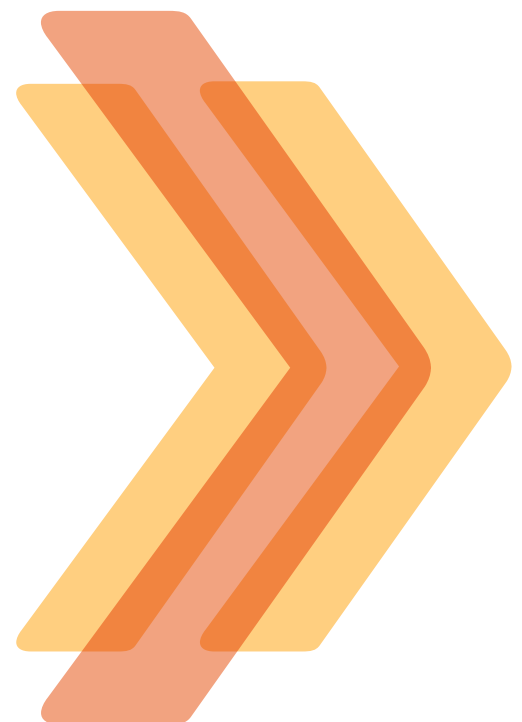The King's Fund>

Strategic quality improvement

An action learning approach

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Introduction

Quality improvement in health has many definitions, but it is commonly understood as an approach that enables an individual, team or organisation to improve performance by identifying and eliminating poor quality in any aspect of service delivery. Health organisations that adopt this approach commit to creating a culture in which constant evaluation and innovation thrives.

Quality in health care has two aspects: first, clinical outcome and second, an individual patient's subjective experience. Organisations that place strategic importance on continuous quality improvement should keep both aspects in mind. In its recent publication, *Improving quality in the English NHS*, The King's Fund argued that the NHS 'cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy' (Ham *et al* 2016).

One of the principles of creating a culture in which continuous quality improvement flourishes is that it should involve staff at all levels. Enabling staff to explore and co-create the process makes it more likely that the whole organisation will own the approach; responsibility for quality then ripples out to teams, reducing the pressure on one resource or set of people.

Oxleas NHS Foundation Trust provides a wide range of community health, mental health, and learning disability services for people across Greenwich, Bexley and Bromley as well as health services in prisons in Greenwich and Kent. It has 3,500 staff, working in 100 health sites as well as in local schools, children's centres and in people's own homes, providing care for around 30,000 patients a month.

Oxleas is recognised for its high-quality services, through positive feedback from patients and carers, achievement of key quality targets, and national accreditation of its quality governance processes. It also scored highly for staff engagement in the 2015 NHS Staff Survey and in the Stonewall Workplace Equality Index for its inclusive policies for lesbian, gay, bi-sexual and transgender (LGBT) employees. The trust has invested substantially in developing leadership capacity in its clinical leaders.

To build on its commitment to quality, the Medical Director, chair of the Oxleas Quality Board, commissioned The King's Fund to help the organisation assess

its existing quality improvement work and to develop a strategic approach. The Oxleas board was convinced that by taking a more organised approach to quality improvement, the trust would achieve better outcomes. By deepening our understanding of this issue in partnership with the trust board through an action learning approach, we have identified a staged approach to quality improvement that can be adapted to suit the culture of other organisations.

The approach and philosophy behind The King's Fund programme were explicit – we were not teaching quality improvement methods or tools (many organisations have their own resources); instead, we were helping the organisation to develop the ability to appraise its own approach to quality improvement with a view to improving performance, achieving better clinical outcomes, and building on its existing capacity as a learning organisation.

The Oxleas Quality Board invited people from each of the trust's five directorates, as well as clinical and non-clinical staff from the board and quality improvement team, to participate. The action learning process involved the following stages:

- gathering information on existing quality improvement projects to understand the organisation's current approach

- holding a workshop to establish how different parts of the organisation define and implement quality improvement work (including a self-evaluation exercise)

- holding a second workshop, with three areas of focus:
  - to explore leadership approaches, particularly around inspection/regulation
  - to assess ability (as individuals and directorates) in four of the five key lines of enquiry in the Care Quality Commission's 'well-led' domain
  - to explore the current state of clinical/medical engagement within each directorate

- assessing participants' readiness to innovate

- three months after the final workshop holding a follow-up session to identify what was learnt.

The action learning process

Understanding your current approach

Most health care organisations aim to continually improve the quality and safety of their care. However, it was our hypothesis that even those organisations that are committed to quality improvement often lack a managed or strategic approach.

The first exercise we undertook with the Quality Board was to gather information on all of the quality improvement projects that were running across the entire organisation. Oxleas had already invested in a small quality improvement team, which assisted the participants in the programme to gather this data.

We then ran a workshop for the programme participants to build a shared understanding of how the five directorates within the trust currently define and implement continuous quality improvement.

During the workshop we invited participants from each of the five directorates to evaluate their approach to quality improvement, sharing definitions and examples from their own culture and specialisms of community health, mental health and learning disability services. We asked them to rate themselves (on a scale of 0–5) in response to the following statements.

- There is end-to-end board/senior leadership team involvement and oversight.

- There is an accountable team for quality improvement with a defined role and protected time.

- We use a common and consistent language of improvement.

- We have a relentless focus on patient and staff experience.

- We are data-orientated in all decisions.

- We have a repeatable, locally configured process for implementing quality improvement.

- We have supporting infrastructure – architecture, visual cues, behaviours, data availability.

- There is bespoke local training (of everybody at all levels).

- We are constantly searching for new ideas and benchmarking ourselves against mental health services nationally/internationally.

After this self-evaluation exercise, we shared the data on existing quality improvement projects in each directorate. Participants were surprised at the number of quality improvement projects and audits being undertaken.

In their directorate teams, participants took time to articulate what they believed to be the goals of their directorate, focusing on the top three. They then considered how their current quality improvement projects fitted with these goals. We suggested that participants share these discussions with others in their directorates to get feedback, and bring that feedback to the next workshop.

The questions we asked them to explore were as follows.

- How appropriate are these projects?

- What areas of overlap or duplication were there?

- Was there a conflict between any projects?

- Which of the projects were mutually reinforcing?

- Which of the projects have areas of interdependence?

- How consistent are the quality improvement projects with the overall strategy of the directorate and the organisation?

This exercise enabled participants to identify the techniques and tools used within their directorate and across the organisation as a whole, to provide a fuller picture of where quality improvement expertise lay.

Leadership approaches to quality improvement

The next workshop with the Oxleas team focused on leadership approaches, including an exploration of their approach to inspection/regulation.

First, participants created a set of criteria against which they would like their quality improvement initiatives to be measured. These were then discussed by one other directorate (peer-to-peer assessment) during the workshop and refined for discussions in their wider teams.

The second focus of this stage was for participants to consider – as individuals and directorates – their ability to meet the needs of four of the five key lines of enquiry in the Care Quality Commission's well-led domain. They were instructed to omit 'vision and values', which had already been covered (*see* Appendix 1 for the checklist they worked from).

We know from other high-performing health care organisations that no quality management system or approach flourishes without good leadership. We also know that organisations like Intermountain Healthcare and Mayo Clinic measure their performance over and above the areas in which they are regulated or targeted, and that quality improvement and measurement of clinical outcomes are actively encouraged by their boards and driven upwards from clinical teams.

The third and most important focus of the second workshop was an exploration of the current state of clinical/medical engagement within each directorate.

Clinical/medical engagement

Clinical leaders, with or without formal authority, influence the culture of the teams that in turn contribute to defining the culture of the organisation. High-performing health care organisations such as Salford Royal NHS Foundation Trust, Virginia Mason, Intermountain Healthcare and Mayo Clinic create a climate in which clinical leaders at all levels are involved in continuous quality improvement. Role-modelling an ongoing interest in and curiosity about quality improvement through conversation, behaviour and practice creates a 'compact' between clinical and non-clinical leaders. Benefits to patients and staff accrue when medical engagement is part of a much wider organisational culture process.

We invited each directorate to do a quick 'health check' on their level of engagement with clinicians, particularly doctors. Prior to distributing the checklist, we defined 'medical engagement' as the extent to which clinicians were actively engaged in the management, leadership and improvement of services, helping to create a culture that supports the delivery of sustained high-quality, safe and efficient care for patients and service users.

The statements (*see* Appendix 2) were designed to provoke thought and discussion about the extent to which medical engagement was being actively sought and developed at Oxleas. The first section focuses on the strategy, processes and ways

of working within the wider organisation, while the second focuses on the role of the individual medical leaders.

Participants found the clinical engagement/medical engagement exercise illuminating, and it helped the trust to reinforce its strategy of developing clinical/medical leadership.

Linking innovation with quality improvement

The link between innovation and continuous quality improvement is well-documented. Don Berwick (1996) suggested that measuring the effectiveness of innovation was key to achieving effective change in health care organisations. Taking an innovative approach to improving clinical pathways has been a welcome focus for quality improvement projects. Similarly, innovations that have evolved from closer teamworking across departments and specialties have had a positive impact on organisational culture.

The impact of new technologies and innovation in medicines/drugs and improvements in clinical support and administration processes both point to the strong connection between innovation and continuous quality improvement.

In a 1991 paper, *From continuous improvement to continuous innovation*, Robert E Cole wrote that: '…innovation is best associated with creative solutions, and these can occur at a small as well as a large scale, and can be more, or less, discontinuous. Put more bluntly, there is plenty of innovation that occurs in the course of continuous improvement.'

We had the chance to hear from five directorates at Oxleas, each of which expressed a desire to be more innovative. So, to gather information about their readiness to innovate, we asked participants to rate themselves (on a scale of 0–5) according to the following statements.

- In general, we are open to new initiatives, projects and processes.

- We readily generate new ideas within our unit/organisation.

- We are committed to learning from, adapting and adopting new ideas from outside our unit/organisation.

- We provide regular opportunities for all staff to take time out to review and improve individual and collective performance.

- All staff are empowered to intervene to ensure they provide high-quality care.

- We support individuals and teams when new ideas they try out do not succeed.

- We evaluate new initiatives, projects and processes during and after implementation.

- We are good at recognising and rewarding quality improvement and innovation at all levels.

Participants were then randomly assigned to one of four teams, each of which was asked to suggest how they could enable a climate in which innovation fits with a strategic quality improvement approach.

The final stage of the process was to get the now self-named 'community of quality improvers' at Oxleas to appraise its system. In small groups, participants answered the following questions, noting those that were easy to answer and those that they struggled over.

- What are your goals for improvement and how clear are you about these?

- To what extent do you have teams in place charged with improving the performance of key processes and outcomes for the key populations you serve?

- To what extent does your unit/organisation manage quality improvement projects that are focused on issues of strategic importance to the organisation?

- How widely distributed and how well understood is your quality improvement approach?

- To what extent are you capable of training, developing and supporting large numbers of staff to improve and innovate with new care models?

- To what extent are the metrics used to assess performance developed or adapted locally?

- How well understood and how widely available are performance data and reports?

- To what extent do you feel personally capable of leading quality improvement in your area?

What we learnt

The action learning process that we engaged in with Oxleas reinforced much of our own thinking about what is needed to make continuous quality improvement a strategic imperative for health care organisations.

First, leaders at all levels of the organisation placed importance on this, which cleared a path for all the participants in the action learning pilot. Second, introducing peer-to-peer learning – with participants sharing information and critically evaluating each other's plans – helped to build a community of 30 individuals who have created a quality improvement movement on which Oxleas is building its capability. Participants and those initiating the process accepted the need to do some new things, to review what has worked, to drop some activities that didn't add value, and to do some things differently.

The Quality Board at Oxleas acknowledged the following points.

- Building leadership at all levels was a critical part of the process.

- Creating a 'coalition of the willing' from the five directorates enabled a sense of shared ownership.

- Embedding a quality-focused approach in day-to-day work made it a part of 'business as usual' as opposed to a tick-box exercise.

- Engaging in the process built rapport between directorates and this, in turn, facilitated conversations about the importance of creating the right infrastructure for quality improvement.

- Directorates reported that participating in this process had captured the energy and imagination of many clinicians in a way that other initiatives had not.

- Directorates reviewed the number of quality improvement projects (more than 300) and were able to reduce them by 50 per cent.

- Work remained to be done on developing meaningful measures, and devising a single repeatable process and language around quality improvement that suited the culture at Oxleas.

Conclusion

Through our working relationships with leaders in the NHS we know that there is a commitment and intention to deliver safe, effective and high-quality care. Our work last year on *Better value in the NHS* identified opportunities in which leaders in health could improve the quality of care through examining 'overuse, underuse and misuse' of resources and suggested that this practice would also lead to the identification and removal of unwanted variations in clinical practice (**Alderwick et al 2015**). Both of these objectives are attainable if NHS organisations invest and commit to leading cultures in which continuous quality improvement is part of their strategy.

Oxleas NHS Foundation Trust is an established, high-performing organisation, which was already investing in a culture of continuous improvement of quality. Its willingness to embark on this action learning process reinforces its commitment to being a learning organisation. We believe that through sharing this case study and the action learning process we co-created with Oxleas other NHS organisations can gain insight into their own approaches to quality improvement.

Appendix 1

During the second workshop in the action learning process, the focus of the second stage was for participants to consider their ability – as individuals and directorates – to meet the needs of four of the five key lines of enquiry in the Care Quality Commission's well-led domain.

Checklist: Leadership in a well-led organisation

There are five key lines of enquiry in the Care Quality Commission's 'well-led' domain. 'Well-led' means that the leadership, management and governance of an organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The questions below are designed to provoke thought and discussion about how well your leadership behaviours support the organisation being well-led. We have already looked at vision and strategy, so these questions relate to the other four key lines of enquiry.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Key line of enquiry: Does the **governance** framework ensure that **responsibilities** are clear and that **quality**, **performance and risks** are understood and managed?					
Performance management					
1. I am clear about what aspects of quality, performance and risk I am accountable for in my role	☐	☐	☐	☐	☐
2. I have a good understanding of the organisation's performance management policies and procedures	☐	☐	☐	☐	☐
Key line of enquiry: How does the **leadership** and **culture** reflect the organisation's vision and values, encourage openness and transparency, and promote good-quality care?					
Quality of care					
3. I understand the challenges to delivering good-quality care and I can identify the actions needed to address them	☐	☐	☐	☐	☐
4. I work collaboratively, resolve conflicts quickly and constructively, and share responsibility to deliver good-quality care	☐	☐	☐	☐	☐
Key line of enquiry: How are **people** who use the service, the **public** and **staff engaged** and **involved**?					
Patient and staff engagement					
5. I understand how the organisation gathers and acts on the views and experiences of patients, service users and the public	☐	☐	☐	☐	☐
6. I actively engage my team in decision-making processes	☐	☐	☐	☐	☐
7. I value when staff in my team(s) raise concerns	☐	☐	☐	☐	☐
Key line of enquiry: How services are **continuously improved** and how is **sustainability** ensured?					
Quality and sustainability					
8. I consider the impact on quality and sustainability before implementing changes to services	☐	☐	☐	☐	☐

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
9. I monitor the impact on quality and sustainability after implementing changes to services	☐	☐	☐	☐	☐
Improvement and innovation					
10. I strive for continuous learning, improvement and innovation in my role	☐	☐	☐	☐	☐
11. I support staff in my team(s) to undertake continuous learning, improvement and innovation in their roles	☐	☐	☐	☐	☐
12. I strive to invest resources to build the capability needed to support staff in my team(s) to innovate and improve	☐	☐	☐	☐	☐
13. I have a focus on continually improving the quality of care I am responsible for delivering	☐	☐	☐	☐	☐
14. I look for ways to learn about and share innovative ideas for improving the quality of care	☐	☐	☐	☐	☐
15. I recognise and reward team members who develop innovative ways of improving the quality of care	☐	☐	☐	☐	☐

Appendix 2

Section 1: Your organisation

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Improvement and innovation					
1. Medical engagement is a key and explicit component of our organisation's strategy	☐	☐	☐	☐	☐
2. The board and executive team (including non-executive directors) are fully committed to medical engagement	☐	☐	☐	☐	☐
3. Medical engagement is promoted and brought to life by the chief executive, chair, medical director(s) and the director of nursing	☐	☐	☐	☐	☐
4. The chief executive, chair, medical director(s) and the director of nursing regularly engage and communicate with the medical workforce	☐	☐	☐	☐	☐
5. Our organisation structure and governance arrangements reflect a culture that seeks high levels of medical engagement	☐	☐	☐	☐	☐
6. Our talent management/succession processes are able to meet the need to develop our medical leadership pipeline	☐	☐	☐	☐	☐
7. Doctors are empowered to innovate and lead quality improvement initiatives	☐	☐	☐	☐	☐
8. Junior doctors are offered appropriate leadership development opportunities, particularly around quality, safety and service improvement	☐	☐	☐	☐	☐

Section 2: You as a medical leader

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Improvement and innovation					
1. I have a good understanding of the organisation's policies and procedures for attracting, recruiting, inducting and developing medical leaders/consultants	☐	☐	☐	☐	☐
2. When following these policies and procedures, I ensure I connect and reflect the aims, values and goals of the organisation	☐	☐	☐	☐	☐
3. When recruiting, I ensure appointments are made through a competitive and competency-based process that reflects the organisation's values	☐	☐	☐	☐	☐
4. I thoroughly engage in job planning, appraisal and revalidation processes	☐	☐	☐	☐	☐
5. Clinical staff in my teams are regularly involved in strategic planning and prioritising for our division and the organisation	☐	☐	☐	☐	☐
6. Clinical staff in my teams are regularly involved in the planning and accountability of the services they contribute to	☐	☐	☐	☐	☐
7. Clinical staff in my teams who have formal leadership roles are given adequate time to undertake management and leadership of their services and quality improvement projects	☐	☐	☐	☐	☐
8. I ensure that the contribution of clinical staff in my teams who have formal leadership roles is recorded, measured and valued	☐	☐	☐	☐	☐
9. I spend time developing organisational capacity and capability for developing and supporting leadership and quality improvement methods	☐	☐	☐	☐	☐

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