -ation* | Process | ISO 9001: 2000 (rev03)<br>IHSAB/HIQA ACAS 2nd ed. | Q Manual:<br>Guidelines, procotocols, procedures | F/w for CD Mtgs<br>Q Manual<br>Paeds Guidelines/ procs<br>OG Clin MW/N Glines<br>OG Safety PolsProcs<br>OG Q Pols&procs | Clinician schedules<br>Clinical Audit<br>5-step CD Formation<br>Clin review mtgs<br>Protocol review<br>RM feedback<br>Orientation eg to Accreditation | Labour Ward Forum<br>Protocol review<br>RM feedback<br>5-step CD Formation<br>Orientation eg re Accreditation | Patient Comment/<br>Complaints Feedback | Focus Groups<br>(eg Galway Focus) |
| *Realis -ation* | Outcomes | | Incidents, claims, Litigation<br>HR Annual Report / Training PIs<br>Patient Activity Vols<br>Clinical PIs<br>(no Hosp AR)<br>ISIT dept PIs | Pat Activity Vols<br>Clinical PIs<br>Incident Report<br>CD Report to EMT<br>CD Ann Rept 07 | HIPE<br>Clinical Audits | | Patient Comments/ Complaints<br>Discharge summaries<br>Notification eg births | |

# Conclusion

- Dominant
  - strong activity and leadership in intent
  - substantial achievement in realisation
- Weak spot
  - direct patient involvement at system level (planning and above)

# Qualitative Analysis:
## Main Emergent Categories

Clinical Directorate

Formative Influences; Perceived Purpose; CD Scope/Logic; CD Role;
CD Team & Reporting Relationships; CD Status & Leadership;
Clinical Leadership; CD Characteristics

Performance Management

IT and IS; Performance

Quality Management

Quality Model; Quality Structures; Quality Management Overview

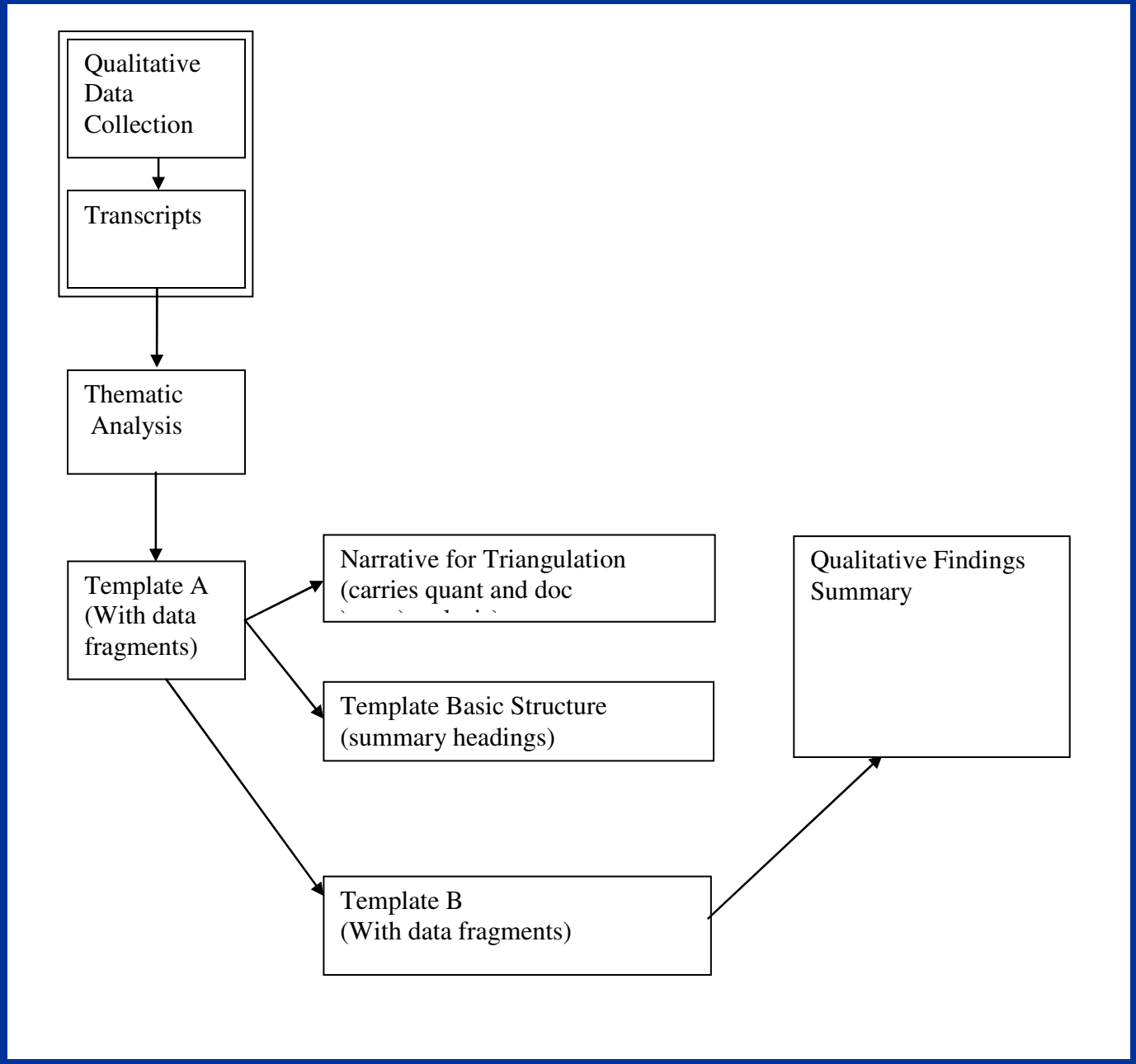
Constraints

External: HSE Management & control; HIQA
Internal: Limited Budgetary Devolution & Control; Ownership & Control

Prospective Change

Budget & Control;
Clinical Governance & Leadership;
Capacity & Capability

# Qualitative Analysis: Templates (see appendix in report)



# Quantitative Analysis

Response Rates

CGCQ Factors by Grouping

Composition of CGCQ Factors (from review of box-plots)

CGS components (from review of box-plots)

# Quantitative Response Rates

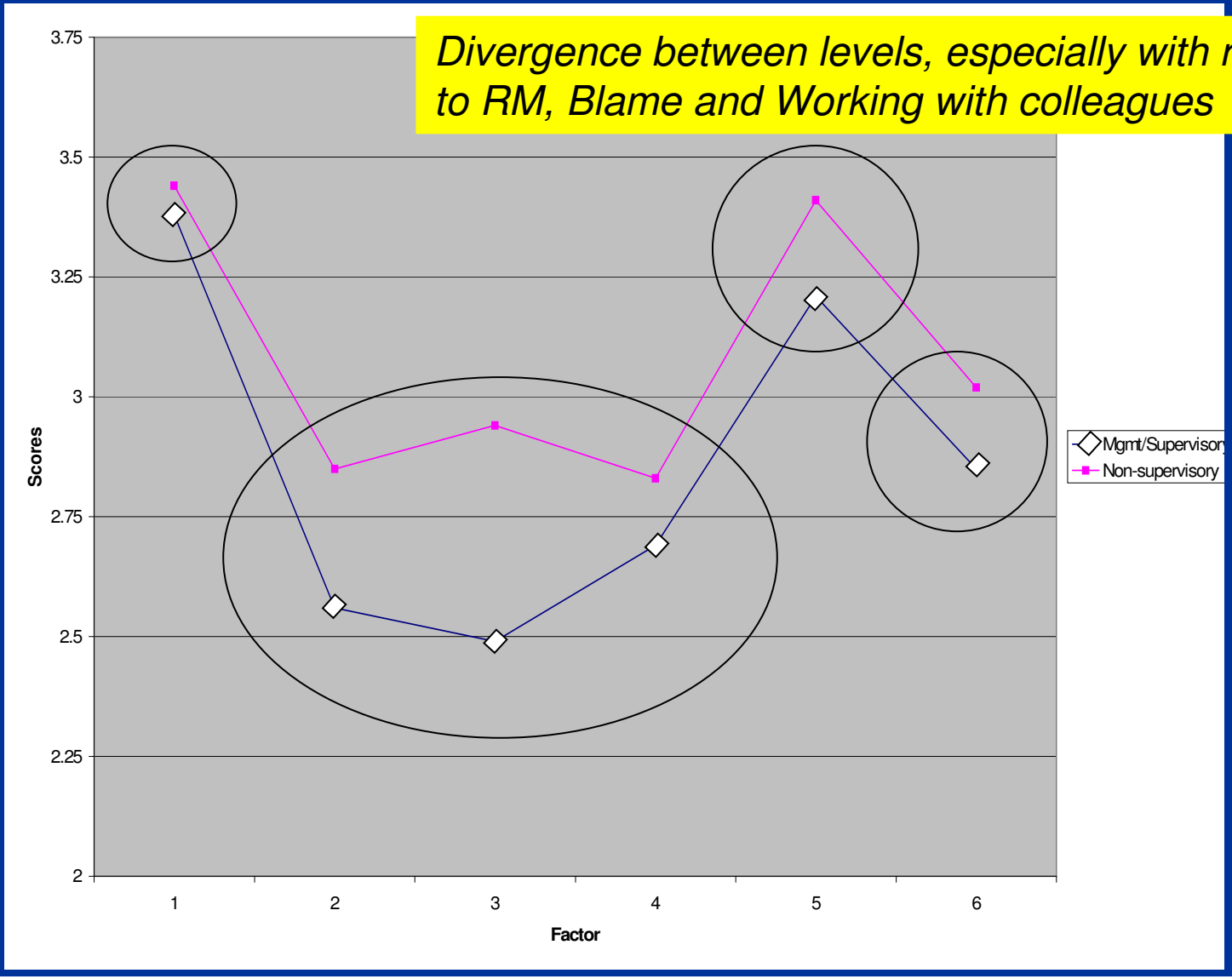
| Level / Category | L1/L2 Supervisory | L3 Non-supervisory | Total |
|---|---|---|---|
| Medical | 40.0% | 36.7% | 37.5% |
| Nursing/Midwifery | 69.2% | 18.4% | 25.2% |
| AHP | | | 50.0% |
| Admin/Mgt | | | 45.5% |
| Other | | | 23.1% |
| Total | 72.5% | 21.2% | 27.9% |

CGCQ Factors by Grouping

# Summary of Clinical Governance Climate Survey

| CG Climate Factor | Level Effect | Department Effect | Role/Profession Effect | Observations |
|---|---|---|---|---|
| 1. Planned and Integrated QI Framework | Poor<br>no difference | Poor<br>Close | Neutral: Med & AHP<br>Poor: Nursing & Admin | Strong/neutral: vision/motivation<br>Weak: Reactionary; no time to reflect; immediacy over long-term |
| 2. Proactive Risk Management | Good: supervisory<br>Neutral: non-sup | Fair<br>close | Good: Med<br>Fair: AHP, Admin, Nursing | Overall: good/neutral<br>Good on assessment/learning<br>Ward dubious re assessment |
| 3. Absence of Blame | Good: Supervisory<br>Neutral: Non-sup | Fair:<br>close | Very good: Med<br>Good: AHP<br>Fair: Nursing & Admin | Generally: Absence of punishment, good atmosphere<br>but, Ward level dubious |
| 4. Working with Colleagues | Fair<br>Close | Good: Gynae<br>Fair: Paeds<br>Neutral: Obs | Good: Med<br>Fair: Nursing, AHP<br>Poor: Admin | Generally positive: Know, understand, and respect each other<br>Some evidence of pecking order! |
| 5. Training and Development | Poor<br>Close | Poor:<br>Close | Neutral: Med & Admin<br>Poor: Nursing/AHP | Generally: neutral/negative<br>Absence of time to reflect<br>Dev needs (of individuals) not addressed<br>(profession over person? for beginners? take for granted?) |
| 6. Organisational Learning | Fair: Supervisory<br>Neutral: non-supervisory (close) | Fair: Paeds<br>Neutral: Obs<br>Poor: Gynae | Fair: Med<br>Neutral: AHP, Nursing, Admin | People rather than teams share practice issues |

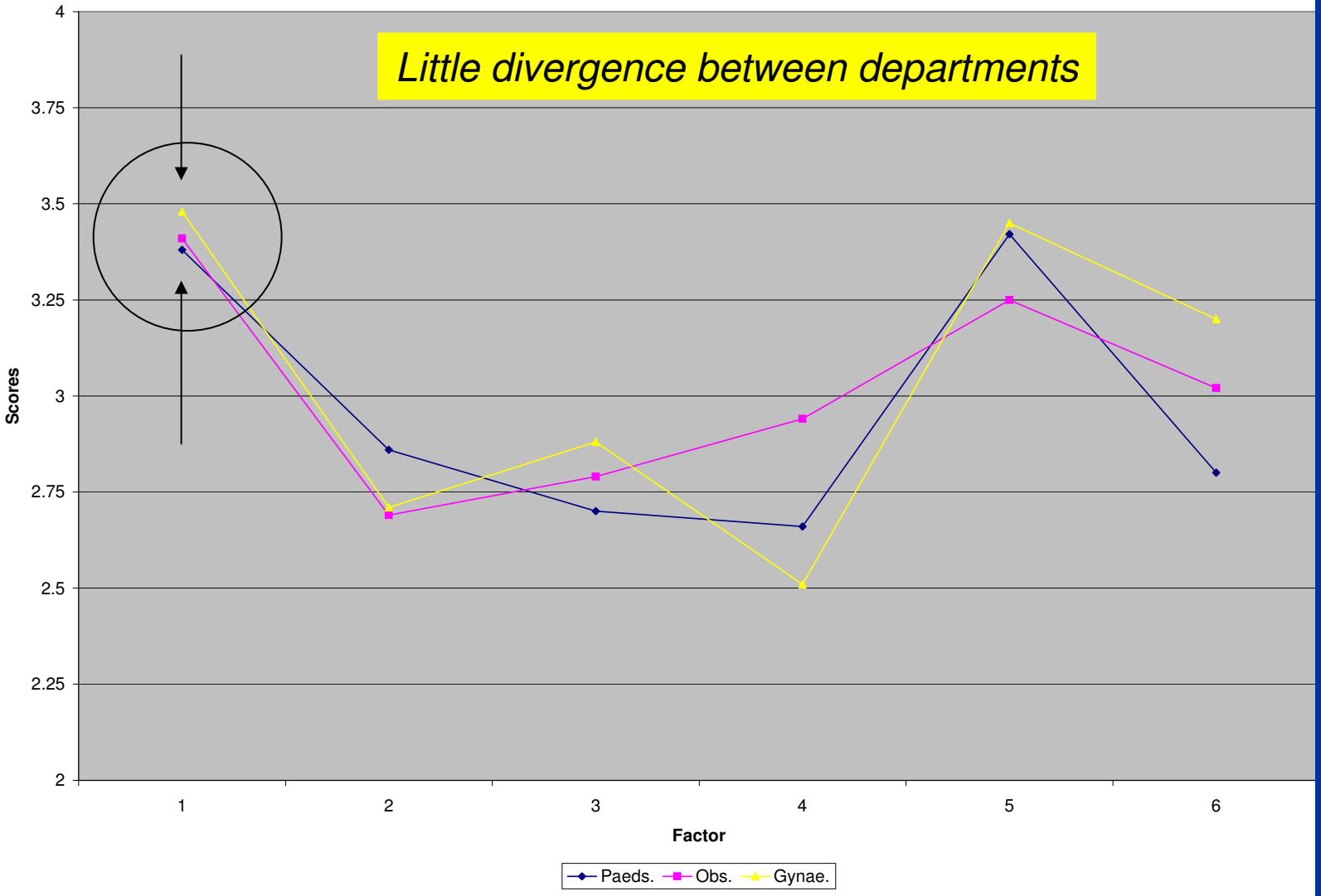
# Climate: Supervisory Vs non-Supervisory ("ward")




*CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.*

*(A lower score indicates greater satisfaction in a factor)*

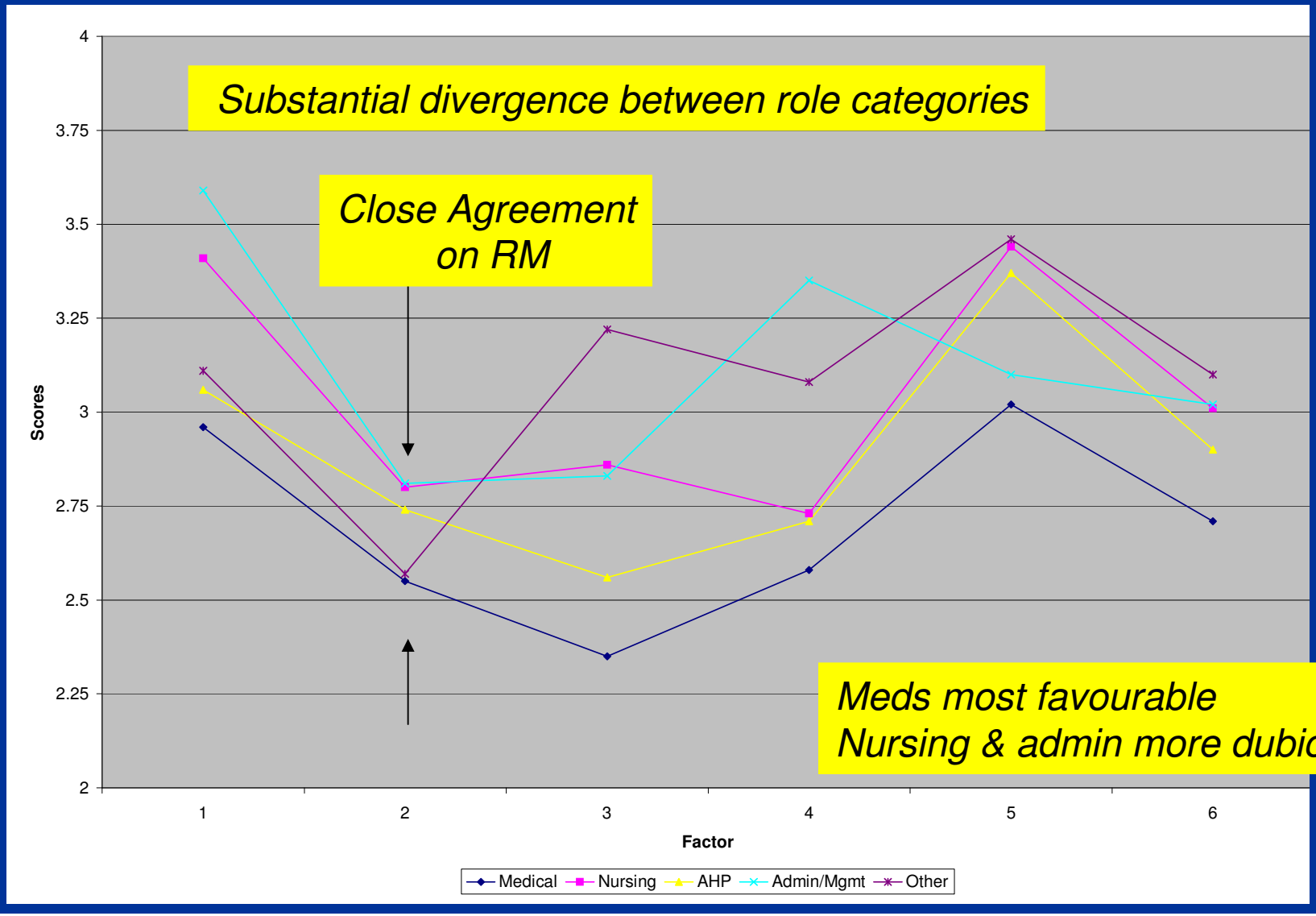
# Climate - Department (Paeds, Obs, Gynae)




*CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.*

*(A lower score indicates greater satisfaction in a factor)*

# Climate - Role Category (Med, Nursing, AHP, Admin-Mgt, other)




*CGCQ Factors: 1. Pl/integ QI; 2. Proact RM; 3. Abs blame; 4 work colls 5. T & dev 6. Org Learn.*

*(A lower score indicates greater satisfaction in a factor)*

# Climate - Summary over all Six CGCQ Factors (from box-plots)

| | CG Climate Questionnaire Responses | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| CGCQ_F4 | Working with Colleagues | | X | X | | | SW= |
| CGCQ_F3 | Climate of Blame and Punishment | | | X | x | | M+ AHP+ S+ O+ G~ P~+ |
| CGCQ_F2 | Proactive RM | | (x) | X | | | All agree |
| CGCQ_F6 | Org Learning | | | X | | | Admin~- SW= OGP= |
| CGCQ_F1 | Planned and Integrated QI programme | | | X | (x) | | AHP+ SW= OGP= |
| CGCQ_F5 | Training and Development Opportunities | | | (x) | X | | M~ Admin~- S~ P~ |

*legend for Observations*

S Supervisory (inc management) W Ward (non-supervisory)
M Med, N Nursing, AHP, Admin
O Obs, P Paeds, G Gynae
*status is perceived as*:
++ excellent + good ~ neutral - poor -- very poor

*Components as follows:*

# F1 Planned & Integrated QI Framework (box-plots)

*Enthusiastic re ostensible QI;*
*less so re anticipative, resourcing*

| | CG Climate Questionnaire Responses | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| **CGCQ_F1** | **Planned and Integrated QI programme** | | | X | (x) | | Specialists- Levels- |
| CGCQ39 | People share a common vision of service delivery | | X | X | | | M+ N~ AHP+ Admin~+ W+ S/W+ |
| CGCQ57 | People are motivated to improve quality | | X | X | | | M\N- S/W+ |
| CGCQ24 | There is no support to deliver service changes | | | X | | | AHP-~ W+ SW= OGP= |
| CGCQ25 | There is no clear vision of what the organisation is trying to achieve | | | X | | | S+ P+ |
| CGCQ33 | The first we know of quality improvement selsewhere in the organisation is when we feel their effects | | | X | | | AHP- Admin- S\W- G- |
| CGCQ46 | People don't have shared service goals | | | X | | | AHP+ Admin SW= G+- |
| CGCQ60 | People are highly motivated to make changes to clinical practice | | | X | | | AHP+ SW= |
| CGCQ20 | Good practice stays in isolated pockets | | x | X | | | M+ Admin+ S+ S\W- |
| CGCQ29 | There are lots of quality improvement initiatives, but no real change | | X | X | | | M~ N- AHP+ S\W- OGP- |
| CGCQ36 | Quality improvement is imposed from above rather than built from below | | X | X | | | M~ N- S\W- |
| CGCQ41 | There is pressure to solve problems quickly rather than take the time to do it properly | | X | X | | | M~ N- S/W~+ |
| CGCQ58 | There are few opportunities to use new skills learned as part of development | | X | X | | | S~ S\W- |
| CGCQ59 | People are forced into making service changes rather than encouraged to make them | | X | X | | | M~ AHP+ S~ S\W- |
| CGCQ18 | Long-term planning for quality improvement gets lost in the day-to-day | | X | | | | M~ AHP+ SW= OGP= |
| CGCQ34 | Service improvements tend to be crisis led | | X | | | | SW= G~ |
| CGCQ38 | there is no time to get togather to share ideas | | X | | | | all agree |
| CGCQ42 | We don't address the accidents waiting to happen | | X | | | | M+ N- AHP- Admin- SW= |
| CGCQ48 | People don't know about good practice taking place elsewhere in the organisation | | X | | | | M~ SW= OGP= |
| CGCQ50 | Immediate pressures are always more important than quality improvement | | X | | | | all agree |
| CGCQ51 | Quality improvement activity is largely a response to external pressure | | X | | | | M~ AHP+ SW= G~ |
| CGCQ56 | We react to problems rather than try to prevent them | | X | | | | M~ SW= OGP= |

# F2 Proactive Risk Management (box-plots)

***Generally: good ;***
***no predominantly disapproving responses***

| | CG Climate Questionnaire Responses | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| **CGCQ_F2** | **Proactive RM** | | (x) | X | | | |
| CGCQ14 | We collect information on clinical risks | | X | | | | |
| CGCQ43 | Clinical risk policies are shared throughout the organisation | | X | | | | M~ SW= OGP= |
| CGCQ52 | Risk assessment processes are updated in the light of clinical incidents | | X | | | | all agree |
| CGCQ54 | When something fails it is used as a learning opportunity | | X | | | | M~ Admin~ S/W+ O~ |
| CGCQ27 | We don't collect information on the clinical risks that matter most | | | X | X | | M++ N~ AHP~ S\W- |
| CGCQ21 | Identified clinical risks remain unaddressed | | | X | | | M+~ S+ S\W- OGP= |
| CGCQ22 | Clinical risks are identified in a systematic way | | | X | | | M+ Admin+ S+ OGP= |
| CGCQ30 | There is no common approach to risk management | | | X | | | S+ (S\W-) O+ G- |
| CGCQ35 | When a clinical risk is identified, there is always action to address it | | | X | | | AHP~+ SW= P- G+ |
| CGCQ37 | We systematically assess clinical risks | | | X | | | AHP~+ Admin~+ S+ S\W- |
| CGCQ44 | Clinical risk information is used routinely to inform decisions | | | X | | | AHP+ Sup+ |

# F3 Climate of Blame and Punishment (box-plots)

***Generally: good ;***
***is Q1 actually disapproving?***

| | CG Climate Questionnaire Responses | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| **CGCQ_F3** | **Climate of Blame and Punishment** | | x | X | | | M+ W&Ad(-) |
| CGCQ3 | Error reporting systems are basically a stick to beat clinicians with | | | | X | | |
| CGCQ7 | Staff appraisals are used to punish staff | | | | X | | SW= OGP= None <~ |
| CGCQ11 | The emphasis is on how an incident happened not who made the mistake | | X | X | | | M\N- S\W- OGP= |
| CGCQ26 | We work in an atmosphere of blame | | | X | X | | M++ N~ S\W- |
| CGCQ5 | People involved in clinical incidents are made to feel guilty | | | X | | | M+ Admin+ S+ |
| CGCQ12 | People who make mistakes are supported | | | X | | | M+ SW= OGP= |
| CGCQ16 | When there is an error, we look for failures in systems rather than blaming the individual | | | X | | | S+ OGP= |
| CGCQ1 | When things go wrong, there is an automatic assumption that 'someone is to blame' | | X | | | | Admin-- |

# F4 Working with Colleagues (box-plots)

***Generally: good ;***
***is Q55 really disapproving?***

| | CG Climate Questionnaire Responses | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| **CGCQ_F4** | **Working with Colleagues** | | X | X | | | |
| CGCQ8 | People have a good knowledge of the skills of their colleagues | | X | | | | |
| CGCQ19 | Colleagues are dishonest with eachother | | | | X | | Admin~ SW= OGP= |
| CGCQ40 | There is mutual respect for the contributions of all | | X | | | | AHP~ SW= |
| CGCQ45 | People don't know what their colleagues expect of them | | | | X | | M- Admin- W- |
| CGCQ53 | Colleagues don't seem to understand each others roles | | | | X | | Admin- SW= O~ |
| CGCQ55 | Everyone has the same standing regardless of professional background | | | | X | | M~ SW= OGP= |

# F5 Training and Development Opportunities (box-plots)

***Generally: Dubious***
***Lack of time to reflect is conspicuous***
***Staff development weakness is surprising***

| | CG Climate Questionnaire Responses | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| **CGCQ_F5** | **Training and Development Opportunities** | | | (x) | X | | M(n) P(n) |
| CGCQ4 | Critical appraisal skills training is available to those who want it | | | X | | | N- W- |
| CGCQ6 | career development needs are assessed alongside the strategic needs of the service | | | X | | | |
| CGCQ15 | Technical help with evidence-based practice is available | | | X | | | M+ O+ |
| CGCQ17 | Appraisal does not identify the real development needs of staff | | | X | | | AHP- SW= OGP= |
| CGCQ28 | There is no training available in searching for research evidence | | X | X | | | M~N- AHP- S~ S\W- |
| CGCQ9 | We have protected time for quality improvement activity | | | | X | | None >~ SW= |
| CGCQ47 | There is time to reflect on practice | | | | X | | M~ Admin~ SW= OGP= |
| CGCQ49 | Development needs are regularly assessed | | | | X | | AHP~ Admin~ SW= OGP= |

# F6 Organisational Learning (box-plots)

***Generally: good ;***
***Not clear why Org Learning rates so low overall (earlier slide)***

| | **CG Climate Questionnaire Responses** | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | Observations |
|---|---|---|---|---|---|---|---|
| | | | | | | | + good resp ~ neutral - poor resp |
| **CGCQ_F6** | **Org Learning** | | | X | | | Ad(-) |
| CGCQ23 | People share practice issues with others in different parts of the organisation | | X | X | | | M+ W+ (S/W+) |
| CGCQ2 | Good practice ideas are shared with others outside the organisation | | | X | | | Adm- SW= OGP= |
| CGCQ13 | We work together across teams to make quality improvements | | | X | | | Admin+ S+ P+ |
| CGCQ31 | Teams from different parts of the organisation share their good practice | | | X | | | W- G- |
| CGCQ32 | People devote time to disseminating good practice | | | X | | | SW= G- |

CG Survey

# Summary of Clinical Governance Survey

| | | |
|---|---|---|
| Presence of plans and actions | strong awareness of incident reporting mechanism, audit, consequent corrective action | weaker on:<br>assessment of clinical risk<br>review accuracy of record-keeping |
| Awareness of process | Good awareness of<br>EBP, deveopment programmes, QA, Learning from complaints | overall weak awareness of professional procedure - with notable exception of medics who have high awareness |
| People in roles | Very strong awareness of individuals re RM, CA, Compplaints<br>Strong awraeness of multidisciplinary Q meetings/process | Poor awareness re person(s) and Q in business planning, workforce planning, cinical effectiveness information; involvement of all relevant staff in CA |

# Clinical Governance Survey: Presence of Plans and Actions

***Generally: good for ostensible activities (sharp end)***
***less clear on support (blunt end?)***

| | CG Survey Responses | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Yes | Sometimes | Rarely | No (never) | | Observations |
| | | | | | | | + good resp ~ neutral - poor resp |
| CGSQ5 | Does CS use a hosp incident reporting mechanism to ensure AIs are identified? | x | | | | | all++ |
| CGSQ15 | Does this meeting recommend changes in how services are provided and ensure these happen? | x | | | | | Adm:S P:S~ S:Y\W:S |
| CGSQ6 | Are adverse events openly investigated, lessons learned and changes made? | x | x | | | | N:S Adm&P&O:S/R; I2&3:S |
| CGSQ7b | Does the clinical service routinely put action plans in place to reduce risk to patients? | x | x | | | | M++ P&O S L2&3: S |
| CGSQ11 | Do the results of audits bring about changes to working practices | x | x | | | | S/S-Y N+Adm:S;msg:Level |
| CGSQ7a | Does the CS routinely assess clinical risks? | | x | | | | N&Adm:S/R P:S; I2&3:Y/S |
| CGSQ8 | How often is the quality of clinical record-keeping routinely monitored? | | x | x | | | M:S/R |

# Clinical Governance Survey: Processes

***Generally: good for ostensible activities (sharp end)***
***less clear on support (blunt end)***

| | CG Survey Responses | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Strongly Agree | Agree | neither | Disagree | Strongly Disagree | |
| | | | | | | | + good resp ~ neutral - poor resp |
| CGSQ17a | Evidence-based practice is supported and applied routinely in everyday practice | | x | | | | Ad- G+\P~ |
| CGSQ17c | Development programmes aimed at meeting the needs of... | | x | | | | M(+) AHP(-) O(+) |
| CGSQ17d | Processes for assuring the quality of clinical care are in place in the service | | x | | | | OG+ S+\Q~ |
| CGSQ17e | Lessons are learned from complaints and recurrence of similar problems is avoided | | x | | | | M~ Adm~ G++ W+ |
| CGSQ17b | Workforce planning and development is fully integrated within the service | | | x | | | M++\- |
| CGSQ17f | Professional performance procedures that help... | | | x | | | M(+) P-\G+ |
| CGSQ17g | Clear procedures exist that allow staff to report concerns about a colleagues professional conduct and performance | | | x | | | M(+) S(+) |

# Clinical Governance Survey: people

***Generally: good for ostensible activities***
***less clear on reflection; coordination/involvement; support***

| | **CG Survey Responses** | | | | | |
|---|---|---|---|---|---|---|
| CGSQ4… | Does the Clinical Service (CD) have a Person responsible for the management of the following… | Yes | No | Don't Know | | + good resp ~ neutral - poor resp |
| CGSQ4a | Person...CRM | x | | | | Ad~ |
| CGSQ4b | Person...clinical audit | x | | | | Ad~ |
| CGSQ4c | Person...complaints | x | | | | Ad~ |
| CGSQ9 | Does the CS have a CA programme? | x | | | | M+/~ |
| CGSQ4f | Person...setting service quality standards | x | x | | | M~ |
| CGSQ12 | Does the CS routinely hold a meeting to discuss quality issues? | x | x | | | AHP&Adm++, P:N~(OG++) |
| CGSQ14 | Is this (Q) meeting multidisciplinary involving all parties, including managers? | x | x | | | M:Y O:Y S:Y |
| CGSQ16 | Are you discussing quality issues as part of the CS's business planning process? | | x | | | M:Y N:N~ S:Y~\W:N~ |
| CGSQ4d | Person...workforce planning | | x | x | | N+ Adm+ M~ AHP~ |
| CGSQ4e | Person...coordination of clinical effectiveness info | | x | x | | all~Obs++G+P~ |
| CGSQ10 | Does the CA programme involve all relev clin staff? | | x | x | | AHP:N W:~ |

Resonance between CGCQ and CGS

# Resonance – 1 of 3

| CGCQ *Factors* | Overall Rating | CGS Status | Grade | Level |
|---|---|---|---|---|
| Proactive Risk Management? | 2.76* | (4a) Individual responsible for Risk Management | 88% yes | High |
| (Quality Management) | | | | |
| Working with colleagues? | 2.77 | (4f) Individual responsible for - setting service quality standards | 87 % yes | High |
| (Clinical Directorate) | | (4b)Individual responsible for - CA | 86 % yes | High |
| | | (4c) Individual responsible for - Complaints | 84 % yes | High |
| | | (4d) Individual responsible for - w/f planning | 72 % yes | Medium |
| | | (4e) Individual responsible for - Coordinating clinical effectiveness information | 71 % yes | Medium |
| Absence of unjust blame | 2.79 | (17g) procedures for reporting concerns | 3.02+ | Sometimes |
| (Constraints) | | | | |
| | | | | |
| Organisational learning? | 2.95 | (17e) lessons learned from complaints | 2.37 | Agree |
| (Performance Management) | | (17a) EBP routine | 2.29 | Agree |
| | | (6) Adverse events/ lessons are learned… | 2.1 | Rarely |

Scales are as follows:

* 1 = strongly agree with a positive statement, or strongly disagree with a negative statement (lower is more positive ie 1 = "very good", 2 = "good", 3 = "neutral", 4 = "poor", and 5 = "very poor")

\+ 1 = no (never), 2 = rarely, 3 = sometimes, and 4 = yes (always)

# Resonance – 2 of 3

| | | | | |
|---|---|---|---|---|
| Have a QI programme? | 3.34 | (17d) Q assurance processes-clinical care? | 2.48 | Neutral/agree |
| (Quality Management) | | | | |
| | | (5) risk – incident reporting | 2.89 | Sometimes-rarely |
| | | | | |
| | | (7a) clinical risk – routine assessment? | 2.29 | Rarely |
| | | (15) Q meeting makes changes? | 2.26 | Rarely |
| | | (7b) Clinical risk reduction plans? | 2.21 | Rarely |
| | | (11) CA changes work practices? | 2.2 | Rarely |
| | | (6) adverse events – open investigation? | 2.1 | Rarely |
| | | | | |
| | | (8) monitor Q of clinical records? | 1.74 | rarely/never |
| | | | | |
| | | (9) CA programme? | 82% yes | High |
| | | | | |
| | | (10) CA involves all clinical staff? | 69% yes | Medium |
| | | (14) Q meeting multidisciplinary? | 67% | Medium |
| | | (12) meeting for quality issues? | 65% yes | Medium |
| | | | | |
| | | (16) Q issues input to business planning? | 48% yes | Neutral |

# Resonance – 3 of 3

| | | | | |
|---|---|---|---|---|
| Training and development opportunities? | 3.35 | (17c) Development programmes – to meet individual-clinical service needs | 3.03 | Neutral |
| (Performance Mgt) | | (17f) professional performance support | 3.10 | Neutral |
| | | (17b) integrated workforce planning/dev | 2.99 | Neutral |

# Triangulation

Clinical Directorate

Performance Management

Quality Management

Constraints

Prospective Change

X

- Docs

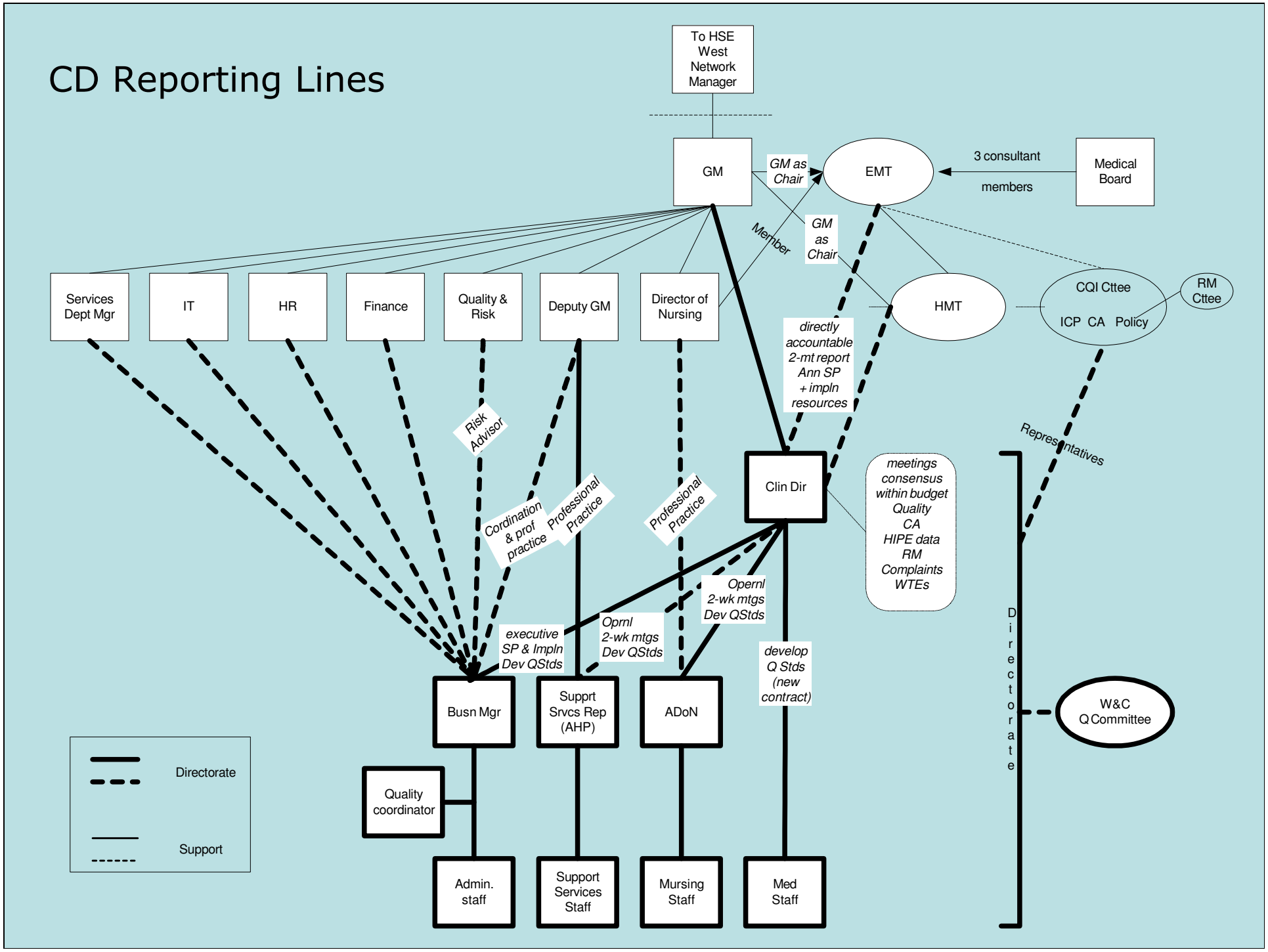
- Qual

- Quant

## 1: CLINICAL DIRECTORATE:

Organigram
Formative Influences
Perceived Purpose, Scope and Role
CD Boundaries
CD Function & Reporting Relationships
CD Control
CD Leadership Style

# CD Reporting Lines



## CD: Formative Influences: (Hospital & CD Mgt)

**[Doc]**

*EXTERNAL*: Resonance with Q&F; HSE documents less specific.

Reform 2003 :

"devolving accountability for spending to the most appropriate decision-making level";

clinicians personally accountable for cost as well as clinical performance. They should be fully brought fully into planning, management and control processes.

Finance and performance key focus

*But, CD model not explicit*

HSE Corporate Plan 2005-8:

Code of Governance, and

"strategic and business planning approach based on best evidence".

*without specific mention of CDs*

Transformation: reference to 'clinical leadership and team-based service delivery' (e.g. Prog6, staff).

*INTERNAL*: *CIM model synonymous with CD model.*

ref to Two Deloitte & Touche reports on GRH management structures, 1999

GUH Strategy 2006-10: CIM model to the forefront of hospital strategy; formed in a participative and wide-ranging programme.

Partnership Annual Report 2004: Joint problem-solving strong in GUH (formation of Mission and Vision lauded as national exemplar)

## *CD: Formative Influences*

**[Qual]**

External influences:

- national and international evidence that CDs work (1, 2);
- the system wants them (2).

Internal influences:

- Inadequate arrangements in the past , e.g.
  - Heads of Department and Clinical Co-ordinators without formal authority and accountability,
  - Centralised structure without clinician input (1).
- Hospital Management initiated CIM project;
- Intention:
  - facilitate hospital-wide integration;
  - enable participative decision structures and accountability (1, 2).

**[Quant].** Not available.

# CD: Perceived purpose, scope & role

**[Docs]** CD in Medicine Newsletter: purpose of the CD/CIM structure:

- Serve conjoint clinical and managerial decision-making
- Decision-making close to clinical activity

Job Descriptions for Clinical Director and Business Manager: purpose:

- Deliver the annual service plan at CD level
- Link among specialities in CD, between specialties, and with the hospital
  - report to EMT and HMT
- Manage resources provided and not deviate from the budget
  - Run meetings, deliver bi-monthly reports to EMT
- Promote cooperation with hospitals, services and healthcare providers
- Deliver/support RM, Complaints, CA, HIPE, CQI, benchmarking and PIs, and accreditation
- Control WTE staffing

Workshop "What Works":

- Positive outcomes – chiefly better communications
- Also some negative experiences
  - Unclear boundaries, lack of budget and real decision-making.

Framework for a Clinical Directorate: definition of CD structure:

- Formal statement of recurring meetings with scope and frequency.

## *CD: Perceived purpose, scope & role*

**[Qual]**

Clinicians - close to the patient; - have direct service influence.

Their input to and awareness of *service issues* and the high level of their spend, points to the need for 'self managed' CDs (1).

"In the past, such involvement would have caused them (clinicians) fear of compromising their patient care" (1, 3).

More accountable and cohesive *governance structure* envisaged(1).

CDs will have *local ownership* of performance management with a budget, staff control and management of service quality and its improvement (2,3P.4OP).

## *CD: Perceived purpose, scope & role*

**[Quant].**

Awareness of scope of CD responsibility

- 88 percent of staff members believe that there is an individual within the CD responsible for clinical risk management.
- Only 72 per cent of staff members are aware of the presence of individual responsible for work force planning.

Supervisory marginally more aware of presence of such individuals

# CD: Boundaries

**[Doc]**

*Rationale for clustering* into CDs not explicitly stated:

- Passing reference to Deloitte & Touche reports of 1999 on GRH organisational structure.

What-Works Workshop 2007:

- Some activities inappropriately pass outside CD boundaries

## *CD: Boundaries*

**[Qual]**

CD boundaries reflect

- historical relationships,
- rationalisation goals and
- the scope and scale of units (1).

The combination of O/G & Paeds in W & C is based on historical links and needs (1, 2, 3P, 4)

"We were doing it except we didn't have the title" (2b)

Model: endorsed having observed a UK site (1.3P)

Some see the decision as arbitrary but recognise the need for some link (3.OP)

Scope/Scale: The CD terms of reference are defined at a senior level and are intended to empower so as "to manage within constraints" (1a)

However, people unaware of the terms of reference at dept level (3.OP)

CD boundaries have implications for CD learning and manageability

Accountability lines still go to the GM and Professional Bodies (1)

# CD: CD function and reporting relationships

**[Docs]**

GUH Hospital organisation:

(ref GUH Organigram supported by departmental charts)

Deputy General Manager's Office

Director of Nursing Department

Finance Department

HR Dept

Information Services Dept

Quality & Risk Dept, and Services Dept

Composite organigram is presented on earlier slide.

- complex reporting arrangements are provided.
- dual lines of authority for each individual on the management team.

***continued over***

## *CD: Functions & reporting relationships*

**[Docs]**

Clinical Director (Job spec) :

need for both clinical and managerial leadership capability and attitude:
"lead and manage", "coordinate … implement", "manage resources",
"organise and chair meetings", "advance the unification of GUH",
"promote cooperation with other hospitals…"
"Facilitate … CQI programme".

Business manager (job spec):

Focus on coordination

Both Clinical Director and Business Manager:

Some basic training in management processes (job spec; HR training plan)

Insufficient (What Works Workshop Sept'07).

Nursing? AHP?

## *CD: CD Team & reporting relationships*

**[Qual]**

CD functions include

- resource management (3.OP)
- service planning (1)
- extend to
  - sharing problems and communications with Paeds (3.O),
  - improving service standards and performance
  - dealing with needs and issues (3P.4P).

The Director reports to EMT through the GM (also interacts positively with peers) (1).

Team members accountable to the Clinical Director (2)

Decisions referred to HMT and EMT (1), reports to those levels (2). 4.OP).

Dual role-relationship issues regarding the DGM and DN.

## *CD: Functions & reporting relationships*

**[Quant I].**

Staff members are reasonably positive toward the experience of working with their colleagues (mean =2.77).

- Supervisory more positive than non-supervisory.
- Medical staff most positive to team colleagues.
- Admin/management grades least positive.

**[Quant II].**

High level of Awareness (80%+) of person designated for:

- Setting clinical service standards,
- Risk Management,
- Clinical Audit,
- Complaints.

Medium level of Awareness (70%+) of person designated for:

- workforce planning,
- coordination of clinical effectiveness information

# CD: Control

**[Docs]**. (various)

*No explicit discussion of control*

Clinicians have say in selection of the C Director, as peers

Monthly clinician meeting: ADoN and Services Rep (AHP) are observers

Operational control appears to centre on performance

Nature of any sanctions/influence is unclear* (within or without the CD)

Union relations problematic in specific context of CDs (union recognition)

(What Works Workshop; HR annual report)

* NB: not documented, by deduction.

## *CD: Control*

**[Qual]**

Control is located at both hospital and HSE levels (1)

Consultant independence (2) is a challenge to the authority and accountability of the Clinical Director (1, 2)

Good teamwork but unification is slow (1)

CD described as “two departments merged” (1), “exist as two departments” (4P)

Gradual engagement of Paediatrics in the CD is noted. (3.OP)

Problems in recognition by unions (2), and professional bodies (3P)

CD management assert that there is unity; Good meetings & feedback

But, cross-disciplinary working is mainly for medical policy and guidelines (2).

**[Quant]**.

issues over involvement, time to reflect, support (eg staff development support), and achievement of action;

(point to issues of double-loop learning?)

(ref: various question responses; CGS; CGCQ)

# CD: Leadership Style

**[Docs]: none**

**[Qual]**

Leadership style democratic and team based (2)

Two members are described as very persistent

another as a good communicator with very strong work ethic, quality orientated, and sees the big picture

All very service and quality orientated (3.O)

Barriers to leadership:

- Traditional directive style (1),
- Unions (3.O),
- Layers of management (2).

Clinical leadership:

- "Definitely there", "good with some subjectivity" (1) "trickles down" or "comes from the ward", "you can feel it on the ground floor" (2, 3.O, 4.O).
- But, "unfortunately, the culture of this organisation does not really have any arena for good leadership" (3.O).
- "For years it was confined to higher management of the hospital" (1)

## *CD: Leadership Style*

**[Quant]**

Significant relationship between organisational levels in terms of their perception of the relative absence of a blame culture:

The lower a person is within the organisational hierarchy, the greater the perception that a climate of blame and punishment exists (p=.007).

# 2: PERFORMANCE MANAGEMENT

IT and IS
Performance

# Performance Management: IT and IS

[Docs] : *Hospital/National*

National Hospitals' Information System group: Strong GUH representation

- Progress constrained by uncertainty re status of (national) system supplier in 07
- Publication of HSE ICT strategy delayed; leadership uncertainties (email)

*Hospital*

Hospital adopts a de-facto strategy in the absence of strong central leadership:

- Anticipates emergent national direction
- Shifts from operational to developmental focus; Support dept/CDs re own data:
  - Develop key user capability, and data accountability
  - Project management capability (eg Prince II).
  - Service contracts for routine IT support by independent suppliers
  - Infrastructure/ integrate islands of software when replacing / investing
- Develop single electronic medical record, ref national developments and local practicality
- Key justification criteria for investment: Risk, efficiency (less paper) & access:
  - Access to information is critical for clinicians ('only what I need when need it'; now), for patients (e.g. information leaflets)
  - Information for GPs e.g. prescriptions
  - HIPE data for casemix-based payment and for planning, confidentiality and security.
  - High quality IS/IT service and performance

## *Performance Management: IT and IS*

Data Quality (DQ) programme:

Data warehouse structure to underpin access to multiple applications

New enterprise-level high speed network back-bone.

IS expenditure controlled centrally through a "16/97" process ( "circular 16/07")

cumbersome (IS-WP-07), but also forces better thinking.

*W&C Directorate*

Obs-Gynae: core application *Euroking* has worked well for 14 years, but is due for update. it is an information island.

W&C is exemplary: ref Obs-Gynae tradition:

wide range of PIs in daily use; service support

developments e.g. discharge documents.

CD form is a useful locus for ISIT activity:

Communication, development, empowerment at local level

Response to technology needs

*ref: GUH IS Work-Plan for 2008 ; National Information Strategy 2004 (of minor relevance).*

## *Performance Management: IT and IS*

**[Qual]**

National

Inadequacies at National IT level necessitated local initiative and engagement with some IT role distribution to hospital units (1).

Hospital

References made to STARS, EuroKing, Q Pulse (3) and an evolving Dashboard (1)

Local deficiencies are reported

e.g. Finance, HR, Medical Records, HIPE limitations,

restricted CIS with some exceptions (1, 2, 3.OP).

W&C Directorate

CIS works with IT and is quite good (1, 2, 3.O)

Needs an upgrade but could become the national standard (1)

Paeds are very low in technology (1) with information consequences (3P)

Clinical information is crucial !:

"my clinical data was most helpful to me in analysing the issues and trying to ascertain where the priorities lay" (2a)

but some clinicians have limited use of data (3P)

# Performance Management: Performance

**[Docs]** *External*

Reform 2003, Transformation, and the Corporate Plan 2005-8:

- Performance management central to HSE policy and strategy
- to support accountability, integration, efficiency, and response.
- Strong resonance with Q&F 2001 [1]

Corporate Plan: special section on Accountability and Performance Management.

- Aims to connect Q&F with business planning, performance monitoring and accounting
- SPs at national, hospital, and departmental levels:
  - monthly for operational control, annual for external reporting.

*Decision-making and control*:

- Service planning, with associated monitoring and review processes at levels (e.g. HSE, Hospital, CD) as integrating framework.
- Financial Vote and WTEs as key instruments.
- References to: objectives, resources, WTEs, corrective actions, and in particular performance (rather than quality) as focus of control
- National Performance Indicator suite referenced but not disclosed.
- Performance managed nationally by Performance Management Unit (PMU) (*HR AR*)

1. Q&F is central plank of GUH Strategy, and runs down through EMT, HMT terms of reference, Job specifications for Clinical Director and Business Manager, and Suggested Mode of Operation of a Directorate

## *Performance Management: Performance*

**[Docs]** *Internal*

HIPE a core data source (IS Workplan; "What Is HIPE") eg diagnostics/therapy volumes, LOS. HIPE uses ICD-10AM.

IS Workplan: more use could be made of HIPE data stream; Inadequate capacity for coding, a sustained substantial backlog.

Organisational functions produce PIs on their own activity:

- HR: monthly list of PIs relating against targets to: numbers receiving training, participant satisfaction ratings, staff absenteeism, and so forth.
- IS: Dept activity PIs.

CDs report performance with ref to SP targets, bi-monthly to EMT and to HMT (Reporting Template):

- Quality PIs: IS & Directorates developing PIs relevant to CD needs
- OG/W&C Annual Report 06, 07: wide range of performance indicators of their choosing are in use, e.g.patient volumes by dept and by diagnosis/treatment category.
- W&C CD: designated person (MH) coordinates data collection, produces and presents the corresponding reports using applications supported by IS

Performance management of individuals focused on goal-setting with Personal Service Objectives (PSOs), and an account of progress and achievements.

## *Performance Management: Performance*

**[Qual]:**

Performance Management is under-developed and under-invested.

- Real self-regulation is limited.
- EMT monitors CD performance (1) but there is a view they "don't really measure for results" (2c)

Some Performance Indicators are agreed for some specialities.

- Plan to develop through a national project and the service plans.
- However, "they are difficult to implement when I look at my own level of performance (WTEs)" (1a)
- Activity targets are devolved: W&C sets action plans, measures and outcomes and have a reasonable handle on their activity and performance (1).

Performance management is progressing in W&C:

- Its "getting going philosophically as a combined Directorate" (1a),
- "general agreement on the Directorate Model" (2a).
- CD characteristics are "good", "very good teamwork", "unity", "good relationship with staff" (2)
- Very innovative, cohesive and patient focused (1b).
- Service improvements (2, 4.O) & increased activity (2).
- More to be done:
  - Low level of CD awareness and impact at the front line (4.OP).
  - Communications; "need better communication from Director down…" (4P).

## *Performance Management: Performance*

**[Quant]:**

*(note: surveys were focused on clinical governance not performance in general)*

Climate survey:

There are positive responses to “working with colleagues”, and to “people share a common vision of service delivery”,

But, this is countered by agreement with sentiments such as “service improvements tend to be crisis-led”!

Respondents indicate a weakness in organisational learning, and training and development: Overall, responses are neutral at best.

- Supervisory and Med report slightly higher levels (“fair”) than others

CG Survey:

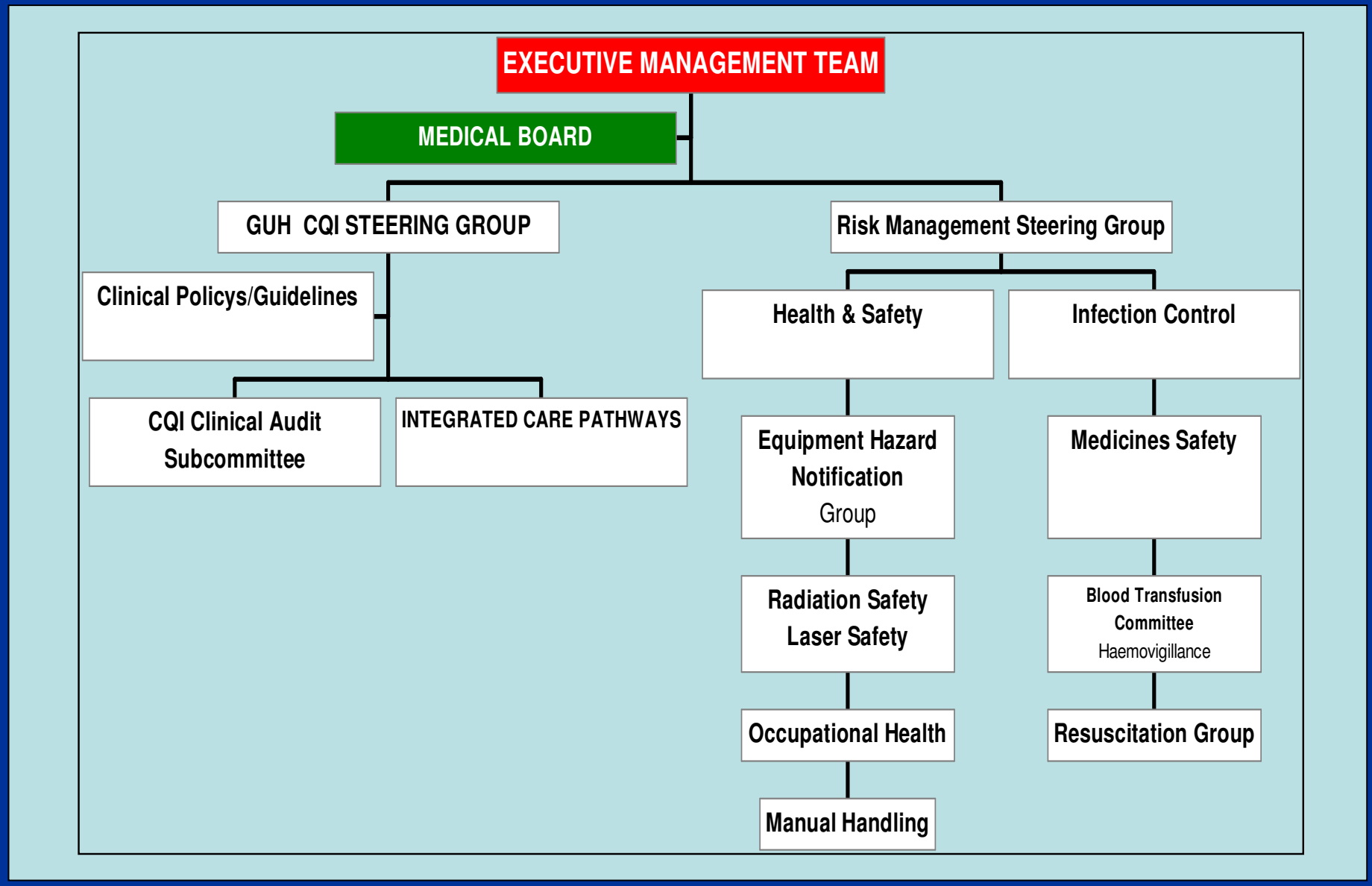
Good recognition of EBP and awareness of development programmes (though this is countered as noted above by perception of inadequacy!)

# 3: QUALITY MANAGEMENT

GUH Q&S Framework (Organisation)
Quality Model
Quality Structures
Quality Management Overview

**[Docs]:**

Quality & Safety Framework for Galway University Hospitals (CQI Strategy, fig 6-1)



# Quality Management: Quality Model

**[Docs]:**

*Espoused quality model*

Defined in several documents:

- GUH CQI Strategy
- GUH Healthcare Risk Management Strategy 06
- GUH Clinical Audit Policy 07
- GUH ICP policy

Corresponds to Strategic Objectives Quality, Governance in GUH Strategy 2006-10

Congruent with Acute Care Accreditation Scheme Standards and Guidelines (e.g. ref IHSAB ACAS 2nd ed.)

*Model in Use*

ISO 9001:2000 (revised 2003) at Dept level is held by Obs-Gynae Dept since 1996.

Developments reflect feedback from earlier accreditation visits (appendix 1 attached to CQI policy), and ACAS demand for written evidence of process:

Accreditation is an explicit plank in GUH strategy to raise the quality, performance and growth agendas.

Risk Management model informed by Aus/NZ 4360:2004 standard and previous experience eg in Health and Safety.

Importance attached to RM by hospital is indicated by the very large RM orientation programme for all staff in 2006.

## *Quality Management: Quality Model*

**[Qual]:**

No formal Q Model in use.

There is a combination of Q approaches and fora (1.2.3OP).

One perspective: "Quality talk tends to be about improving service and not quality" (3.Oa)

Another: "standards are my own personal experience…" (3P).

There are strategies and plans for Q (1, 2).

"The GM message is that Q is in everything" (1k).

While some say that Q does not go on the CD agenda (2b, 3Oc), others disagree or associate it with the development of guidelines and procedures (1, 3P).

## *Quality Management: Quality Model*

**[Quant]:**

*Climate*

The average score for "existence of a planned and integrated QI programme" at 3.34 (out of 5) suggests incompleteness or a level of fragmentation. Some staff disagree strongly that a planned and integrated QI programme exists.

However, Staff members positive toward the presence of "proactive risk management".

(Of all Factors, this was most positively scored)

Managerial / supervisory report greater proactive risk management than non-supervisory.

*CG Survey*

Awareness (80%+ i.e. high): CA programme

but, Awareness of Q issues as input to business planning only 48%.

Neutral/agree: quality assurance of processes for clinical care.

Sometimes: risk incident reporting.

Rarely: routine assessment of clinical risk, quality meetings to make changes, clinical risk reduction, CA changes work practices, adverse events open investigation.

Rarely/never: monitoring quality of clinical records.

# Quality Management: Q Structures

**[Docs 1 of 2]:**

Well-defined Hospital Management *Teams*

EMT: accountable through the GM to the Network Manager.

EMT defines and implements the structures of the hospital, including setting up and reviewing the work of hospital committees, and the relationship of the directorates with HMT

EMT accountable for "the utilisation of resources and the provision of an efficient and effective quality service, which is patient-centred and achieves value-for-money, as agreed in the GUH annual service plan".

HMT: the principle hospital forum for managing delivery of the strategic vision of EMT. In 2004 (HMT Terms of Reference 30th Sept 2004).
At hospital management level, there is a Quality and Risk Department, a CA manager, an ICP Coordinator and Risk Advisors.
Director of Nursing designated as hospital Patient Relations Manager.

In the HR Dept there is a Learning and Development Manager.

## *Quality Management: Q Structures*

**[Docs 2 of 2]:**

Well-defined Hospital *Committees* for quality (reporting into EMT) [*see next slide*]:

CQI Steering Committee:

Departments, including OG and Paeds, are represented.
Reporting to the Steering Committee are Sub-Committees, each with formal terms of reference): Multidisciplinary Policies & Procedures Committee (~7 members); ICP Development Committee (~ 6 members); Clinical Audit Committee (clinician-led, and –constituted, ~ 12 members)

Risk Management Steering Group.

There are two Risk Advisors who liaise with the CDs.
There are several Sub-Committees: Health & Safety, Equipment Hazard Notification group, Occup. Health, Manual Handling, Infection Control, Medicines Safety, Blood Transfusion Committee, Resuscitation Group.
At CD & ward level, Risk Registers are maintained, and there is a forum to discuss risk issues at least monthly (eg CD meeting and Labour Ward Forum).

CD Quality Coordinator

Reports to the BM
Liaises with all depts, levels & categories within the CD

## *Quality Management: Q Structures*

**[Qual]:**

Q structures include the *CQI Steering Committee*.

CDs nominate representatives and submit issues,

Examines multi-disciplinary policies and procedures (1).

Chair links to the Medical Board. It is very clinical-led, 2 years ago it would not have happened (1j)

but it can only pick small areas at a time (1k)

In W&C, Director and BM have responsibility for managing Q.

The QI team meets monthly (3.OP)

*Clinical Risk Management Committee*

W&C Rep (2)

Input to CR and Patient Safety (3P).

The Clinical Director provides an overview of risks and addresses them (3P)

Very active risk group who produce policy, procedure and reports (1)

RM needs a dedicated person otherwise it comes back for follow up (2)

RM reviews take place weekly with the GM (1j) and monthly Q meetings (2b) , at CD meetings (2b, 3Pa) and in the Labour Ward (or more frequently) (3.Oa)

## *Quality Management: Q Structures*

**[Quant:]**

*CG Survey:*

Strong Awareness

- incident reporting mechanism
- audit
- corrective action

Medium Awareness (60-70%):

- CA involving all clinical staff
- Q meeting multidisciplinary
- Meeting for quality issues

- Assessment of clinical risk; accuracy of clinical record keeping

## *Quality Management: Q Structures*

**[Qual]**

Labour Ward Forum:

All disciplines discuss issues

e.g. risk and recurring topics (3.0)

Monthly Clinical Audit (CA):

Reports and Reviews include Caesarean Sections and Perinatal Mortality (3).

There is a need for improvement in CA.

Hospital Management observes that there is insufficient CA; at best it is selective and primarily medical (1).

Departmental Management confirm that it is mainly medical and some “don’t audit as such” (3P).

In any case “Ireland is very poor in auditing outcomes (3P).

## *Quality Management: Q Structures*

ISO in Obs-Gynae:

- Very positive recognition in the management of Q since 1996 (1, 2, 3O)
- Facilitated the transfer to Accreditation (1)
- The Accreditation Group will decide about if for Paeds (3.0P)
- Benefits from ISO:
  - Systematic management of Q (3Oa)
  - Comprehensive good policy and procedures (2.3O)
  - Internal Q Audit standards for compliance and correction (3P)

## *Quality Management: Q Structures*

Accreditation*:*

Positive dimensions:

Multi-disciplinary teamwork, development, training, and

Putting Q on everyone's agenda (1).

Self-assessment process flags up deficits in policy and guidelines (1) and

Highlights good points and deficiencies (3P)

There is a commitment to (1) and pre-occupation with Accreditation (2)

Alternative perspectives:

"it has no impact on practice" (3P)

"not hugely impressed- site visit didn't engage clinicians or women…" (3.O)

"an overwhelming process…" (3P)

# Quality Management: Q Management Overview

**[Docs]:**

Promotion of quality activity:

- Channelled through CQI Steering Committee
- Quality written into all job specifications
- Quality-driven procedures, protocols and guidelines
- Special Q&R department at hospital level
- Support from HR
  - Structure
  - Change management
  - Training/education
- Support from IS
  - For gathering quality-related data
    - (application development, specialist users at dept level)
  - In a quality manner
    - (eg Data Quality project).
- CD:
  - Quality essential part of job specs of Clinical Director & Business Manager
  - Q activities built into the workings of CD (ref “method of working of a CD”)
- CQI Steering Committee incorporates & complements RM Committee activities

## *Quality Management: Q Management Overview*

*Hospital strategy* is informed by a participative style incorporating the interests of a wide stakeholder base (GUH Strategy for the Future 2006-2010)

- Patient/Community input
  - Galway Focus; Special focus group projects
- Participative organisational development pervades major changes
  - In particular the formative development process for CDs (ref 5-stage CD Formation Cycle; 'What Works" Workshop)

Self-Assessment Team Summary Profile Report prepared by the W&C QI Team for Accreditation 2007 shows volumes, PIs, incidents, QI plans and improvements.

*CD*

There is a W&C response to each of the 17 IHSAB Care Standards

Version-controlled lists referenced by Obs-Gynae Q Manual:

- Clinical Midwifery/Nursing Guidelines (182)
- Safety Policies & Procedures (50)
- Quality Policies and Procedures (48)

A well-used laminated risk rating sheet is testimony to rating in everyday use.

Minutes of quality committee meetings: demonstrate staff commitment and the quality of tasks undertaken e.g. for accreditation.

Wide-ranging documentation and its quality attest to substantial on-going QI activity in the Directorate

## *Quality Management: Q Management Overview*

Patient advocacy is a core activity.

- The Director of Nursing is the designated Patient Relations Manager
- Combines statutory duties of hospital Patient Complaints Officer.

The hospital initiated a Customer Comments process, and this complements and facilitates the statutory complaints-handling process.

- It is notable that the GUH comment card system captures much more feedback than arises solely from complaint, and this yields a stream of positive changes on the ground.

## *Quality Management: Q Management Overview*

Substantial number of QI project proposals

- Feed into Service Plans at CD, Hospital levels, and 1697 ISIT submissions
- Arrangement of QI projects by intent (strategy, planning and evaluation) and by realisation (structure process and outcomes) is presented in appendix C2
  - Structure: Risk Register, physical refurbishment (of holding nature) in Gynae
  - Process-level and evaluative: OG
  - Strategic direction: (aspiration?) focused on Paeds

A large staff training programme in Risk Management is reported (30x1½ hour training sessions, 1600 attendees in 2006).

Substantial Clinical Audit activity is reported for W&C

- Breastfeeding audit & re-audit, audit of 3rd Degree Tears & re-audit,
- audit of Neo-natal Admissions, Baby Temperature audit,
- Audit of Supplements Given to Children, Hysterectomy ICP audit,
- Paediatric DNAs (did not attends), CPR Trolley audit)

## *Quality Management: Q Management Overview*

**[Qual]:**

refs Q Management in general.

CQI Steering Group has made a huge impact.

- "It is very good" (3P, 4P)

W&C doing well (3.O)

- Very strong team (1), very effective and better than most (2)

Nursing standards are extremely high (Paeds) (3P).

OG score high on listening to patients.

It has made inroads to Q (3P)

- Come a long way in Q & R,
- Has a Q patient-centred focus (1)

Benchmarking is primarily connected with Paeds:

- Vermont/ Oxford database
  - International comparison on Q and Outcomes in neonatal care (2.3)

## *Quality Management: Q Management Overview*

**[Quant]**

*Climate*

"Fair" re vision/motivation

In general responses are surprisingly at a neutral level (e.g. imposed/forced)

Lessons rarely learned from adverse events/ Insufficient time to reflect on practice/ QI activity seen as reactive rather than anticipatory.

*MARQuIS survey*: A high level of quality activity is reported.

Peer professional review, ISO and "other"; active pursuit of accreditation and re-accreditation.

While not at full strength in all departments, and apart from staff issues (eg turnover, absenteeism), a wide range of PIs covering both utilisation/operation and clinical indicators, is available on both management and clinical agendas.

Performance is regularly reviewed, and consequent action taken to develop services in response to feedback, even if this activity is not fully systematic in all areas.

While there is very little actual collaboration of patients in developmental work, patients views are taken into consideration.

Systematic QI takes place in 'some' depts, Internal Audit in 'most' depts.

Absence of regular staff performance reviews, (but documents prepared for accreditation show forms for carrying this out indicating the system is either in place or coming on stream)

No benchmarks were available for MARQuIS.

## *Quality Management: Q Management Overview*

*Quality Cost Template:*

Current W&C Incident Report (for 31st October 2007 to 29th Feb 2008) shows.

- Incidents categorised with frequency and severity, allowing ranking.
- E.g. bulk of the moderate and high risk cases are attributed to Treatment Incident, Other, and Perinatal incidents.

Cost data are not assigned specifically to incidents in the directorate (e.g. clinical negligence claims).

# 4. CONSTRAINTS

External

Internal

Ownership and Control

# Constraints: External

**[Docs]:**

Reform '03 and the HSE Corporate Plan

Fragmentation a core system constraint

Weaknesses in planning capability (eg service planning) a major constraint

*Goal: a unified and accountable system*

*Incidentals:*

Activities of the HSE PMU place a large burden on hospitals to provide data (GUH HR Annual Report '07)

Considerable disruption to training schedules by visiting HSE corporate staff (GUH IT Work Plan '08)

## *Constraints: External*

**[Qual]:**

HSE: Management & Control

Concerns re management capacity and extent of central control in the HSE

- "Many managers are nominal, more staff advocates the decision makers"
- Time-served rather than trained-and-developed are management selection criteria (1)
- Inefficiencies and layers of management (1)
- Top-down centralised style removed local power/ flexibility; limits GM decision authority (1.3O)
- "HSE is hugely micro-managing the system" (3P)
- Service Plan targets are dictated by the HSE (1)
- Paradoxically, "the HSE don't want any change" (1) and "local managers can't make changes" (1)

Consequences: it is "managed by resources and unions" (1k)

- "local management are undermined" (1)
- "motivation is being eaten because we are constrained with the environment of the HSE" (3.O)
- Because of the embargo there are fears of non-replacement (3.O)

HIQA

- "Their standards create more pressures" (1)

## *Constraints: Internal*

**[Docs]:**

Internal:

Limited Budgetary Devolution and Control

The What Works Workshop ’07: Key obstacles to CD performance:

- Lack of budget control
- Control over decisions on allocation of WTES

W&C Annual Report:

- Absence of promised shadow budget.

## *Constraints: Internal*

**[Qual]:**

There is an emerging scepticism (3P).

No budget and no control over staff numbers!

This resonates through all levels of GUH/CD (1, 2, 3OP, 4OP).

e.g. Finance never devolved the budget" (1)

it has not yet set any budgets for the Directorate (2)

"Someone in Finance is looking into it!" (2).

Regarding staffing issues, "they don't know the level of vacancies or the costs or control over staff numbers" (4.OP).

They want to develop new governance structures but are under-resourced (1).

"At the moment our whole lives are hinging around two things- WTEs and bed capacity" (1).

# Constraints: Ownership and Control

**[Docs]:**

Reluctance of departmental staff to take on responsibility for signing-off on information generated in departments (IS Work Plan '08)

Disappointing uptake of training; especially as the content offered was identified by a participative training needs assessment (GUH HR Annual Report '07)

## *Constraints: Ownership and Control*

**[Qual 1 of 2]:**

CDs have yet to take full ownership and management:

"I empower others, but yet I am expected to have the answer- nobody likes making unsavoury decisions" (1b).

Thus hospital management engage CD input to reports for HSE but must deal with issues raised (1).

In contrast, CD & Dept management say CD Authority and responsibility is very limited (2.3.O).

"There is limited control over what we can do" (3Pa).

no scope to solve problems, change services or anything that might influence (3.O).

The GM decides priorities and the EMT ultimately make the decisions (2).

Things are not devolved down to the level of Directorates- it is still back to GM (3P). more direction than discussion (4.O) so people need to start letting go (2)

## *Constraints: Ownership and Control*

**[Qual 2 of 2]:**

Complaints about status of new CD structure from all levels (1, 2, 3, 4):

- Not a huge buy-in from all stakeholders (1)
- Resistance on the ground to a clinician in charge, it is not clear if nursing has taken it on (1)
- They still have a close working relationship with all ADNs (1). The Nurse line is dual (CD & DN), an operational blur (1)
- BM is expected to be "all things to all people", role needs review (1)
- "More layers of management"! (2); "another layer to go through/ between clinical staff and management" (3.O); "a lot of layers in the system and more difficult to get decisions" (3P).
- "Too many nurse managers" (4.O)
- Little evidence of training for the Clinical Director or BM (2)

## 5: CHANGE
(expectations/requirements)

Change

Budget and Control

Clinical Governance and Leadership

Capability and Capacity

# Change

**[Docs]:**

The Clinical Directorate Workshop, “What Works and What Does Not Work”
prime document

suggests: changes to the CD structure
ways of working from a staff perspective.

highlights for attention:
communication lines with sub-management levels in Directorates
communications vertically with hospital level
CD budget and control over WTEs
within the CD:
management training for Business Manager and Clinical Director
dual linkages and porous boundaries as difficulties to be addressed

# Change

**[Qual]:**

Change expectations relate to

- control
- clinical governance
- capacity and capability
- and structure, management, facilities/staffing generally

# Change: Budget and Control

**[Docs]**:

Reform '03 and the HSE Corp Plan:

constraints on goal of unitary control and reduced fragmentation:

- better service planning and control at hospital level,
  - reinforced by improved accountability,
    - especially of clinicians for the financial impacts of clinical decisions
- team-work
- Involvement of patient voice in service developments in setting service goals at all levels.*

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* At hospital level, accreditation visits (02, 04-06 ref appendix I in CQI strategy) had earlier identified Service Planning, and a Utilisation Management Programme as important deficits requiring attention.

CD operation is premised on the early deployment of a "shadow budget" (see "method of working for a CD" in CDir job spec).

## *Change: Budget and Control*

**[Qual]:**

There is a significant call for more localised control from all levels (1, 2, 3.OP, 4P)

This focuses primarily on the budget

eg full involvement, autonomy, more support and power, flexibility and the need to reward people for change (1);

responsibility for spend.

The call is for devolution otherwise it is a pseudo-Directorate with HMT allowing unions not to acknowledge the Directorate (2).

"When we get a budget we will make more strides, (3.Oc),

manage our own affairs; these things need to be in our hands (3.O).

The required combination is to own the budget, have staff control (4P) and more information and autonomy (1, 2).

# Change: Clinical Governance & Leadership

**[Docs]:**

Clinical Governance is subsumed in the broad QI/RM agenda

“Governance” is a firm component of GUH Strategy for the Future 2006-10

## *Change: Clinical Governance & Leadership*

**[Qual]:**

Clinical Governance (1, 2, 3.O)

needs more clinician buy-in (1)

clinical leadership (3.O)

more general involvement (2)

and pro-active reporting of incidents (2).

# Change: Capability & Capacity

**[Docs]:**

The CD Workshop What Works flags the need for more training for the Business Manager and Clinical Director

## *Change: Capability & Capacity*

**[Qual]:**

Role of Clinical Director needs to be formalised nationally and given substance (3).

The 2 units have to be combined to gain efficiencies (3).

Management training (3.O) and better communications from Director down is necessary with opportunities for more input (4P).

Facilities, staffing levels and bed capacity have also to be improved (4P).

End of Triangulation

Onward!

# Mapping Study

baseline for reflection phase

- Intent of policy and procedure — Espoused theory
- Realisation in practice — Theory in action

A grounded basis to adjust or modify in a contextual learning process

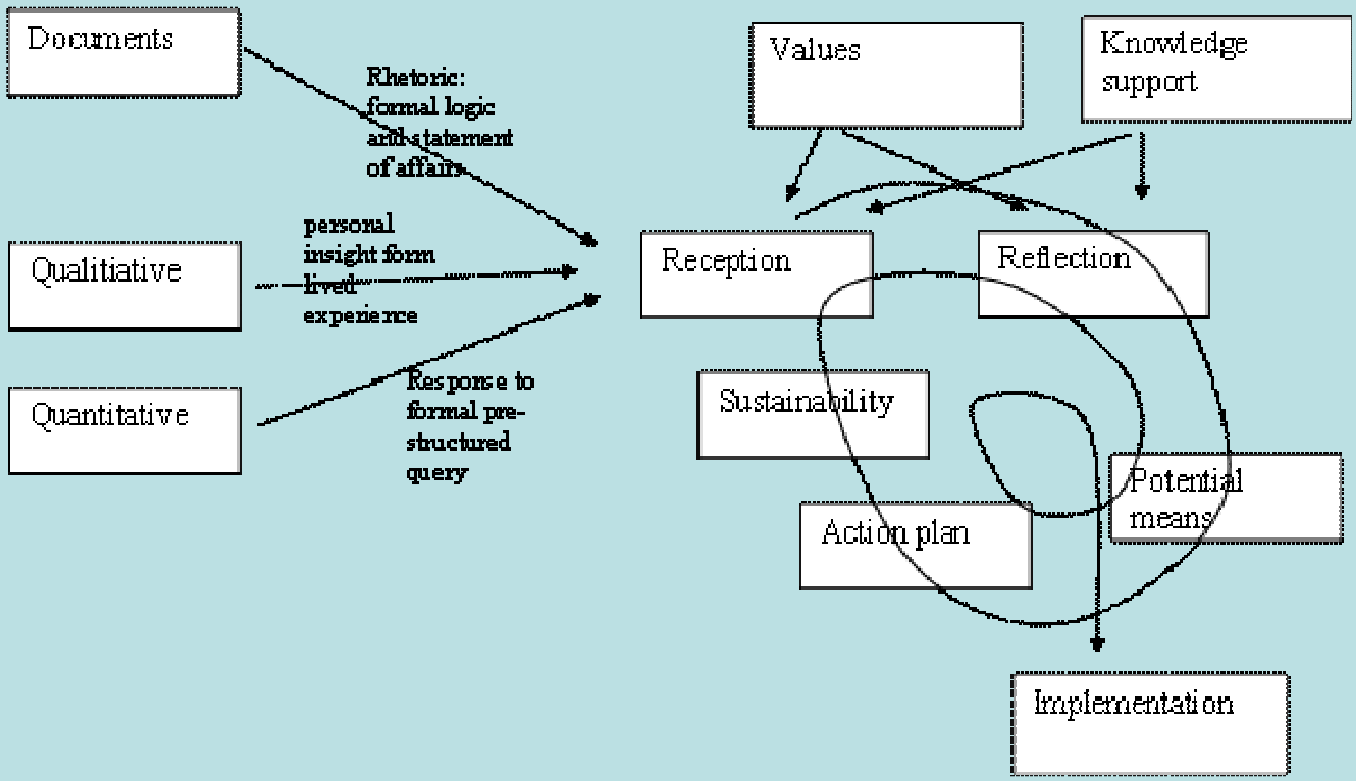
- relates to values, leadership/followership, attitudes, capability, capacity and knowledge/information
- will clarify and support the what, who and how of GUHs trajectory

# Reflection

A suggested approach in moving to the reflective phase is undertaking the following:

1. Identify the incongruities between policy intent and external and internal influences with the reported reality of experience and dominant perceptions.
2. Engage various levels and disciplines in reconciliation and review exercise based on the triangulation material i.e. documentary, qualitative and quantitative findings under thematic headings.
3. Compare results of Mapping with the extant literature.
4. Consider benchmarking vis-a-vis MARQuIS, WHO-PATH and comparable service units and arrangements.
   - Comparable with?

# Prospective: Next Steps



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