

Quality improvement in hospital trusts

Sharing learning from trusts
on a journey of QI



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About the Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We register health and adult social care providers.

We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

We use our legal powers to take action where we identify poor care.

We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can



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Foreword

Demand on health and social care services is increasing year-on-year. This increased workload puts quality of care at risk but, despite these pressures, we have found that hospital trusts that put a focus on continuous quality improvement have demonstrated that they can deliver high-quality care. In those trusts we have rated as outstanding, we have found a culture of quality improvement embedded throughout the organisation.

In our 2017 report, *Driving improvement: Case studies from eight NHS trusts*, we found that the quality of leadership is a key influence of the ability of trusts to improve. Leaders needed to be seen to lead, and drive a culture of improvement across the whole organisation. We saw that several trusts on their improvement journey out of special measures or from a rating of inadequate used a quality improvement (QI) method – particularly around safety. This was having a direct impact on the quality of care for patients and improved outcomes for them – for example a reduction in falls and pressure ulcers and improved mortality rates. Where a culture of improvement is driven by the hospital trust's leaders, QI becomes a frontline activity in many trusts, where staff are directly able to listen to patients and implement changes that make a real difference to patient care.

We wanted to explore further to hear trusts' experiences of QI as a systematic approach to improving service quality, efficiency and morale – not just as a mechanism to problem solve in failing parts of the organisation, but as a way of expanding improvement beyond organisational or functional boundaries, so that impact is possible across the wider health and social care system.

QI has been shown to deliver better patient outcomes, and improved operational, organisational and financial performance when led effectively, embedded through an organisation and supported by systems and training.

When QI is used well, it gives us confidence about the long-term sustainability of the quality of care. More informally, when we visit trusts that have an established QI culture, they feel different. Staff are engaged, they are focused on the quality of patient care, and they are confident in their ability to improve. This is also reflected in surveys of staff and patient satisfaction.

We would expect that a hospital trust committed to delivering high-quality care should be embedding a systematic and effective approach to QI. However, we recognise that it is not easy. Rather than a quick fix, this is a challenging endeavour, changing behaviour in complex organisations and developing an effective leadership and organisational culture.

We think this report will be particularly valuable to healthcare organisations considering adopting QI, particularly senior leaders committed to delivering sustainable high-quality care for patients.

This report is not a 'how-to guide', but uses the words of hospital staff and case studies of successful initiatives to share learning about trusts on a journey of QI – where curiosity and humility are essential improvement behaviours. We describe what the organisations look like, rather than prescribing how to get there.

Professor Ted Baker
Chief Inspector of Hospitals

Introduction

The Care Quality Commission has unique insights from the comprehensive inspection programme of all health and social care providers nationally. Alongside the traditional regulatory role, we were given an additional mandate in the Health and Social Care Act of 2012 – to encourage improvement.

We have found that the quality of leadership is a key influence of both the quality and of the ability to improve in health and care providers. This has been reported in our series of *Driving improvement reports*, which includes *Driving improvement: Case studies from eight NHS trusts*.¹ We have also evolved our regulatory model to focus more on leadership in the annual trust-wide well-led inspection programme.

In some hospitals, there has been a journey of building and embedding a systematic process to improve the quality of care, usually referred to as quality improvement (QI). QI has been shown to deliver better patient outcomes alongside improvement in operational, organisational and financial performance, when led effectively, embedded through an organisation, and supported by organisational systems and training. When we visit these organisations, they ‘feel’ different – there is a palpable focus on quality and patient-centred care, with engaged staff that are enabled to make improvements to the care they deliver.

Our **State of Care**² report in 2017 found that almost all the trusts rated as outstanding had a clear model for QI across the trust.

We also saw leaders who:

- were passionate about the delivery of high-quality care for patients
- were actively engaged
- sought the views of staff and patients
- were committed to organisational development

- had a clear vision and strategy that was understood by staff
- made sure that governance was strong, so that problems were dealt with swiftly.

This report focuses on leadership, alongside the behavioural and cultural aspects of hospitals that have built and embedded a process to improve the quality of care. It aims to share learning from such hospital trusts to inspire and encourage wider improvement in the quality of care delivered.

“My advice to anyone thinking about embarking on this journey is to get out and see somewhere where they are already doing this. QI isn’t a quick fix – go and get a feel for it. Someone who will give you the ‘warts and all’ version.”

Sarah Scales, Head of Programme Management Office, Royal Surrey County Hospital

This report is particularly aimed at those in healthcare organisations considering adopting QI as a strategic priority, particularly senior leaders who are committed to delivering sustainable, high-quality care and looking to develop their organisation with that strategic intent. Importantly, this report is not a ‘how-to guide’, but should be taken as a tool to build curiosity and share learning. We are describing what the organisations look like, rather than prescribing how to get there.

What do we mean by quality improvement (QI)?

We have seen significant improvements in quality of care through our regulatory processes. These improvements are achieved through a variety of means, which can be ad hoc, and not part of an improvement programme or aligned to an organisation's strategy.

By contrast, QI is an approach to improving service quality, efficiency and morale simultaneously: this is done by systematically enabling staff and leaders in the continuous study of improvement of their work, anchored in methodologies and tools from improvement science. Critically, it requires staff, operational managers and senior leaders to work together, with decision making and problem solving happening as close to the issues being experienced as possible. The difference that we see in trusts using a systematic QI approach is the confidence that we are given about the sustainability of the quality delivered, and the trajectory of ongoing improvement in the quality of care.

This approach has a variety of names (including Continuous Improvement and Lean). In this report we refer to any systematic approach to improvement, anchored in improvement science as QI.

The concept of a QI journey

The process of adopting and embedding QI across an organisation was often described by hospital trusts as a journey, with several common elements described (**FIGURE 1**):

- Leadership for QI – where the strategic plan to adopt QI is supported by unwavering commitment from senior leaders, who model appropriate improvement-focused leadership behaviours and a visible and hands-on approach to QI.
- Building improvement skills at all levels, using a systematic framework for building skills, facilitating improvement work and sharing learning.
- Building a culture of improvement at all levels, which is modelled by the senior team. The approach engages clinical leaders and empowers and enables all staff to make effective and sustainable improvements.
- Putting the patient at the centre of QI – the QI journey sharpens the focus on delivering high-quality patient care and aligning improvement activity to outcomes and experience for patients. To deliver this, patients must be involved and enabled as true and equal partners for QI.
- Applying systems thinking in QI activity, which results in improvement beyond organisational or functional boundaries, with impact from improvement activity seen across health, social care and wider systems.

It is important to note that these are not sequential steps – the QI journey is not a linear process. All organisations are starting at different places, with different cultures, opportunities and challenges. We have found that trusts adopt elements in a different order and often overlap them.

FIGURE 1: COMMON ELEMENTS OF QI



“We are continually learning. There are different phases of QI for the organisation, and each requires different approaches”.

**Birju Bartoli, Executive Director
of Systems, Strategy and
Transformation, Northumbria
Healthcare NHS Foundation Trust**

How we carried out this work

The report has been compiled using insights from:

- CQC’s comprehensive inspection programme of all healthcare providers nationally, including the new programme of annual ‘well-led’ inspections
- CQC’s new model of ongoing relationship management with all trusts, and
- CQC’s regulatory framework, particularly the well-led framework, developed in collaboration with a range of stakeholders and coproduced with patient groups.

We interviewed 20 members of CQC’s Hospital Inspection Team (including Chief and Deputy Chief Inspectors, Heads of Hospital Inspection, Inspection Managers and Inspectors linked to trusts).

We interviewed inspection teams after trust-wide ‘well-led’ inspections, also using additional insights from their regular engagement (‘relationship management’) meetings with local trust leaders. In these interviews, we explored their experiences of trust leadership, culture and staff engagement, and processes for learning, continuous improvement and innovation. We also reviewed published trust board reports, trust websites and publications demonstrating the impact of local QI work. Through this process, we identified 19 NHS trusts (acute, community and mental health) to include in this report. We conducted 31 semi-structured interviews with trust staff (from all levels, including non-executive and executive board members, local leads for QI, and patient partners), where we asked about:

- the beginning of the QI journey
- the commitment of senior leaders to the QI journey

- the impact of senior leadership behaviours on improvement cultures
- how senior leaders were developed with improvement skills
- how QI expertise was brought in to the trust
- their experience of applying improvement science and using a QI method
- how success and learning from QI was celebrated, shared and scaled
- how staff were engaged with the approach to QI
- how staff were enabled to deliver QI
- how patients and the public were engaged in the QI approach and enabled to support QI
- the impact of QI in the trust and beyond
- key lessons learned along the journey towards QI.

We also visited six of the trusts to see their QI in action, and during those visits we met a

significant number of frontline staff to discuss their involvement in QI.

We collated the findings into lessons to be shared with others on this journey towards embedding a culture of continuous quality improvement across an NHS trust. Many of the trusts included are cited in this report, but lessons from other trusts which we interviewed are also included.

We would like to open with an expression of our heartfelt thanks to all those who have given up time, modelled humility and a commitment to shared learning by supporting this report.

Our aim in publishing this report is to share learning from these organisations to drive improvement in the quality of care by inspiring and challenging other leaders in hospital trusts to embed this approach.

Clear strategic intent for QI

We have found that the QI journey has to start at the top of the organisation, with board members and senior leaders jointly setting out the vision to provide the highest possible quality of care – in some cases ‘perfect care’.

“One of the challenges of leading this at board-level leadership was to be prepared to say things among peers that might mark you out. Perhaps take an unorthodox approach. We set a direction that was more ambitious than others are expecting – for perfect care. There was no precedent for this in the NHS. We had to work in two worlds – the first a conventional evidence-based path, alongside a visionary path of innovation. Looking out, and hearing from our service users and carers helped us to set the agenda on this.”

**Dr David Fearnley, Medical Director,
Mersey Care NHS Foundation Trust**

During this early process, we heard that senior leaders clarify the purpose and define the strategic intent for QI across the organisation. This involves carefully planning how QI will be introduced, and rigorously measuring and tracking progress, which is aligned to strategic priorities. Alongside this sits the narrative around the purpose for QI, which is used to shape opinion leaders and win hearts and minds. This includes identifying and sharing ‘quick wins’ for QI, which builds momentum along the QI journey.

We have observed the importance of commitment from the board and senior leadership in ensuring success on this QI journey, with senior leaders acknowledging from the outset that QI would be a long-term journey and that everyone in the trust would need to make a commitment to it.

“For me, the reason QI isn’t doing what it should do is that our leadership don’t fully understand the process. Winning hearts and minds is yet to happen – the senior team still see it as a project and it’s not business as usual for our trust. If I had my time again, during the first year I would spend more time getting all the leaders in the organisation on the same page. I would focus all my attention on ensuring full commitment from the senior leaders within the trust to adopt quality improvement as business as usual.”

Anonymous Medical Director

There are a variety of triggers that lead organisations to start this journey: several organisations described tragic events that challenged assumptions and operational priorities. Others described a curiosity about how an organisation could ‘future proof’ itself against the growing complexity of healthcare.

CASE STUDY – RECOGNISING THE NEED FOR QI

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

At Doncaster, during a challenging time of financial turnaround, it became clear that there wasn't the service improvement capacity or capability needed to readily implement the necessary changes. It was well recognised at board level that an organisational approach to quality improvement was needed. Alongside the challenges of turning the financial situation around, the senior leaders noticed that quality indicators were not affected during that time, and in some cases actually improved. They attributed this to the existing knowledge and experience in improvement within their workforce, which wasn't being as effectively used or developed as it could be. As a result, a QI strategy was agreed, and a QI team established to develop a culture of continuous improvement and bring a more systematic approach to QI with staff and patients.

The Health and Social Care Act and the **Keogh**,³ **Darzi**,⁴ **Berwick**⁵ and **Francis**⁶ reports were all cited to be influential in encouraging senior leaders to consider how they could define a clear purpose and focus on delivering high-quality care within their organisation.

When is the right timing for QI?

All organisations have different starting conditions for QI. When considering the timing of each trust's QI journey, we heard about the importance of evaluating the context in which this transition would be made. In general, trusts with a systematic and embedded approach to QI often attributed this to the stability and cohesion within the board, and we found that organisational stability was an important consideration for this shift, as a culture of systematic continuous improvement takes years to embed. Similarly, trusts experiencing difficulty embedding a culture of QI attributed this to turnover in senior leadership or an inconsistent commitment to QI among the senior team.

“Quality improvement isn't a way out of quality assurance problems. You have to sit assurance alongside QI and alongside control. The key is an emphasis on leadership behaviours which encourage improvement to flourish.”

Jonathan Warren, former Director of Nursing and Deputy Chief Executive, East London NHS Foundation Trust

Careful consideration should be taken around when would be the most suitable timing to set out on the QI journey. We heard from trusts that have successfully adopted QI strategically and systematically who felt that it was not an appropriate shift for trusts with regulatory breaches and enforcement action, since more urgent action would be required.

“You can do all the quality improvement you want, but if you don't focus on the basics – check that resus trolleys are equipped, ensure staff are trained, then you won't provide safe care today, let alone tomorrow.”

Steve Dunn, Chief Executive, West Suffolk NHS Foundation Trust

Although most often we have seen organisational stability as the starting condition for QI, some organisations have used a crisis as the trigger to adopt an organisation-wide approach to QI. We have seen organisations without an embedded approach to QI deliver fast results by partnering with leaders who have sufficient experience of, and confidence in, QI methods to drive improvement action quickly. In these situations, QI has delivered quick and sustainable improvement, but only where leaders already have the necessary improvement skills and behaviours and, therefore, are in a position to put their ‘shoulders to the wheel’. There are emerging examples of QI being used, alongside other interventions, to tackle turnaround situations.

We have seen a simultaneous ‘fast-slow’ phenomenon in the evolution of QI culture: while operational results can be delivered quickly and grow incrementally, the organisational shift takes time. Where teams commit to working on improvement projects and do them properly, results can be seen quickly, particularly if modelled by senior leaders. However, the challenge is ensuring that a systematic approach is embedded in the culture of the organisation.

However, a consistent message from these trusts is the importance of finding ‘quick wins’ from QI. These build confidence in QI as the process unfolds, and encourage the senior leaders to be patient with the process as QI is systematically embedded.

We have seen that trusts with a long track record of delivering QI have taken a deliberate approach to make them organisationally robust so the QI approach is not dependent on individuals (see case study on page 24).

Understanding the nature of the QI journey

Board members usually described the process of establishing and committing to the QI journey as lasting over several years: nurturing a culture of QI throughout an organisation generally has taken five to ten years. Those who saw a swift transition to an improvement culture

adopted across the organisation attribute this to commitment, drive and modelling of expected improvement leadership behaviours from the senior leaders (see page 12).

Non-executive directors and other board members describe impatience to see return on investment and outcomes. The paradox is senior leaders often will *not* commit until they see results, but *results* will not come without senior leadership commitment. An early priority should be the intentional targeting of QI training to senior leaders to actively engage such impatient leaders in developing their own skills and behaviours, alongside identifying appropriate areas for QI ‘quick wins’ and sharing the impact from such projects to build momentum.

Board members also described the importance of understanding the cumulative nature of the return on investment.

“A key reflection from the beginning of our journey was just how important it was that we had complete buy-in from the senior leadership team to this vision. We had consistency of leadership, approach and message, and supported each other in shifting our behaviours, to adopt coaching relationships. There were times when we had to hold our nerve – when it didn’t seem to be going well. There were times when we weren’t sure we’d done the right thing. You could call it ‘strategic patience’. What helped was sharing the journey with our QI partner – being supported by an organisation that had already pioneered this approach, seen success and could share their learning with us was invaluable.”

**Marianne Griffiths, Chief Executive,
Western Sussex Hospitals NHS
Foundation Trust**

Learning from others leading QI

“The key thing is that this is a journey we’re on as an organisation. It’s not a quick fix, and it’s been a bumpy journey – but that in itself is not a bad thing. We are learning as we go – we need to do this to become an organisation that is continually improving.”

Sarah Scales, Head of Programme Management Office, Royal Surrey County Hospital

Experimentation is key to any improvement approach, which must sit alongside explicit permission to fail. Senior leaders should demonstrate humility and curiosity in seeking shared learning and partnership on the QI journey to support that experimentation approach. We have found that organisations already on a QI journey are keen to share learning, help others and support other organisations.

“It’s a balancing act of looking in and looking out. We as the leaders have to be prepared to learn from others – doing this is humbling, but the only way to improve is find out who else is doing it and learning from them. Not just similar organisations in the UK. Look across the world, in other sectors. But don’t just look. Make sure they hold the mirror up to you, your leadership, and allow them to challenge. This brings the learning.”

Dr David Fearnley, Medical Director, Mersey Care NHS Foundation Trust

The importance of networks and shared QI learning experiences was often emphasised, and thought to be important right from the beginning of the journey. We heard of leaders visiting and learning from organisations with an established QI culture, both in healthcare and

other industries, including motor manufacturing, aviation and financial services. The common theme is a commitment to shared learning on the QI journey.

“We went to a few places – healthcare and industry, including some international visits. This has encouraged me to remember that everyone is on the journey. We are all struggling with the same challenges and this has given us confidence to continue with the approach – having that network is important. It has also allowed us to tweak as we go by, sharing in learning.”

Sarah Scales, Head of Programme Management Office, Royal Surrey County Hospital

“We started this journey back in 2007 across our Strategic Health Authority. A number of local trusts went to visit Virginia Mason to understand the application of ‘Lean to healthcare settings’. We also did visits to Seattle and Japan. We were supported by experts from the Virginia Mason Institute who ensured we set off on the right foot. They led training workshops – we focused on training ‘certified leaders’ as our early adopters.”

Colin Martin, Chief Executive Officer, Tees, Esk and Wear Valleys NHS Foundation Trust

There are many ways of building improvement focused networks with like-minded organisations. These can be formal and informal, commercial (such as the Virginia Mason Institute and the Institute for Healthcare Improvement) and community (such as the Health Foundation’s Q community), and through secondment opportunities.

“In the end, we chose our QI partner because we felt that they understood the scale of the cultural shift required for us to make this ‘the trust way’ and they offered a real and dynamic way of achieving that. Our QI partner helped us develop a Lean transformation roadmap, jointly identifying top strategic priorities to be cascaded throughout the organisation.”

**Marianne Griffiths, Chief Executive,
Western Sussex Hospitals
NHS Foundation Trust**

Leaders with a focus on QI create the necessary conditions, where services are designed to deliver value and patient-focused outcomes. Achieving other operational and financial targets are subordinate to this, with other targets improving as a consequence. One such target is a favourable CQC rating. There are several trusts that are further along the journey to embedding improvement culture, where effective improvement-focused leadership has engaged, empowered and enabled staff, patients and carers in improving services. We have seen this approach reflected in achieving outstanding ratings.

“There are no magic bullets in healthcare. You can’t lift and shift a QI approach from other trusts. Or expect immediate results. It needs translating into different environments. But we must learn from each other.”

**Dr Helena Jopling, Consultant in
Healthcare Public Health, West
Suffolk NHS Foundation Trust**

Strategic decision for QI

The journey of QI throughout hospital trusts consistently started with a board-level strategic decision to pursue QI. Laying out the strategy includes careful planning around the timing and introduction of QI, combined with rigour in measuring and tracking progress, and identifying and sharing quick wins.

“My key lesson from this journey would be – don’t gallop to the start line. Take time to build the aeroplane before you take off. Sort out the governance. Make sure you have a way to record every project. Ensure you have metrics, and use national metrics (where possible) to align projects. Time spent on engagement is invaluable and will reap dividends down the line – harnessing the creativity and drive of your staff is the only way you’ll shift the culture.”

**Jane Bradley, Deputy Director
of Patient Safety and Quality
Improvement, Northampton General
Hospital NHS Trust**

Leadership for QI

The most important determinant of quality of care is leadership. These trusts have a strategic plan for QI, which is supported with unwavering commitment from the senior leaders, who model appropriate improvement-focused leadership behaviours and a visible, hands-on approach.

“We transitioned from questioning ‘what is quality’ into ‘how we can improve things?’”

**Dr David Fearnley, Medical Director,
Mersey Care NHS Foundation Trust**

Leadership behaviours for QI

We have seen common leadership behaviours that effectively build organisation-wide commitment to QI (**FIGURE 2**). These include courage, persistence, humility, curiosity, a willingness to challenge their own assumptions and practices, a commitment to transparency and a commitment to shared learning across the organisation and beyond.

FIGURE 2: COMMON LEADERSHIP BEHAVIOURS THAT LEAD TO ORGANISATIONAL COMMITMENT TO QI



This finding is supported by the Developing People, Improving Care framework,⁷ which sets out that leadership to deliver a culture of continuous improvement requires compassionate, inclusive, effective leaders at all levels, and a knowledge of improvement methods and how to use them at all levels.

The impact of such behaviours is that staff feel valued as individuals, harnessing their creativity and ingenuity to solve problems. Frontline staff are given the freedom to innovate using a systematic approach, which is aligned to strategic priorities and embedded into day-to-day operations.

“Our current priority is around developing behaviours which embed our values – we need to ensure that we have the appropriate environment for leaders to move away from firefighting and solving problems, towards behaviours where our leaders are coaching and enabling improvement from the ground up. Our leaders need to be giving frontline staff permission to make the improvements they know will make a difference.”

Sarah Scales, Head of Programme Management Office, Royal Surrey County Hospital

Coaching for QI

“Effective leadership for quality improvement must be ‘step in and step out’. The leaders must step in to ask the right questions to get wheels in motion. And the leaders must step out, to allow the wheels to start spinning in the right direction. The role of the leader is to set up the ‘sandbox’ for the organisation to play in. Without permission to think and experiment, improvement won’t be realised.”

Donald Craig, Deputy Head of PMO, University Hospitals of Derby and Burton NHS Foundation Trust

The leadership model seen in QI shifts from a top-down model, to a coaching model, where leaders support and enable improvement work delivered at the frontline. Staff at all levels are both trusted and enabled to deliver sustainable improvements at the level at which problems are identified.

“I had to change my style of leadership: the senior leaders were there to remove barriers to improvement, and provide support and training for success. I now have my team to remind me when I need to ‘take my cape off’ – I’m not to swoop in and tell staff how to improve, but I need to ask how I can support them in their improvement work.”

Marianne Griffiths, Chief Executive, Western Sussex Hospitals NHS Foundation Trust

I can see that staff feel your respect for them more when you meet them in their work space, “walk in their shoes” and see, feel and experience the challenges from their perspective. Coaching individuals and teams to work out the answers to problems for themselves, and being there to support them if it gets tough, is the best gift we can give every day.

**Helen Gilbert, Kaizen Promotion
Office Lead, Leeds Teaching Hospitals
NHS Trust**

Board leadership for QI

In moving to a QI culture, we have seen trusts shift their emphasis, starting at the board level, from an assurance model to an enabling improvement model. This modelling of behaviour sets the tone for leadership throughout the organisation.

Developing senior leaders’ improvement skills is key to enabling them to facilitate improvement work – trusts that had committed to the journey started by training all their senior leaders in QI.

“QI means a transition in leadership: moving away from conversations that start with ‘I want you to...’ and moving to conversations that start with ‘Can I share my vision with you?’ and then ‘How can I help you to get to this?’”

**Donald Craig, Deputy Head of PMO,
University Hospitals of Derby and
Burton NHS Foundation Trust**

Senior leaders have another important role to ensure that there is sufficient time and space for improvement activity, at all levels within the organisation. Senior leaders are explicit about processes and expectations that are made to ensure staff, students and patients have regular time to take part in improvement activity. This activity might include attendance at rapid process improvement workshops, improvement collaboratives or team away days.

Creating time and space for improvement can add further pressure to staff in the short term, and engagement with all staff needs careful consideration on how most effectively staff can be engaged, particularly around the purpose and potential benefits of QI, and sharing success from quick wins.

Board members model their commitment to QI by taking part in improvement at the frontline and with frontline staff:

“One of the founding principles of QI is the ‘gemba’, where the work is done. Decisions and improvements are better made if they are done at the workplace. So we, as leaders, need to be there. Not remote, sitting in meetings.”

**Dr Des Holden, Medical Director,
Surrey and Sussex Healthcare NHS
Trust**

CASE STUDY – ‘THE LEEDS WAY’

LEEDS TEACHING HOSPITALS NHS TRUST

Leeds went into their QI project with the knowledge that good staff engagement is essential for good QI. This knowledge was based on the experience of developing ‘The Leeds Way’, a set of values and behaviours developed collaboratively to capture the things that staff themselves know to be a crucial part of providing excellent health care for patients.

They feel that investing in a systematic application of QI into this environment is a natural fit. At high level there is national partnership between NHS Improvement, the Virginia Mason Institute and chief executives from a network of trusts at a similar stage of adopting QI. A transformational guiding board drawn from these partners meets monthly.

Locally, the guiding team includes local trust executive directors and the Kaizen lead. The impetus for change is very much led by staff themselves and, from the range of opportunities offered, the guiding board identified five patient pathways or ‘value streams’. Work developed iteratively to make very local improvements based on an in-depth understanding of how to make efficient processes by eliminating waste.

Each value stream is enabled by an executive director taking personal accountability for leading the operational steering group. The executive sponsor is supported by the Kaizen promotion team and local clinical and non-clinical leaders identify opportunities for improvement on the operational pathway. Local staff are keen to make operational improvements and appreciate the visibility and engagement of trust executive colleagues who are able to support, based on a real involvement in the work. The executive director reports back on progress into the guiding team at board level, based on engagement from staff at all levels.

Leaders are strategic in how to spread and reinforce QI – we have seen regular learning and sharing events to celebrate improvement work, which includes learning from less successful activity. These sit alongside formal support for the spread and recognition of improvement throughout the organisation, such as through newsletters, social media, posters and journal articles. There is a training and development strategy for improvement and innovation, with active monitoring, such as numbers of staff and patients taking part in improvement projects, and attendances at training events.

An important feature of effective executive leadership for QI includes having a publicly available quality strategy, which designs QI into strategic plans and sets the organisation’s QI goals. Quality is seen to be a priority at the board, in board meeting agenda and minutes, and through publishing a specific report on quality that is also available to the public.

We have found that it is difficult to embed a culture of QI where a board prioritises finance, performance and other issues over the quality of care. There are two key features that demonstrate what a commitment to QI looks like for the senior leaders:

- Firstly, there are structures in place to oversee QI work, with several executive directors involved in regular overview of the deployment of a trust-wide QI strategy.
- Secondly, the executive team and clinical leaders are *all* able to demonstrate their active involvement in leading improvement, supporting teams in their QI work and developing a practice and culture for QI to flourish in the organisation.

“We first focused on building improvement capability and enthusiasm among the senior leaders in the organisation. It is now the expectation that our leaders lead and coach the improvement work – they aren’t just there to be reported to. They bring the organisational perspective, and opportunity to understand and remove barriers to improvement.”

Anil Matthew, Director of Continuous Improvement, Western Sussex Hospitals NHS Trust

Measures for improvement

The QI journey connects leaders to the frontline using measures for improvement. The senior leaders ensure that any measures seen at board level are connected through the system, that measures are used appropriately at all levels and they develop skills for understanding variation over time.

We have seen a move away from the traditional model of ‘reporting to’ senior leaders (where aggregate reports and data are reviewed in meetings) to a model where leaders engage with improvement work at the frontline. There can be a tension between leadership behaviours which facilitate QI and those which are focused on traditional assurance processes. In the QI model, performance is still monitored and additional assurance is taken by confirming that improvement culture is emerging at the frontline. This validates and confirms improvement by connecting to places where the work is being done. Some improvement programmes incorporate assurance and control alongside improvement (see the case study below).

CASE STUDY – ASSURANCE ALONGSIDE QI

EAST LONDON NHS FOUNDATION TRUST

The quality system at East London NHS Foundation Trust incorporates quality planning, quality control, quality assurance and quality improvement, bringing them together into a single quality system to meet their performance goals and improve care for people using services.



The logo of QI at East London NHS Foundation Trust demonstrates that QI is delivered through a combination of assurance, control and improvement.

Effective QI also requires good systems for measuring and sharing improvement, which allow senior leaders to review data over time and understand normal and special variation, rather than just report the situation – this shapes the entire conversation:

“We ended up with a dual approach of encouraging QI throughout the organisation: board reporting was changed so all data was presented using SPC run charts on a Quality Improvement Scorecard (which is publicly available). The QI team support those with responsibility for programmes with their ongoing improvement work. They also have a ‘bottom up’ approach, supporting frontline staff through project proposals, aligning them to strategic objectives and connecting to other related improvement

work. QI projects are only supported if they meet corporate objectives, and the project proposal form helps the QI team coach them through this. In general they have found that most projects are easy to align to objectives with support from the central QI hub.”

Jane Bradley, Deputy Director of Patient Safety and Quality Improvement, Northampton General Hospital NHS Trust

There is an important difference between data for assurance and data for improvement, and boards understand both and use them in balance. Over time, risks and actions on the board assurance framework change and do not remain at high scores for a long period. The actions linked to these risks should form part of the improvement plan or strategy for the organisation and link to the improvement aims and projects reported by staff. In addition, problems are analysed within board reports and at sub-committees, using appropriate data analysis tools (such as SPC and Pareto charting) with a record and description of decisions taken, and SPC limits are adjusted as improvements take place.

Leading from the frontline

One of the principles of QI is that decisions are better and improvement is more effective if delivered at the workplace – the frontline. The result of embedding a QI approach is that senior leaders are more connected (including physically) to day-to-day operations. This is shown by their visible presence, supporting teams and getting involved in their QI work – at the frontline, where problems and inefficiencies are encountered.

“The key investment to make in this shift is time – we need to give teams time and space to be able to problem solve. For example, the Rapid Process Improvement Workshop (RPIW) ‘Away’ team have no clinical duties during the week, so that they can focus on rapid improvement. There is also a ‘Home team’ for the RPIW who cross-cover clinical duties, but also test improvements during the RPIW.”

Sara Reeve, Associate Director of Performance, Midlands Partnership NHS Foundation Trust

Decision-making responsibilities are devolved to the frontline, where leaders ensure that problem-solving and resources are brought to where the problems are being experienced, rather than being dealt with away from the context. Senior leaders act as ‘champions’ within projects – a visible reminder of the senior commitment to QI, championing the improvement work and, where necessary, removing barriers to improvement. Senior leaders engage regularly with staff and, critically, adopt an enabling role with frontline teams, supporting and coaching in problem solving rather than imposing solutions from the top. We have seen a demonstrable shift in leadership behaviours, away from a command and control, performance management approach, towards a devolved, enabling model of leadership.

“We try to use little command and control in our leadership. There is a time and a place for that sort of leadership – for example, during a major incident – it’s not an everyday approach and one that is not right for developing a culture of improvement and engagement – where you want to enact change with people – staff and patients.”

Birju Bartoli, Executive Director of Systems, Strategy and Transformation, Northumbria Healthcare NHS Foundation Trust

Building improvement skills at all levels

We have found that these trusts use a systematic framework to build improvement skills at all levels, to facilitate improvement work and to share learning.

Aligning QI to organisational priorities

When a strategic decision has been made to adopt QI, senior leaders set organisational priorities and create space for experimentation and innovation around those priorities.

“Improvement work is focused around a few strategic themes. However 80% of improvement work is generated from the shop floor.”

Colin Martin, Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust

Adopting QI at scale requires an appropriate infrastructure – this includes a robust framework for frontline teams, alongside mechanisms to share learning and scale improvement across the organisation. The framework also provides structure and alignment to organisational priorities, where projects at team level align with strategic objectives for the organisation. In general, we found that QI was best embedded where work was aligned to strategic objectives within the organisation.

Coaching improvement projects to align to strategic objectives came from both the senior leadership and the central QI team.

Using a QI model

In organisations with an established QI culture, we see that a clear and consistent improvement

method is in use and is demonstrable across all areas of the organisation. Commitment to the chosen methodology has resulted in a sustained and embedded culture of QI. The key is not the choice of one methodology over another, but the commitment to a coherent, systematic improvement methodology that is anchored in improvement science. This methodology can then be adapted over time, as suited to the organisation. The common features of these methods include:

- applying ‘systems thinking’ to understand the problem
- experimentation as a discipline for improvement
- hands-on, visible, enabling leadership as a fundamental practice
- a focus on key improvement principles over the tools themselves.

A variety of structured QI tools are in use, which include ‘the model for improvement’, Institute for Health Improvement (IHI), Lean in Healthcare (including Virginia Mason and Thedacare), and Haelo. These tools often bring partnerships with experts in like-minded organisations, provide networks for shared learning, peer review and mentoring, and build improvement skills across and throughout an organisation.

A systematic approach to QI also prioritises the use of measures as a lever for learning and improvement, as opposed to a traditional management control mechanism.

Data is used to monitor the progress of improvement work against predicted outcomes and ensures sustained improvement.

Measurement should be supported by information technology systems to support data extraction and monitoring.

CASE STUDY – ALIGNING QI TO ORGANISATIONAL PRIORITIES

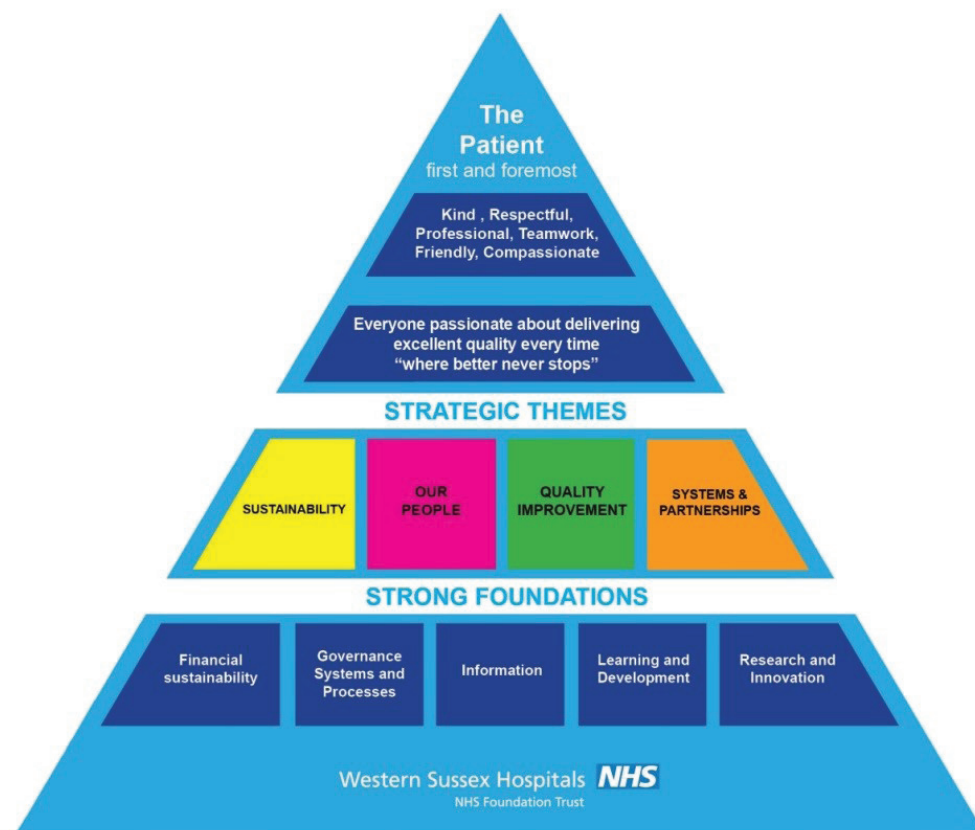
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST

The QI programme at Western Sussex is called 'Patient First', designed through Lean principles, with four clear strategic themes, to which all QI must be aligned.

Their QI partner supported them to set up a new QI department, which focused on supporting the trust to build systems to support continuous improvement using Lean principles and a training programme for all staff to develop skills in improvement. They also developed a Business Performance System to build systems that enabled service areas to deliver continuous improvement, and provided coaching to the Kaizen office in conducting large improvement initiatives. The vision is that this empowers frontline staff to initiate and lead positive change:

"Through our Kaizen office, we aim to create a 'trust-wide' army of Problem Solvers, empowered to make improvements to processes and pathways using Lean tools, that is sustainable and shows tangible benefits for patient care, service and experience."

Marianne Griffiths, Chief Executive, Western Sussex Hospitals NHS Foundation Trust



Schematic of Patient First at Western Sussex Hospitals NHS Foundation Trust

“It is the responsibility of leaders to understand, run and improve our business. It feels different because we are learning a structured management method to develop a deeper understanding of our processes so we can focus on what matters every day for our patients. A lot of small-scale improvements impact our patients’ experience positively faster than you realise, and staff can embed small changes in their working practices relatively easily. You can see that teams enjoy measuring changes when you give them easy ways to do it and you celebrate the improvements in a meaningful way.”

**Helen Gilbert, Kaizen Promotion
Office Lead, Leeds Teaching Hospitals
NHS Trust**

A common lesson is the importance of engaging staff early in the QI journey to understand why outcomes are being measured, and addressing potential concerns that metrics are being collected for top-down performance management. The key shift is that measures are used by staff and managers together, in context, to learn and improve, and are embedded into day-to-day operational systems.

The QI method usually includes building a network of QI experts and coaches at all levels throughout the organisation. In some trusts, this is facilitated by a central QI team or hub. The role of this team is to support improvement work and build improvement skills, with an explicit focus of transferring expertise in improvement methods, tools and skills to frontline staff, managers and senior leaders across the organisation. They often deliver training, coaching and mentoring, both on improvement methodology and tools, and on leadership for improvement.

The QI team, which often includes programme managers, provides robust, regular and local support across all areas of the organisation to help teams using QI to solve complex quality issues, align QI to strategic priorities, and choose measurements that demonstrate improvement. The team may also communicate success and learning from QI work and keep a central record of improvement work to support future QI. This team may also ensure the adaptability and evolution of the QI methodology to ensure that it continues to fit with the natural evolution of a trust.

The impact of empowering staff to deliver sustainable improvements is that, over time, staff are less dependent on support from a central QI team.

Developing improvement skills

We have seen a commitment to building improvement skills throughout an organisation at all levels – this includes developing QI skills in board-level leaders, developing QI sponsors and coaches, staff leading QI projects, and a strategy to get all staff involved in QI. Some described this approach as a ‘pyramid of capability building’, tailoring intensity to positions of leadership for improvement.

CASE STUDY – STRATEGIC AND SYSTEMATIC APPROACH OF BUILDING IMPROVEMENT SKILLS

EAST LONDON NHS FOUNDATION TRUST

East London NHS Foundation Trust strategically identified the levels of QI skills needed at all levels to deliver the strategy, and planned their approach to build improvement skills systematically – see diagram below. This includes training for those at board level (both non-executive and executive), and a basic introduction to quality for all starters as part of induction. All staff in management or leadership roles are expected to undergo the six-month improvement leaders programme, to equip them to run and lead QI projects.

Directorate leaders are responsible for assessing capability within their teams, and identifying which staff need training. They have a variety of learning options for staff to access, in addition to the intensive six-month course, alongside many refresher masterclasses, workshops and webinars:

- ‘Pocket QI’ covers the basics of improvement science in two half-days of classroom-based training, and is accessible to everyone.
- The Improvement Advisor Program provided by the Institute for Healthcare Improvement is aimed at a small number of central full-time improvement experts.
- The Senior Clinical Leader Program develops senior clinicians to sponsor improvement work and display the leadership behaviours that promote continuous improvement.
- The introduction to QI for people using services and carers enables them to contribute meaningfully, alongside staff, to QI in the services they use.

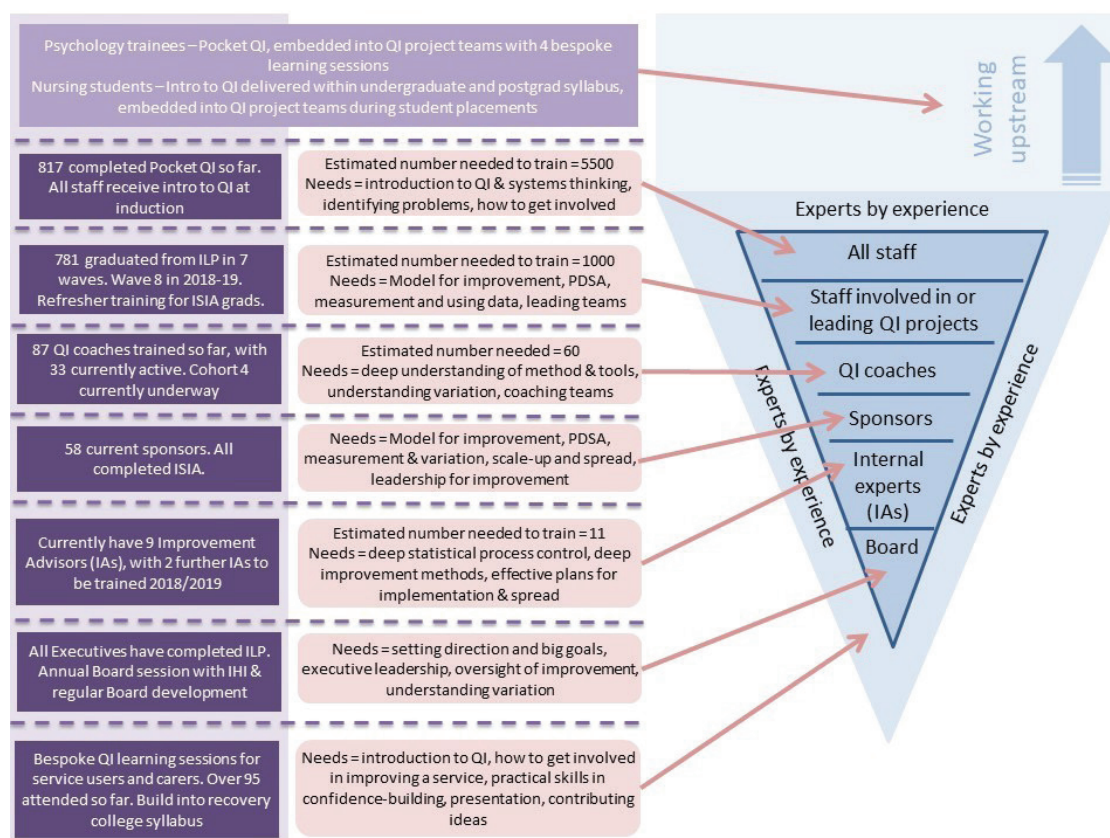


Diagram of East London NHS Foundation Trust's strategic plan for capability building

One of the consistent themes in trusts where a culture of improvement has been embedded is that all those in leadership positions are expected to undergo QI training. We have also seen divisional leads assessing which staff need training and at which level, so that resources are deployed strategically.

We also found that trusts that encountered difficulties at the beginning of a QI journey had not been able to convince all the senior leaders to undergo training, coaching and mentoring to lead improvement work.

The pyramid approach, referred to above, builds capability in those who sponsor and coach projects, those who lead projects and for all staff. To embed a culture throughout an organisation, all staff at all levels, grades and sites, need 'basic' training to give an awareness of QI.

"We've adopted a pyramidal approach to QI training. We have taken a coaching approach to our QI training for leaders. This is based on problem solving – solution focused coaching. We have taken 800 of our leaders through this approach – we are giving band 7 and above staff both tools and ideas about how to enable all staff to think through possible solutions. We are training them to think more broadly, and to support their teams to think more broadly. They have ways of inter-relating with staff at their fingertips – they are no longer trying to problem solve themselves, but are now thinking through how they can enable staff to problem solve."

**Ruth Briel, Senior Clinical Director,
Kaizen Promotion Office, Tees, Esk
and Wear Valleys NHS Foundation
Trust**

After a strategic decision has been made to adopt QI, recruitment can reflect the necessary values and skills to deliver QI. Induction for new staff includes QI training. Critically, organisational systems (such as performance management, governance, recruitment, and induction) need to be redesigned and aligned to support this. Developing improvement skills for leaders ultimately results in the QI method becoming the leadership model, where leaders model improvement behaviour and coach others in QI. As improvement skills are developed, QI stops being a 'thing', and becomes the way the organisation is run. As people develop and practice improvement skills, it becomes the method of management.

Building a culture of improvement at all levels

We have found that these trusts build a culture of improvement, which enables all staff to make effective and sustainable improvements.

“Everyone at [Northampton General Hospital] has two jobs – to deliver care and to improve care.”⁸

**Dr Sonia Swart, Chief Executive,
Northampton General Hospital NHS
Trust**

In **CQC’s State of Care 2015/16** publication,⁹ we reported that in hospitals rated as good or outstanding, the trust boards had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice. In *Driving improvement: Case studies from eight NHS trusts*, we reported that some trusts made substantial improvements in quality by engaging staff and empowering them to drive improvement, and breaking down barriers between teams so they could work together on solving problems.

“A problem you walk past is a problem you accept – I told the staff that I wanted them to take ownership of solving problems.”

**Steve Dunn, Chief Executive, West
Suffolk NHS Foundation Trust**

We have seen the impact of full and unwavering commitment from all senior leaders in the trust to adopt a QI approach as ‘business as usual’. This means leaders support QI to be embedded through all trust activities, and it connects senior leaders to frontline staff. We have seen how the shift at board level to focus on quality of care

at the frontline has been a key step to engaging staff, patients and carers.

“My learning from this journey is that the key is a culture of continuous improvement... we need to support our staff to really understand what designing services to add value really means... My experience is that if you talk, if you listen, keep asking why, you can get down to really unblocking culture and changing it.”

**Dr Des Holden, Medical Director,
Surrey and Sussex Healthcare NHS
Trust**

Shaping the organisational culture

A culture of continuous improvement emerges as senior leaders commit to QI, model improvement behaviours and coach teams in delivering QI. In these organisations, staff are valued as individuals, and QI harnesses their individual creativity and ingenuity to problem solve, aligned to the purpose and organisational priorities.

“The big step of our QI journey is not just the tools but the culture we create at all levels of our organisation – empowering staff at all levels to make improvements.”

**Anil Mathew, Director of Continuous
Improvement, Western Sussex
Hospitals NHS Trust**

The improvement culture comes when all staff understand the purpose of the organisation, actively focus improvement in ‘value streams’, which achieve that purpose, supported by systems and processes designed to support improvement and do what matters to patients and outcomes. Organisations with strong systems for improvement, innovation and learning can articulate clearly and succinctly their improvement aims, their progress and their approach. Improvement is seen as the way to deal with performance and for the organisation to learn.

Senior leaders have a pivotal role mobilising all the organisational effort around the purpose and adding value, ensuring that effort is focused on improving the quality of care delivered. They do this by modelling that patients, clinical staff, operational managers and senior leaders do the work together, and ensure that any obstacles to improvement are dealt with and the organisational systems and processes are aligned to facilitate this.

This approach changes the culture, but it is not the primary intention. We see staff throughout the organisation and from a variety of backgrounds who can talk about the approach to QI and how they have been involved and the difference it has made.

“Close working between the QI team, and colleagues in HR and Organisational Development (OD) is essential so we work collectively to develop a culture of improvement and create the ‘conditions for QI success’. We all bring different but complementary expertise and so can support teams in different ways – but do this in a joined-up way.”

Petra Bryan, Head of Qii, Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust

CASE STUDY – STABLE CULTURE THROUGHOUT TRANSITIONS

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

Tees, Esk and Wear Valleys NHS Foundation Trust started the journey to QI along with local partners in the strategic health authority. It was championed by the former Chief Executive, who led the organisational development to build an improvement culture, with lean transformation using the Virginia Mason Production System.

From the outset, their aim was to embed a culture of continuous improvement across the trust, developing a QI system to reduce waste, while continuing to deliver high-quality, effective services that meet the needs of their patients. When there was a change in Chief Executive, the embedded QI culture gave resilience to the transition, and the trust continues to coach and mentor other trusts embarking on a journey towards QI.

“Some of the key contributors to ensuring sustainability through the transition were:

- *Board buy-in*
- *Clinician buy-in – seeing QI as better for patients*
- *Middle managers seeing that this way of working made life easier for them*
- *Having a Kaizen promotion office to support the organisation with QI.”*

Ruth Briel, Senior Clinical Director, Kaizen Promotion Office, Tees, Esk and Wear Valleys NHS Foundation Trust

CASE STUDY – CELEBRATING LEARNING AND SUCCESS

MIDLANDS PARTNERSHIP NHS FOUNDATION TRUST

At Midlands Partnership NHS Foundation Trust, there has been an emphasis on celebrating learning and success as a means of engaging staff in QI. Friday afternoon ‘report outs’ are used to share success from a Rapid Process Improvement Workshop (RPIW), a Kaizen event or at the end of a ‘Leading QI’ project. During an RPIW, an improvement report is shared on Friday lunchtime that includes the action plan, with a 30-, 60-, 90-day and 1-year monitoring of metrics set. This is used to share success within the team and beyond, and is also used to update on progress from previous QI projects. All staff are encouraged to come to the ‘report outs’ – the events are filmed and streamed live throughout the organisation. Stories are developed for use on the trust screensaver, and are incorporated into the trust newsletter. Consideration is made on how best to communicate any learning from huddles and improvement work, to be shared across organisation – for example, huddles must decide on the key communication ‘tweet’ and updates from previous improvement work.

Engaging clinical leaders

This model of improvement leadership requires leaders of all backgrounds and frontline staff to work together in improvement. This approach breaks down barriers between managers and clinicians, so there are no longer distinct clinical and managerial goals, but shared purpose and methodologies. We see them work together on the system in which clinicians practice – a shared purpose to improve its function, and to deliver better care to patients.

“We’ve emphasised clinical leadership as part of our model – we now have strong pairings between managers and clinicians. Each comes with different skillsets. There’s balance in that relationship, and we’ve found it effective for embedding a culture where improvement is ‘what we do’.”

**Birju Bartoli, Executive Director
of Systems, Strategy and
Transformation, Northumbria
Healthcare NHS Foundation Trust**

Clinical engagement in QI happens when clinicians understand that the purpose of QI isn’t an external challenge of clinical or professional practice, but a method which will support them to deliver better services to patients. Significant effort is needed to work with clinicians to move beyond clinical audit and research as the only means for improvement. Early engagement around the purpose of QI is important, particularly framing the rationale for QI in a way that will resonate with the core purpose of staff.

We have also seen that the visible commitment of senior clinical leaders to QI is crucial in engaging clinical staff. Where this commitment is missing, we have observed doctors feeling professionally undermined by the suggestion that they need to improve. In some trusts, we have seen an intention to engage other clinical staff groups (such as allied health professionals) in improvement work.

“Using a structured method helps us really understand in depth how the skills, knowledge and talent of our workforce are applied in the work they do for our patients. How respectful are our systems and processes in creating meaningful work that benefits from this talent? I have really found that these conversations create a connection with clinical staff who get frustrated with tasks that don’t support/enhance patient-centred care.”

Helen Gilbert, Kaizen Promotion Office Lead, Leeds Teaching Hospitals NHS Trust

“Clinical engagement was an important part of the journey. We found that having medics in our QI office made a difference. We approached this in a variety of ways. We did small group teaching with doctors, which allowed us to have more of a conversation, and was about winning hearts and minds. However, we also made some structural changes – we ask about QI in medical appraisals. We have it in clinician’s job plans – an objective around developing knowledge and skills in QI. We are transparent on attendance at QI training – and sharing learning with medical leaders. We have even started recruiting based on interest in QI – this investment has become self-sustaining. We’re now on the front foot so we are able to create space to do the improvement work. Alongside winning the hearts and minds of clinical staff, engagement was also achieved by incorporating QI into the processes for

performance and organisational learning, such as staff induction, training and appraisals.”

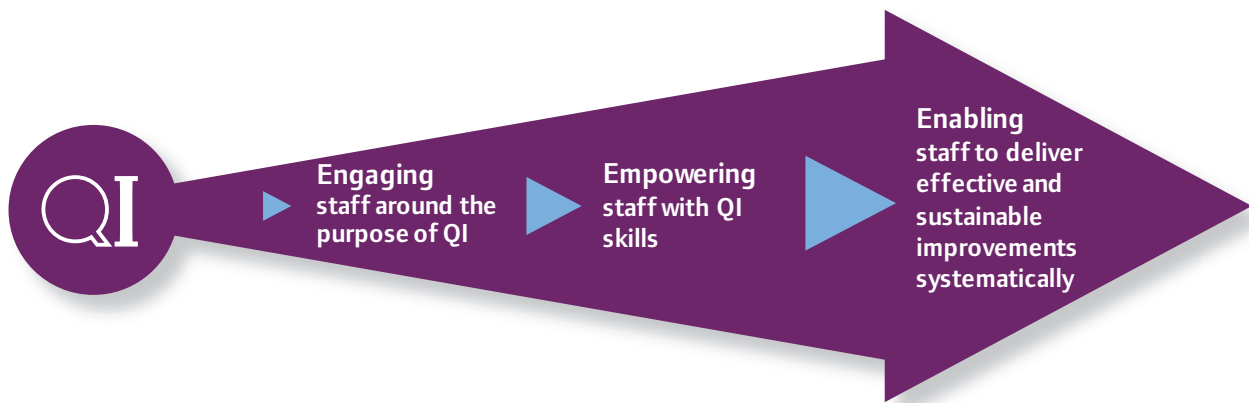
Ruth Briel, Senior Clinical Director, Kaizen Promotion Office, Tees, Esk and Wear Valleys NHS Foundation Trust

At several organisations, we have seen rotational junior doctors in training who are actively engaged in QI. In these cases, a central QI team have supported junior doctors in complete QI projects and formal assessments, which are often required for progression in training, and have coached and coordinated the publication of improvement work. Conversely, where there is less support for junior doctors in delivering their QI projects, the hospital trusts are less likely to benefit – projects aren’t necessarily aligned to strategic priorities and there is a failure to sustain and scale improvement, share learning from the improvement work.

Engaging, empowering and enabling staff

QI brings a deliberate change in the leadership role, which results in engaged, empowered and enabled staff (figure 3). The leadership behaviours take time to embed, and all staff in the organisation have to practice this approach. This can be counter-intuitive and counter-cultural; leaders need help to give up long-established top-down management habits, and to develop empowering approaches – it happens in steps, not in one single event. QI involves changing long-established practices and learning new skills, which happens incrementally as QI expertise is built over time.

FIGURE 3: THE IMPACT OF THE QI APPROACH ON STAFF ENGAGEMENT, EMPOWERMENT AND ENABLING TO DELIVER IMPROVEMENT



QI brings genuine staff engagement, with leaders and staff working together on problems. Staff are empowered when:

- improvement skills are built across and throughout the organisation
- a coaching style of leadership is used, which is modelled by senior leaders
- decision making is integrated and redistributed closer to where problems are being experienced
- they feel trusted and secure in delivering improvement
- the leadership model focuses on supporting staff do good work, and take away blockages to improvement.

“However wonderful the methodology, unless it sits in the right culture, you won’t be able to make a difference. The best thing about our leadership culture in how it supports our QI endeavours is that it’s transparent and supportive: we see improvement materialise partly as it’s championed by the leadership team. The executive team and senior leadership team talk about the QI results every month, for example using metrics from a Rapid Process Improvement Workshop.

These leadership huddles on a monthly basis help to remove barriers to ensure improvement continues and spreads. I am confident that the senior leadership are aware of all improvement activity and are active in enabling the frontline staff to realise their ideas for change. I can say to the teams ‘these results will come because the senior leaders are talking about what you are doing and will unblock any barriers which you cannot remove at team level. We have over a 95% success rate in the realisation and sustainment of the improvements teams want to make.’

Katy Morris, Head of the QI Academy, Midlands Partnership NHS Foundation Trust

CASE STUDY – DEVELOPING THE JUST AND LEARNING CULTURE

MERSEY CARE NHS FOUNDATION TRUST

While considering how they could define and focus their work on improving the quality of patient care, the trust found this impacted on how they treat their staff. The vision was that they rediscover the importance of a compassionate approach, the importance of relationships.

With the support of Professor Sidney Dekker, they have set an aim to move the culture away from a blame culture into a restorative model, supporting staff through incidents in a way that encourages learning: understanding what went wrong and why it went wrong, rather than focusing on who was involved.

The trust made a public commitment that they were going to develop ‘a just and learning culture’, defining how success will be measured (for example in their quality accounts, and reviewing their HR processes), and what behaviours they expected to be seen. Although they have focused on building a just and learning culture, they have seen an impact on sickness, absence, and clinical outcomes.

Learning from healthcare models in the USA, they set out to apologise when things go wrong (which included training for staff on how to apologise) and shared the review early in the process. They also learnt from the communication resolution programme in the USA. When looking at safety incidents, they reviewed the way they handled investigations and staff suspensions, with the aim of setting up a psychological ‘safe space’, to create that space for learning.

Putting the patient at the centre of QI

In State of Care 2016/17,² we reported that “there were improvements for people when providers reached out to local communities and partners, involving patients and the public in shaping services, and collaborating with local groups”.

We have found tremendous synergy when patients, carers, people using services and the public are meaningfully involved and incorporated into QI, alongside an engaged, empowered and enabled workforce.

“We intentionally called our QI programme ‘Patient First’. Everything we do should always contribute to improving patient experience. We call this our ‘true north’ – the one constant that all improvement should strive to achieve, directly or indirectly. This approach really helped to engage staff with this transition: we all aim to deliver excellent quality, patient-centred care. We want to understand what stops you delivering the best patient care.”

**Marianne Griffiths, Chief Executive,
Western Sussex Hospitals NHS
Foundation Trust**

We have heard of the journey these organisations take, transitioning from consulting patients on service developments and improvement work, to building true partnership for QI with meaningful patient and public involvement. In co-production, patients are actively and meaningfully involved. In looking at systems design and improvement, they define what matters. This is different to traditional forms of consultation.

CASE STUDY – INVOLVING PEOPLE IN A MEANINGFUL WAY TO IMPROVE EQUALITY AND QUALITY OF CARE

EAST LONDON NHS FOUNDATION TRUST

We rated East London NHS Foundation Trust as outstanding in September 2016. Their approach to QI systematically involved frontline staff and patients in making services better for everyone. As part of this they developed an equality, diversity and human rights strategy that commits to:

- assessing inequalities in how Black Caribbean and Black African people access and experience services
- reducing sexual orientation discrimination in inpatient and outpatient environments
- finding out how well the trust complies with human rights law in inpatient wards by using an independent human rights expert to interview patients, and then working with frontline staff and patients to improve how the service protects and promotes people's rights
- increasing the diversity of staff at senior management level
- improving staff engagement at all levels.

Example from Equally outstanding: Equality and human rights – good practice resource, Care Quality Commission¹⁰

Delivering high-quality patient care is the purpose of healthcare

"We can only do meaningful improvement if we see the patient as our customer. It can't be something that is just right for my organisation, it has to be right, first and foremost, for the public (patients and staff) that we serve."

Birju Bartoli, Executive Director of Systems, Strategy and Transformation, Northumbria Healthcare NHS Foundation Trust

When an organisation considers embarking on a QI journey, there must be clarity about the purpose of the organisation, so improvement work is aligned to that purpose and directed to where the 'value' is. In healthcare, we have seen that QI has sharpened the focus on patients as the 'customer' of a service, improved staff understanding of what matters to patients, and helped to achieve positive outcomes.

"The most important lesson of the journey we have been on is the utter importance of engaging users and carers at all stages of the journey. Without the 'customer voice', which in health is the patient, you cannot effectively deliver quality in healthcare. Too often we think the customer is the commissioner or the regulator."

Dr David Fearnley, Medical Director, Mersey Care NHS Foundation Trust

We have seen the QI journey help trusts to focus on delivering quality care, over and above focusing on delivering performance targets or financial stability. The paradox is that achieving performance targets and regulatory judgments comes as a result of tailoring improvement to where the value lies in an organisation. We heard about how external targets were subordinated to their QI priorities (their 'true north') which has led to improvements against the targets as a consequence. They have focused on purpose, adding value and addressing flow, which results in improvement across the board.

“When we did a Rapid Process Improvement Workshop with some of our crisis teams, one of our participants that week was a carer who said to us, ‘Don’t be disheartened that you’ve only saved an hour at this point in the process – you don’t know what a difference that hour makes when a loved one is in crisis.’ Similarly, when we did a Rapid Process Improvement Workshop on place of safety, a service user involved in the week told us ‘It’s not just changing the process for now, it’s improving it for every service user who ever goes through this service’.”

Katy Morris, Head of the QI Academy, Midlands Partnership NHS Foundation Trust

This clarity shifts the emphasis onto the quality of services delivered and onto where improvement efforts add value. We have seen this in all aspects of work in the healthcare system which has the patient at the centre.

Many trusts have been embarrassed about this realisation – “I’m not sure what we thought we were doing before.” They describe the many and complex demands on healthcare providers that distract them from understanding who the service is for.

Enabling patients as equal partners in QI

Our definition of what good leadership looks like includes listening to the views of people using services, and using their feedback to improve the way services are provided. (One of the key lines of enquiry in the well-led framework is ‘Are the people who use services, the public, staff and external partners engaged and involved to ensure high-quality sustainable services?’). Without patient and public engagement, QI would not address the needs and expectations of patients.

However, this true involvement is more than consultation. We see services developed with the full participation of those that use them, as equal partners with staff, board members and external partners. Patients and carers are actively involved in QI; in the study of the problem, in experimenting with improvement and in the process of redesigning systems.

Northampton General Hospital has developed the role of a Patient-Family Partner to ensure co-production in QI, and patients and carers also lead QI projects.

“We are really proud of our dedicated QI patient partners: all our QI projects involve patient partners – they have been invaluable in demonstrating how blinkered we can be when we think about quality. For example, when we look at patient pathways, they also bring perspectives that our teams wouldn’t have thought of. They also seek opinions of other patient groups to ensure our patient involvement isn’t tokenistic.”

Jane Bradley, Deputy Director of Patient Safety and Quality Improvement, Northampton General Hospital NHS Trust

As equal partners in QI, patients need to be recruited based on suitable skills and behaviours, and given necessary training and development to support improvement work.

“If you bring someone with lived experience in to support this work, they need to have a role in the team, and clear expectations for them. Having lived experience is an additional skill, but it’s not the only skill we are looking for. We recruit those with lived experience against what is expected of them, and when they are at a place well enough to bring their perspective.”

Danni Cook, Trust Recovery Lead and College Operations Manager, Midlands Partnership NHS Foundation Trust

Previously, trusts described patient involvement as ‘uncomfortable’ or ‘tokenistic’, but those who are further on the journey describe it as an important step in understanding quality, and an integral part of their day-to-day business – a voice that is really important in shaping current and future services.

“We’re early on our journey with true patient involvement in QI. Our Darzi fellows have led some really good co-design programmes, which has underlined the difference of having a single ‘professional’ patient representative in the QI workstream compared to true co-design. There is richness in understanding what is important to patients and tailoring our services to that. This voice is important for the clinical leaders of the organisation – even though the clinical teams are working really hard, how we structure services is not usually how people want them to be organised.”

Dr Des Holden, Medical Director, Surrey and Sussex Healthcare NHS Trust

We have seen that meaningful and systematic involvement of patients and carers becomes a ‘way of being’, and becomes woven into the culture and day-to-day processes of the organisation. This includes having advocates for every patient group and service, and patient or carer involvement in internal staff training, reviews of incidents and complaints, recruitment and staff appraisals.

“I wish we had done more around true co-production and co-design of QI earlier in our journey. We should have developed more capacity for this. At the outset, we did have patient involvement, but the later part of the journey is more about patient participation in QI. It takes time to develop Experts by Experience but it’s worth the time. We developed them through the Recovery College, but now we have them as paid members of staff.”

Ruth Briel, Senior Clinical Director, Kaizen Promotion Office, Tees, Esk and Wear Valleys NHS Foundation Trust

CASE STUDY – INVOLVING PATIENTS

MERSEY CARE NHS FOUNDATION TRUST

Mersey Care is a large mental health and community health provider spread over 70 geographical locations. They were one of the early adopters of service user involvement in organisational development and performance. Since the creation of the trust, there has been a director on the board to represent the people using services, who has been influential in bringing challenge about what openness and transparency looked like.

Dr David Fearnley, Medical Director said:

“It’s no longer a question of whether we involve patients because it has changed the way we work as an organisation. We always have service users involved – nothing happens without service user and carer involvement. It runs through everything we do. Service users sit in consultant appraisals, on interviews panels, in design work – task and finish groups, engagement and development work, peer mentoring, on the quality committees, even in root cause analysis. This voice is really important: it influences how we write reports. We have to consider whether it’s comprehensible to staff and service users. We have service users advocating for every patient group – so we have patient forums in the high secure service.”

The system view

True improvement comes when QI is anchored in an understanding of the system and its purpose. It comes where all staff and leaders work together to align the component parts of the system, to achieve high-quality patient care across the end-to-end system.

“We’ve been using our people to support QI in another clinical area – we see the benefit of a fresh pair of eyes. For example, we had an improving access to psychological therapies (mental health) service under pressure. A team from community occupational therapy / physio supported the project, who gave an external view on the process mapping. They asked important questions, like ‘why do we do it this way?’. This had a secondary benefit, taking the learning back to their own clinical area. It’s become a social movement, a way of doing things now.”

Stephen Collman, Director of Operations, Worcestershire Health and Care NHS Trust

Many of the current challenges in healthcare relate to the relationships between multiple parts of the system, such as the links between health and social care and commissioning. CQC has reviewed how services are working together in health and social care systems and published the findings earlier this year in ***Beyond barriers: how older people move between health and care in England***.¹¹ This reported that people experience the best care when people and organisations work together to overcome the fragmentation of the health and social care system and coordinate personalised care around individuals. The report recommended action to remove barriers to collaboration at a local and national level and incentivise joined-up working,

for example in commissioning. We also recognise that the regulatory framework in which we operate will need to adapt to working across such local health and care systems.

Truly patient-centred care cannot come from a single organisation view, but with the recognition that high-quality care is only delivered when all parts of the health system work effectively together. We have seen this in organisations with an embedded and effective approach to QI.

QI based in system thinking

Health and social care organisations are complex, adaptive systems. QI methods recognise this, and help leaders and teams lead systematic improvement in this context. Moving beyond organisational and functional boundaries and traditional hierarchies requires systems thinking. In the context of healthcare, a systems approach has been defined as one that integrates people, systems, design and risk perspectives in an ordered and well executed manner.¹²

Clarity on the purpose of QI focuses improvement activity on delivering high-quality patient care, and often results in wider consideration of patient experience and their journey into and through healthcare services. As improvement teams experiment and problem solve, the patient journey is understood across internal and external organisational boundaries. QI also identifies all parts of the system that influence the quality of care that can be delivered for the patient. Ultimately this leads to collaboration and improvement across functional boundaries to improve patient care – where improvement teams are thinking and working across the system.

CASE STUDY – A SYSTEM APPROACH

MERSEY CARE NHS FOUNDATION TRUST

Following a series of in-patient deaths, MerseyCare NHS Foundation Trust were inspired by stories from the Institute for Health Improvement about ‘Pursuing Perfection’ in healthcare and the board started a journey, thinking about setting higher, absolute standards than their commissioners or regulators had.

The board committed to two initial projects: ‘no force first’ and ‘zero suicide’ – this revealed deeper design issues, contributing to safety incidents. They created the Centre for Perfect Care, by amalgamating the research team, a small improvement team and the innovation team. By seeing safety incidents as a design issue, they have focused on building a culture of systems learning to deliver change with design thinking. They target improvement on re-designing processes, systems and pathways specifically to be safe, and to support ‘no force first’ and ‘zero suicide’.

Delivering improvement using systems perspective

There is a momentum to a QI journey, when the approach moves beyond pockets of improvement within organisational and functional boundaries.

The ‘system’ approach is key in embedding and maintaining QI in an organisation. We see adaptive, experimental and opportunistic ways of thinking about improvement, where QI becomes the ‘way things are done’ throughout an organisation.

CASE STUDY – SYSTEM THINKING IN QI

EAST LONDON NHS FOUNDATION TRUST (ELFT)

All QI work at ELFT is anchored in systems thinking, using a number of tools to support teams to understand the complexity of the system through the work. They have recently published a large-scale QI project aimed at reducing waiting times from referral to first appointment and non-attendance for a wide range of services providing primary and secondary care mental health and community health services.¹³ Fifteen community-based teams (from different services and regions) collaborated with the shared goal of improving access. A collaborative learning system was developed to support the teams to come together at regular intervals, share data, test and scale-up ideas through quality improvement and access coaching from skilled improvement advisors. Over the course of the two-year project, there was a 23% reduction in waiting time from referral to first face-to-face appointment, 36% reduction of non-attendance at first face-to-face appointment, alongside a 25% increase in referral volume.

Systems leadership

In *Beyond barriers*,¹¹ we reported that local and national leaders need a single, shared approach to measuring how well their whole system meets the needs of people using health and social care services.

We have seen two key aspects in the hospital trusts on a journey of QI:

- a change in leadership role, where decision making is devolved to staff, who are trusted and enabled to make changes, and who deliver improvement aligned to the organisational priorities, with leaders then working on systemic blockages, constraints and boundaries
- the use of improvement science to deliver a systematic approach to provide rigorous

evaluation and sharing of learning across the organisation and beyond, with leaders understanding health and care as a complex system, rather than limiting improvement to organisational structures and functions.

There are a few organisations that have been exemplars of delivering an embedded systematic approach to QI. In these organisations, we have seen leadership, improvement skills and influence beyond traditional organisational boundaries, shared across the health and social care system. This has required a shift in thinking, a shift in approach, and a perspective on where the 'value' lies, beyond the traditional organisational boundaries, such as a hospital trust. It has also led to learning being shared across sustainability and transformation partnerships, place-based collaborations, and improvement in non-traditional health settings, such as in prisons.

CASE STUDY – SUPPORTING QUALITY IMPROVEMENT ACROSS THE LOCAL HEALTH SYSTEM

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) are 10 years into their QI journey, having originally partnered with Virginia Mason as part of the North East Transformation System. They are now supporting QI across the local health system. One example is the Darlington Dementia Collaborative, which ran for three years, involving teams from the local acute trust, the clinical commissioning group, the local authority, local care home providers, and TEWV as the local mental health trust.

All organisations that were signed up to the Collaborative released frontline staff to attend 10 cross-system Rapid Process Improvement Workshops, facilitated by QI teams, and involving 160 staff from across the local health system. This involved system-wide process mapping of pathways for dementia, and improvement work resulted in:

- daily nurse-led multi-disciplinary ward reviews for all patients, including liaison psychiatry staff
- a reduction in lead time for referrals to liaison psychiatry
- improving access to continuing healthcare provision and social care provision
- making nursing staff more visible to patients
- significant changes to the physical environment, including new ward signage and introduction of red toilet seats
- a reduction in the length of stay.

A similar model continues to run in Teesside where a similar methodology was used. The trust have also supported improvement work looking at care for the frail elderly with a local primary care vanguard, and improving healthcare provision in prisons.

Closing summary

We have learnt from our inspections and ongoing relationships that high-quality organisations delivering outstanding care have embedded systematic improvement cultures.

QI should not be an optional extra for hospitals, but considered essential to providing sustainable high-quality care.

However, QI is not a magic bullet – these trusts have shown that it is not an easy journey. QI is a strategic decision that requires commitment of senior leaders with behaviours that model improvement and coach staff to solve problems for themselves.

Effective leadership for QI develops a culture where staff are engaged, empowered and ultimately enabled to deliver improvements with the greatest impact and value at the frontline. Building improvement skills and the systematic use of a QI methodology will require this enabling leadership model.

An understanding of quality requires meaningful patient involvement in service development,

which is systematically integrated into the QI methodology, and a commitment to improve patient experience and health outcomes, by collaborating for improvement across the health system.

At CQC, we recognise that we too are on a journey of improvement, and are learning from organisations who are doing this well. Our strategic priorities include encouraging improvement and we are developing a more flexible approach to regulation to enable this.

The trusts that we have looked at have developed partnerships for shared learning. Rather than being a 'how-to' guide, we hope that this report encourages further shared learning to encourage wider improvement in the quality of care.

Further resources

Advancing Quality Alliance	Supports member organisations in QI, across the North West and beyond
Developing People – Improving Care	A national framework for action on improvement and leadership development in NHS-funded services
The Health Foundation	Q Community Quality Improvement made simple Building the foundations for improvement Using communications approaches to spread improvement Evaluation: what to consider
The Healthcare Improvement Studies Institute	Creating and strengthening the evidence-base for improving healthcare
Institute for Healthcare Improvement	An independent not-for-profit organisation supporting health and healthcare improvement worldwide, based in the USA
The Kings Fund	Systematic approaches to improving the safety, experience and effectiveness of care, including recent publication, Embedding a culture of quality improvement
NHS Improvement	Guide to building Quality improvement capability and capacity for providers NHS Partnership with Virginia Mason QSIR – through the ACT Academy Making data count Valued care in mental health: Improving for excellence
NHS Quest	QI network for NHS trusts
Royal Academy of Engineering, in collaboration with the Royal College of Physicians and the Academy of Medical Sciences	Publication: Engineering better care: a systems approach to health and care design
Examples of QI at trusts	QI at ELFT www.qi.elft.nhs.uk The Sheffield Microsystem Coaching Academy

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