European Partnership for Supervisory Organisations in Health Services and Social Care

Meeting Report

EPSO Working group Effectiveness - Reykjavík, Iceland, September 25th 2017

09:30-12:00 at the Embætti landlæknis (The Directorate of Health) offices, Barónsstíg 47, 101 Reykjavík.

Participants: Riitta Aejmelaeus-Co-chair (Finland), Ian Leistikow- Co-chair (The Netherlands), Eve Pilt (Estonia), Andrew Terris (New-Zealand), Bee Tin Chew (Singapore), Leifur Bárðarson (Iceland), Kevin Mitchell, Rami Okasha (Scotland), Peder Carlsson, Klas Öberg (Sweden), Alvaro Moreira da Silva (Portugal), Anette-Lykke Petri (Denmark), Jooske Vos, Mari Murel (author of report) EPSO.

Introduction

EPSO has convened three prior meetings for the Working Group Effectiveness. At the last meeting , April 2017 in London, we decided on a theoretical framework that we would use to discuss how to formulate goals of regulation[1] and make the effects of regulatory actions visible. Aim of this meeting is to try using this framework to see if this can help us to make explicit what we try to achieve as inspectorates. We will test this with 3 case studies from the Netherlands (example), Sweden and Finland. This framework is a result of previous EPSO effectiveness meetings and discussions and discussions in Dutch Inspectorate. Many of us are challenged by the outside world (and also ourselves) what the effect is what we are doing. For example in the Dutch inspectorate the effect of their work is measured how many inspections and reports they present and if they fulfill the given number- then this is good. That can be frustrating for the inspectors, because it does not represent properly their energy they are putting into improve the quality of healthcare.

[1] The terms regulation, inspection and supervision are sometimes used interchangeably. For clarity we only use the term "regulation", and with this we mean: "sustained and focused control exercised by a public agency over activities which are valued by a community" (Selznick 1985)

European Partnership for Supervisory Organisations in Health Services and Social Care

Proposed theoretical framework for EPSO Effectiveness working group

Proposed theoretical framework	specification	Dutch example	Swedish case	Finnish case
For regulation to be possible, the following elements must be defined as concrete as possible, focused on a specific risk or problem (eg pediatric anesthesia, use of restraints in elderly care, role of municipalities in medical device safety, care for asylum seekers):		**Learning from adverse events (AEs) in Dutch hospitals (Ian Leistikow)**	**Learning from inspection-activity/ project at emergency wards in Swedish hospitals (Peder Carlsson)**	**Learning from adverse events in Finland: mistakes made by medical students (Riitta Aejmelaeus)**
1) The overarching mission of the regulatory agency (what is its goal and jurisdiction, how are responsibilities for care quality divided between regulator, state and providers);	What are your responsibilities and challenge to explain the context.	The Dutch Healthcare Inspectorate want to supervise the learning capability of hospitals. Hospitals are responsible for the quality of care they deliver.	The Swedish Inspectorate aims to supervise the healthcare providers to conduce the evolvement of secure working processes. The focus in this inspection activity was the capability of prioritising patients in the emergency ward and the ability to cooperate within hospitals. Hospitals (different specialties) are responsible for the safety and quality of the care they deliver.	Valvira supervises and guides social and healthcare professionals
Comments and feedback from the working group				

2) The risk, or problem, to focus on – and how to frame this ;	Based on Malcolm Sparrow work- Find a problem, solve it and tell everybody. So first thing you have to find a problem that matters. And while solving it, you have to deconstruct the problem to understand what it is.	The risk is that a hospital experiences an adverse event and does not take adequate improvement measures, thus sustaining the safety issues that made this AE possible.	The risk for the patients are too long waiting time for initial medical assessment and correct treatment. The waiting time for the most urgent ones!	The supervising of medical, dental and nurse students acting as professionals was inadequate and enabled serious mistakes
Comments and feedback from the working group	In Finnish case what seems to be a problem is actually not a problem, but there is a problem behind the problem (problem with supervising, educational procedures etc).			
3) The behavior expected from healthcare providers (norms, rules, regulations, self-monitoring etc.);	You have to explain what you expect from the providers.	We expect hospitals to execute a proper AE investigation, leading to improvement measures	That healthcare providers execute a proper treatment process, as well as internal revisions (self- monitoring) assuring this. There are rule for the maximum waiting time (4h rule- governmental expectation) in general, but this is same for the most urgent cases and least urgent cases. The problem is that it does not fit into reality in most urgent cases.	According the Finnish legislation medical/dental students are entitled to work in a temporary locum role in health care centers and hospitals following the full completion of their fourth or fifth year of study, but they must have a supervisor, who is available all the time. After five years they can work in outpatient clinics and acute care, and they must have a supervisor within reach.
Comments and feedback from the working group	We need to make this point more specific- what behavior we expect from the healthcare provider in which specific situation. Present answer is too broad and if you want to make a change, it helps to focus on more specifics. – what you need them to do and what you actually want them to do. In Sweden they are also investigating the first line/primary healthcare (GP) effectiveness in health care, as lack of the			

	possibilities in emergency rooms is an effect something happening or not happening in somewhere else. So this could be very specific or very broad. Then we get a new question- who is blocking? – If the primary care patients are, then the problem is not solved at the ER. If the problem is that cardiology patients are dying, then this is a problem for cardiology. You cannot only look the problem in ER, you have to look the continues care broader and see where the problem lies, where it is not functioning. In Sweden 70% of the ER patients are actually primary care patients. It is also important in case of waiting time -what are you waiting for? Is the solution only in ER or should have you been treated already somewhere else. Often the solution is not to do anything and send them away to make room for more urgent ones. Service expected is a balance between qualitative and quantitative measure. It is easy to measure 4 hours, but to measure quality it is much more difficult. Under that quantitative measure (4h) there is lots of interventions that are good, but underline there are ones who are not quick enough. In Scotland when they are setting their expectations, they try to be more specific in qualitative as well as in quantitative ones.			
4) The addressee (who/what needs to show the expected behavior);	From whom do you expect it from, who you address? Who it is who should prevent that risk?	The hospital's board of directors and their AE investigation committees	The concerned healthcare providers including all levels (Politicians, clinics and hospital's board of directors and units working with quality of care an patient safety.	Valvira expects leaders to appoint a supervisor to the students and make a written agreement. The supervisors ought to be available, active and participate in the everyday work with the students.
Comments and feedback from the working group	This is a good framework as you can use it in different (addressee) levels. Discussion shows that it is difficult to get this framework point right – the addressee. If you won't get that right, the rest is not going to work either. Sometimes we need to empower somebody to become an addressee. Because you need the person or entity to make a change, but they are not empowered (nurses, students). If you look at the addressee, you also have to look at the cultural aspects, what is happening there.			
5) The goal (what effect does the regulator hope for);	What does the regulator hope for? That can be long time goal.	Each Dutch hospital can execute a proper AE investigation (eg Root	Each healthcare provider can execute a proper improvement work to	Assure the safety of the patients.

		Cause Analysis)	enhance medical care quality and patient safety with right priority.	
Comments and feedback from the working group	This is a very important point and that the improvement is enhanced by the individual patient experience. What they found in Scotland in the past ,is when they made recommendations for improvement, people were improving for them (supervisors) rather than for people they are working for (patients). It is good to think about how the assessment of improvement looks like. It is not about compliance with their (supervisors) expectations and agreeing with them, but to really take patient-centred approach. Therefore he likes the end of Swedish answer - *to enhance medical care quality and patient safety with right priority* –this is exactly right way to address this point. Not too narrow, not too broad, achievable and time bound.			
6) The intervention (what will the regulator do to achieve the goal);	What will the regulator have to do to achieve the goal.	We will measure the quality of AE investigation reports, give specific feedback on inadequate items and track the quality of these reports over time	The inspectorate will inspect the emergency ward and discuss how the work is performed and their ability to internal revision (self-monitoring) and in what way improvement systems are used to improve quality and patient safety.	Valvira made a survey together with medical/dental/nurse associations and asked the students, how the supervision was organized and available
Comments and feedback from the working group	Sometimes in the Netherlands the inspectors have difficulty to keep the goal small and always go for the big goal , for the great experiences for everyone. Sometimes the effect is already putting the topic on the agenda and gather people to collaborate to improve it. So in Swedish case the goal could be to start the process in which professionals themselves create differentiated waiting time norms for the different types of patients. And such a goal (start the process) you can achieve already within a year. Question is- are we just going to tell the healthcare provider to do it or we are going to tell how to do it, because they need to do something. As in Sweden they cannot visit everyone and those who they visit they cannot go into too detail, so their aim is to make a change happening by the provider without doing too much of their work. They have			

	too few inspectors to do too deep diving. That depends on the culture. Idea is to create a common problem and to create a solution that fits in the local context. And like Scotland brought out, we do not want them to do it for the sake of compliance with the regulator, but for intrinsic motivation to improve. The inspectorates work is in Swedish case to get the right professionals together and tell what we see as a problem and ask if they recognise it as a problem and if they think that regulators can do something to find a solution to this problem. Then you are putting the problem back to their hands. And there is procedures how to put right pressure in the circumstances that they come up with the right solution and then inspectorate can say if this is a right behaviour and if this is the right solution to the problem. If you break down the steps, you can actually measure your own process. Don't take too big bites on an apple and make goals that are reachable within certain timeframe. In Finland they think they should have also included doctors and young doctors too in this survey. What they always remind themselves in Scotland is that primary responsibility is for improving the rest of service and we as supervisors will support that improvement. Involving students into survey was a very smart move, they are part of the system and are factor for the cultural change.			
7) The effect (how to assess the consequences of intervention);	how to assess the consequences (not to use word effect) of intervention.	The difference in quality score for AE investigation reports over time	Different ways can be used to assess the effects. One way is to repeat the inspection and follow up in what way quality improvements has been executed.	Severe shortages in the orientation period and supervising.
Comments and feedback from the working group	In practice it is very difficult to prove the causal relationship (the effect), because lot of things happen at the same time. How can we be sure that the visit (work done by inspectorate) created the change? In Sweden they have different ways to assess it – send feedback forms, visit, have discussions with stakeholders. In the Finnish case the effect seems actually to be one of the problems and should be rephrased. The effect is that there are now discussions about it and this is on the agenda to change the cultural behaviour and procedures, which is already tremendous effect. (This hospital in Finland actually hired a professional only available for the students and			

	leads them and added support for the starting doctors.). Also in Scotland they struggle with (evidence based) added value. If the improvements were made, how much part it was as a result of our (supervisors) efforts and intervention, when the primary responsibility lies on a service. It is hard to quantify that as it is actually a bit of both and in different circumstances maybe that they go and inspect and use that as a diagnostic and you identify weaknesses that services were not safe. And when you go back and re-inspect or resurvey, there is an improvement and it is nice to think that it was because of your (inspection) intervention, but when we ask to quantify that into evidence added value, it is quite difficult. How do you put that value on it? Impossible, but you have to give examples where evidence starts to support the improvement support and a positive outcome. You should not get too tight in knots to trying to see in which extent it was thanks to inspection and which to services itself. As long as we can show the evidence of improvement, we have done our scrutiny tasks. Also point about failure is a serious point, because if improvement does not happen, then it does not mean that we have failed in our responsibilities as a regulator and the risk of public credibility and trust around our work is really important question. Even if we are fathers of the success it is sometimes wise not to claim that success. It can work demotivating for the health care providers and medical professionals. In the Netherlands it is sometimes hard for them to share their success with the outside world, has they have strategic reasons to be modest. They don't want them do advocate their responsibilities to supervisors.			
8) How to distribute the knowledge gained in the process;	How to tell people that you have fixed the problem and how to make solution available to other similar problems.	Publish the results, use the results in one-on-one discussions with hospital boards to reflect on the quality of their learning process compared to peers	Examples that are used. Publishing the results in reports, use the results in discussions with healthcare providers/clinics/hospital boards/politician to reflect on the quality of their improvement process	Valvira published a report, that was distributed to all our health care units. We´ll repeat the survey next year to find out the effect it had.
Comments and feedback from the working group	Portugal suggests to add –the Framing- how do you present it to the outside world, so they would not misuse the outcome. They usually present 3 cases (hospitals) to take off the political tension. As similar things happen in different hospitals and they have usually always to take similar examples from other hospitals in the same level to show. In Portugal they have those discussions/meetings with the board of hospital and everybody at the leadership act			

	very collective and supportive and are putting on 'good face', but when they leave the doctors say – what a waste of time, I need to treat patients here. Effective communication and Collective collaborative practice is important. In Sweden they need to communicate more with the politicians and they need to figure out how to present results of their work in a better way to deliver the message and when to approach them (so it wouldn't backfire). They have long tradition doing that in social care, but not in health care. In the presented emergency room case, they did not discuss it with the politicians, but they made a report. Feedback is crucial. They can only make a change if they sit down and discuss with different parties, who has the power to make a change. They need to develop this framework point –feedback- to make a change. In the Netherlands they recognize the issue of who has the power to change. Sometimes it is not one party but entity of multiple parties and they see their role in bringing all those parties together and put enough pressure on them to collaborate. One of the lesson they have learned in Scotland from their strategic inspections is that at the regional level, when they are engaging with their chief officers, then instead of just providing the feedback to the senior officer the professional dialogue is really crucial. So instead having one dialogue- feedback, they are now having up to 6 formal professional dialogues during different stages of inspection and when they are progressing they starting to ask questions about their weaknesses what might occur or not and to encourage them through dialogue. It does not necessary help them on strategic level, but on service level. That way they can gather impartial information about the services vs strategic component, when commissioning those services and trying to influence that. The professional dialogue is absolutely crucial as that itself can generate change and improvement. Kevin personally sees more effect in feedback and professional dialogue than strategic inspection report, where are no surprises. You get more engaged with people when discussing your report. When they value leadership, they do not value individual leadership, but collective leadership and accountability (on strategic level) to encourage collective responsibility. Professional dialogues they start with the chief executive officers (chief officer of education, social work etc.), but they always give feedback and they always go back to top to make sure they are accountable not about what they

	found, but to take the agenda forward. They find it important process to drive the improvement and to take ownership and responsibility at highest level.

General discussion and comments:

It is very important to be able to tell people what the effect of their work is. There were lots of discussions in **the Netherlands** that not the provider, but the inspectorate should do the investigations of their serious adverse events. Public found it strange that the organization that made the mistake, will do their own investigation and for instance concludes that they are not to blame. The inspectorates on the other hand feel that it is very important that the hospitals will do their own AE investigations, because they want them to learn. Thanks to the data they have from the hospitals, they can show it (prove it) to the politicians that the way they are doing it now has improvement element –effect. So they did not change the policy for the hospitals, but they did that for handicap care and elderly care as they do not have the data from those organizations.
Such an approach really helps to explain what you are doing and to see what needs to be improved when the results are not great, instead of raising the inspected number of hospitals i.e. from 300 to 400.

Sweden as done similar way as Dutch and wants the providers to learn, but it often stops there. How do you make sure that there is really learning process happening or they are just doing fine paperwork? It is hard to see the real outcome if you stop there. It really needs to be connected to the real work.

Indeed the reports what the providers are sending in (NL) are theoretical. Wishes.
In **the Netherlands** they faced a dilemma couple of years ago: If you pinpoint what you really want, then it is safer environment for the patients. But you cannot achieve it with one step, you have to sort of move back in time. So if you want to reach the safer environment you have to look and improve the processes what have gone wrong in the past. Before that is the improvement measure and before that is that they come up with the improvement measure. And before that is that they investigate what went wrong. And before that that they are open about (report) what went wrong. Then step before is that they see what went wrong. Often they do not even see what went wrong- the relationships. And from that stage you cannot jump to the end goal. 4 years ago they asked the Dutch hospitals to write down what went wrong and the improvement measures, but when they looked those measures they did not find them a good improvement measures, like –*next time pay more attention*; *we should send our people more on trainings*; *we should discuss it during our morning meetings*

etc. So those measures would not improve the health care. Therefore before the inspectorate force them to implement the improvement measures, they first want the measures to make sense.

In **Portugal** very similar issues. Question – what triggers those processes? The death? Which means we are always the step behind of the real problem.

Portugal example (Alvaro Moreira da Silva):

They operate in 3 ways:

1. Investigation, rather than inspection;
2. Guarantee access to health care, quality and safety.
3. Doing studies and recommendations (3 months you have time to fix this etc.).

After that they go to provider to see what has been done, what is missing and what is the real problem. Sometimes they have the same problem- that some problems are not hospitals fault, but the policy of the health care. Common answers they get are –We do not have human and/or financial resources to do that. In Portugal they can recommend acts to the health minister and tell them that ministry is responsible for the mistakes that can happen (threaten with fines). Those are the last steps and often media gets involved and they pick up the tragedies, not the small matters. Unfortunately such news are used to gain political advantage and instead empowering them (supervisory body) as the organization, makes them the bad guys.
Therefore he likes to add to the framework – the Trigger and –the Outcome. He feels there is a need for mutual confidence.
To **point 8** he likes to add –the Framing- how do you present it to the outside world, so they would not misuse the outcome.
They usually present 3 cases (hospitals) to take off the political tension. As similar things happen in different hospitals and they have usually always to take similar examples from other hospitals in the same level to show. So they ask them to provide patients quality of health care and to be able to provide this, they have to do that, that and that. Problem is that most attention is given to 'death cases' and people are in some reason afraid to work with the adverse events. Probably less urgent.

One is to measure improvement of those we supervise. Other is to be the protector, to make sure the healthcare provider won't get worse in their safety & quality. The fact that we exist has already effect on those we supervise. There are providers in different level and they would like to see the movement (improvement). The organisation can be reactive or protective. But first they have to choose where they have to do the inspections and how do find them. In

Sweden they discuss a lot a risk-based analyse, made based on complaints, reports, earlier visits, media etc. This year they are looking the emergency rooms, because there has been a peak of problems.
As an inspectorate they also have to prevent the providers to become worse, dangerous. To help them to stay stable and to help the good ones to get even better. They often see there is a certain timely interval between being stable and safe and unstable/unsafe.
Inertia can often be the indicator to unsafe organisation and there are also examples where single dentist has been very stable for 30 years, but also unsafe.

In **the Netherlands** it is very difficult for them to determine what element and/or interaction works.

Same in **Sweden** and therefore they are gathering the intelligence to know where to focus on. Sometimes it is very easy (especially new inspectors) to focus on details and on daily work. Peder prefers to work more on organisational level and somehow collect samples from the daily work to see the symptoms of the lack of organisation. Then they are effective to work on next levels. He sees the main role of supervisors has a stop to prevent the health care providers to fall back in their level (to become worse) more than to help them to get excellent:

Other thought is that they need to communicate more with the politicians and they need to figure out how to present results of their work in a better way to deliver the message and when to approach them (so it wouldn't backfire). They have long tradition doing that in social care, but not in health care. They need to sit with the politicians around same table and discuss:
-how to solve this problem?
-what is the problem? Do we see the same problem?
-what we are going to do about it? Who has power to change it?

And it has really worked in those few cases they have done it.

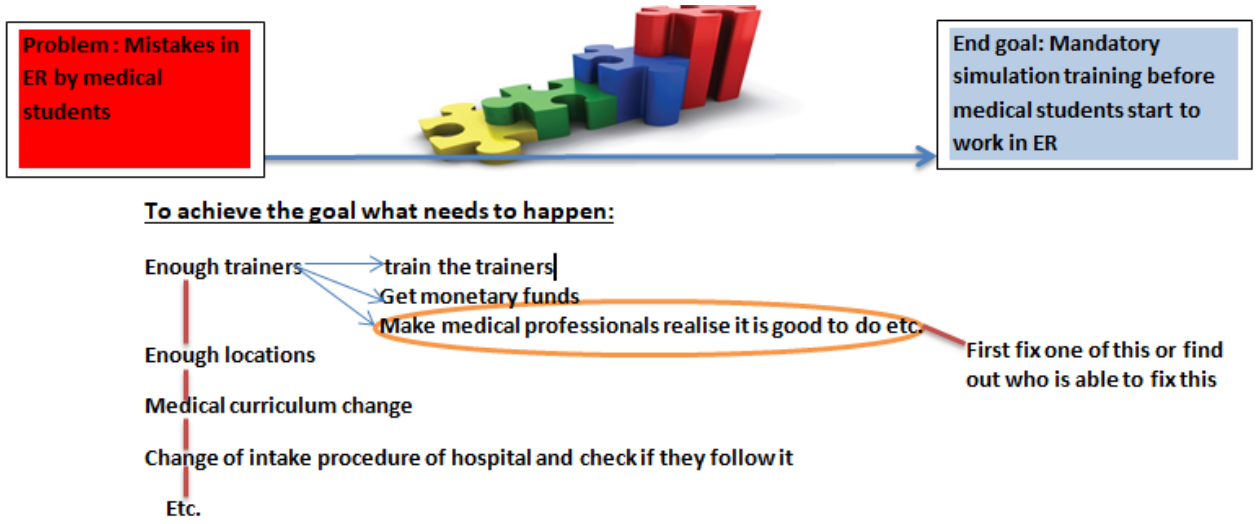
In **Portugal** in reality they have 3 hierarchies: doctors, nurses and sanitary. If there is a problem in one level, they have been asked to remove the problem. Safety is essential issue, but how to improve quality? For that they need a common framework. Their framework is to inspect and to correct, the hospitals framework is to see patients and treat them. No one receives profit doing the right thing on a right way on a right time. He sees that the collective way is not working, the doctors are not connecting with the other levels. He sees in Finnish case the problem of the procedure- who is responsible at the end (i.e. discharging the patients). Not correct to put pressure on such a young doctors to make such an important decision as discharging the patient and if they ask help (as they should) it is seen as an weakness.
Same problem in **Iceland** and the problem is how we organize it- we allow senior doctors to work from home.

They had similar discussion in Sweden and they said to hospital that the senior doctor has to be present and they got discussion what does 'present' actually mean (is it minutes or meters). They decided that the senior doctor have to be present in ER, which means reachable within the hospital and not at home.
This is often related with the money and resources. Good quality costs money, but bad quality can cost even more.

In the Netherlands there were case concerning child deliveries and they asked hospitals to have a gynecologist and anesthesiologist to be available within the hospital 24h, which cost a lot of money for the hospitals, so the consequence (effect) was that lot of smaller hospitals stopped delivering babies in their hospitals.

If nothing happens anymore, this is also sign of the downfall of the quality.
Life has no price, but it has a cost. And society often blames money if someone dies. In Portugal 80% of their complaints are non-clinical related.
In Portugal they need to practice first on surgical simulation, which could be solution in Finland's case.

Example of improvement science method that could help Finland based on Portuguese solution (presented by Ian Leistikow):



U break the end goal into sub goals and you can break the sub goals into little ones etc. When you do this long enough, then you will find things that you can actually change, because you cannot achieve this in one step. Sometimes we make a goal to assure the safety of patients and we need to take steps which are not too big. You find who can fix all those sub problems and together we all achieve the end goal.

Next steps for the Working Group

2018: we reconvene and discuss progress on the issues we discussed in September and keep up developing and improving the framework. We ask new case studies to be tested with this framework and to be presented and discussed during the meeting.