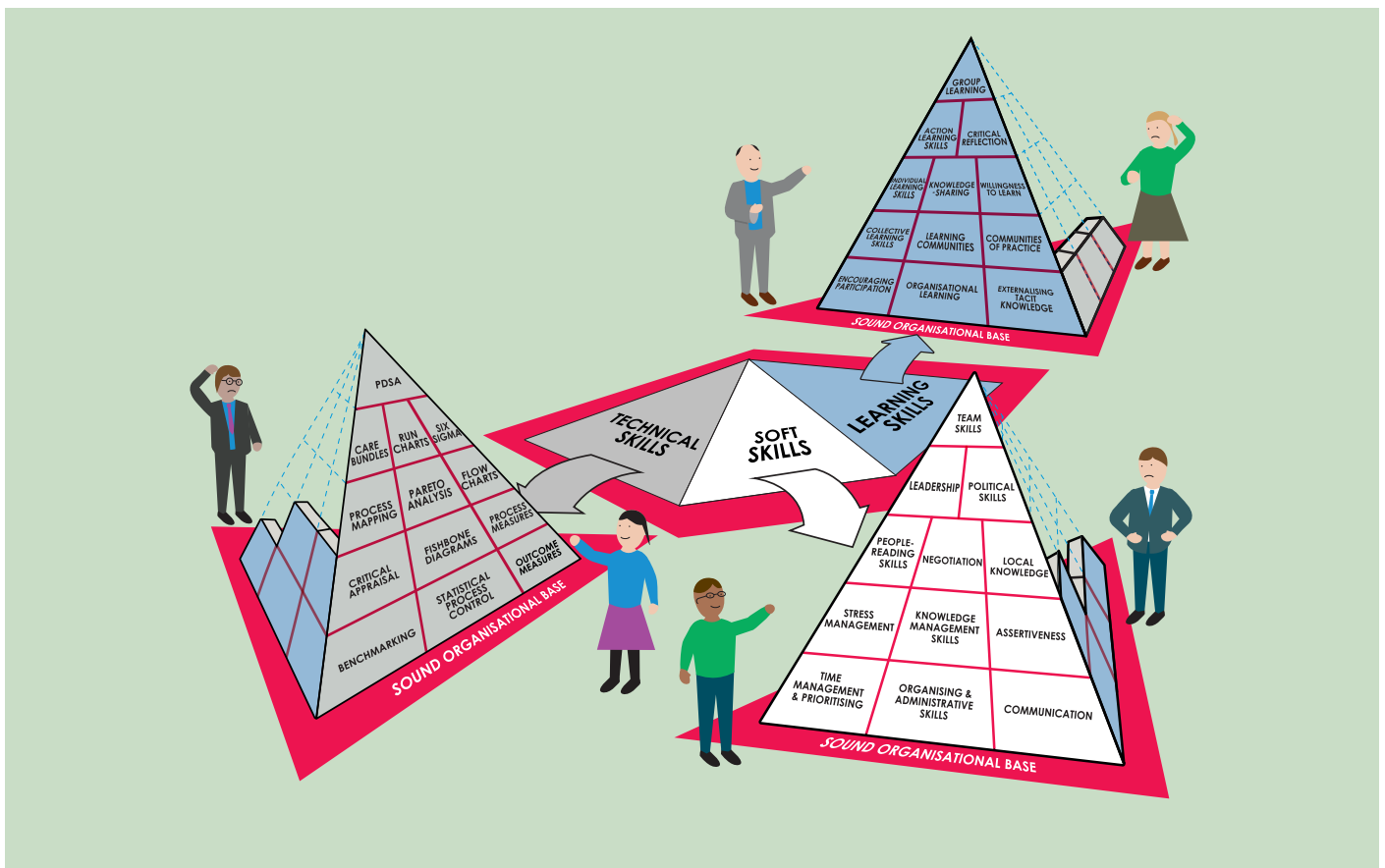# In brief

Skilled for improvement?

Health Foundation summary and analysis

March 2014

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www.health.org.uk/publications/skilled-for-improvement

Building blocks for successful improvement – the Learning Communities Initiative

Introduction

When the Health Foundation first conceived the Learning Communities Initiative, the intention was to study the use of organisational techniques, such as learning communities and communities of practice, to see how these approaches could increase the knowledge and skills in improvement methods among NHS staff.

The theory was that staff teams with greater awareness and practical skills, working and learning together, would be better able to lead quality improvement in action. The plan was for an 'action research' approach in which the Heath Foundation would fund a study team who were also expert facilitators to work with local improvement groups on specific projects, with the team studying and evaluating the projects to draw out the lessons for successful healthcare improvement.

The study was designed to be carried out in organisations (improvement sites) where improving quality was an established part of the delivery of healthcare services. What was envisaged was smooth implementation of a well-planned initiative in a receptive environment, welcomed by clinicians, managers and patients alike. Four years later, it is clear how optimistic this was.

The study has had periods where little or no progress was made. Delays to projects were caused by factors including changes of personnel in the improvement groups, structural changes across the English NHS, and shifting priorities and organisational changes in each of the healthcare organisations involved.

Rather than the exemplar study that we initially envisaged, what we actually received was something much more useful (and more likely to ring true with 99% of NHS staff reading it). In their report *Skilled for improvement?*, summarised here, the study team have provided a graphic and illuminating description of the difficulties and barriers which arise in improvement work. The authors look deeply into why this work is hard, even when organisations make improvement a priority and build capacity for it. They show how it is even harder when organisations have not built the capability and capacity at every level and in every corner of their services. The report shows the reality of trying to carry out improvement work in NHS organisations where restructuring and conflicting priorities undermine previously agreed strategies and de-rail approaches to improving services for patients.

Write-ups of improvement work are often criticised for being overly positive and not providing enough detail of the context for the work and the changes that happen throughout the course of planning and implementing a project. This study enabled a highly experienced team of researchers to investigate small-scale improvement projects in depth and over time, something that rarely happens.

We believe that *Skilled for improvement?* will be a real eye-opener for anyone designing and implementing improvement in healthcare. At its core is a stark message: improvement is difficult – even harder than you might think. But, at the same time, the findings provide a huge learning opportunity for those tasked with bringing about improvements to the quality of healthcare. Through the detailed exploration of four different improvement projects and the people involved, a fascinating story is told. The authors describe the factors affecting the projects on a number of different levels, and how these different factors impacted on the projects' success.

In *Skilled for improvement?* the study team draw on the Health Foundation's earlier analysis of the challenges to improving healthcare quality[1] and show what they mean in practice. The authors describe how changes in management, location and service design over two years will sap the enthusiasm of even the most motivated. They show how a lack of communication channels blocks improvement across organisational boundaries and different professional teams. Furthermore, the complexity of healthcare organisations can mean cultures of improvement and high performance might not be as widespread as senior managers assume. They also make clear that the overall lack of time and space for people who are supposed to run a 'seamless service' to actually meet and talk to each other can hinder improvement efforts.

The study team found factors in all of the improvement sites that affected the sites' receptiveness to change: the external environment (eg reorganisation vs stability, multiple targets, cross-cutting national programmes); internal organisational culture (eg the prevailing managerial approach to quality improvement, internal wrangles); and resources, structures and processes that might help or hinder the work of the improvement groups and their appetite and capacity to learn.

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1 Dixon-Woods M, Martin G, McNicol S. *Overcoming challenges to improving quality.* London: The Health Foundation, 2012.

In *Skilled for improvement?* the authors describe how three sets of skills – not just technical improvement methods (such as Lean methodology, PDSA (plan-do-study-act) cycles, run charts and care bundles) but also 'soft' skills and 'learning' skills (including learning to learn collectively as a group) – are essential for successful implementation of improvement. We suggest that these skills need to be recognised as a core part of the skills necessary for planning, implementing and leading improvement in the NHS. Opportunities need to be available to support people to develop these skills. Ultimately these skills need to be valued as a central part of managers' and practitioners' roles – not just for the enthusiast fringe, but for people working across healthcare.

The Learning Communities Initiative

The Learning Communities Initiative was rooted in the idea that learning is not merely an individual act but a social one, with collective and collaborative dimensions. When a member of a healthcare team learns something new about an element of practice, they do not simply store it and hand it on unchanged; it is continually recreated and evolves in a process of 'organisational learning'. 'Communities of practice' – groups that come together informally to discuss and resolve practical problems or concerns, and share a desire to learn from each other so as to improve what they do – were therefore fundamental to the initiative, providing the foundation for collective learning and the medium for organisational learning.

As part of the initiative, a two-year study was carried out that worked with two healthcare organisations (improvement sites) on four specific improvement projects. The study aimed to shed light on how organisations and the individuals and teams that comprise them – from senior management through to frontline clinical and other staff – behave when they are learning and striving to improve the way they provide care for patients.

Their experiences are captured in the report, *Skilled for improvement?*. This *In brief* explains the processes involved in the study, and highlights the three sets of interrelated skills that the study team found to be the fundamental building blocks for successful and sustained improvement: 'technical', 'soft' and 'learning' skills.

The study team

The study team comprised four experts with extensive knowledge and experience in public health, nursing and the application of management science to healthcare improvements.

The team's remit was:

– to elicit from local participants their perception of the problems that needed to be overcome in order to bring about the desired improvements, and to identify their collective learning needs in terms of improvement techniques

– to design a series of learning events to meet those needs, based wherever possible around specifically convened improvement groups who would be encouraged and helped to work as communities of practice or learning communities

– to use an 'action approach' (combining action research and action learning) where the study team, while working with participants to facilitate the flow of knowledge and learning among the improvement groups, would also draw wider lessons about the organisational learning process and its place in health service improvement initiatives.

The question of ethical approval was discussed with the chairs of the relevant research ethics committees, who decided that the work was to be considered as service development rather than research.

Using methods specifically adapted for this initiative,[2] the study team used their expert facilitation skills to work closely with key protagonists in each organisation throughout the process, helping them to establish the improvement groups, prioritise their concerns, and agree their improvement project. The team continually studied and evaluated the processes involved and the dynamics at play within each improvement group and setting, with a view to helping maintain momentum (or pushing things along where necessary).

They also tried to help each group to function as a learning community, including organising a series of learning events. It was originally envisaged that each group would hold three learning events, but as it turned out, nine were actually held: the Danelder and Dandem improvement groups held two each; Furncop held four, while Furndem held just one, towards the end of the project.

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2   The study team used a technique adapted from 'fourth generation evaluation', which they describe as 'systematic prior interview-based analysis of claims and concerns' (SPIBACC). This technique used semi-structured telephone interviews to elicit participants' 'claims (of success) and concerns' about the service or improvement project at hand. This process often produced long lists of concerns, which were then analysed and grouped into categories through a process called 'subsequent open prioritisation' (SOP). During this process, the study team helped group members collectively work through the concerns identified during SPIBACC in order to identify topics for the learning events. The interview and observational data were also used to study the improvement process. Another distinctive aspect of the method was the use of specific facilitation styles.

The improvement sites

The two sites chosen (given the fictional names of Dansworth and Furnhills) were selected because they had a clear vision and mission about quality that was aligned to strategic and organisational development plans, as well as a strong belief in the potential of their staff to develop skills and improve services. Each site had a strong track record of working to improve quality, backed up by investment in the learning and development needed to support this kind of work.

The Learning Communities Initiative supported two improvement projects at each site. The study team worked closely with managers and teams for each chosen project, identifying staff who would be responsible for leading and implementing the activities agreed through creating an improvement group, comprising people who had been brought together specifically to work on the project.

The projects were given specific names derived from the site and service.

At Dansworth, the originally agreed projects were:

– **Danelder**: Improving **Dan**sworth hospitals 'medicine for the **elder**ly' service, focusing on better discharge planning

– **Dandem**: Improving the care provided to patients with **dem**entia who are admitted to **Dan**sworth's hospitals.

And at Furnhills:

– **Furncop**: Improving the uptake and delivery of appropriate long-term care for patients in **Furn**hills with chronic obstructive pulmonary disease (**COP**D)

– **Furndem**: Optimising **Furn**hills' community **dem**entia services by reorganising the way in which memory clinic services are delivered.

The four improvement groups proved very different in their characteristics, organisational cultures and processes – and ultimately in the extent to which they were able to achieve the aims of their improvement projects. The study team were able to observe how each group's approach to improving services varied depending on the organisational culture (and subcultures) in their working environment and partnerships. As part of the process, each group summed up their own learning achievements, and reflected on the extent to which they had developed as a learning community; some continued beyond the lifetime of the specific project, whereas others only functioned as a learning community (if at all) for the project's duration.

The four improvement projects

Did the improvement groups succeed in achieving the aims of their chosen improvement projects? This section highlights some of the key issues that each group encountered. It focuses on the broader organisational environment in which the projects were conducted, the extent to which participants formed a learning group, and whether the group functioned as a learning community.

The Danelder project

The Danelder improvement group surpassed their aim for improving the medicine for the elderly service (to improve and embed the use of estimated discharge dates). The group benefited from (and made good use of) a strong improvement structure and culture that Dansworth's management had long invested in and fostered.

However, during the course of the group's work, they had to navigate various cultural tensions – between different groups of physicians (reflecting different specialties and levels of staff seniority), different wards and different sites. The group's ability to do this was partly down to the skills of the project lead, a very capable and respected clinician with a strong background in improvement and experience of using key techniques such as PDSA cycles.

The Danelder group functioned well as a learning group, both in terms of their own membership and in spreading the learning they generated more widely.

The group's learning outputs included:

– conducting a review of evidence to support their chosen project

– introducing a standard operating procedure

– using small tests of change that could be tried in other units

– taking their experiences and improvements beyond the boundaries of their service and into other wards.

The group felt they had created an extended learning community involving colleagues in other sectors and organisations, and were continuing to identify new projects to work on.

The Dandem project

The early stages of the Dandem project helped to foster better understanding between staff working in different sectors and disciplines. This helped the project lead develop a dementia improvement plan spanning the different sectors, which was ratified by the local health board. However, as the project got under way, the Dandem group had to revise their original aim (improving care for people

with dementia who were hospitalised) due to changing realities on the ground, including a new government framework. The group subsequently agreed to focus on identifying ways to improve the knowledge and skills of staff, working at a certain level,[3] providing dementia services, in line with the new framework. This was much broader than the original acute setting, and now spanned health services, social services and the voluntary sector.

Due to a range of external and internal pressures on service managers, particularly the project lead, no learning community was established as part of the Dandem project. They did manage to organise two learning events to work towards developing dementia training for level 3 staff, but after these the improvement work stalled. The improvement group, such as it was, only acted as a learning community during the two events. Follow-up interviews nine months later found that little had happened as yet to develop level 3 training, with most efforts so far focusing on staff at levels 1 and 2. The improvement culture at Dansworth that had been so evident in the work of the Danelder group did not seem to have reached the area of dementia services, which were located away from the main hospital site.

The main contribution of the Learning Communities Initiative for Dandem was therefore in providing an opportunity to bring together key people involved in dementia care, across all relevant sectors and disciplines, in an open and facilitated discussion where all those represented felt their voices (and concerns) were genuinely being heard.

The Furncop project

The work of the Furncop improvement group did contribute to achieving Furnhills' targets for improving the care for patients with COPD in the community. Moreover, as a result of one of the learning events, the group wanted to radically alter their approach to helping primary care teams deliver the necessary improvements. However, the new approach the group was advocating proved incompatible with the performance management culture that was prevalent in Furnhills. By the end of the project, the group was still swimming against the tide to implement the changes they wanted to see.

Despite Furnhills having an organisational culture and structures designed to support improvements, Furncop was undermined by constant organisational tensions and transitions as a result of the reorganisation brought in by the Health and Social Care Act. The broader organisational environment, and the clash of managerial cultures and agendas, constrained what the group could achieve.

Four learning events were held as part of the Furncop project. These focused on:

– strengthening the interpersonal skills (including assertiveness and conflict management) of group members, all of whom were from the public health nursing team

– social marketing techniques (to help group members 'sell' to patients and clinicians the idea that COPD was a treatable condition that should be properly managed in primary care)

– introducing the principles of improvement science (with a presentation by a senior and inspirational leader from among the Health Foundation's network of experts)

– how to put those principles into practice.

Through these events, the Furncop group had developed into a learning community whose members were learning (from each other and from different parts of their organisation) how best to enhance the quality of patient care. The group benefited from exchanges about the contributions, practices and constraints of the different professions and sectors involved in providing and managing care. They also received help and advice on overcoming personal and organisational obstacles to improvement, as well as about improvement techniques and the value of learning such things collectively as a community.

The Furndem project

The Furndem project's original aim was to relieve the pressure on the over-subscribed memory clinic service by redesigning dementia pathways. However, this was eventually broadened to focus on wider, well-supported GP care for patients in the early stages of dementia. The project did open up a dialogue between staff from different dementia services, which eventually led to significant changes in care pathways. But improvements in terms of reducing the waiting lists for the two memory clinics were largely due to a parallel project based on process mapping, which was separate from the Learning Communities Initiative.

The Furndem project had begun in difficult circumstances, in an environment characterised by poor communication, alienation, and even resentment, which limited the buy-in of key staff. The work stalled for nearly two years, due to various internal political factors, including a stand-off between key parties (eg memory clinic staff and GPs, or the primary care trust (PCT) and the trust) and the managerial preference for improving services by means of commissioning and planning structures. Although the wider organisational culture espoused an appetite for quality improvement, there seemed to be less appetite for its application in specific parts of the organisation.

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3   The project specifically focused on 'level 3' skills – those needed for delivering 'enhanced' care, which included diagnosis, assessment and post-diagnostic care. Levels 1 and 2 skills were those required by all staff and those for staff who have direct contact with dementia patients, respectively.

Only one learning event was held, towards the end of the project, and it was only then that anything that could be even loosely described as an improvement group was put in place. Despite the project's inauspicious start, and anticipated resistance on the part of the key players (staff working in the clinics and their colleagues in primary care), the learning event succeeded in opening up a dialogue between those who had not previously had the opportunity to meet with the specific purpose of discussing the difficulties surrounding the delivery of community dementia services. Major improvements in the service were brought about as a result.

Key findings

The three sets of skills needed for improvement work to succeed

The study team found that all four improvement projects relied on individuals (and the learning communities they formed) having or developing certain knowledge, skills and techniques. These included the 'technical' skills usually associated with improvement science (such as Lean methodology, PDSA cycles, run charts and care bundles) but also two significant additional skill sets, 'soft' skills and 'learning' skills, that proved to be fundamental building blocks without which improvement would not happen.
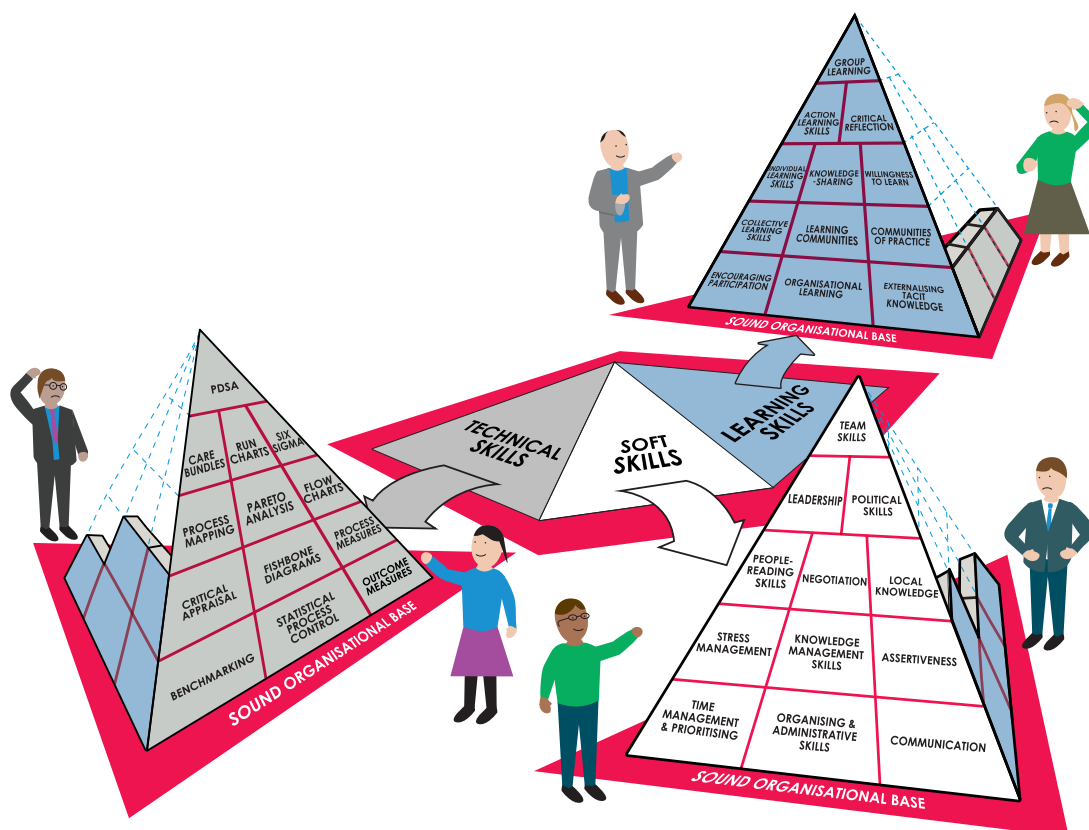
Soft skills included good communication, conflict management, assertiveness and negotiation (the subject of the first learning events held by two of the groups which, interestingly, were the only two groups that recognisably functioned as learning communities and achieved tangible improvements as a direct result of the initiative). They also included time management, stress management, leadership and team-working skills, and organisational and administrative skills. Sound knowledge of the local health economy was another important factor. This, combined with strong interpersonal/political skills, proved vital in enabling participants to navigate their projects through the vested interests and power bases involved in different areas of care. Interpersonal skills were also evident in participants' ability to 'read people', time interventions and listen to and understand the views of others.

The final set of skills involved collectively learning how to improve services. These learning skills enabled improvement group members to learn from each other and to develop as a learning community. These skills also appeared to play a key role in the extent to which projects achieved their aims. Learning skills included collective reflections such as listening, debating, distilling and thinking-through-together the myriad consequences of the project.

The study team use the analogy of building a three-sided pyramid to convey the interdependency between the three sets of skill and also the wider factors at play (see Figure 1).

Figure 1: The three-sided improvement pyramid

Too small a base (red) will not support the three sides to any worthwhile height. If any of the sides falls short, the pyramid cannot be completed and the top cannot be reached, and the higher level of skills in the other sides will be wasted.

To reach the point of sustained improvement (the apex of the pyramid), the organisational base (environment, culture, structures and resources) should be broad and solid enough to support the construction of the three 'walls' (each of the three sets of skills) to the same (maximum) height. But most importantly, the pyramid cannot be built if one of the three walls comes up short. The absence or weakness of skills needed for quality improvement in one area (not enough bricks in the wall) will lead to a lack of progress overall, irrespective of the strengths of the other two sets of skills (walls).

Organisational environment

In *Skilled for improvement?* the authors observe that the organisational environment (internal and external) and approach to improvement can both have a critical bearing on a project's outcome. Whereas Furnhills' previous successes with quality improvement had stemmed mainly from their outstanding prowess in commissioning and performance management, Dansworth's quality improvement achievements were driven by the executive team's enthusiasm for an approach rooted in improvement science. This had already led to significant investment in staff capabilities and support for developing improvement skills and strategies.

Achieving change through applying improvement science requires those pursuing that change to navigate complex interpersonal, political and organisational realities in which organisational subcultures can also play a key role. There is often a disparity between what management might espouse as the approach to improvement and the realities on the ground. The subcultures that exist partly explain the differences in process and outcomes between two projects (Danelder and Dandem) at the same site, which were ostensibly subject to the same overall organisational culture.

Improvement resources, structures and processes

Both sites had already put in place quality improvement structures – the Quality Improvement Academy (Furnhills) and the central improvement team (Dansworth) – but these were very different in nature. There were also differences in the extent to which the four improvement groups utilised internal resources, structures and processes to help with their improvement projects. At Dansworth, for example, the Danelder group were quickly able to agree a clear process for improvement, to manage the project efficiently, to use tools such as PDSA, to measure progress, and so on – all techniques familiar to them because of the pervasive improvement culture. In contrast, the leaders of the Dandem group, who had not (as one Dansworth

senior manager put it) 'had their brains rewired' for the local improvement culture, were slow to recognise how the Learning Communities Initiative could help their group deal with the many demands for service improvement they were being required to handle. Clearly then, even in high-performing organisations where there is strong backing for improvement work (centrally and managerially), there may still be large groups of staff or teams that have not embraced that approach.

It is also noteworthy that in Furndem as well as Dandem, the main efforts to introduce improvements – which did achieve tangible results – were being strongly pressed forward by individuals or processes outside of the Learning Communities Initiative.

At Furnhills there was a continual tension between two contrasting approaches to improvement, which had a major bearing on the Furncop project. A top-down, performance-led managerial style driven by the primary care trust (PCT) in a high-profile programme to improve management of patients with COPD in primary care was leading to resentment and resistance from frontline staff, despite the fact that its aims (ambitious performance targets for treatment and referral) were broadly supported. In addition, the PCT's strategy involved focusing on 'hotspot practices' (the poorest performers), yet these were the very practices where the public health nurses trying to improve COPD care were finding it difficult to win over GPs and practice nurses (which is why they prioritised strengthening their communication and conflict management skills as the topic of the first learning event). Had they had more autonomy to implement the improvement project, they would have taken the approach of spreading improvements through what they came to call 'improvement conversations' – beginning their work with willing clinicians and then harnessing their influence to help win over the recalcitrant ones. But the PCT's target-driven culture dictated what they could do.

Major developments in the external as well as internal environment also determined what the improvement groups were able to achieve with their projects. For example, the Furncop group had to contend with the impact of major NHS reorganisation, whereby the PCT was to be abolished and replaced by a GP-led clinical commissioning group, with the upheavals inevitably taking time and energy. They feared their improvement project might also be swallowed up by a new programme for generic chronic disease management, which involved a fundamental shift away from single-disease pathways. The prevailing national climate had strengthened the resolve of those resisting the Furncop group's desire to use 'improvement conversations' and bring about a very different approach to improvement methods in their service.

Key lessons

Perhaps the most important lesson drawn by the *Skilled for improvement?* authors is that applying the techniques of improvement science alone is unlikely to be sufficient to deliver sustained quality improvements in healthcare. Other lessons they highlighted include the following:

– Any organisation wishing to improve quality – whatever its starting point – must invest in developing three sets of skills: 'technical', 'soft' and 'learning' skills.

– Developing these skills (including helping staff to learn collectively as a group) must be a central part of managers' and practitioners' roles – not just a marginal 'add on'.

– Creating an organisational environment that is conducive to improvement means providing strong and sustained institutional support (culturally, financially, and inter-personally), compatible with the principles of proven methods of improvement.

– Improvement work should not underestimate the influence of key individuals who can either drive projects forward or hold them back, whether those individuals are working at the grass roots or in more senior positions. Projects need enthused, motivated, trained and empowered people to lead them and navigate the many obstacles that inevitably arise. Where possible, these individuals should be identified early on and every effort made to ensure their competence across all three sets of skills.

– When planning and managing improvement projects, it is vital to assess the range and depth of skills that individuals and project teams have, particularly those who are likely to be at the forefront of the work (and in the frontline of caring for patients), so that the right skills can be brought into play.

– An organisation's approach to staff development and education is also important. Feedback indicated that participants greatly valued being given the opportunity to share knowledge and skills with colleagues and to debate contentious issues with key people involved in service provision in their areas, both clinical and geographical, in an (often novel) action learning and problem-solving setting.

– Strong leadership is a prerequisite, not just to manage the day-to-day work of an improvement group effectively and contribute to the learning community, but also to manage the organisational environment and partnerships that are integral to achieving the desired improvements.

– Improvement projects require in-built flexibility to adapt to changing realities. Some of the improvement projects were revised and 'co-designed' as the groups began their work. All parties must be prepared, from the outset, to accept this.

– Differences or lack of engagement and partnership working between various sectors and disciplines can also determine the success of improvement interventions. In three of the four improvement projects, the groups found it difficult to engage more than a very few enthusiastic GPs in their work.

– Availability of sufficient time is crucial. One of the main resource constraints across all four projects was staff time – in terms of carving out the time to work specifically on the project, and to find times when all relevant staff across sectors and disciplines could meet.

– It is generally easier to move forward with an improvement project when the project coincides with existing work streams.