AQuA

Advancing Quality Alliance

A Sense of Urgency, A Sense of Hope

Building a culture and system for continuous improvement

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The Advancing Quality Alliance (AQuA) was established in 2010 to improve health and care quality in North West England. Our aim is to be a trusted and respected source of quality improvement expertise for the NHS and social care system.

We work with around 70 member organisations on a long-term basis, to help build improvement capability at all levels of their workforce, develop and implement quality strategies and to address their quality priorities through our extensive range of membership offers.

These aim to address four main priorities:

1. Delivering High Quality Care
2. Supporting System Transformation
3. Delivering Person Centred Care
4. Building Capability for Improvement

Our work spans across a range people and settings, from individual staff, teams, patients and service users, to whole departments, services and systems; covering frontline clinicians and support staff, to senior leaders and Boards.

We also carry out Consultancy commissions with a range of organisations across the UK; working with them to adapt our existing offers, or to design and deliver a bespoke package of support to suit their individual needs.

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Contents

Introduction

'Developing People, Improving Care' was published by NHS Improvement in 2016. It urges NHS organisations to nurture compassionate and inclusive leadership and to invest at scale in improvement skills across the workforce as a whole. In 2017 the Care Quality Commission (CQC) issued a revised inspection framework which puts this vision at the heart of what it means to be a 'well-led' healthcare provider and the paper endeavours to reflect CQCs well-led 'Key lines of enquiry' or KLOEs, (CQC, 2017).

This paper has been written in the light of that national guidance as both a practical support and a stimulus for action. It will be of interest to organisations and individuals looking to explore an approach to building a culture and system for quality improvement (QI), and those who have already commenced on this endeavour, who want to go further, faster and deeper.

The thoughts and ideas in it are based on a review of the evidence, augmented by the personal experience of the authors. We have both had lengthy careers in complex healthcare systems, including almost a decade as leaders within a regionally based healthcare improvement body called The Advancing Quality Alliance (AQuA). This hands-on engagement with the issues has inevitably shaped our thinking.

Many of our conclusions have been generated from the privilege of working alongside and supporting organisations in AQuA membership who are committed to making our NHS safer, more clinically effective and with the best possible experience both for those receiving care and those delivering it.

The focus is particularly placed on providers of care, although the key principles and messages are equally relevant to those in commissioning organisations who themselves must play their part in ensuring care providers are embracing their responsibilities to drive continuous improvement.

We recognise the move towards providers working in collaboration within place based systems of care. There is a great opportunity, over time, to evolve the framework we describe so it can operate at a system level, creating a common approach to improvement across multiple partners. However, very few, if any, systems are as yet at that level of maturity. We therefore believe that individual providers should make progress in building their 'in-house' capability and approach as a staging post towards a genuinely whole system improvement effort.

The paper starts by setting out the case for change, asking the question 'Why' this is so important. Next, it describes AQuA's five domains which outline a whole organisation approach to improvement. This forms the 'What' of building the culture and system for improvement. It is hoped that readers will see the potential to use the framework as a self-assessment diagnostic to assess organisational 'state of readiness' and to build an implementation plan.

The paper concludes by describing 'How' organisations who wish to explore this approach further might seek help and support as they move forward on their transformational journey.

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The Case for Change

Healthcare today within both the NHS and across the world faces a hugely significant set of complex challenges. These are often described as the 'burning platform' driving reform and transformation. There is a pressing need to provide better person-centred care and better health at lower cost. This is against the well-recognised backdrop of ever increasing health care demand and an aging population exhibiting multiple co-morbidities. Skills and capacity gaps within the workforce, alongside the need to adopt new technologies and embrace new treatment opportunities, are pushing against severe financial constraints making for the perfect storm.

The response of leaders in this environment cannot be an acceptance of the status quo. What is needed is a burning ambition to bring about radical transformation. Now, like never before, there is a growing sense of urgency to this task. Across the globe there are organisations that are committing to quality as their underpinning strategy and are finding a way to do this in the face of financial and operational challenges.

Delivery of 'Next Steps on the NHS Five Year Forward View', (NHS England, March 2017), calls for a leadership that is confident and competent in change management and the transformation of systems; who recognise the value of improvement approaches to support the delivery of that change.

All health care organisations in the NHS are required to improve the quality of care. One key line of enquiry used by the Care Quality Commission to establish if an organisation is well led is whether robust processes are in place to support learning, continuous improvement and innovation. (CQC, key lines of enquiry.) This means that inspectors and regulators are now asking searching questions of Boards about their approach to quality improvement.

However, a drive for transformation can't be "inspected in". The King's Fund's, 'Transforming the NHS from Within' (Ham, 2014), concluded that an ambition to provide high quality care at a time of severe financial constraint and workforce shortages can't be instilled by external diktat. Those healthcare organisations regarded as international exemplars of high quality and continuous improvement – The Mayo Clinic, Jönköping in Sweden, Kaiser Permanente – have a strong intrinsic desire to improve. They have invested systematically in improvement capability over many years and have won the hearts and minds of those at the front line and those who use their services.

> ***Transforming the NHS depends much less on bold strokes and big gestures by politicians than on engaging doctors, nurses and other staff in improvement programmes.***
>
> ***(Ham, 2014).***

The Case for Change

Recent research indicates that QI works most effectively when it forms part of a coherent, organisation-wide approach as opposed to discrete time limited projects, (Dixon-Woods and Martin, 2016). It is certainly the case from the observations made by those leading improvement efforts within AQuA, that those organisations who have adopted a systematic whole-system approach to improvement have made the most ground.

Such a link between investing in improvement capability and improved results, both in quality and in productivity, would come as no surprise.

Other industries use a range of approaches, including Lean and Six Sigma (sometimes collectively known as systems engineering) to drive simultaneous improvements in productivity, efficiency, reliability and quality. An authoritative US report produced in 2014 argued convincingly that the same benefits could accrue to healthcare organisations if only they are willing to make the necessary investment of time, will and effort (President's Council, 2014).

NHS Improvement, the regulatory body for providers of NHS care, recognise this and have concluded that "developing (improvement) capabilities, and giving people the time and support required to see them bear fruit, is a reliable strategy for closing the three gaps identified in the NHS Five-Year Forward View." (NHS Improvement, 2016).

Five Domains to Building a System For Improvement

At least a 3 to 7 year plan to evidence the wider-scale results

The above five-step framework has been developed from a distillation of 'learning by doing' over time, careful study of the literature, collaborative conversations with our respected partners, such as The Institute for Healthcare Improvement (IHI), and from listening to the many customers and member organisations of AQuA.

The framework supports AQuA's mission to improve health and the quality of care, by embedding an organisational system and culture to drive continuous improvement. Its goals are those of the IHI's Triple Aim of improving service user experience, improving health and care outcomes and achieving best use of resources, with an additional fourth aim of valuing and developing staff.

Within the framework, all five domains are important and inter-connected. There is no current evidence which argues for the framework to be delivered as sequential, but a strong case to suggest that all elements should be present. To focus only on capability building without a strategy is to be in danger of merely 'sheep dipping' staff with ineffectual results. At the same time, a strategy without the means to give it effect on the ground is merely an academic exercise.

The framework is a general guide, not a fixed recipe, and it needs to be applied within a local context with all of its individual and unique circumstances.

Vision

The role of the Board is to set direction and develop strategy. The quality strategy should include an inspiring vision describing clearly what high quality care means for patients and a long-term commitment to improve. The strategy should include details of the QI methodology and approach and provide clarity for both internal and external stakeholders; ensuring people have tangible, measurable and reportable goals to aim for. It is not necessary to prescribe one improvement methodology above another, but rather to demonstrate the importance of having selected one and driving wide-scale, standardised approaches to its adoption and application.

Developing the quality strategy and the vision will require the Board to commit the necessary time to build a collective definition of quality. They need to identify what the organisation's definition of what 'good' looks like and to be clear on how they reached that definition. A review of what constitutes world-class performance in the quality of care might provide their benchmark.

They might ask themselves:

- **Do we know how good we are?**
- **Do we know where our variation exists?**
- **Do we know where we stand relative to the best?**
- **Do we know our rate of improvement over time?**

A well delivered engagement strategy, utilising staff and stakeholder feedback, will ensure that the vision is recognised and owned at all levels.

The Board will set a small number of bold aims through which the strategy will be measured by the triangulation of qualitative and quantitative data.

Those aims may well track the dimensions which AQuA have adopted as our own definition of quality; that is care which is safe, effective, timely, efficient, equitable and person-centred. Under such an approach there is no conflict between 'quality' and operational performance, as operational 'targets' only address the different dimensions of this broader quality definition.

The establishment of the improvement aims should take account of available information from sources such as the CQC assessments, staff survey results, patient complaints and cultural diagnostic assessments. The improvement aims will have clearly articulated measurable goals, which are focused on achieving aspirational breakthrough results which look to the best performance possible; not a simple comparison or benchmarking against similar organisations.

The quality strategy will put emphasise on the organisation developing its own approach to improvement; which becomes 'THE' management method rather than 'A' method used in certain areas of the organisation and on a small number of disparate time limited projects. The most successful organisations adopt and adapt approaches from a range of disciplines to do this; encompassing organisational development and systems thinking, as well as the application of QI methods and tools. The key is their commitment to spread that approach and to use it consistently.

Vision

As well as describing the areas and aims for improvement to be reviewed annually, the strategy will describe how the Trust will support the whole workforce to attain both skills and capacity in improvement science, and how the Board and senior leaders will engage actively in the coherent and well managed programmes of improvement projects.

The strategy will articulate a genuine engagement and empowerment of patients and families in all stages of the design and delivery of improvement. The value of co-creation between staff and service users will be explicit, as will the behaviours of the Board and leaders at all levels; who through their actions, will ensure the culture for quality improvement creates the environment necessary for the work to flourish and the successes to be whole heartedly celebrated. There should be an open and transparent approach to learning both from when improvement endeavours have been successful but also the honesty and safety to embrace the valuable learning from an experience of failure. The phrase ‘fail fast and move on’ can support the principles of a learning organisation.

Vision

In Summary: Vision

- **Mission, Vision and Aims**
  - Definition of quality
- **Measurable Goals - 'Big Ticket'**
  - Owned by the Board, refreshed annually
- **Patient and Family Centred**
  - Meaningful deep involvement and co-created improvement
  - Transparency and candour
- **Delivery Plan**
  - Improvement method/system
  - Measurement
  - Staff training & capacity in improvement
  - Programme of improvement projects
  - Leadership for improvement at every level
  - Culture
- **Communications and Engagement Plan**

What Are The Key Tests?

Questions to ask of your quality strategy

1. Does a clear vision for quality exist, which is understood and owned by all?
2. Does the quality strategy set a few bold system aims with an accompanying measurement and reporting plan?
3. Has an engagement plan ensured everyone has bought in?
4. Do we have an adopted coherent improvement method?
5. Have we committed to invest to develop wide-spread capability in that method?

Case Study: Strategy & AQUIS - Aintree University Hospital NHS Foundation Trust

NHS
Aintree University Hospital
NHS Foundation Trust

Aintree University Hospital NHS Foundation Trust is a teaching hospital delivering specialist and general hospital services located in North Liverpool. In 2014, Aintree's Board approved an ambitious three-year strategy setting out a number of bold aims for improvement. The strategy was developed with extensive engagement of staff, governors, patients and wider stakeholder groups.

Alongside the strategy, and key to its implementation, was a commitment to develop improvement capability at scale. This approach was known as the Aintree Quality Improvement System (AQUIS). This involved training leaders and front-line staff in improvement methods, the human factors approach to improving safety, and staff engagement techniques.

Over a three-year period over 60 leaders have been trained in the AQUIS approach and over 90 staff are now AQUIS practitioners. Between them they have completed almost 50 improvements projects.

These have supported the achievement of ambitious goals, which have gone well beyond regulatory requirements, in areas such as reductions in falls, healthcare acquired infections, and mortality rates. The reduction in falls with harm was 41% over the three years of the strategy, whist improvements were achieved in areas such as Ventilator Acquired Pneumonia and Central Line Infections which hadn't even been measured previously.

Despite this the Trust, in common with others across the NHS, continues to experience severe pressures, and maintaining the delivery of good quality care is a daily challenge. Consequently, the hospital sees the first three years of the Strategy simply as having established the platform for a continuous journey of improvement.

Leadership and Culture

The single most important reason why attempts to build an improvement system succeed or fail is how leaders behave. It is not sufficient for those occupying the highest offices simply to espouse an improvement ethos, they must visibly adopt behaviours which illustrate that 'this is the way we do things round here'.

The case for quality improvement is well made in the recent joint report from The King's Fund and The Health Foundation (Alderwick et al, 2017) which identifies ten lessons for NHS Boards and senior leaders. Another recent paper from The King's Fund, 'Embedding a culture of quality improvement' (Jabbal, 2017) takes the reader through the findings of interviews with senior leaders involved in quality improvement initiatives. The body of literature is growing around the critical importance of leadership at all levels if an improvement culture is to take root and grow.

The CQC have identified eight 'Key Lines of Enquiry'- KLOE's in the 'well-led' domain of their regulatory assessment framework. A rating of Outstanding is defined as, 'the leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care'. Leaders are required to demonstrate robust systems and processes are in place for learning, continuous improvement and innovation. This 'leadership for improvement' culture should demonstrate that a literacy in quality improvement method is present both at Trust wide level (including by Board members) and at service levels.

From AQuA's experience, those organisations who have paid attention to developing a leadership and culture for improvement, most typically demonstrate the greater strides toward achieving tangible improvements in safety, positive patient experience and clinical care outcomes. Historically, too much leadership development has been isolated from the practical skills required to lead for improvement and transformational change. AQuA and key partners such as NHS North West Leadership Academy recognise the need to integrate leadership development and improvement activity, and many collaborative development programmes are now available. The national framework 'Developing People - Improving Care' (NHS Improvement, 2016) perhaps for the first time sets for a call to action addressing the critical capabilities for development: systems leadership skills, improvement skills, compassionate, inclusive leadership skills, and talent management.

Particular attention is given to the sort of behaviours required to create just, learning cultures where improvement methods can engage staff, patients and carers. Compassionate, inclusive and effective leaders are required at all levels. By placing an emphasis on 'all levels', we start to appreciate that the role of senior leaders is to develop their own skills and those of everyone else so that the culture embraces the sense that this is everyone's responsibility. Everyone is accountable for making their part of the system better through the act of continuous improvement.

Leadership and Culture

So What do AQuA See in the Best?

The best organisations don't just have a few people with improvement skills or the title 'quality lead'; beavering away in worthy but disconnected improvement endeavour. Instead, improvement is everyone's business every day.

It is often said that the currency of leadership is attention (Heifetz, 2002). Certainly, AQuA would observe that the best quality performers have senior leaders who are highly visible. They don't only determine the strategy and the improvement priorities, they actively engage in making progress toward the measurable goals that they have set.

- Improvement is seen as a distributed leadership priority. There is an acknowledgement that the culture is set at the 'top of the house' and the Board and senior leaders take time out to develop the necessary skills they require. This is then cascaded as a means to develop leadership for improvement at every level of the organisation.

- There is a strong desire to move beyond disconnected initiatives to a more strategic approach which will build a sustainable 'system for improvement'.

- Leadership for improvement is nurtured at every level of the organisation.

- Senior leaders demonstrate a daily shared commitment to quality and it appears on the Board and executive agenda as equally important to the finance and operational aspects. Transparency of quality data is apparent alongside the pledge to action. Senior leaders send out signals that they want to learn from when things go wrong to prevent them happening again.

- Leadership behaviours include executive walk rounds, daily safety briefings, improvement huddles and tangible "hands on" involvement in improvement programmes. There is a supportive climate where staff are encouraged to identify opportunities for improvement, bring them forward in an open way and given the skills, confidence and resources to take action.

- Staff are recognised and celebrated for their improvement endeavours and emphasis is given to strong team work, as well as attention paid to the human factors underpinning the drive for high reliability.

- Leaders take responsibility and accept that their job is to remove the excuses and to support and enable others. They signal that they care about steady, systematic, reliable improvement; where data and knowledge is used well to navigate the journey over time.

- Staff can speak up in regard to any concerns about the quality and safety of care they see, and are respected as individuals and as part of well-developed teams.

- Emerging leaders at every level are developed and encouraged.

- The organisation takes staff survey results very seriously and engages in 'listening into action' approaches to address staff concerns.

So, how can organisations work to deliberately reshape their prevailing culture? One of the foremost thinkers on the topic, Edgar Schein, argues that culture change must address the full range of HR systems and processes, described by him as the 'primary mechanisms' (Schein, 2010).

The later section on the fifth domain of our framework, aligning support services, explores this further.

Leadership and Culture

The building of a leadership and culture for quality will only happen over time and with a continuity and consistency of effort. Yet the results can be profound; as illustrated in the case examples drawn together by the Care Quality Commission, Driving Improvement (CQC, 2017). Drawing on the findings from inspection reports, CQC's 2016 State of Care report concluded that effective leadership and a positive, open culture are important drivers for change. The CQC followed the efforts of eight Trusts that had been in special measures or received a rating of 'requires improvement'.

By leaders engaging and empowering staff at all levels of the organisation, underpinned by shared values, these eight Trusts showed a strong correlation between improvements in each of the characteristics of 'well-led' that CQC uses to inspect and rate trusts and overall improvements in quality and safety.

Edgar Schein's view of what leaders do to change patterns of behavior

Primary Mechanisms

- What you pay attention to, measure, and control on a regular basis
- How you react to critical incidents and organisational crises
- Observed criteria by which you allocate scarce resources
- Deliberate role modelling, teaching, and coaching
- Observed criteria by which you allocate rewards and status
- Observed criteria by which you recruit, select, promote, retire, and excommunicate organisational members

Secondary Mechanisms

- Organisation design and structure
- Organisation systems and procedures
- Design of physical space, facades, and buildings
- Stories, legends, and myths about people and events
- Formal statements of organisational philosophy, values, and creed

Leadership and Culture

Case study: Building a Culture for Change - Manchester University NHS Foundation Trust

Manchester University NHS Foundation Trust (MFT) formed in October 2017 through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester (UHSM); bringing together 20,000 staff across 10 hospital sites and Managed Clinical Services.

Alongside their aim to improve their CQC rating from 'Good' to 'Outstanding', the Trust wanted to support staff across the following areas:

- **Creating a Culture for Change**

  In order to help sustain continuous improvement, it was essential for the Trust to continue to create the right culture around delivering change across each hospital / division; through embedding the necessary values, behaviours and leadership for inclusive leadership and high quality and compassionate care.

  Building on previous work by Professor Michael West, the King's Fund and NHS Improvement, the Trust wanted to develop a collective leadership culture that is distributed across all levels of staff; with both formal (line managers) and informal (wider staff) leaders working together to model shared values and share responsibility for improving quality of care.

- **Building Capability**

  Aiming to build staff capability for leadership and change, the Trust's OD and Transformation teams developed a four-tier pyramidal model; which aims to build the necessary knowledge, skills and capabilities across these levels by 2020.

  AQuA have supported staff with a number of on-site QI programmes and are now helping to spread this through a 'Train the Trainer' approach and the co-design of a new expert-level programme; whilst the Trust has also mapped wider staff development opportunities against each tier of their development model.

  Over the next three years, the Trust want to ensure there are enough QI trained staff at each level across each site and clinical service, alongside maintaining staff enthusiasm and engagement for improvement through regular Transform Together events and other opportunities.

"Transforming Care for the Future is our large scale quality improvement programme, focusing on creating a sustainable long term future. To achieve our vision, improvement needs to be part of everyone's business in MFT and requires strong leadership."

- Vanessa Gardener, Chief Transformation Officer

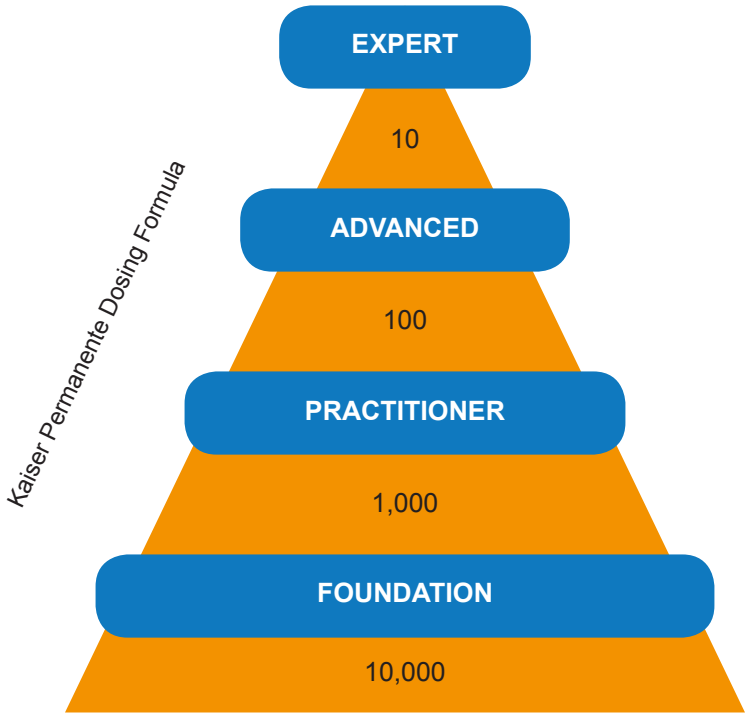
"Positive and trusting relationships, working collaboratively, a continual focus on team work and development, prioritising quality and patient care overall is at the heart of what we do – we believe and evidence supports our belief that this is the right way to ensure the best for staff and patients."

- Helen Farrington, Deputy Group Director of Workforce & OD

Leadership and Culture

Build Capability

Clear methodology and build skills to deliver transformational change and continuous improvement. Use of the dosing formula to ensure right numbers of staff are trained.



Definitions	Course Offerings
EXPERT Relates to a limited group of staff whose reputation and credibility is recognised by their peer. Demonstrating significant experience and leadership in one or more improvement topics through the practical application of theory in specific contexts.	Dedicated Change and Transformation Role
ADVANCED Relates to staff with improvement experience who will lead, coach and support others in service improvement initiatives within and across departmental and professional boundaries.	Advanced Practitioner Programme (AQuA)
PRACTITIONER Relates to people in leadership and clinical roles who want and need to innovate and improve local services.	Newly Appointed Consultant Programme School for Change Agents Improvement Practitioner Programme (AQuA)
FOUNDATION Relates to all staff in order to develop an understanding and basic awareness of their personal responsibilities for continuous improvement of local services.	Improving Quality Programme Quality Improvement Basics (AQuA) On the Receiving End of Change eLearning Introduction to Improvement (AQuA) Basic Lean

Leadership and Culture

In Summary: Leadership and Culture

- Improvement seen as a leadership priority
- Leadership for improvement is developed at every level
- Quality is as important as financial and operational performance, given equal weighting
- Visible leadership focuses on ‘action’ behaviours, executive walk about and improvement huddles. Investment is made in relationships
- Transparency - understanding and owning the improvement needed. Data used effectively
- Empowered and engaged staff with the skills for improvement and confidence to speak out
- Success is celebrated publicly
- Clinical leadership and team work is valued

What Are The Key Tests?

Questions to ask of your leadership and culture

1. Do our Board meeting agendas place priority on quality matters and are they given as much time and attention as finance or operational performance?
2. How does the Board know about and engage with the improvement programmes and hear first-hand about quality performance issues?
3. If ten different staff were asked whether the organisation empowered and valued them and had a compassionate, inclusive leadership approach, what would they all say?
4. What does the hard data say e.g. staff survey, culture surveys and other HR instruments? How is this triangulated with what is seen in practice?

Capability

Improvement Skills for Clinical Outcomes, Processes and Systems

The publication of 'Developing People - Improving Care' (NHS Improvement, 2016), urges organisations to review their people development strategies, and notes that those organisations rated as 'Outstanding' by the CQC have used quality improvement methods to achieve their success in operational performance, staff satisfaction and quality of outcomes. It sets an ambition for all NHS-funded organisations to make an investment in building skills in quality improvement, so that from the Board to the front-line everyone has the ability to contribute.

What Are Quality, Quality Improvement and Quality Improvement Science?

The terms quality and Quality Improvement (QI) can mean different things to different people in different contexts. For the purposes of this paper we are using The Institute of Medicine's adopted Six Dimensions of Healthcare Quality: (IoM, 2001)

- **Safe**
- **Timely**
- **Effective**
- **Efficient**
- **Equitable**
- **Patient-Centred**

Whilst there is no single definition of quality improvement, a number of definitions describe it as a systematic approach that uses specific techniques to improve quality. One very important aspect essential to success and sustained improvement, is the way in which change is introduced and implemented. Whilst consistency is key, AQuA would also suggest that it is vital to triangulate improvement techniques with organisational development strategies and strong effective leadership skills.

The Health Foundation helpfully suggest the definition of quality improvement should reflect a combination of 'change' (improvement) and a 'method' (an approach with appropriate tools), while paying attention to the context, in order to achieve better outcomes.

Alongside the definitions for quality and quality improvement also sits the term, 'science of improvement'. This is an applied science that emphasises innovation, rapid-cycle testing in the field, and spread in order to generate learning about what changes, in which context, produce improvements. It is characterised by the combination of expert subject knowledge with improvement methods and tools. It is multidisciplinary; drawing on clinical science, system theory, psychology, statistics and other fields.

Stick to a Consistently Applied Method

It has long been known that investing in improvement capability, energises, and engages staff, and empowers them with the permission and confidence to take daily action towards making care better. As previously stated, this is less about what method of improvement an organisation adopts, be it Lean, or the 'Model for Improvement' (Nolan et al, 1996) for example; more about the act of adoption itself and the consistent, reliable application of whatever method is chosen, by staff who are confident and capable in its execution.

In any event, modern day approaches to QI largely draw on the work of its founding fathers such as Schewart, Deming and Juran. A systems approach, an understanding of variation and attention to managing the psychology of change are all likely to be important.

Building capability without the existence of an organisational quality strategy, is likely to result in failure to move beyond a few disconnected initiatives. The ultimate result is a squandering of resources and effort as the organisation fails to distil learning, make connections, inspire and enthuse others. For a culture and system of continuous improvement to develop, all the domains of this framework must be present and work together.

Find Some Quick Wins

Quick wins are important in the early stages of an organisation's improvement endeavour. Picking one or two 'high impact' issues which are critical to safety or quality, and setting challenging transformational goals inspires and builds commitment. Focusing senior clinical and managerial time and attention onto these improvement priorities, signals to all stakeholders the importance placed on the improvement approach. Supporting the team to gain essential QI skills and to apply them in relation to specific early wins, builds momentum, provides evidence and maximises the principles of learning through doing. As the improvement programmes begin to yield results, they can be expanded to new priorities, learning and celebrating along the way.

This suggested approach is made against a backdrop of experience that tells us it is of limited value to build capability simply by 'sheep dipping' large numbers of staff through QI training, without an opportunity to apply those skills. There needs to be an appreciation of which staff require which skills and knowledge and at which levels of the organisation, ranging from a foundational understanding for all staff through to deep expertise for a limited few.

Build Capability for the Long Term

Sitting alongside the quick wins, must come a longer-term commitment to a training and development system for building capability at scale. The first step is to identify staff with existing skills. These can then be harnessed to support work on corporate improvement goals. It is highly likely that there will be at least a few individuals who have had previous experience of improvement work or have undergone specific QI training. It is however, common to find these individuals are unknown, or sit in isolation from each other and disconnected from the corporate quality improvement plans.

Ideally, workforce planning will promote capability building and will triangulate organisational skill gaps with particular workforce groups and areas of improvement need. Training should be targeted according to the competencies required at different levels of an 'improvement skills escalator', to maximise the investment being made in capability building.

The building of an improvement coaching approach is invaluable and ensures that ongoing support and encouragement is given and that a continual learning ethos becomes part of the organisational culture. Many organisations are now recognising the value of coaching, and are investing in staff acquiring these skills as part of their overall approach to building capacity for improvement.

The Health Foundation publication, Building the Foundations for Improvement (Jones and Woodhead, 2015) illustrates through case studies, the work of five Trusts who have built QI capability at scale.

Capability

Case Study: Mental Health Restraint Reduction - North West Boroughs Healthcare NHS Foundation Trust

North West Boroughs Healthcare NHS Foundation Trust signed up to the restraint reduction programme alongside the majority of mental health trusts in the North West region. The Trust identified a small project team from their quality team and training department to support implementation.

The aim of the programme was to reduce incidences of restraint on mental health inpatient units by 40%. To implement the approach, the Trust recognised the need to both reduce restraint and sustain this beyond the life of the programme.

To support this, they identified champions from across five inpatient teams; staff with an interest in the subject were trained in the restraint reduction approach and quality improvement methodology. AQuA also provided additional support to the team, to help train staff at practitioner and advanced practitioner levels of quality improvement.

In line with other North West Trusts, North West Boroughs saw a 40% reduction in restraint on their wards, and have strengthened governance on restraint further on the back of this success.

Building QI capability across the Trust has led to more wards actively participating in the programme; helping them to ensure QI is what drives change and ensures champions are supported both as improvers, and as QI flag wavers in engaging staff in improving outcomes for patients.

To help align wider improvement activity, the Trust has continued to identify QI champions across a variety of clinical settings within each of its boroughs, and continues to work with AQuA to help train staff and embed QI across the organisation.

You can read more about North West Boroughs Healthcare NHS Foundation Trust's restraint reduction programme in the latest CQC best practice guide:

https://www.cqc.org.uk/publications/themed-work/mental-health-act-restrictive-intervention-reduction-programmes

The work of these Trusts is impressive and is to be commended, but the reality exists that these and other organisations have made significant investment often over a decade of concentrated effort. Whilst the numbers of Trusts who have successfully built capacity at scale are few, more and more organisations are actively looking to develop their own system-wide quality improvement capability programmes; recognising that they still have a great many clinicians and managers without the knowledge and skills needed to improve quality in health care.

Develop a Small Cadre of Experts

AQuA has observed the value to be gained by establishing a corporate improvement team made up of a few individuals with deep QI expertise, including coaching for improvement. They can provide the necessary support to programmes sitting beneath the quality strategy, as well as training individuals and teams on the ground engaged in improvement projects. Of course, creating such a resource in a financially challenged system isn't easy.

Capability

But in our experience, organisations often have a considerable number of small discrete teams with relevant skills operating independently from one another; labelled variously as clinical governance, service development, clinical audit, or transformation, and working in silos reporting to Finance, Medical and Nursing Directors. Drawing these together into a coherent, well directed resource can greatly magnify their impact.

The training and development of the staff within the central improvement team, and the workforce as a whole, often requires a partnership approach with an external improvement agency; which can assist in the co-design of the capability building approach and execution plan. Those who have undergone training in QI and experience of its direct application become the mentors and champions for future cohorts of improvers. Taking such a 'train the trainer' approach builds internal capacity and creates a group of ambassadors who are credible with their peers, and seen as part of the fabric of the organisation. Through such an approach, organisations build sustainability and resilience; which allows for a gradual reduction in their need for support from external agencies.

Over Time, Train Everyone in Improvement Method

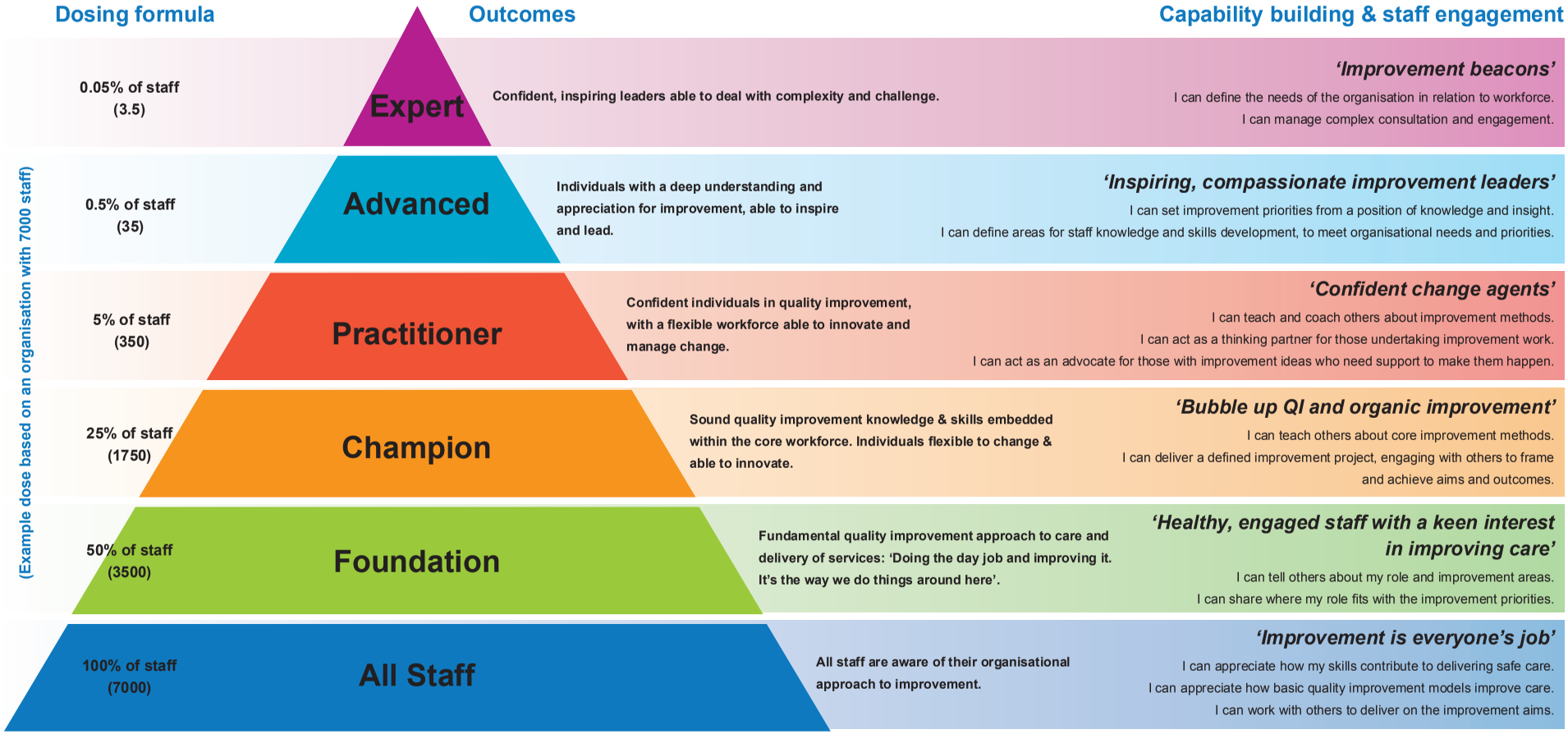
Successful organisations promote the view that improvement is everyone's job. Whilst they do usually establish a corporate improvement team, they make it clear that the use of improvement skills is not the sole province of these experts, but an expectation of every staff member. There is a culture, whereby staff members become empowered to focus on where they can make improvements to the work they do; no matter if it be in clinical care, financial systems, estates and facilities or human resources.

As the improvement work moves forward, there will be enormous learning from both the successes and from those times when we fail. Just as failure might be seen as our friend for the new knowledge and wisdom, we can harvest from the experience, success must be purposefully managed too. An improvement gain realised in one clinical area or support service must be tested for its potential spread and adoption elsewhere.

Failing to plan for scale-up and adoption is to risk having many disparate improvement gains which fail to sustain and which only accentuate variation. The building of improvement capability and capacity must therefore also include the development of spread strategies, as well as an understanding of variation, and its impact on quality and safety.

AQuA has been working through its Academy to understand what it takes to develop a learning system which includes an approach to building capability at scale. Capacity must be built at all levels of the organisation and must include meaningful engagement of service users, families and carers. A multi-level approach has been designed and adapted from the IHI's 'dosing formula', and can be tailored to any organisation.

Below is an illustration of AQuA's adapted 'dosing formula'



Capability

Developing a learning system requires that everyone becomes engaged. The Board must take the time out to build its own capability and understanding of its role in quality and improvement, just as all other staff must see improvement as part of their daily work. A curriculum should be established at each level of the skills escalator; building competencies, skills and knowledge for the 'many' who require a foundational awareness of quality improvement, through to the 'few' who are seen as deep experts.

Deeply Engage Patients and Families

AQuA has been working for some time to better understand how to enhance the meaningful engagement of patients, carers and public in its improvement programmes. The NHS is now starting to understand that an occasional, often tokenistic involvement of one or two patient/carer voices is wholly inadequate. The situation leaves individuals feeling disregarded and squanders the opportunity to truly co-create new solutions around quality and safety challenges.

When organisations look to build the capability and capacity for quality improvement within the staff group, they must also work toward finding ways in which those who use their services can also have the skills and opportunities to improve those services.

AQuA has established a 'Lived Experience Panel' (LEP) to provide support and advice to improvement teams. The LEP works to ensure that a person-centred approach to improvement is taken by co-producing AQuA programmes. The work is now extending its reach to member organisations looking to develop their own lived experience panels and to developing improvement knowledge and skills in panel members; so that they might confidently join front-line improvement teams considered within any capability building process.

The perspective and insight from service users is always enormously valuable, but the means by which this is harvested and applied should be purposefully considered within any capability building process.

Case Study: Lived Experience and Co-production Across Whole System Flow

Our Lived Experience Panel work closely with our programme leads to ensure the service user and carer voice is at the centre of our work. This co-production approach has had a highly positive impact on our work; with Lived Experience Affiliates aligned across the development, delivery and evaluation of our programmes.

Our Whole System Flow programme is a great example of the power of co-production; with a key factor of member systems being accepted on to the programme being how they demonstrated and recognised the importance of co-production.

Early in the programme, a number of our Panel worked with the three participating systems as active, equal partners; engaging with service users and carers to capture their real experience of using the system. This engagement used a range of methods, including semi-structured interviews, attending peer support groups and running focus groups.

Within months, all systems highlighted that using this approach alongside the Panel was a significant and successful driver for their work to improve their respective systems; providing detailed information and shedding light on people's experience across the whole system.

Capability

In Summary: Capability Building

- The imperative is now set by regulators to evidence how capability for quality improvement is being built in organisations
- Organisations seen as ‘Outstanding’ have invested attention, time and resources into building capability for improvement at all levels
- Method is less relevant than the consistent, reliable application
- Building early wins and engagement are important. Start by picking one or two ‘high impact’ areas for improvement
- Taking a whole organisation approach to capability building takes investment for the longer term, with no ‘quick fix’
- Building capability must include ‘learning by doing’ principles. This stuff needs practicing
- Organisational development strategies must triangulate training needs analysis, targeted workforce groups with alignment to corporate improvement aims
- Improvement coaches can provide ongoing support and training within a self-sustaining, continuous learning model
- An organisation wide capability building system should include a skills escalator and adapted ‘dosing formula’, working from the Board to the front-line
- Meaningful engagement and capability building for ‘lived experienced’ service user partners adds huge value to the improvement team

What Are The Key Tests?

Questions to ask of your capability building approach

1. Do we have a system to identify and engage those staff with existing quality improvement capability, and do we connect and support their work around application to ensure impact?
2. If an approach or methodology for quality improvement has been agreed, is it reliably deployed within the organisation?
3. Have we undertaken any diagnostic to understand our QI training needs, alongside using a dosing formula and skills escalator to support our capability building ambitions?
4. How do we identify improvement efforts, learn lessons and celebrate successes, as a means of engaging and supporting our staff?
5. Do we have service user engagement in QI, and how could we move to further strengthen or develop their contribution as members of the improvement team?

Developing an Operating System

Members of staff within a large number of the organisations AQuA has worked with, have received training in improvement methods and carried out improvement projects; a number of which have produced good results. Yet, they haven't translated into a step change in performance across the organisation as a whole. This is an all too familiar picture in healthcare.

Successful organisations, both inside and outside of healthcare, approach things differently. They link improvement activity closely into their mainstream business objectives, and develop processes and systems for building it in to the DNA of their organisation. As a result, companies like Alcoa and Toyota have developed "an approach to managing exceptionally complex work that has mustered the hands and minds of hundreds of people so that improvement, innovation and adaptation are constant", (Spear, 2009).

A few leading-edge health care systems, such as Thedacare in Wisconsin and Virginia Mason in Seattle, are getting close to embedding improvement to such a deep extent. There are two facets to what they do to achieve this: 'strategy deployment' and 'making improvement a daily activity'. Taken together these begin to build an operating system to support a culture of continuous improvement.

Strategy Deployment

This is a term most often used by Lean practitioners. It involves aligning the organisation's goals with the improvement efforts of front-line staff through a process of engagement, goal-setting, review and continuous improvement, (Dennis, 2006).

The typical 'business plan' in healthcare is seen as the province of the Board and a few senior leaders. It's often developed in haste and driven largely by the requirement to report to regulators. Whilst most organisations make an effort to communicate its main messages, these rarely penetrate deeply into the workforce.

By contrast, in an improvement focused organisation a more rigorous process of 'strategy deployment' is used:

- The Board and senior leaders develop an inspiring vision with a few bold aims. A process of engagement makes sure all staff are aware of the aims, sometimes known as 'True North' goals.
- The annual business plan is then developed through a process known as 'Catchball'. This involves a cascade of conversations with teams throughout the organisation so that every level engages with the vision and priorities and sets their own goals to support delivery.
- The biggest risks and challenges to delivering on these objectives are clearly articulated and improvement projects established to tackle them. Improvement expertise and effort are directly aligned to the most important organisational goals.
- The 'Catchball' approach extends to setting team and individual objectives so that these are aligned to the overall priorities.

Developing an Operating System

- Reporting dashboards are designed to support continuous learning and improvement, not just upwards accountability.
- Progress is made through an iteration of plan, do, study, act cycles testing and embedding incremental improvements.

Making Improvement a Daily Activity

The operating system for improvement connects the long-term goals developed through strategy deployment, to the daily work of every employee. As Jönköping, the leading Swedish health care provider, says, “everyone has two jobs; to do your work and to improve your work.”

In the best organisations, part of the daily work of leaders is to coach front-line staff in the use of improvement methods, to tackle the problems they face every single shift. Improvement moves from being a classroom based activity, or a limited range of discrete projects, to ‘the way we do our work every day.’ This is tough to do in a pressured healthcare environment.

The challenge is to free up time by culling the number of meetings and committees endlessly discussing the same intractable issues without finding solutions, and to redirect that effort towards more focused improvement activity.

Thedacare has gone so far as to define the standard daily work for leaders at each level in the organisation. Coaching and a continuous appraisal of the performance of leaders are used to ensure that they support and empower staff to find solutions for their own problems. (Toussaint et al, 2010).

Developing an Operating System

In Summary: Operating system

- A step change in performance requires organisations to move beyond isolated projects to embed their approach by developing an 'operating system'
- This involves using strategy deployment to align everyone's efforts towards a few bold aims
- A process of 'Catchball' cascades these aims throughout the organisation
- Leaders support staff to embed their improvement work into a daily activity
- Such a system greatly increases the chances that good results will be sustained, and that small-scale improvements will add up to a larger scale transformation

What Are The Key Tests?

Questions to ask of your operating system

1. Have we considered how to align our chosen improvement approach with our most important organisational priorities?
2. Have we engaged all staff in this process, and are our 'big aims' widely recognised and understood?
3. Are our improvement programmes and expertise focused onto those key aims?
4. Do our leaders coach and support staff to use improvement methods to do their work better every single day, and do they apply this to themselves and their own work?

Case Study: Strategy Deployment - Thedacare

Thedacare is a mid-sized, not-for-profit health care provider based in Wisconsin USA. It has two major hospitals, 20 primary-care offices and a network of community facilities, nursing homes and home health services. It has been on a journey of transformation since 2002; adapting the Toyota Production System (Lean) into healthcare.

As part of this approach, Thedacare has applied what is known to Lean practitioners as 'hoshin kanri', or strategy deployment. This has involved senior leaders working together to refine the wide range of potential organisational objectives to just a few big priorities. These are known as 'True North' goals and have become the focus of all improvement efforts.

Clear metrics measure the goals for safety/quality, people, customer satisfaction and financial stewardship. Targeted improvement programs, led by named senior leaders, support delivery, whilst an extensive process of engagement has been used to align staff across the organisation with the True North goals.

John Toussaint, the former CEO of Thedacare, believes that a failure to get leaders aligned behind a few big priorities is a common and damaging mistake.

He says, "Thedacare would have made far faster strides in our Lean conversion had we begun strategy deployment from the beginning with clear metrics." (Toussaint et al, p144).

Aligning Support Services

The five-part framework described in this paper is intended to support organisations to move from seeing improvement activity as a series of discrete projects to regarding it as "the way we do things around here." This isn't a quick or trouble-free journey. Multiple barriers may still exist even after staff have been trained in improvement skills and their efforts are aligned to key priorities.

The move towards an improvement culture and system will be frustrated if important elements of the organisation's infrastructure are pulling in the opposite direction. For example, if:

- The people who are recruited and promoted have no improvement skills and adopt a 'just do it' leadership style.
- The management accounting systems incentivise short-term cost-cutting and get in the way of transformational redesign.
- Staff lack the data they need to inform their improvement work and to measure progress.
- The physical layout and quality of facilities impede effective team working, and hamper the delivery of patient centred care.
- Organisations that do manage to embed their chosen improvement approach and deliver sustained results, meet these challenges head-on. They align key support services with their improvement efforts; including HR processes, financial systems, digital technologies and informatics and the physical estate (Fillingham, 2008). The good news is that many talented and enthusiastic staff are working within these areas. They are a great asset to draw upon on the transformational journey, provided the systems within which they work are redesigned to be helps not hindrances.

Human Resources

Senior leaders who are committed to reshaping organisational culture, need to pay close attention to the systems and processes by which people are recruited and managed. All too often, long established HR processes don't fit well with an improvement approach. This leads to those individuals being recruited or promoted into leadership positions on the basis of their technical competence, rather than their will and ability to engage staff in improvement activity. The result is a culture of management through top-down targets accompanied by an exhortation to 'just work harder'. By contrast, in an improvement culture leaders continuously engage with front-line staff to support them in setting their own stretching goals for improvement.

Traditional

- Top down/externally imposed targets
- Problems worked around or passed upwards
- Few leaders...who are always in meetings
- Management based on anecdote and politics

Improvement Focus

- Self devised goals and measure for improvement
- Root causes addressed at source
- Many leaders who constantly "Go and See"
- Management based on data and scientific methods

Aligning Support Services

The challenge for leaders in HR and OD functions is to redesign their critical 'people systems' in a way that constantly reinforces a compassionate and inclusive leadership style, and encourages staff to take an improvement approach to their day-to-day work. This includes the way people are recruited, inducted, trained, appraised, rewarded and promoted. The deep involvement of patients and families in this, for example, participating in recruitment panels, engaging alongside staff on improvement projects and contributing to ideas for future job roles, can bring a fresh perspective which adds great value.

Finally, it has to be recognised that delivering care to patients is one of the most demanding jobs that exists – intellectually physically and emotionally. As a consequence, it is not uncommon for groups of staff to demonstrate signs of stress and fatigue. Work undertaken by Bryan Sexton and colleagues at Duke University in the U.S has shown the critical importance of diagnosing situations of burnout and addressing the root causes. (Sexton J.B et al, 2016.) Unless this can be achieved, then staff do not have the resilience or motivation to engage in improvement activity.

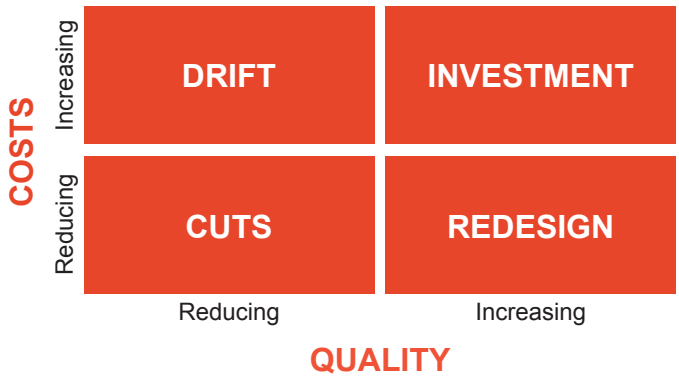
Financial Systems

There is a problem with management accounting. Traditional methods of cost allocation and reporting can lead organisations to optimise parts of the system at the expense of sub optimising the whole (Cunningham, 2003). For example, a Radiology department might deliver year on year 'cost improvement' savings and achieve its financial goals, yet at the same time the hospital may have a significant shortfall in diagnostic capacity. This leads to excess length of stay, and costs which are far greater than any savings resulting from cost control within the Radiology department itself.

This scenario applies even more strongly when separate institutions, such as hospital, community services and social care providers are seeking to work together to deliver improvements on a whole system basis. Changes in one part of the system may generate benefits which are realised in another part; creating financial disincentives to support radical change.

Improvement focused organisations tackle this by evolving more insightful accounting practices, such as the development of service line costing to support whole pathway redesign, and new types of partnership models and risks/gain sharing agreements at the system level.

As finances become tighter in all health care systems it becomes ever more important to emphasise the links between improved quality and improved productivity. The framework shown below is helpful in distinguishing between different scenarios.



Source: Jim Easton

Aligning Support Services

Those organisations striving to build a system and culture for improvement, will aim wherever they can to gear improvement activity towards service redesign; where costs are reduced and quality improved at the same time. A programme to reduce falls, for example, may also significantly reduce length of stay; thereby cutting in-patient costs. An innovative approach to developing virtual outpatient consultations using tele-medicine to make an attendance at hospital unnecessary, might be a better experience for patients and also a more cost effective use of clinician time.

Informatics and Digital Technologies

Robust data is essential to driving forward improvement. Without an established baseline, measurable aims and a means of tracking progress, there is no way of knowing whether or not changes that are being implemented are leading to improvements. As W Edwards Deming is reputed to have said, “In God we trust, all others must bring data.”

Developing a strong informatics capability which is orientated towards supporting improvement activity is a vital step in this journey. Unfortunately, skilled and experienced analysts are hard to come by. The calibre of informatics support across NHS organisations is highly variable (Bardsley, 2016). Even where capability does exist, it is often geared towards providing data for accountability purposes, to meet the needs of assurance systems and external regulators. The data needed for improvement is different in both nature and presentation.

Jim Reinertsen, in his work on the IHI Boards on Board programme, describes it as the difference between data for compliance and for transformation:

Compliance

The Comparison Dashboard

- **How do we compare to...**
  - Other hospitals?
  - Regulatory standards?
  - Targets?
  - Pay for performance thresholds?
- **Hundreds of measures**
  - Processes
- **Measures are typically**
  - Externally defined
  - Risk-adjusted
  - Apples to apples (rates per procedure)
  - Slow
  - Tinged with fear

Transformation

The Strategic Dashboard

- **Are we on track to achieve our aims?**
  - Reduce harm
  - Improve outcomes
  - Improve satisfaction
  - Reduce costs
- **A few key measures**
  - Outcomes, Drivers
- **Measures are typically**
  - Internally defined
  - Close to real time
  - “Good enough”

Aligning Support Services

In a truly improvement focused organisation, the Board becomes more data literate and is comfortable using techniques such as statistical process control charts, to understand variation and to identify and tackle the root causes of performance challenges.

Closely allied to the need to develop informatics, capability is the need to build the will and expertise to seize the opportunities provided by new digital technologies. There are many exciting examples of initiatives in this field that are simultaneously improving productivity and the quality of care. These range from tele-health and telemedicine programmes, virtual outpatient clinics, the use of online shared decision-making tools and other innovative approaches.

The Physical Estate

Hospitals can be confusing and forbidding places. Research by Paul Bate and Glenn Robert into the use of experience based design methods has shown how the layout of facilities can be disempowering for patients; increasing levels of stress and vulnerability and impacting negatively on experience (Bate, 2007). Poorly designed premises can also, quite literally, build walls between staff that reinforce silo working and get in the way of the effective team-working.

An organisation that is deeply committed to continuous improvement will need an agile and responsive estates function. It is highly likely that improvement projects will need to re-design the physical layout, to support new service models and ways of working.

The supporting functions, HR, finance, informatics and estates, are critical enablers of an improvement system. However, if not redesigned as part of the journey towards becoming an improvement organisation, they can also be significant barriers. Boards and senior leaders need a deliberate plan to transforming them to support their emerging system. This will require training and coaching for leaders and staff in these functions, just as important as in patient facing areas.

Aligning Support Services

In Summary: Operating system

- Support services such as HR, Finance, IT, and the physical estate can be important drivers of improvement; but, if unreformed, they can be major frustrations and barriers
- HR systems play a vital part in shaping organisational culture and need reframing to support inclusive, compassionate leadership and an engaged workforce
- It will be necessary to diagnose and address underlying causes of staff burnout, including workload pressures and job design, as part of building an improvement culture
- Involving patients in key HR processes, such as recruitment, and training and development, can add great insights and value
- Financial systems can inhibit the development of radical proposals for transformation, and they may themselves need to be redesigned
- Finance staff can be invaluable in helping frame the business case for improvement and in realising the benefits
- Informatics systems need to provide usable data to support the drive for improvement
- Organisations should seize the opportunities of the digital revolution, and build these into their improvement plans
- Physical estate may need to evolve rapidly as organisations redesign care, and develop a more patient centred approach

What Are The Key Tests?

Have we considered the need to align our 'support services'?

1. What unintended adverse impact do our existing ways of managing people, money, data and facilities have on our improvement effort?
2. How could those services be redesigned to tackle that?
3. Have leaders and staff in HR, Finance, Information / IT and Estates had training in our improvement approach and the opportunity to apply it?

Leading the Transformation

Building a system and culture for improvement doesn't happen overnight. Some early improvements can undoubtedly be secured and are important in generating momentum, but a whole organisational transformation takes years, not months. It requires constancy of purpose and consistency of leadership over the long-term.

There is no cookbook formula that leaders can follow to achieve this, but the different elements described in this paper are all normally present. The following reflections draw on our review of the published evidence base, and also our personal experiences of leading improvement 'hands on'.

Those organisations that stay the course show many, if not all, of the following qualities:

A Learning Board

These Boards are reflective and committed to their ongoing development. They recognise that to shape the culture of their organisation, they must first reflect on their own culture. They invest time and effort to improve the way they work together. They act as role models by becoming fluent in improvement methods and applying them to their leadership endeavours.

Distributed Leadership

It's not just about the Board! The most successful organisations develop leaders at every level, clinical and managerial; who share a common vision and values. These compassionate, inclusive leaders support and empower front line staff to solve their own problems. Such leaders are highly visible; they see the bigger picture but stay closely in touch with daily realities. They communicate constantly, never ignoring or minimising the scale of the challenges they face, but keeping their own and others' optimism high even in the toughest of times.

Balancing Short Term Imperatives and Long Term Goals

These organisations recognise that to win the space to deliver their long term ambitions, they must "stay on the pitch" by delivering short term 'must do's' in finance, access and other aspects of performance. It's all too easy to get mired in these 'here and now' imperatives; much harder to juggle those successfully while keeping an eye on the ultimate goal. Sometimes they find the need to resort to hands on performance management to deliver 'business as usual'. If so, they are conscious of the dissonance between that and a true improvement approach, are honest about that, and seek early opportunities to visibly demonstrate the extension of a more engaging style of leadership.

Celebrating Success Without "Over Claiming"

Transformational leaders recognise that people need praise, encouragement and support. They create multiple ways to celebrate the gains made through improvement, even if only a handful of patients have benefited. They recognise and reward those leading improvement efforts. Yet, at the same time, they avoid "over claiming". They ensure that their successes are based on robust data and set their celebrations in the context of the significant challenges they still face.

Seeking Help and Inspiration From Others

Curiosity is a defining feature of organisations that transform themselves. They want to find out what works well elsewhere and to adopt and adapt it for their own situation. They often seek help and new knowledge in unexpected places. The avoidance of a 'not invented here' attitude and a large dose of humility are the hallmarks of improvement minded leaders.

Leading the Transformation

Staying the Course

Leading improvement on any scale is a tough ask. A large scale transformation lasting many years is particularly testing. Leaders need to build their own and others' resilience; watching out for signs of stress and burnout, providing support and comradeship and sticking together as a team. Unless we care for the caregivers, they can't improve the care they give.

Leading the Transformation

Case Study: Leading Transformation – Mid Cheshire Hospitals NHS Foundation Trust

Mid Cheshire Hospitals NHS Foundation Trust is a small district general hospital near Crewe, Cheshire. Just over a decade ago, the Trust was in major difficulty after regulators identified extensive issues around leadership, governance, quality and safety, and staff morale and culture for reporting incidents. The Trust was also missing most of its national minimum targets and running a significant financial deficit.

Since then, the Trust has appointed a new Executive team and Board and has achieved massive improvements; spurred by their aim to achieve Foundation status and achieving excellence through leadership, engagement, involvement of staff and building relationships with key stakeholders.

With the support of staff, patients and the public, the Trust developed a five-year quality strategy to lay the ground for strategic improvement across all levels. Further to this, they also became a founder member of AQuA, participating heavily in our Mortality programmes and reviews, as well as requesting further reviews from Royal Colleges.

Development of their Board was also a significant focus; with AQuA helping to co-design a development plan, deliver facilitation through our 'Board on Board' programme, and the Trust receiving additional support from the NHS Leadership Academy and NHS Employers.

Whilst this initially focused on improving quality and safety of care, their journey moved towards supporting them to develop necessary improvement skills and oversight, changing organisational culture, and creating a unified vision to support continuous improvement.

Further work also took place to develop their medical leaders; with the Trust developing a two-year Clinical Leaders programme to help clinicians moving into leadership roles, as well as working alongside Stockport NHS Foundation Trust to create their Consultant Foundation programme, to help new consultants transitioning from trainee roles.

All of this has been supported with a wider offer of accredited training for staff wishing to move to leadership roles, or existing leaders seeking promotion; with the executive team delivering a significant number of these sessions to help promote messages around culture and behaviour. This has also been supported by Executive walk arounds to speak to staff and patients, and other opportunities, such as weekly drop-ins, staff inductions and meetings.

Despite still experiencing periods of severe pressure similar to all hospitals, the Trust now ranks as the number one national performer for 18 week RTT, second across all cancer targets, sixth most efficient and productive among Foundation Trusts, and has received a number of national awards and accolades to support this.

"The single biggest personal investment from me as CEO, was staff engagement and a focus on building relationships and having positive conversations, and this has had a huge payback in terms of loyalty and commitment of staff.

"There are a significant number of corporate engagement events, which are well attended, and where staff have come to expect a candid and transparent update on the success and challenges of the Trust."

- Tracey Bullock, Chief Executive

Conclusion

A Sense of Urgency, Sense of Hope

We have argued in this paper that Boards and leadership teams should work to build their own systems and cultures for improvement. Indeed, they are now required to do so by inspectors and regulators. That isn't the main reason why they should do this however; they should do it because it's the only chance we have of tackling the enormous pressures of growing demand, tightening finances and staff shortages. It's our route map to better health and better care at lower cost.

Such an endeavour isn't accomplished overnight. It's likely to take many years of sustained effort. Yet some shorter term benefits can be secured relatively quickly and there is no time to start like the present. A sense of urgency should permeate every boardroom; urgency not just to deliver on performance and financial imperatives, but to do so in a different and more sustainable way.

Freeing up the time and energy to do this won't be easy. The relentless burden of day to day operational issues can feel overwhelming. It requires far sighted and courageous leadership to rise above the fray and to design and implement a better way of doing things. All of the available evidence concludes that this is what the very best healthcare organisations have managed to do.

This can be a lonely path and it pays to seek help and support along the way. This can be found in many places:

- **In the lessons to be learned from international exemplars such as Jönköping, Virginia Mason and Thedacare.**
- **By learning from other sectors, where many organisations are often willing to help the NHS. (One of the authors whilst at Bolton Hospital developed fruitful relationships with businesses as diverse as Warburton's Bread and the US Airforce!).**
- **From 'think tanks' and repositories of expertise such as The Health Foundation, The King's Fund and the Nuffield Trust.**
- **From national bodies such as the NHS Leadership Academy, Health Education England and NHS Improvement.**
- **From regionally based improvement organisations, such as AQuA, the Yorkshire and Humber Improvement Alliance, Haelo, NHS Elect and Academic Health Science Networks.**
- **And from each other; by developing 'buddying' arrangements and peer support networks.**

What is needed is a willingness to learn and the humility to recognise that help is required. Most of all, leaders have to master what the business author Jim Collins has called the 'honesty/faith' paradox. Collins studied the leadership teams of businesses in many sectors, whose performance moved from merely mediocre to the best in their respective fields. He concluded that one of their defining characteristics was the ability to maintain a brutal honesty about the facts of their situation, never minimising the scale of the challenges they faced, whilst at the same time having a resolute faith that if they stuck with their plans and engaged their people they could ultimately achieve a transformation in their fortunes (Collins.)

NHS leaders need the same approach: honesty about our predicament to drive a sense of urgency, but faith in the power of compassionate leaders engaging staff in improvement to engender a sense of hope.

Conclusion

Here are seven recent developments to bolster hope for a better future:

1. **The Royal College of Physicians now has a QI Hub based in Liverpool lead by Dr John Dean with a faculty of some 30 people.**

2. **The Health Foundation continues to support some fundamental approaches to change, such as Flow, Engineering and systems thinking partnerships, and the new Healthcare Improvement Studies Institute based in Cambridge.**

3. **The Academy of Medical Royal Colleges is implementing 'Training for Better Outcomes' which will change the content of all postgraduate medical curriculae, and thus what employees and employers need to do.**

4. **Health Education England is taking seriously its role to support change in many regions. For example, in the South West, training sessions have been held for medical educational supervisors on enabling trainees to become expert at QI methods.**

5. **Collaboratives for improvement are starting to be built into national audits thanks to HQuIP.**

6. **The Well Led criteria being promulgated by CQC provide a great opportunity and many Boards recognise this as does the CQC itself and NHS Improvement.**

7. **Safety investigations will add a new perspective to systems thinking, fair blame cultures and transparency. (Woodhead, 2018)**

Most of all we draw hope from our daily interactions with leaders and staff within the NHS across AQuA's membership in the North West of England. Despite hugely stressful circumstances, they remain resilient, optimistic and passionately committed to improving the care of the patients they serve. They also know all too well that a fresh approach is needed. They embody both the sense of urgency and the sense of hope that we need to carry us forward.

Find Out More

If you are interested in finding out more about how AQuA works, or would like to explore our approach to strategic partnerships, then please do contact us for an informal discussion.

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Advancing Quality Alliance