Closing the Gap through Clinical Communities

April 2012 Report

Project Title

Enhancement of the ability of the Royal College of Psychiatrists' quality improvement networks to bring about improvement in local mental healthcare services (QI Networks).

Lead Organisation

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI)

Partner organisations:

The Royal College of Nursing (POMH-UK)
The United Kingdom Psychiatric Pharmacy Group (POMH-UK)
Rethink (POMH-UK)
British Association for Pharmacology (POMH-UK)
Mind (POMH-UK)
Foundation for People with Learning Disabilities (QNCC)
Association of Therapeutic Communities (Community of Communities)

Lead Clinician

Dr Mike Crawford

Contents

Appendices to be read in conjunction with this report

Appendix 1: External Improvement Work
- Appendix 1a: Case study, Collaborative 1
- Appendix 1b: Case study, Collaborative 2
- Appendix 1c: Case study, Collaborative 3

Appendix 2: Internal Improvement Work
- Appendix 2a: Case study, Improving the speed of delivery of reports
- Appendix 2b: Summary of internal improvement work

Appendix 3: Feedback on content and delivery of Collaboratives

Appendix 4: QNIC Newsletter Issue 04 2011

Appendix 5: POMH conference programme

Appendix 6: Bridging the Gap (article written about the work of Collaborative 2)

Abstract:

This project received funding from the Health Foundation for 2 years, beginning mid-March 2010[1]. During this period, it has been working with pilot services/wards from six of the CCQIs quality improvement networks:

- Accreditation for In-patient Mental Health Services – Working Age (AIMS –WA);
- Community of Communities (C of C);
- Prescribing Observatory for Mental Health (POMH);
- Quality Network for Forensic Mental Health Services(QNFMHS);
- Quality Network for In-patient Child and Adolescent Mental Health Services (QNIC);
- Quality Network for Community Child and Adolescent Mental Health Services (QNCC).

The networks were chosen as each had been working with mental health service providers over sustained periods to improve quality, and had identified intractable problems. The project has been working closely with the pilot sites to develop and test ways of overcoming barriers to improvement. In order to take forward the work beyond the funding period, the CTG Project Team would need to ensure that the CCQI as a department **acquired** and **embedded** the skills and resources it needs to support network members to make sustainable improvements. To this end, the team also supported a range of internal initiatives involving CCQIs staff.

Note to readers: we recognise that the design of our programme of work is different from many of the other CTG projects in terms of the numbers of different improvement topics that we have been working on with teams. This approach was designed to allow us to test best ways of supporting teams to engage in successful improvement projects. In that sense, our teams have effectively been our 'guinea pigs' and the source of much of our learning. For this reason, we have adapted our use of the report template to allow us to tell you about their experiences within their collaboratives – their 'stories' – what they have endeavoured to achieve, the changes they have tested, their outcomes, and the challenges they have faced along the way.

From these stories, the CTG team has been distilling our learning in relation to two key questions which we will begin to answer in sections 4.3/4.4 of our report:

1. What do we need to provide to allow individuals and teams to learn how to undertake successful improvement work?
2. What does a service/team need to have in place if it intends to undertake a successful improvement project?

[1] Note: the Health Foundation has given permission for an under-spend in the budget to be re-allocated to cover staff salaries for an additional 2 months to allow the team to continue to refine their approaches to supporting teams to undertake improvement activities using the IHI's Model.

1. Background

1.1. The quality challenge background knowledge

This has been described for each programme of work or collaborative in Appendices 1 and 2.

1.2. Local problem and context

The CCQI manages 15 national quality networks (www.rcpsych.ac.uk/ccqi) that support UK mental health services through a recurring annual cycle of systematic review against explicit standards of best practice. The standards are drawn from evidence and, where this does not exist, from expert consensus. The review process thus measures the extent of the gap between routine delivery of care and recognised best practice. Also, because the networks support member services through repeated cycles of review, we know which problems are experienced by a large number of services and which problems are difficult to resolve. The latter are indicated by services failing to meet certain key standards year after year.

These persistent and recurring problems also indicate that the CCQI is not as effective as it might be in enabling services to make improvements. The Health Foundation grant is being used to strengthen this aspect of the CCQIs work. If successful, the grant will leave the CCQI a legacy of expertise in improvement science that could, given the right supports, be sustained into the future.

In our original proposal, we undertook to work externally with four topic-based improvement collaboratives made up of member services from our networks:

1. **The management of metabolic side effects for those on antipsychotic medication in the community** (Network: POMH)(completed)
2. **Access to and range of 'non-therapeutic'**[2] **activities for patients** (Network: AIMS –WA); coupled with **providing and evidencing a minimum of 25 hours structured activity per patient per week** (Network: QNFMHS)(completed)
3. **Transitions from inpatient care to community based services**' (Network: QNIC)(completed)
4. **The ways in which therapeutic communities demonstrate their effectiveness**' (Network: C of C)(on-going)

In keeping with the iterative nature of the work, however, we expanded our original brief to include two new topics:

5. **Young people's satisfaction with meals and snacks** (Network: QNIC)(completed)
6. **'Did Not Attends' (DNAs) in an outpatient service** (Network: QNCC)(on-going)

The two new strands of work were added to allow us to further test our ways of working and develop our understanding of how best to support mental health services to engage successfully in improvement work. We are also about to begin work programmes with two new organisations, a large mental health trust and a voluntary sector women's centre where we will be testing 'top-down' approaches to working with teams.

We have also been running a large number of internal improvement programmes within the CCQI that have been designed to help our department to develop capacity to deliver this type of collaborative into the future:

- Improving the speed of delivery of reports (completed)
- Developing an executive summary for local reports (completed)
- Improving staff ratings of their experiences of decision making within their team (on-going)

[2] This term is used to refer to any activity that is not a formally recognised 'therapy'.

- Improving the rate of return on patient questionnaires (on-going)
- Improving member recruitment rates (on-going)
- Increasing the number of peer review teams that include service users (on-going)
- Increasing levels of service user involvement for services in the review cycle (on-going)
- Reducing the time a manager spends on administrative tasks (on-going)

1.3. Intended improvement

This has been described for teams from each collaborative in Appendices 1 and 2.

1.4. Changes along the way

These have been described for each team from each collaborative in Appendices 1 and 2.

2 Methods

2.1 The Intervention

As described above, our original proposal identified four topics that we would be working with through the 2-year period. Our intention was always that both sides of the partnerships would benefit. Teams from the participating networks would be supported to undertake an improvement project and (hopefully) develop the skills and confidence to undertake other projects in the future, and; through an iterative programme of reflection and learning, the CTG Team would refine a model for how best to support teams to learn about improvement science.

The intervention used by the Team was the application of the Institute for Healthcare Improvement's (IHI's) 'Model for Improvement' within the context of a collaborative of teams from different services. In the initial months of the project, the team was very conscious of our lack of expertise in the subject of 'improvement science' and so leaned heavily on the advice and guidance of our improvement fellow. We were also very conscious of our desire to develop skills and knowledge and so increase the capacity and capability of the team to continue the work beyond the period of funding. To this end, we adopted a three-pronged approach to our development:

1. We asked our improvement fellow to lead on the first collaborative i.e. to teach the technical sections of the learning events and lead/participate in the monthly teleconferences. For the second collaborative, our improvement fellow shadowed our work and provided feedback.
2. The project manager undertook the IHI's 10-month Improvement Adviser Personal Development (IAPD) course.
3. The team members would have on-going access to 1:1 mentoring/coaching from our leadership development consultant (LDC).

In relation to the intervention itself, each of our four collaboratives was supported to apply the IHI's 'Model for Improvement' 10-month programme to their given topic area, i.e.

- **Learning events:** during this 10-month period, the teams came together for four learning events.
- **Action periods:** each learning event was followed by a 3-month action period where teams carried out small 'Plan Do Study Act' (PDSA) cycles and collected simple on-going progress measures.
- **Additional supports:** during the action periods, the CTG Team hosted monthly teleconferences to review progress, discuss challenges, and agree ways forward. Additional on-site support visits by a member of the CTG Team were also available by arrangement.

With these four collaboratives, participating teams signed-up to a common 'topic'. It was not until the first learning event that work began on defining the specific aim and measures for their improvement activity.

The four 10-month collaboratives were planned to run in series, starting at three-month intervals. Our learning has therefore been highly iterative and very much in keeping with the Model's emphasis on reflection and learning. Indeed, it was as a consequence of this that we opted to run the fifth collaborative of external work listed in Section 1. Unconvinced that the 10-month programme of work had been effective for all teams, we tested a far shorter programme initially scheduled to last 12 weeks, i.e.

Week	Event
1	Learning Event 1
2	1:1 'phone call
3	1:1 'phone call
4	Group teleconference
5	Gap week
6	On-site visit to your service by member of CTG team
7	Gap week
8	On-site visit to your service by member of CTG team
9	Gap week
10	Learning Event 2
11	Gap
12	Group teleconference

With the shorter collaborative, teams were asked to gather baseline data **before** the first learning event. This allowed them to have a clearer understanding of the nature of the problems.

2.2 Measurement

This has been described for each team from each collaborative in appendices 1 and 2.

3 Results

3.1 Outcomes

These have been described for each team from each collaborative in appendices 1 and 2.

3.2 Challenges along the way

These have been described for each team from each collaborative in appendices 1 and 2.

3.3 Impact and successes

These have been described for each team from each collaborative in appendices 1 and 2.

4 Discussion/learning

4.1 Summarise the most important successes and difficulties in implementing your intervention and main changes observed in the quality of care, and in increasing clinical engagement and skills in Quality Improvement.

While each of our collaboratives focused on a different topic, a number of core elements were identified across the board as aiding in team's success, or hindering their progress.

Success factors

- **A strong cohesive core team**
    - A project lead who:
        - demonstrates strong leadership;
        - has dedicated time to lead the work;
        - is charismatic;
        - is able and willing to address barriers;
        - has good communication skills;
        - has links to management.
    - Consistent and reliable administrative support.
    - Service user involvement.
    - Team members need to:
        - be stable in their roles;
        - have time to work on the improvement area;
        - be enthusiastic, committed, determined and focused;
        - have a unified identity.
    - Committed 'champions' for the work i.e. people who were nominated to lead on aspects of the work.
    - Making best use of the different skills and experiences within the staff group.
- **Including/making links with the right people**
    - Involving the wider staff team from the beginning.
    - Starting working with those members of the team who are enthusiastic, experienced and open to change.
    - Having a good rapport with service users and links with other local professionals.
    - Linking with overlapping projects.
- **Strong communication**
    - Having regular opportunities to discuss the changes that were being tested, what was working, and what was not.
    - Keeping the wider staff team aware of what was happening and why e.g. via regular meetings, e-mail updates and in-house education sessions.
- **Visible management support**
    - Management awareness and verbal and practical support of the project.
    - Commitment to improvement and positive attitude of management towards the work.

Challenges

- **Service/organisation re-structure/relocation**: this affected nearly every team we worked with, from the ward manager going on maternity leave, to teams being disbanded and absorbed into other parts of the service, to teams moving base half-way through the programme of work.
- **Staff retention/sickness:** sometimes because of service reconfiguration, e.g. one ward had three different managers during the 10-month programme.
- **Size of project team:** some of our teams struggled to recruit to their core improvement team, limiting their ability to motivate the wider staff team to test changes and hindering the speed of progress.
- **Competing priorities**: leading to a lack of resources, such as time and availability of staff.

The successes and challenges have been described for each team from each collaborative in appendices 1 and 2.

4.2 Please explain how you established the clinical community; how you think it impacted on the success of your project and what was the added value of approaching the problem through a clinical community?

Each collaborative was made up of member services/wards from one or more of the quality networks or accreditation networks managed by the CCQI. These networks are themselves large clinical communities who share a common commitment to improve their practice through a system of self- and peer-review.

We approached these large networks and asked for four to six of their members to put themselves forward to become a smaller clinical community, and work collaboratively, to improve practice in one specific area.

Our first collaborative was made of four teams belonging to POMH. Teams were made up of a range of pharmacists, psychiatrists, team managers, social workers, community psychiatric nurses, service users and audit staff.

The second collaborative had five teams, three from AIMS-WA and two from the QNFMHS. These teams were made up of ward and team managers, psychiatrists, social workers, nursing staff, health care assistants, occupational therapy staff and in some cases service users.

The third of our collaboratives was made up of teams from QNIC. As the topic for the improvement activity focused on the boundary between in-patient and community services, these teams involved staff from the inpatient ward, members of the community team, and members of the in-reach/outreach services.

Our fourth collaborative was formed of four therapeutic communities belonging to C of C. These teams were lead by those involved with the management of the communities but the wider teams encompassed all members of their communities.

The fifth collaborative was formed of staff from five QNIC inpatient wards. These teams were made up of staff, including chefs, dieticians, nurses, health care assistants, ward managers. Although not involved in the learning events, service users were actively involved in all of the local project teams.

The sixth piece of external improvement work is with a single outpatient team. This project is being worked on by the entire team, which includes nursing, occupational therapy and psychology.

The map below shows the geographical localities of each of the collaboratives.

	Collaborative 1- teams from Bradford, North London, South London & Sheffield
	Collaborative 2- teams from London, Warrington, Greater Manchester, Runcorn & Bodmin
	Collaborative 3- teams from Northumberland, Tyne & Wyre, Liverpool, Swindon, Somerset & London
	Collaborative 4- teams from Aylesbury, Buckinghamshire, London & Dover
	Collaborative 5- teams from London, Manchester and 3 from Middlesbrough
	Bespoke work is taking place with a team from Wolverhampton.

Clinical teams from services coming together to undertake the work seemed to strengthen their experience and bring unexpected benefits – both for pre-existing and 'new' teams, as these quotes illustrate:

"The big impact was that it changed the culture…it was not a dreadful culture…..it was a good steady one that is now up a couple of notches… it was a struggle and it was tough… but the ward is now confident and has a strong sense of its own purpose."

"There were a number of other spin-offs - including cooperation between us and community teams, and the managers. It's now a good working group that has ensured regular communication."

"The problem can be with improvement that it can be too management led – but this is kids-led and engaged the Ward Manager, involved the private firm domestic service supervisor and the dietician."

In relation to their experiences as members of a collaborative, in general the teams found the collaborative groups a useful and safe place to share successes, ideas for change and any challenges they were facing. As the collaboratives were made up of teams from similar services they felt comfortable with one another and able to offer constructive criticism as well as ideas, as these quotes explain*:*

"It was a great learning curve especially being aware of how other health care professionals carried out their project and what results they have achieved."

"(I) loved listening to the other groups – hugely interesting, informative and reassuring."

One advantage of inviting participation from a larger clinical community i.e. the CCQI network, was that teams were ready and willing to engage in the work and make changes. In some cases, there was also a mild sense of competitiveness between teams, as this quote illustrates:

"The mere fact that the delegates are from different organisations, it made me focus on getting the job done."

The teams' identification of themselves as members of a CCQI network came as a mixed blessing. As one manager explained:

"I use the phrase 'Royal College' five times in the first sentence (in a report to senior managers)…we don't want to look bad in front of the Royal College…its kudos…if it has that stamp its more likely to be taken seriously."

Conversely, one 'high achieving' team withdrew from their collaborative at an early stage, in spite of a visit and discussions; we could only conclude that they felt challenged by the open and sharing approaches engendered by the learning events and group calls.

4.3 /4.4 Achievements, the challenges, the things that didn't work out quite as you planned and our interpretation

As previously described, our initial plan was to follow a 10-month programme with each of our four collaboratives. Although successful for some, this approach did not work for every team and we have continued to test and are still testing new approaches to working with the 'Model'. This iterative learning that has been supported by our multi-topic design has allowed us to explore the answers to two key questions.

1. What do we need to provide to allow teams to learn how to undertake successful improvement work?
2. What does a service/team need to have in place if it intends to undertake a successful improvement project?

Question 1: What do we need to provide to allow teams to learn how to undertake successful improvement work?
When we began the work, we were highly dependent upon the expertise of our improvement fellow. However, as a result of the development opportunities we were able to create for the Team, this has reduced over time and we gained confidence in trusting ourselves to modify the supports we offer teams. We have therefore been able to test changes to address the challenges we have come across whilst working with our teams.

Our use of language
At a very concrete level, the language of the IHI's Model is American and hence uses terms that can alienate people, as one participant from our first collaborative explained:

"At times it felt that the Model over complicated the process of change – I feel it could have been simplified."

We have worked to reduce our use of jargon and to replace some of the terms with more familiar and acceptable alternatives e.g. for 'measures', we now refer to 'progress measures'. This links to a separate point: the structure of the Model itself.

Key learning:	***Keep the language familiar and avoid 'mystifying' people***

Overcoming conceptual barriers to applying the Model
There are two components of the Model that can be very challenging to teams.

1. ***The requirement to 'measure'***: many health service staff associate 'measurement' with 'performance management'. This has been a hard barrier to overcome. Furthermore,

when we ask a team to provide us with their measures in advance of, say, a monthly teleconference, this can bring up 'fear of failure' or 'judgement' from other teams in the collaborative. Interestingly, when teams do collect measures, they rapidly grasp the huge value of having evidence of their improvement. The challenge is to get them to collect measures so that they overcome the initial fear! We have modified our approaches to our work with the new teams from Collaboratives 5 & 6. With Collaborative 5, we used a 12-week programme of work and offered more intensive supports from the outset. This meant that teams were actively supported to develop their measures and were able to feel more confident about their early 'wins' before being exposed to the first group call (week 4). This approach appeared to overcome some of their fears and to instil a more constructive view of 'measures' as a way of guiding the teams towards their stated 'aim'.

2. ***The PDSA cycle****:* for many teams, the invitation to 'test changes' is surprisingly difficult, as this quote illustrates:

"Getting used to a new method and understanding it's okay to try things and stop if they aren't working (having permission to do this as well)."

This is something we have explored with them. Staff feel under considerable pressure to 'implement' - policy changes, practice developments etc. They are not accustomed to 'testing' a new idea in the workplace. In part, this may be due to the fact that nursing practice models advocate that changes are **implemented** and then **reviewed**. Given that this is instilled in nurses from an early stage of their training, it is perhaps not surprising that many struggle to adapt to the requirements of the 'Model'. For some, the PDSA cycle carries with it notions of 'failure', rather than 'empowerment'. Interestingly, some of the teams we have worked with were able to embrace this aspect of the Model from the outset, as these quotes illustrate:

"The actual idea of PDSA cycles is good in the sense of making small changes and evaluating them – and the fact it doesn't matter if something doesn't work – just learn from it and move on. Seems very practical."

"PDSA cycles revealed the need to run (training sessions) – that was a big hit….start small and increase were things we learned from Maureen's sessions and with the other Trusts taking part….when we got good hits then my team were getting excited."

"We learnt that PDSA is not another piece of paper – it changes the way you think; its another way of being."

We have been able to identify a number of indicators that suggest that a team will readily adopt a PDSA-approach to working:

- teams that have a culture of being empowered to try things out;
- strong, cohesive teams that hold each other in high regard;
- the absence of a 'blame' culture.

Key learning:	***It is easy to lose people at an early stage if they feel confused and/or fear failure. Many teams need more intensive supports at the early stages of the work. It is important that teams see the improvement adviser as a 'critical friend', rather than an external inspector. Whilst labour intensive, this approach would seem to yield far better results.***

Key learning:	***Not all teams will automatically feel comfortable with the iterative approach of the PDSA. Active support is needed to assure staff that there is no such thing as a 'failed' PDSA.***

Our teaching methods
In our first learning events, we adopted a largely didactic approach to teaching people about the Model i.e. lots (and lots) of detailed slides. Many participants appeared overwhelmed with the complexity of this new 'science' ... the phrase 'rabbit in headlights' was often used. As we moved through the collaboratives, we adapted and simplified the slides and structure of the learning events to make them more interactive and grounded in real-life examples. This proved successful to some extent. However, with our new work (5 & 6), we took the brave step of avoiding the 'science', and instead plunged straight into the practical application of improvement methods to the problem at hand – very much 'learning by doing'. The plan was that we later revisit their work, draw out the technical components of Model from the lived example, and use that to help them draw up a Charter for a new improvement project. Encouragingly, Collaborative 5 got off to a tremendous start. Each team seemed to grasp the methods quickly and was able to move forward rapidly. As previously described, the teams brought baseline measures to the first learning event, which allowed them to focus in on their aim, measures and change ideas from the outset. They were also set homework to consult with the young people on their wards before their first 1:1 call the following week. This more grounded approach, coupled with very concrete expectations of teams yielded great successes. It is yet to be discovered whether teams from this collaborative are able to take this learning forward and apply it to other improvement challenges.

Key learning:	***Teams learn to use improvement methods more readily with a 'learn by doing' approach.***

Involving service users
Our department has a strong history of working with service users. Our CTG team includes a 0.2 WTE service user advisor. For various reasons the person undertaking the service user advisor role has changed several times throughout the course of the work. Whilst each new member has brought a different approach and perspective to the role, this has also caused some anxiety within the Team. As a role, it has taken some time to grasp from the advisor's point of view.

From the outset, we did what we could to encourage and support the teams in our external collaboratives to involve service users in their improvement activities. This included the following:

- including a chapter on best practice in working with service users as part of the introductory project management pack that we sent out to all of our teams before they started working with us;
- running sessions on the subject at the learning events;
- ensuring that our service user participated in all events and teleconferences, where possible;
- offering on-site visits by our service user advisor.

Our efforts were, however, largely unsuccessful. On reflection, we believe that we were asking too much of our teams. Many teams struggled to grapple with the complexity of the Model (as we taught it in the early collaboratives), so they simply found the idea of involving service users 'one hurdle too many!' It is fair to say that this was further hampered by our own fears. Although we encouraged teams to bring service users along to learning events, we were concerned that the highly technical nature of subject matter for the first learning event (as evidenced by the multitude of PowerPoint slides) might prove off-putting for them. We therefore broke the first cardinal rule of user involvement i.e. involve people from the start (and therefore avoid tokenism).

With the benefit of hindsight, it is clear that service user involvement must be approached on a case-by-case basis, depending on the subject and focus of the improvement work. With a more systematic approach, the extent of involvement that is **required**, and its actual **feasibility** for the service(s) involved can be understood by all concerned – i.e. the CTG team and the participating

teams - before the work begins. This approach allows time for necessary supports to be put in place before the work begins and for expectations to be managed accordingly.

Again, this is something we have been able to address with our most recent collaborative (5) which worked on improving young people's satisfaction with food on the ward. Although young people were not able not attend the first learning event, the requirement to both consider **how** they would be involved in each aspect of the activity, and to report back on their subsequent **consultations** with them, were made an intrinsic part of the early project set-up and its associated paperwork. The results have been astoundingly powerful and moving, with teams not only achieving high levels of involvement, but also attributing substantial changes in the relationship between staff and young people to the improvement work. Clearly, the approach with the Collaborative 5 has demonstrated ways in which service user involvement can be achieved with resounding success. This is summarised in the following brief vignettes.

Team A involved their young people in the improvement work in a number of ways including classroom surveys about their views and experiences of snacks on the ward, and getting them involved in choosing and buying snacks, and designing 'healthy eating' posters. As well as impacting on satisfaction with snacks, the ward team reported improved ward atmosphere and a greater sense of co-operation both between the young people themselves, and between the staff on the ward and the young people. They linked this to having actively involved the young people in the innately nurturing subject of improving their satisfaction with snacks.

Team B began by asking the young people to help them to generate a series of questions that they felt related to their satisfaction with meals on the ward that could be used as an ongoing survey tool (see Figs 1 & 2, below). This led on to the young people designing templates for the survey tool. As a consequence of the hard work of the project team, improvements were rapid and in response to this, the young people wrote a letter to the catering manager thanking her for her efforts (see Fig 3, below). As well as improving satisfaction with meals, staff reported a similar sense of improved co-operation to that of Team A, and a much improved experience of mealtimes - which had previously be fraught and stressful for all concerned!

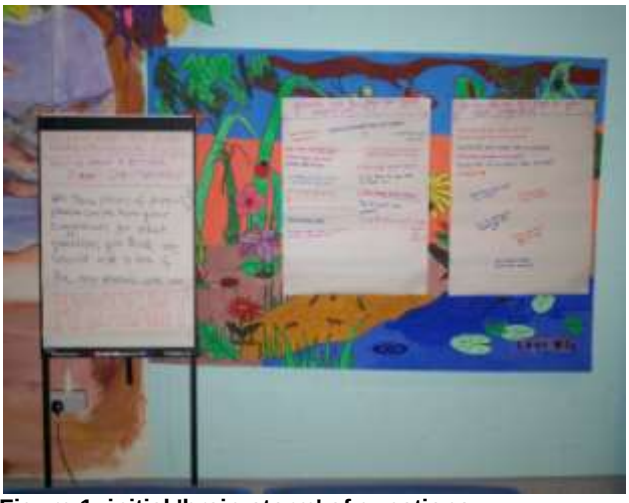

Figure 1: initial 'brain-storm' of questions

Figure 2: choosing which questions to use

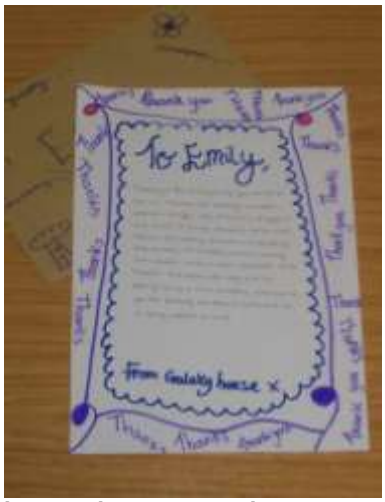

Figure 3: letter to catering manager

Key learning:	***If you want teams to fully involve service users in their improvement work, this needs to be made explicit from the outset, integrated into the project planning materials, and reviewed with them on an on-going basis.***

On-going supports

At the end of each 10-month programme of work, the teams within each collaborative were asked for feedback about various aspects of the content and delivery of the project (Appendix 3). The learning from this feedback was used to refine our ways of working with teams.

Learning events: the feedback we received was favourable:

"Learning events were really good – when we were struggling it's very comforting to know others were in same position. Good for clarifying what we would do next."

"Valuable reflective space in learning events to analyse results, identify challenges and plan future strategies to improve results."

"The support has been fantastic – I left the learning events inspired and enthusiastic."

Teleconferences: having group calls did not work for all of our teams as one participant explained:

"Teleconferences very difficult when in a shared office."

We were able to offer alternatives. One geographically dispersed team chose to have a group call with just their team members. Another found it hard to commit to joining a group call at a specified time so opted to provide weekly email progress updates which the CTG team commented on.

In general, teams were anxious about venturing into the world of 'improvement science' and valued active one-to-one support and encouragement, as these comments reflect:

"The questioning and monthly contact from the team kept the impetus going."

"Very worthwhile and useful. We would have got there ourselves I think, but not so fast or with such confidence. But – Lau Tse did say that the best leaders are those whose followers say that they got there by themselves!"

"We opted out of the teleconferences – but Maureen offered consultation to the team….she

was flexible, encouraging, able to facilitate discussion allowing us to come up with ideas but had stuff she could pop in if we were flagging."

" ...what was so important was the support in helping us work out how to do it ..."

"They were brilliant…..their styles of the facilitation…constantly reassured people….very positive….we were so fortunate in this….a constant sense of positive, supportive message….but not nicey-nicey, they were challenging but in a facilitative way…and they kept their promises…there was a very mutual feeling and very respectful."

"Maureen and Sam's role was about leading us without leading us; supporting us to do it ourselves. They kept us in the safe path and nudged us when we needed it."

Key learning:	***Opportunities to get together at learning events are highly valued, as are 1:1 visits. Group teleconferences meet with a mixed response. We are still exploring different ways of keeping in touch with teams so that teams feel supported.***

Questions 2: What does a service/team need to have in place if it intends to undertake a successful improvement project?

It has become clear from our work-to-date that the likely success of an improvement project is strongly influenced by factors associated with the service's context and culture.

Reconfiguration: it barely needs to be stated that significant organisational change, as experienced by many of our teams, will hamper even the most enthusiastic team, as this participant explained:

"We should have considered what else was happening within our service at the time – significant change in the service structure, staff moves and other projects running concurrently significantly impacted on our ability to achieve CTG. It might not have been the best time for us to try and take on another project."

In spite of our initial visits to teams where we explained the requirements of participation, it would appear that a lot of change (or maybe its impact) cannot be predicted!

Key learning:	***Teams facing major change should be advised to delay starting their first improvement project as an unsuccessful experience would be likely to hamper their involvement in any future work.***

A cohesive team: well-established teams with members who are known to each other were able to bypass the time and energy-consuming stages of team building. This made it much easier for them to agree their aim, organise themselves (including sharing tasks), and communicate effectively. In turn, this meant they were able to see progress more quickly beyond the initial period of fear and doubt experienced by many teams, as this participant explained:

"My team were getting excited…… without the team it couldn't have happened."

Conversely, instability amongst the team membership came with a high price:

"The core team continually changing led to communication problems and confusion about the Model and what we were trying to achieve."

Key learning:	***Where a team is not well-established, additional 'pre-work' may need to be done to ensure cohesion among the team so that the improvement work gets off to a good start.***

No blame: as previously noted, the extent to which team members are accustomed to being empowered to try out new ideas and perhaps even 'fail' (though the Model would always suggest that there is no such thing).

Key learning:	***Where a team is not well-established, additional 'pre-work' may need to be done to ensure that all team members understand the nature of improvement work.***

Visible support for senior management: while it seems imperative that the topic for the improvement activity is owned by the team, it is also vital that the team has strong connections to its senior management team. This was echoed in the feedback from our evaluations with teams. When asked what they would do differently, these were some of their reflections:

"Wider involvement from trust management at the outset."

"Ensure senior management professionals involved throughout supporting the project."

"Establish communication systems to higher management so that they understood the positive spin off for them and so they asked us to report on progress – make us more likely to stick with it."

There are many possible benefits of involving senior management. Not only can it enhance the chances that the improvement work will be successful, it can boost the morale of the hard-working project team and even protect the team from impending service cuts, as these quotes reveal:

"It's grown by word of mouth….we were invited to present at the Executive meeting at the end of year."

"...the Service Director was impressed which is important because it reduces the chance of them cutting us."

One particular example of good practice was where the day-to-day leadership of the improvement work was overseen by the local manager, in this case the ward manager, but the project team included a senior colleague who had active links to a receptive audience of senior colleagues. This approach was particularly effective when the local manager went on maternity leave and the senior colleague was able to ensure that the team members were supported to complete their work. However, less regular but well-timed senior input can be equally valuable, as this quote shows:

"... it's now a good working group that has ensured regular communication. This was very much in consciousness of the Service Manager - who was involved in the first meeting - and more senior managers were also involved."

Key learning:	***It may be advisable to ask for written support from the senior management team before allowing a team to engage in an improvement project e.g. a 'declaration of understanding' that details the expectations on both sides.***

Clear communication: the most successful teams met regularly but did not necessarily expect everyone to attend each meeting; minutes and action points were made easily accessible to all team members. This engendered a greater sense of continuity and shared responsibility and stopped the teams from losing momentum.

Key learning:	***Where a team does not have well established communication systems, additional 'pre-work' may need to be done to ensure that the improvement work gets off to a good start.***

Everybody's business: there is a tendency for new initiatives in healthcare to be seen as 'someone's project' – which can alienate colleagues. Teams that were able to effect the greatest improvements took steps to inform and update the rest of the team with the work. A good idea used by one team was to appoint 'champions' – individuals who showed a strong interest in the topic and were willing to work to enthuse and involve others.

Key learning:	***Review team membership at regular intervals to ensure all key personnel are involved.***

Resources: it perhaps goes without saying, but many services are finding it harder to find monies to cover travel and accommodation costs for staff to attend external events. With Collaborative 5, this resulted in us having to postpone the second learning event.

Key learning:	***Plan dates of events well in advance and encourage teams to book advance travel OR go to them.***

5 Resources to share

Attached to this report, are resources that we have developed and used with the teams in our collaboratives:

a. CTG Project leaflet
b. CTG information sheet issued to interested services
c. Example of a Project Management Pack
d. Example of recruitment presentation (given at initial meetings with teams)
e. Slide sets from Collaborative 1 (Learning events 1 -4)
f. Slides sets from Collaborative 3 (Learning events 1-4)
g. Slide sets from Collaborative 5 (Learning events 1 + 2)
h. Sample Charter form
i. Sample PDSA forms
j. Sample record sheet & action planning sheets
k. Draft improvement workbook

6. Plans for Sustainability

It has been our experience that teaching teams how to undertake an improvement project is far from straightforward. It is also labour intensive, both for the improvement advisers and the teams themselves. For this reason, the issue of 'sustainability' is of great importance i.e. do the 'ends' justify the 'means'. We have been attempting to explore three aspects of sustainability:

1. in relation to the chosen topic and associated aim, i.e. the extent to which teams maintain or improve on the gains made whilst working with us;
2. in relation to the on-going engagement of individual team members in improvement activities, i.e. the extent to which they apply the methodologies to new topics, and;
3. in relation to the organisational learning about improvement methodologies, i.e. the extent to which the new approaches are 'spread' to other colleagues, teams, or parts of the service.

Our work-to-date has allowed us to explore aspects 1 and 2: the topic for each of the first four collaboratives was chosen by the relevant CCQI staff team based upon their experiences of running the networks. An invitation was sent out to interested teams who, taking advice from the project management pack, formed their local project team to take the work forward; consequently, teams were generally made up of people who had a very close interest in the chosen topic. As previously noted, participants from each collaborative were surveyed at the end of the 10-month period about their experiences of taking part. This survey included questions relating to *predicted* sustainability (Appendix 3). Here are some positive reflections about the sustainability of the work:

> *"I think the changes made are more likely to remain in place than results of RPIWs from LEAN work because the process is more incremental."*
>
> *"PDSAs and the Model for Improvement are now an everyday part of my work."*
>
> *"A fantastic experience that has taught me new methods that I will share with others including students."*

We are attempting to keep in touch with our teams to follow-up their experiences of *actual* sustainability and spread. We predict that some will achieve sustainability of the first type and there will be localised examples of the second. Feedback will be contained in our final report later this summer.

We believe that all three aspects of sustainability are important and suspect that in the current 'cash-strapped' NHS, attainment of the first type alone may not be sufficient. In order to explore aspect three, over the concluding months of the project, we will be undertaking new work programmes with the senior management team of two organisations: a large mental health trust, and a women's centre. It is hoped that we can work with them to test the hypothesis that a 'top-down approach', coupled with 'bottom-up' engagement by clinical teams, leads to greater sustainability across the board. This prediction is founded on an early observation that the application of the Model in the US is often 'top-down', driven through private healthcare systems by direct or indirect financial incentives. We would hope to be able to test the impact of coupling this approach with our learning-to-date about what we need to provide to allow teams to learn how to undertake successful improvement work**.**

7 Plans for Spread

7.1 Explain your plans for spreading the learning and outputs of this project.

The CCQI has agreed to provide top-up funding for the CTG team until the end of 2012. During this time, we will be required to generate income to supplement our costs. It is therefore vital that we are able to distil approaches to working that are not only cost effective to deliver, but are attractive to our potential 'customers' – the aforementioned cash-strapped NHS.

At this stage, we are envisaging that we have two 'audiences' for our programmes of work:

- front line clinicians – to support improvement around specific clinical areas;
- senior managers – to support improvement around corporate priorities.

Two 'packages' of training and supports are being developed:

Package 1 • **Aim: to skill individuals to lead improvements in circumspect areas of clinical practice.** • **Target audience: clinicians who are in a position to lead a small project to improve an area of clinical practice.**
Stage 1: Acquisition of basic improvement knowledge and skills • **Length:** 6 weeks

- **Topic:** simple, non-clinical, and within their control e.g. improvement of the running of a regular meeting
- **Teaching methods:** pre-work; learning event at beginning and end; interim reporting by trainee; weekly 1:1 contact via 'phone/email.
- **Learning objectives:** an understanding of improvement process undertaken, achievements made, and challenges faced.

Stage 2: Supported management of improvement project

- **Length:** 12/16 weeks.
- **Topic:** owned by identified lead but with (1) evidenced support of associated local project team, and (2) ability to make changes and have links with management to support changes requiring additional resources.
- **Teaching methods:** pre-work; visits to clinician and their team at beginning and end; interim reporting by trainee; weekly/fortnightly 1:1 contact via 'phone/email.
- **Learning objectives:** ability to formulate a Charter, support delivery of ongoing progress measures, co-ordinate the testing of changes, motivate and trouble-shoot on behalf of the team. In short, we would expect participants to be confident to act as the improvement adviser to future clinical projects within their teams and, hopefully, beyond.

Package 2

- **Aim: to skill individuals to lead improvements in line with organisational priorities.**
- **Target audience: senior managers who have the support of their organisations to dedicate time to developing their improvement knowledge and skills with the aim of becoming recognised and equipped to lead programmes to address organisational challenges and threats.**

Stages 1 & 2 would be run, as described above.

Stage 3: Supported application of new skills to a top-down organisational improvement project

- Length: 15-26 weeks
- Topic selected by the senior management team.
- Teaching methods: pre-work; visits to improvement adviser and their team at beginning, mid-point, and end; interim reporting by improvement adviser; weekly/fortnightly 1:1 contact via 'phone/email.
- Learning objectives: as for Stage 2, with the addition of being able to direct implementation and spread from any improvement work.

7.2 How are you going to promote your innovation and convince others of its value?

Firstly, as part of our package of supports, we have asked our leadership development consultant to undertake an external evaluation of the impact of our work. This is generating very positive feedback, some of which has been quoted in this report. We have also gathered feedback from each team at the end of their work with us and are following this up with a 6-month follow-up survey. Already, we have evidence of the effectiveness of our interventions and we expect this body of evidence to grow.

Secondly, the CCQI has active links with the members of its many networks through a number of media including email discussion groups and project newsletters – both of which offer excellent channels for communicating the successes of our teams. Indeed, already an article by one of our teams has featured in the network's newsletter (Appendix 4), and another has presented their achievements at a recent network conference (Appendix 5). Beyond the immediate confines of the CCQI, word about the success of the methods has also been shared through a journal article by the service user expert on one of our teams (Appendix 6).

We would aim to recruit participants for 'Package 1' through our internal networks. Given that stage 1 of the package is non-clinical, and stage 2 is delivered on a one-to-one basis, we envisage opening up the stage 1 training to all of our networks. More thought and discussions with our new pilot organisations is required to determine best ways of recruiting services into the more intensive 'Package 2'.

7.3 What advice would you give to someone attempting to replicate your work in another organisation / setting?

Our team began the work feeling very exposed: improvement work is a relatively new activity in this country and there is limited expertise upon which to draw. It might have been helpful if key project staff from all of the teams had been given an induction in improvement methodologies by the IHI Fellows and/or LDCs at an early stage.

With the benefit of hindsight, our initial, timetabled plan to work with four collaboratives was flawed on two accounts:

- We did not have the capacity to deliver sufficiently intensive supports to four overlapping collaboratives where each team was effectively working on its own project;
- Because of the requirement to carry out the work over two years, we had to carefully pre-plan the timetable for the collaboratives. This made it difficult to make substantial changes to our programme of work once it had started, making it hard to take full advantage of our on-going learning. Fortunately, because we are based in the CCQI, we have been able to quickly engage new teams to help us test new changes.

Beyond this, specific reference can be made to the key learning identified in section 4.3/4.4, above.

7.4 What do you see as the main challenges to the future spread of your work?

There are two main challenges for our team:

1. Being able to cost the programme at a level that is affordable to Trusts but at the same time covers the costs of the intensive support packages;
2. Finding ways of marketing the work to senior executives that target the approaches as providing solutions to organisational imperatives, rather than what might be perceived as 'icing on the cake' 'improvement'.

8 Return on investment

8.1 Can you estimate the cost of the intervention and the benefits accrued?

We discussed this with the IHI fellows and Springfield Consultancy and agreed that our multi-topic, multi-collaborative made this impossible i.e. getting retrospective agreement from each of our participating teams to engage their finance departments to work alongside them to furnish us with data that would allow us to assess the health economic benefits of each of the interventions.

From the perspective of the individual collaboratives and the teams within each, this has been highly variable. While for some, there have been very tangible cost savings e.g. associated with a significant reduction in bed usage. For others, the benefits have been experienced in terms of culture change, as one senior manager explained:

> *"It reminded staff why (ward-based) activity is so important…the measures are hard to prove but people don't abscond, they don't fight …..I'm convinced we've had less incidents. More happy staff and happy patients."*

For others, it was the unintended consequences that had the greatest impact, as described in the two vignettes from Collaborative 5.

8.2 What have been the cost implications to your work?

In short, our learning has been huge and is already having a considerable impact on the way that our department works and thinks about the work it does.

We are getting close to defining a way to take this work forward into the future. The iterative nature of our work over the last two years has allowed us to develop our thinking and test our emergent ideas. We have a high degree of belief that our 'packages' will be highly attractive to the NHS.

It has to be said that the task of driving forward improvement work in the NHS has been fraught with challenges. By the nature of the subject, you are being asked to focus in on problematic areas. This often requires participants to step outside of their comfort zones. Teams and individuals that undertake this type of work require a high level of support and encouragement – especially in the early stages. They also seem to respond well to a high degree of structure and direction. As an improvement advisor, it goes without saying that you are expected to carry a significant body of technical knowledge about improvement science. However, this is not enough. You need to be conversant in the subject matter so that you can not only understand the issues that teams are facing, but if necessary are able to prompt them with ideas or suggestions when they 'get stuck'. This is particularly the case in the early days of the work when teams are struggling to identify the best 'measures' for their work.

8.3 What were the main difficulties you encountered in identifying cost and benefits of your work?

In our discussions with Springfield, we fully recognised the merit of being able to advise potential customers about the relative cost benefit of participation in a 'closing the gap' project. However, this ties in with earlier discussions about sustainability: we still need to establish what evidence would be needed to convince an organisation that it should invest in learning about improvement i.e. evidence that it will return benefits in relation to one specific topic, or evidence that it will develop capacity to undertake improvement work per se. In essence – ***do they want to 'close a gap', or 'close the gap'?*** This difference is expressed in the distinction between 'Package 1' and 'Package 2'. With the former, we are confident that we have sufficient 'evidence' and access to potential (clinical) participants to take this forward. However, we believe that it is Package 2 – which takes participants into the domain of organisational threats and challenges – that will prove more sustainable. It is vital therefore that we further explore how to 'sell' this approach to senior managers.

9 Conclusions

Our work-to-date has delivered mixed results – with many teams achieving huge improvements, while a few dropped out at an early stage! This has provided us with a rich body of ideas to test.

Our learning throughout has been vast and although we have been able to develop many of the theories to the stage that we are ready to implement them – in particular the launching of Package 1 – significant work remains to be done to explore best ways of winning the support (and money) from senior managers to invest in Package 2. This will be covered in our final report.