The Health Foundation
Inspiring Improvement

Building the foundations for improvement

How five UK trusts built quality improvement capability at scale within their organisations

Bryan Jones and Tricia Woodhead

Learning report

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Acknowledgements

The authors of this report are Tricia Woodhead, a Health Foundation Quality Improvement Fellow, and Bryan Jones, Policy Manager at the Health Foundation.

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1 Introduction

The extent to which the NHS has kept abreast of the latest medical and technological advances and trends in health care needs is testament to the commitment the workforce has for continuing professional development. Few other industries can match this capacity for continual learning. However, with the increasing complexity of modern health care, high quality care is less a product of one-to-one clinician–patient interactions and more the outcome of multiple decisions and interventions across many care settings and teams. In this context, it is no longer enough for clinicians to be equipped with specialist medical knowledge; they also need to have the knowledge and skills necessary to improve the quality of care and to work safely and effectively, as part of a team and across the health care system.

Research suggests that a lack of these knowledge and skills among clinicians and managers is a significant barrier to improving quality in health care.[1] Yet in England there is still not a critical mass of staff able to understand and use formal quality improvement (QI) methods and tools.[2] For example, while most clinicians will know about clinical audit and peer review, many are still unfamiliar with organisational or industrial quality improvement approaches such as Lean or PDSA cycles.[3]

Finding a way of developing these quality improvement skills of frontline staff, at scale, has preoccupied policy makers since the turn of the millennium.[4] Over that time various national improvement bodies and quality and safety improvement collaboratives have come and gone. Some of these national collaboratives achieved real impact.[5] But sustaining this success over time, and building on the skills and expertise created, has proved to be more difficult.

The NHS five year forward view is the latest policy document to look at how to equip the NHS workforce with the right 'skills, values and behaviours' to drive improvement and the delivery of new models of care at scale.[6] It sees the 'fragmented and unfocused' state of the NHS improvement infrastructure in England as a major impediment to the type, extent and pace of change now needed. But while there is undoubtedly a case for reviewing the 'improvement landscape' at national and regional level, policy makers might do well to look more locally for inspiration and examples.

However, there are a number of health and social care providers, across the UK, that have succeeded in building, and then sustaining, improvement capability at scale within their ranks over the past decade. This capability has enabled them to deliver real improvements in care in multiple areas.[7] Policy makers and other providers might examine how and why these organisations have achieved the progress they have. The priority then should be to create an environment in which

1 De Silva, D. *Quality improvement training for healthcare professionals*. The Health Foundation, 2012.

2 Boaden R et al. *Quality improvement theory and practice in healthcare*. NHS Institute for Innovation and Improvement, 2008.

3 For an explanation of these approaches, see the Health Foundation guide, *Quality improvement made simple*. www.health.org.uk/qimadesimple

4 Department of Health. *The NHS Plan*. Department of Health, 2000.

5 De Silva, D. *Improvement collaboratives in health care*. The Health Foundation, 2014.

6 NHS England. *The NHS five year forward view*. NHS England, 2014.

7 Woodhead T, *et al*. From harm to hope and purposeful action: what could we do after Francis? *BMJ Qual Saf*; 23: 619–623, 2014.

other organisations have the time, space and support necessary to put in place capability building programmes of their own.

This report, which examines the improvement capability building approaches taken by five health and social care trusts across the UK, has been produced, in part, with this purpose in mind. Improvement capability refers to an approach aimed at encouraging and enabling staff to develop and deploy the skills, tools and knowledge necessary to improve the quality and safety of the care they provide.

The report provides an insight into how and why the trusts embarked on their improvement journeys; the steps they took at each stage; the impact they achieved; and the challenges they encountered along the way. We hope that these case studies, together with our report on how to achieve change in the NHS,[8] will provide policy makers nationally and other providers locally with some of the evidence and ideas they need to create an environment which is conducive to driving and sustaining quality improvement.

With evidence showing that quality improvement can improve patient experience and outcomes – and bring financial and productivity benefits for an organisation[9] – there is an appetite among many trust senior executives and non-executives to invest in capability building programmes. These case studies, will, we hope, provide an additional tool to help them decide how to proceed and what steps they take at each point.

While the case studies each demonstrate the path the trusts have taken, and can all point to impact, hard evidence on impact is not, in every case, listed. This may be because clinical teams in the trusts concerned do not document the myriad of changes tested and seen. It may also be that trusts feel that investment in third party evaluation of initiatives is an investment too far. It is also the case that many improvements are tested in small steps then adapted over time, making evaluation highly challenging. Whatever the reason, a current challenge is to develop a much harder evidence base for the use of quality improvement techniques. This is beyond the scope of this report, but will be addressed by the Health Foundation in the future.

The case studies feature NHS trusts, and not general practices. If new models of care are to be accelerated, then there is a pressing need to consider how capability in quality improvement might be developed quickly in primary care. This will be the subject of further work at the Health Foundation.

Meanwhile, more trusts are developing system-wide quality improvement capability programmes, and more royal colleges and medical schools are beginning to introduce quality improvement skills into their curricula. The Health Foundation has a long track record in funding projects and fellowships for individuals to boost understanding and use of quality improvement techniques and will continue to do so in future. A list of relevant Health Foundation programmes and publications is available in annex 1; annex 3 lists other organisations that may be useful sources of support. NHS England is also committed to developing capability in quality improvement in clinical care, not least through the NHS Improving Quality facility and the co-funding of an initiative with the Health Foundation to develop '5,000 safety fellows'.

There has been no explicit strategy for building quality improvement skills at the frontline across England, as suggested recently by the report *A promise to learn – a commitment to act*, by the National Advisory Group on the Safety of Patients in England, led by Don Berwick.[10] Given the need not only to accelerate improvement in the safety of care, but also in its efficiency as set out in *The NHS five year forward view*, perhaps the time for such an explicit strategy has now come.

8 Allcock C, Dormon F, Taunt R, Dixon J. *Constructive comfort: accelerating successful change in the NHS and how national bodies can help*. The Health Foundation, 2015.

9 Ovretveit J. *Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers.* The Health Foundation, 2009.

10 National Advisory Group on the Safety of Patients in England, A promise to learn – a commitment to act: Improving the Safety of Patients in England, 2013.

2 Our approach

In this report, we look at five organisations of varying sizes and remits which have well-developed, or developing, methods for using quality improvement techniques in frontline care. The case studies range from large acute trusts in metropolitan areas, an acute mental health care provider, an integrated health and social care provider and an acute trust serving a largely rural population. The trusts are also at different stages of their journeys: one (Royal Devon and Exeter NHS Foundation Trust) began to build up its improvement capability in a systematic way over a decade ago, while another (East London NHS Foundation Trust) has only recently started.

To inform the report, 35 staff members from the five trusts were interviewed in December 2014. We sought to interview staff actively involved in managing and delivering the trusts' improvement capability building programmes, as well as members of their executive teams. In the case of three trusts, staff were also interviewed who have received training through their capability building programmes. A full list of interviewees is set out in annex 2.

We used the interviews to elicit why each trust decided to develop its programme; what it aimed to achieve through it; and what expertise and resources it was able to call upon at the start of its journey. We also asked some detailed questions about how they designed and implemented their programmes; what impact they have achieved to date; and how they engaged key internal and external stakeholders. Just as importantly, we asked people to describe the obstacles and challenges they have encountered and to reflect on what they could have done differently.

Table 1: Key statistics about the five case study trusts

	East London NHS Foundation Trust	Royal Devon and Exeter NHS Foundation Trust	Salford NHS Foundation Trust	Sheffield Teaching Hospitals NHS Foundation Trust	South Eastern Health and Social Care Trust
Main areas of activity	Mental health Community	Acute	Acute Community	Acute Community	Acute Community Social care
Size of workforce	3,700	7,000	6,000	16,000	10,000
Annual income	£250m	£370m	£475m	£1bn	£500m
Year achieved Foundation Trust status	2007	2004	2006	2004	N/A
Start of quality improvement programme	2014	2003	2008	2008	2011

3 Key lessons

In this section we set out some key lessons from the case studies aimed at provider organisations that are considering building improvement capability at scale. We also suggest lessons for commissioners and leaders of national arm's length bodies.

Getting early board-level support is essential for any provider organisation considering building improvement capability at scale

Without the active and visible support of the board, it is extremely difficult to put in place an organisation-wide improvement capability building programme. As well as unlocking the investment needed to fund the programme, board-level support is vital in helping to ensure that the programme and its goals are aligned with the rest of the organisation's corporate objectives.

For some of the trusts included in this report, board approval has been relatively straightforward to secure. Strong leadership from the start from the chief executive has often been the key to winning the board's support. Other trusts, however, have had to use different tactics to gain support from their board members. Taking boards to visit trusts which have already built improvement capability at scale – and can point to improved service outcomes as a result – is one such tactic. Of particular value have been board visits to trusts of a similar size which deliver the same type of services. Getting support from the finance director at an early stage, whose opinion often holds great sway among non-executive members of the board, has also helped some trusts to gain board approval.

It helps if board members, particularly non-executive members, also have an understanding of what quality improvement is and what it entails. While many non-executives have strong financial and accounting skills, very few have had experience of how to deliver and sustain improvement in a complex health care system. As such, taking the time to introduce non-executives to quality improvement methods, and the rationale behind them, at the start of their terms, is an approach which could yield important dividends further down the line.

Provider organisations need to think carefully about how they will fund improvement capability programmes

Building improvement capability at scale requires resources – not only the upfront costs of planning, developing and promoting a training programme and recruiting coaches and programme administrators, but also the recurrent costs of sustaining the programme over time.

Having said this, it is perfectly possible to set up an effective programme for a relatively modest cost. One such example is South Eastern Health and Social Care Trust's Safety Quality and Experience programme in Northern Ireland. The trust, whose financial room for manoeuvre is more restricted than foundation trusts in England, has designed, and largely delivered, its programme in-house. All of its improvement coaches and mentors and its programme coordinators have other day-to-day clinical or management responsibilities, so it hasn't had to recruit new staff or backfill existing positions. The trust's only significant outlay has been the purchase of licences to the Institute for Healthcare Improvement's (IHI) Open School[11] and the cost of paying for some programme graduates to attend conferences to showcase their projects and to cover their posts while they are away.

11 www.ihi.org/education/ihiopenschool/Pages/default.aspx

Others trusts, such as East London NHS Foundation Trust, have employed a central team to manage their programmes and provide coaching and support. In East London's case they have built up a team of seven, which includes an associate medical director, a head of quality improvement, three QI clinical fellows, a data analyst and a programme officer. However, aside from the cost of bringing in the IHI as an improvement partner, recruiting the team has been the main expense – and they have managed to cover some of it through funding from Health Education North Central and East London.

Provider organisations need to find ways of freeing up staff time to take part in training programmes

For a number of trusts, the biggest challenge they have faced has been in freeing up staff time to attend training sessions. Even in an organisation such as South Eastern Health and Social Care Trust, where there is strong support for the programme at every management level, it has proved difficult to get all participants to attend the monthly learning sessions. While the programme has become more and more popular each year, a small number of people have had to drop out because they haven't been able to balance their day-to-day commitments with their learning commitments.

With limited resources available to provide cover for staff while they are training, trusts have focused instead on making their programmes as flexible as possible and making the most of the time they have with staff. To minimise the amount of time staff have to take out from their day jobs, most trusts have tried to make some training content available online, or use video conferencing to remove the need for staff to travel. Delivering content through short lunchtime sessions is another tactic that has been used by trusts. Trusts have also worked hard to develop participants' meeting skills and encourage them to think about team dynamics, so that when they begin to deliver improvement projects they are able to make the best use of their time. Guest speakers have also been used to help reinforce participants' learning.

Commissioners need to do more to support organisations developing improvement capability building programmes

Commissioners need to think carefully about whether they are doing enough at present to support providers who want to invest in building improvement capability at scale within their workforce.

Few organisations which have gone on this journey can point to the overall return on investment they have achieved – although East London NHS Foundation Trust aims to do so – but they can all demonstrate impressive improvements in patient and service outcomes in a whole range of areas. East London NHS Foundation Trust, for instance, has already achieved a 20% organisation-wide cut in the level of inpatient violence; an issue previously seen as one of the most intractable in mental health services. Salford Royal NHS Foundation Trust, meanwhile, has delivered a 100% reduction in MRSA blood stream infections and a 90% reduction in *Clostridium difficile* (C.difficile) infections since the publication of its first quality improvement strategy in 2008. This success should encourage commissioners to be more generous in their support of this type of work.

Arm's length bodies need to give organisations the time and space to develop and embed their quality improvement programmes

System leaders in arm's length bodies, particularly those with regulatory roles, need to ensure that organisations developing quality improvement programmes have the time and space to do so. A number of trusts made the point to us that by investing in capability; focusing on quality and safety; and showing a constancy of purpose over time, they have managed to meet, and frequently exceed, their mandated targets. They also recognise though, that 'normal variation happens', and that there will be occasions, if the trusts are being honest and transparent about their performance, when their approach and methods will be subject to intense scrutiny. Staying true to their original intent can be difficult in such situations, especially if an executive team are still finding their feet, which is why trusts need breathing space.

4 Checklist for building improvement capability

Based on what the five trusts told us about their improvement journeys – and also about what they would do differently now if they had their time again – we have compiled a checklist of points for provider organisations to consider before planning, designing and delivering an improvement capability building programme.

However, there is clearly no one approach to building capability. There are lessons that provider organisations can learn from others, but each organisation needs a strategy that bears their particular stamp and is owned and supported by their workforce and service users. Before getting underway, organisations should also do an audit of the assets they already have so that they can make full use of the clinicians and teams with existing quality improvement and patient safety experience.

Testing the water

Before investing in an improvement capability building programme, four key foundations must be in place:

Financial and organisational stability – stability is essential in order to get a programme up and running successfully and ensure that the workforce is ready to engage with it. Any imminent reorganisation, change of leadership or pressing performance or financial challenge will make it almost impossible to gain and retain the attention of your staff.

Board and executive level support – getting the board, particularly the non-executive members, engaged and enthused about investing in improvement capability is critical. Visiting trusts with proven improvement track records and early support from the finance director can help to secure their buy-in.

Robust governance and performance structures – essential pre-requisites for any organisation are a sound quality assurance mechanism and an effective board committee structure. Moreover, adapting corporate processes to ensure that a focus on audit and assurance goes hand in hand with a focus on understanding variation and improving quality is important.

Some existing QI capability and/or a willingness to recruit an external improvement partner – in order to implement and sustain a capability building programme, an organisation must be able to call on people with established QI expertise and coaching skills. In the absence of such expertise internally, consideration must be given to working with an external partner.

Building the right foundations

Having decided that the right conditions are in place to invest in building improvement capability, the following points should be considered:

Develop an integrated approach to quality improvement – ensure there is a purpose for building capability and all strategic aims, structures, work-streams and performance management structures are aligned with the programme.

Make sure the approach reflects the culture and personality of the organisation – the values and vision of an organisation aspiring to continuous improvement need to be clearly articulated and visible at every level.

Put together a business case – How much will the programme cost? Where will the money come from? What approach will be taken? How will the impact be assessed? What return on investment is anticipated and how might one measure at least some of that return?

Establish a central improvement team – at the outset, form a central team to manage and promote the programme, teach QI skills and coach improvement teams. At least some of the team should know the organisation well and have the respect of clinicians and managers.

Spend time introducing quality improvement to the workforce and service users – do not assume that the organisation knows about QI and its potential benefits. Clearly set out the aims and objectives at the start. Make every effort to promote and describe the value that such a programme will provide to patients and staff. Involving clinical and middle management staff is important.

Engage the main external stakeholders – try to get the key commissioners, education providers and regulators involved early on and engage other providers in the local health economy.

Getting started

When developing the outline approach into a detailed strategy and action plan, consider the following:

Give training participants the chance to learn by doing – the evidence suggests that training programmes which include practical exercises and work-based activities are more likely to achieve positive changes in care processes and patient outcomes.[12] However, organisations have to ensure that training participants are part of an improvement team in their service or ward and are supported by their managers.

Ensure that the training content is appropriate for all participants – most existing QI methods and training programmes are geared towards the needs of acute clinical staff. If non-clinical or community or social care-based staff are involved, tailor the content accordingly.

Ensure that participants are given the time and space to take part in training – giving staff dedicated time to participate in training helps to keep the drop-out rate low and signals the organisation's support for quality improvement.

Combine classroom-based learning with access to online resources – aligning what staff see and hear during face-to-face learning sessions with appropriate online content will help to reinforce key messages.

Work with the QI enthusiasts first to gain some early wins – 'go where the energy is' and empower staff to focus on issues that really matter to them.

Focus at the start on QI methods and techniques that are really understood by the team – but make sure they are appropriate for the improvement challenges being addressed.

Once the programme is underway

Once the capability building programme is up and running, start to focus on the following:

Work with service managers at each level to align improvement activity with corporate goals – this will help to ensure the long-term sustainability of any improvement projects carried out by training participants.

Build up a network of training programme graduates to champion improvement and mentor future participants – this will help to create a QI community within the organisation, enable programme graduates to continue to learn from and support each other and remove the need for long-term reliance on the central QI team.

Build up knowledge of a range of different QI methods and techniques – avoid becoming tied to one approach in the long term; be able to use the right approach for each problem.

Evaluate the training offer regularly – where necessary, adjust the programme to meet the changing needs of the organisation.

Be honest and transparent about the process – publishing information online about how the organisation is building capability and the challenges it is addressing helps to encourage and inform other like-minded organisations.

12 De Silva, D. *Quality improvement training for healthcare professionals*. The Health Foundation, 2012.

Case studies

Case study: East London NHS Foundation Trust

Introduction

East London NHS Foundation Trust (East London) provides mental health services in Tower Hamlets, Hackney, Newham and the City of London – one of the most culturally and economically diverse areas in the UK. Since becoming a foundation trust in 2007, East London has also delivered community-based services in Newham and specialist mental health services in other parts of London and the Home Counties. The trust employs around 3,700 permanent staff, operates from 64 community and inpatient sites and has an annual income of more than £250m.

In February 2014, East London launched a trust-wide quality improvement programme, aimed at embedding continuous quality improvement at every level of the organisation. The QI programme aims to reduce harm by 30% every year; improve patient experience; and enable the trust to provide 'the highest quality mental and community care in England by 2020'. Building improvement capability within the organisation is a key aspect of the programme. A training programme allows staff to develop their QI skills over a six-month period through face-to-face and online training, and a live improvement project with support from QI coaches. Several hundred staff have already completed the programme and more than 100 current projects apply improvement methods, concepts and tools to complex quality issues. The trust has partnered with the Institute for Healthcare Improvement (IHI) to provide strategic guidance and support the capability building work.

Why did they start working on improvement?

East London's decision to develop a quality improvement programme was inspired to a large extent by two 'sentinel events':[13] an inpatient homicide followed shortly by an inpatient suicide. The events led the trust to question whether it had the right processes in place to deliver quality care. According to Jonathan Warren, Director of Nursing at the trust, *'We had been running an assurance-based quality programme… but we realised it really wasn't doing much apart from turning boxes green on board papers: for patient experience or staff experience it really wasn't very good.'*

The arrival of the trust's Medical Director, Kevin Cleary, who had been working at the National Patient Safety Agency, was another important catalyst. The trust was building up some quality improvement experience,[14] but Kevin Cleary made the case for a more coordinated and systematic trust-wide approach: '*[While at the NPSA] it struck home that you really needed to have a structured programme around quality improvement or else you weren't going to get anywhere.*'

13 A sentinel event is defined by The Joint Commission (TJC) as any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness.

14 East London was a participant in the Leading Improvement in Patient Safety Programme (LIPS) led by the Safer Care team at former NHS Institute for Innovation and Improvement.

What did they do?

Secured support from the board and executive team and built a broad coalition for change

Discussions about the programme began at board and executive level several years before its launch. The main driving force was Kevin Cleary, with Consultant Forensic Psychiatrist Amar Shah, who had an interest in QI, playing an informal but important role in building the momentum for change and developing the programme. Support, however, was slow to arrive. Many non-executive board members, in particular, were sceptical. It was only once they visited organisations that had successfully implemented QI at scale, such as Salford Royal NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Trust, another mental health provider, that they began to appreciate its potential. Getting the support of the finance director at an early stage also helped to assuage their concerns.

'Our finance director is a real convert: he got it really, really quickly and saw the potential for quality improvement and cost-effectiveness. He was a great champion, which was fabulously reassuring for many of the non-execs on the board: him saying, "I can't support this enough, we should invest the money" was a key moment.' – Jonathan Warren, Director of Nursing

As well as securing the buy-in of senior figures within the trust, Kevin Cleary and Amar Shah worked hard to build a coalition for change. They ran sessions with frontline staff in all services along with corporate staff, service users, commissioners and the council of governors, with a view to preparing people for the advent of a new approach to quality.

Built a business case

With support for the programme beginning to coalesce, work began on developing a strategy and business case for the board's approval – a process that proved equally challenging and time-consuming.

'The whole business case element is quite complex. It took six-to-nine months. We had to think about methodology; how we fund it; what investment is needed over time; and what cash-releasing activities it could support. If you're thinking about a whole organisational programme, it gets quite tough, particularly with few examples of large-scale improvement programmes in a similar context to ours.' – Amar Shah, Consultant Forensic Psychiatrist

As a healthy and financially solvent trust, East London was well-placed to embark on the programme. Nonetheless, the trust needed to identify savings in order to meet the upfront and year-on-year costs of delivering the programme over seven years. According to Amar Shah, *'We have chosen to invest in this work. This is a hard choice to make, but if you look at the longer term we do believe it will demonstrate value.'*

Recruited an improvement partner

A key step was bringing in an external partner with an established reputation for building improvement capability in a health care setting. At the NPSA, Kevin Cleary realised *'you probably couldn't do this by yourself: your staff didn't have the skills and you couldn't by yourself train up your staff or build the will around the organisation.'*

After visiting other organisations with QI programmes, it was felt that an IHI-type approach would be the best fit for East London. Jonathan Warren explained that when they visited organisations that focused on the QI approach Lean, *'I couldn't see the patient in there: I couldn't see how the work I'd valued as a nurse fitted in. But with the IHI, you start by thinking about patients and there's a focus on patient stories.'*

Persuading the board to support the appointment of the IHI proved a challenge, however. There was concern about engaging a partner from outside the UK, with experience mostly in acute health care environments. Support from the trust's chair was particularly important in helping to shift opinion.

As well as providing East London with strategic advice, the IHI works with the trust to build improvement capability. The IHI and the trust's QI team jointly deliver the six-month Improvement Science in Action training programme. This training is designed to allow participants to develop and run an improvement project[15] using the IHI's continuous improvement methodology.

Recruited a central quality improvement team

The trust began the process of building improvement capability by recruiting a central team to manage the programme and provide coaching and support. Three clinicians went on the one-year IHI improvement adviser course and five more will do the same in 2015. A team of seven is now in post, including an associate medical director, a head of quality improvement, three QI clinical fellows, a data analyst and a programme officer. The three QI clinical fellows are all graduates of the first wave of the training programme.

The team's clinical and organisational experience, and its youth, are seen as vital to its credibility and success. Jonathan Warren notes that their QI team *'is led by respected jobbing clinicians within the organisation who are already known for the work they do – they weren't external consultants',* while Kevin Cleary points out that the team works hard because it is *'young and enthusiastic: it's the youngest team in the organisation and that really does come across.'*

The trust is realistic about what a small central team can deliver. In the years ahead it aims to enable more coaching to be done locally rather than all support coming from the central team. A six-month programme has been set up to create and embed a cohort of improvement coaches within local services.

Built the will among staff

Following the launch of the programme in February 2014, the QI team spent the next five months raising awareness and support across the organisation through a QI microsite and a series of interactive roadshows, which reached around 1,000 people.

Interest in the training programme to date has been strong: 85 people signed up for the first wave of training and 150 joined the second cohort. The participants are volunteers, but there is an expectation that anyone in the trust with leadership aspirations should take part in the programme. Crucially, support has been consistent across the organisation. After tailoring the messages slightly for different staff audiences, most staff groups and sites have engaged in the programme in some way.

Aligned the organisation's structures, goals and activities with quality improvement work

A key aspect of East London's strategy is ensuring that the improvement programme is integrated into all the trust's directorate structures and operations and that there is alignment between the programme's goals and the rest of the trust's strategic goals.

To do this, the trust has split its corporate structure into an assurance arm and an improvement arm. The trust's board papers and quality report have also been changed to reflect the new focus on improvement. Unusually, QI is being applied to every part of the organisation: the HR team, communications team and even council of governors all have their own QI projects.

QI also features prominently in the trust's recruitment process and training and development programme for nurses, doctors and pharmacists. It is now part of the core curriculum for undergraduate nurses and every consultant appointed is expected to have an understanding of and commitment to QI.

Importantly, the trust has also started to align the QI projects with its local and system-wide goals. In order to build momentum and support, early participants were encouraged to pursue projects that mattered to them and their colleagues, rather than necessarily focusing on corporate priorities. In 2015, each improvement team is being asked to look at how they might align their project with four overarching priorities.

15 Each participant is expected to work with a wider team in planning and developing their improvement project and building support for their intervention within their microsystem or site.

'We had a great start, it was a real "let a hundred flowers bloom" approach, but you do have to shape the projects in some way without crushing people's ambitions to change difficult issues' – Kevin Cleary, Medical Director

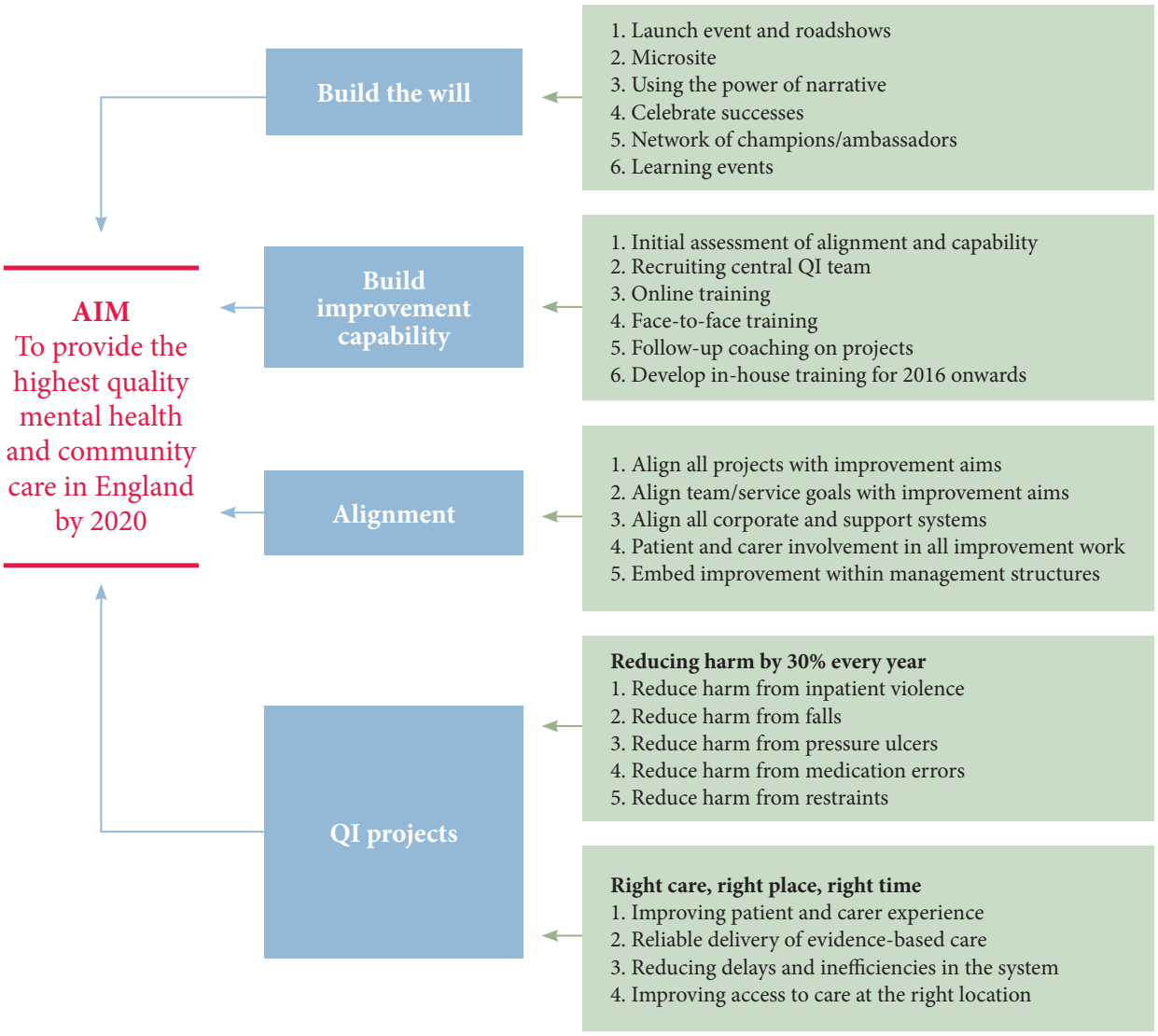
Responsibility for QI projects has now been devolved from the central QI team to each of the trust's locality management teams. This will enable them to align their local priorities and support structures around the improvement projects led by training programme participants, and in doing so increase the chances of sustaining their impact over time.

What impact have they made?

It is too soon for most of the trust's improvement projects to show any meaningful impact in terms of patient or service outcomes. However, two of the early QI projects undertaken by East London, which sought to address violence on adult and older adult wards, have delivered some remarkable results. The trust has succeeded in reducing violence across all 35 wards by around 20% through some relatively simple steps.

An improvement in staff survey scores on questions relating to people's ability to take decisions and influence change, coupled with the fact that the trust has been named as one of the top 10 health care employers in the UK, are also seen as examples of the positive impact of the QI programme.

Diagram 1: Driver diagram showing how the QI programme is being implemented



Advice for other organisations

- Ensure that the board is engaged with, and supportive of, the programme from the very start. Don't begin any work if there isn't stability at executive and board level or if the service is being restructured.
- Ensure that there is a sound quality assurance mechanism in place.
- Ensure that there is multi-year funding agreed upfront for the programme and be realistic about when there will be a financial return on the investment.
- Bring in an external partner to provide strategic advice and an independent view.
- Identify improvement champions and key opinion formers and use them to sell the message among their peers.
- Ensure that any capability building work is integrated into a wider improvement strategy. Building capacity without a clear plan of how to deploy it will undermine its impact and value.
- Show a constancy of purpose – having identified an improvement approach, highlight the long-term commitment to it and don't be distracted by short-term setbacks or criticism.
- Recruit a central team to coordinate the programme, but ensure that it is embedded in the organisation and has credibility with staff.
- Do not underestimate the amount of time and planning required in advance of the programme's launch.

Key components of East London NHS Foundation Trust's improvement training programme

- Pre-work: IHI Open School online modules; reading; and a one-hour conference call.
- Pre-training consultations to develop a QI project with the key elements for success (voice of the patient, team consensus, project team, protected time and alignment with operational priorities).
- Three days' face-to-face learning.
- Three follow-up conference calls with the whole group to share learning and build skills.
- Two whole-day learning sets (at one month and four months post-training) to present project progress and deepen improvement skills.
- Each QI project has a designated person from the QI team to help with methodology, and a senior sponsor from the local directorate to help break down barriers.
- Monthly QI forums in each locality for improvement teams and their sponsors to share learning and discuss challenges. There is a separate bi-monthly meeting for sponsors to support them in their role and ensure a standard approach.

Case study: Royal Devon and Exeter NHS Foundation Trust

Introduction

The Royal Devon and Exeter NHS Foundation Trust (RD&E) employs around 7,000 staff and provides acute hospital services to a patient population of more than 400,000 living in Exeter, East Devon and Mid-Devon. It also offers specialist services to people living further afield in Devon, Cornwall and the Isles of Scilly, Dorset and Somerset. RD&E has an annual budget of around £370m.

The trust has more than 800 beds at the Wonford and Heavitree hospital sites in Exeter. It admits more than 115,000 patients and holds 450,000 outpatient clinics a year. However, with many of its patients living in rural communities some distance from Exeter, the trust is now providing more of its care in the community. It has set up a mobile eye clinic, for example, which takes specialist care out to glaucoma patients in rural towns and oversees day case surgery activity in Devon community hospital theatres. As well as serving a dispersed rural population, RD&E also faces the challenge of ensuring that its services meet the needs of an area with a substantial and growing population of frail older people.

RD&E has a long history of quality improvement and capability building. Its journey began in 2003 when it took part along with other health and social care providers in north and east Devon in the IHI's Pursuing Perfection initiative,[16] which used QI methods to reduce unnecessary admissions and delayed discharges. In the following years, it became involved in a series of initiatives led by NHS Institute for Innovation and Improvement including the Leading Improvement in Patient Safety programme (LIPS) and the Productive Ward and Productive Theatre programme. The trust was also part of the NHS South West Patient Safety Collaborative and for the last few years has been a member of NHS QUEST.

The Connecting Care programme, which the trust launched in 2013/14, is designed to build on the collective knowhow and experience it has generated over the past decade. Drawing on improvement concepts from industry, but implemented in a way that is consistent with RD&E's culture and improvement experience, it aims to enable the organisation to address variation and standardise best practice.

Why did they start working on improvement?

RD&E's involvement in the Pursuing Perfection programme had an important influence on the way in which the trust perceived and approached quality improvement. It exposed the trust to a new way of collaborative working, using small tests of change, which was capable of delivering significant improvement in outcomes.

An early improvement success in the trust's radiology department helped to inspire interest in doing things differently. It showed that relatively simple changes – in this case scrapping a long-standing rule which dictated that all inpatients had to be taken to the radiology department in a bed – could have a big impact on patient care. This one change, suggested by a radiology porter, meant that porters could take double the number of people to the department in any one period. It also eliminated the need to spend money on creating a bigger bed storage area outside the department.

16 Kabcenell A, Nolan TW, Martin LA, Gill Y. *The pursuing perfection initiative: lessons on transforming health care.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement, 2010.

Nonetheless, RD&E has chosen, quite deliberately, not to develop a specific quality or safety strategy. It has focused instead over the past 12 years on embedding quality and safety into everyday practice, an approach which has been largely instigated and driven by the trust's long-standing Chief Executive, Angela Pedder.

'Having a separate strategy for quality and safety puts them into a silo. The approach we've tried to take from the start – it sounds clichéd, I know – is that quality and safety are everyone's business. You get good quality and safety if you drive behaviours and the business so that it becomes "the way we do things here" and a normal part of the work.' – Angela Pedder, Chief Executive

To make this possible, RD&E has sought to build improvement capability across the organisation.

What did they do?

Ensured consistency of approach over time

RD&E's improvement approach has evolved over time, but the trust works hard to ensure that each new tool or concept brought into the organisation builds on its existing approach, and that there is a consistent thread running through all its work. The ideas that the consultancy Unipart Expert Practices[17] has introduced to RD&E, for example, through its involvement in the Ward Management Programme, which has grown into the Connecting Care programme, are designed to overlay the trust's existing culture, rather than the other way around.

Having had the same chief executive in post for 18 years, a stable executive team and a low turnover rate among its staff, RD&E is well-placed to ensure consistency over time and to guard against the loss of corporate experience and knowledge. Chief Nurse and Chief Operating Officer, Em Wilkinson-Brice highlights a key benefit of this consistency:

'There's any number of things which ping into your inbox, but what Angela's provided is that real focused intent on the journey so that you don't get distracted by the latest thing that might be in vogue.'

The aim is to have an organisation which works according to a steady, consistent *'beat of the drum'*, as Pedder describes it.

Embedded service improvement methodology into the organisation

Over the past 12 years, RD&E has sought to embed improvement techniques into teams across the organisation and ensure that staff are able to speak a common improvement language. These tools and techniques have become an intrinsic part of the training and development package that the trust provides to its staff, although they are not often labelled as QI tools, per se. *'If you come into this organisation and ask people about PDSA cycles, some of them will probably say "what's that?" but they'll be able to describe to you how they've used it, how it works and the changes they've introduced on their own wards,'* Pedder explains.

The trust's initial focus was on developing the improvement capability of its senior clinical staff. Through the Connecting Care programme, however, these tools and techniques are now being taught and used more widely: since the start of 2014, more than 1,000 members of staff at all levels, both clinical and non-clinical, have received training to continuously improve as part of their daily work. *'We want everybody to feel that they have the opportunity to solve problems and improve the things that they see every day,'* says Head of Service Development, Martin Smith.

In line with the ethos of continuous improvement, the trust has used feedback from Connecting Care participants to refine its implementation approach over time.

17 www.unipartconsulting.com/sectors/healthcare/

Some of the matrons involved in the programme, for example, found it difficult to come to terms with certain aspects of the Unipart approach and decided therefore to set up their own forum to discuss how they wanted to make changes.

Gave frontline teams the power to solve problems

An important driver behind the launch of the Connecting Care programme was to give teams at ward and department level the opportunity to identify problems and then develop their own solutions to them.

There is also an explicit multidisciplinary focus to the programme. The improvement work taking place at ward-level involves physiotherapists, nurses, junior doctors, housekeepers and ward clerks. They, in turn, are supported and advised by a range of senior nursing and medical staff within the organisation.

Promoted a culture of honesty and transparency

RD&E has worked hard in recent times to foster a culture of honesty and transparency. Staff are actively encouraged through the Connecting Care programme to 'surface problems' and ensure that nothing is hidden from view. Evidence that such an attitude is becoming embedded into the organisation is now mounting. *'We had a blip with pressure ulcers about 18 months ago,'* says Em Wilkinson-Brice, *'and the matrons formed themselves into a task and finish group because they were really horrified, and for me that was a real measure that something had fundamentally changed. It was an attitude of "we've got to solve this" and it was a really action-orientated approach.'*

What impact have they made?

One of the most telling examples of the impact that RD&E's focus on continuous quality improvement has had on its staff comes from its staff survey. This found that while staff are very positive about working for the trust, they are less satisfied with the quality of care they are delivering. The trust sees this as a consequence, in part, of the improvement culture it has been trying to instil, with its focus on empowering staff to surface problems and tackle variation: *'When you unpack these results with people,'* Pedder says, *'it's because they are aspiring for quality to be better.'*

Encouraging wards and departments, meanwhile, to be upfront and honest with the public about their priorities for improvement and why they are needed has begun to change the way in which staff interact with patients.

The emphasis in the Connecting Care programme on multidisciplinary team-based working and local ownership of improvement work is also having a positive impact on service outcomes.

'I think one of the keys to our success is how we work in teams. If I think about the pressure ulcer improvement work going on in theatres at the moment: it's got all members of the theatre professional team involved and working across a patient pathway not in one part of a silo. And if I think about the staff nurses who are leading the sepsis work, they have a multidisciplinary team in ED around them to help solve that problem' – Bernadette George, Lead Nurse Patient Safety and Risk

Advice for other organisations

- Focus on quality, not targets – if effective care is delivered and the focus is on quality, safety and outcomes, the targets are delivered as a consequence of that process, not the other way around.
- Recognise that normal variation happens – anyone who says that they'll hit every target all the time is deceiving themselves and their patients.
- Make sure there is a culture of honesty and transparency – without this it's difficult to identify and tackle problems in an appropriate way.
- Strong leadership and a clear sense of corporate direction are vital to successful improvement.
- Give the organisation the time and space to plan and deliver an improvement approach that's consistent with its goals – and don't be distracted by external events.
- Financial health and a track record of success make it easier to convince external partners to approve investment in improvement, but they can also create a sense of complacency internally, which can make it harder to drive and sustain improvement.

Key components of the Royal Devon and Exeter NHS Foundation Trust's Connecting Care programme methodology and training

At its heart, Connecting Care is about bringing people together to improve the care and services they offer. This focus on collaboration, an essential aspect of an engaged workforce, is mirrored in the training, coaching and facilitation offered by the service development team, whose role it is to implement Connecting Care.

The tools people use as part of Connecting Care are founded on principles that value the individual and understand what is working well and what can be done to get even better. Hospitals are complex and diverse environments. With that in mind, the team is working with people across the organisation to ensure the tools make sense locally while maintaining the core principles underpinning them.

Case study: Salford Royal NHS Foundation Trust

Introduction

Salford Royal NHS Foundation Trust (Salford) is an integrated provider of secondary, primary and community care services. The trust provides a comprehensive range of services to the 240,000 people living in the City of Salford and specialist services to a wider population in Greater Manchester and other parts of the north west of England. Most of its acute services are provided at Salford Royal Hospital, which has 676 beds. Salford is a university teaching trust and achieved foundation trust status in 2006. It has around 6,000 staff and an annual income in the region of £475m. Last year, Salford was rated by its staff as the best place to work in the NHS and by its patients as the best acute trust in the country.

In 2008, Salford became the first foundation trust to publish a quality improvement strategy. Now about to publish its third strategy, the trust aims to become the safest organisation in the NHS. Building up the improvement capability of the organisation is a central part of the trust's strategy. It began by recruiting a stand-alone central quality improvement team and subsequently set up a Clinical Quality Academy to train senior staff in QI methodology. More recently, the trust launched a Clinical Microsystems Coaching Programme.

Why did they start working on improvement?

In 2007, Salford's Chief Executive, David Dalton, and Chief Nurse Elaine Inglesby-Burke took part in the IHI's 'Boards on Board' programme. At the time, the trust was in a strong position financially and was widely regarded as a high-performing organisation. But while on the programme they were asked some questions about the safety of the care they were providing that they found hard to answer. According to Medical Director Pete Turkington, *'They realised that Salford Royal was perfectly designed to harm several thousand patients a year and that we had to do something about it.'*

After their introduction to the IHI's improvement approach, Salford's executive team decided to make quality improvement an organisation-wide priority and to develop a strategy to improve safety and reduce mortality.

The return to Salford of Maxine Power, the trust's current Director of Innovation and Improvement Science, from a year-long Quality Improvement Fellowship at IHI (funded by the Health Foundation) was another important driver. As well as helping to make the case for a QI programme, she provided a crucial source of QI skills and leadership expertise within the trust.

What did they do?

Developed a quality improvement strategy

Salford's approach to quality improvement is captured in an overarching strategy. The strategy and driver diagram (see diagram one) have evolved over time but they have remained underpinned from the start by three core questions: what should the trust measure in order to know it is doing better? what should it do to improve patient safety? and how should it improve workforce capability? In terms of capability, the aim is to develop a skilled workforce who are able to improve their own day-to-day roles through QI methods and techniques.

Recruited a quality improvement team

With the trust in financial surplus in 2007, Salford was able to find around £500,000 to recruit its own central quality improvement team. Led by Maxine Power, a team of 12 to 14 people was recruited in the first 18 months, largely from outside the NHS. The original intention had been to pair QI leads with project managers, but the trust found it hard to find people with the right QI skills at the time. Consequently, most of the first recruits were project managers who built up their QI skills and expertise over time on the job. Quality Improvement Lead, Paul Hughes explains: '*We leant on the IHI hugely, but to be brutally honest it was experience that helped us; we made loads of mistakes on the way. At the time, we just had to have a go at pretty much everything – all the data, all the coaching.*'

Over time the team has grown in experience and confidence and has been able to reduce its size. It now has 10 members of staff, including five QI leads and two project managers. New recruits to the team are also eased more gradually into their role: they spend time shadowing existing projects before taking on work and also go through the trust's own Clinical Quality Academy programme.

Built clinical awareness and support for quality improvement

In the early days of the QI programme, much of Salford's capability building work and improvement activity was carried out using QI collaboratives based on the IHI breakthrough series model. Early successes using this model were crucial in securing clinical support for Salford's QI approach and also in maintaining the morale of the QI team. For Emma Donaldson, Clinical Lead for Quality Improvement and Gastroenterologist, a collaborative that led to a significant reduction in cardiac arrests proved particularly significant: '*It wasn't a directed change; it was a ward-based change, which made a big difference clinically. It was then I think that we really started to get traction in the organisation.*' For the clinicians who participated in the Acutely Unwell Adult Collaborative, the experience proved transformative:

'I remember sitting in Maxine's office and hearing for the first time about breakthrough collaboratives as a means of delivering change. My first reaction was that this is crazy, very American. But nonetheless I decided to embrace it and give it a go, and the rest is history. By using the breakthrough model we reduced cardiac arrests by 60% in two years.' – Pete Turkington, Medical Director

Alongside the collaborative programme, the QI team ran a series of workshops aimed at building improvement awareness and expertise across the wider organisation. Initially, it ran a whole-day session on the model for improvement and two half-day sessions on measurement and reliability science: they were marketed as a set and people were encouraged to attend all three.

Set up a Clinical Quality Academy

Now entering its sixth year, the Clinical Quality Academy (CQA) was set up to develop the improvement capability of senior clinicians within the trust. Based loosely on the IHI improvement adviser course, the programme was led in its first year by Lloyd Provost.[18] Participating teams spend nine months learning about quality improvement, measurement and statistics, principally through three two-day learning sessions, while working on a project in their own area. Around 150 people, including 60 consultants, have now completed the programme.

Set up a Microsystems Coaching Programme

Through the Microsystems Coaching Programme, based on an approach developed by the Dartmouth Institute, teams meet once a week with coaches for around six months to work through an improvement challenge. Teams are encouraged to continue to meet once their formal coaching has come to an end.

18 Lloyd Provost is a Senior Fellow of the Institute for Healthcare Improvement (IHI) and serves on the IHI faculty for the Improvement Advisor Professional Development Program.

Continued to reflect and evolve over time

Salford's approach to quality improvement has evolved over time as the capability of its workforce has grown and a common language around improvement has begun to emerge.

'There's been a gradual shift from topic-based projects such as pressure ulcers and cardiac arrests towards big cultural issues, which are a lot more difficult but potentially have bigger gains, such as seven-day working… This wouldn't have been achievable if the clinical bodies hadn't bought into the quality improvement process.' – Emma Donaldson, Clinical Lead for Quality Improvement and Gastroenterologist

The QI team has also adapted the content and structure of its training offer to meet the changing needs of the organisation and to address gaps in provision. To make its QI workshop programme more accessible and relevant to staff, for example, the team has begun to deliver shorter, more tailored sessions on topics such as Lean: this has helped to boost participation rates. Attention is also being given to developing the improvement capability of the trust's managers, who have had less exposure to the QI projects and techniques of the first iterations of Salford's QI strategy than frontline staff.

Other services such as pathology, radiology and labs, which have had limited opportunities to date to participate in the major trust-wide improvement projects, will also receive a more bespoke service from the QI team in the future. The same applies to community services, which became part of the trust's portfolio of services only in the last few years.

The way in which Salford's board engages with quality improvement has also shifted over time. After the first QI strategy was launched, the board allocated the first two hours of its meetings to quality improvement in line with the IHI's recommendation. This is still the case today, but much of the detailed scrutiny and discussion on quality has been delegated to an executive quality and safety committee set up in 2009/10.

What impact have they made?

Many of the improvement projects implemented through Salford's breakthrough collaboratives, its Clinical Quality Academy and, more recently, its Microsystems Coaching Programme, have made an appreciable difference to the quality, safety and efficiency of care within the organisation.

As well as reducing cardiac arrests, the collaborative approach has helped to radically change the way in which the trust deals, for example, with *C.difficile*:

'We would not have made the inroads into C.difficile. We have without a collaborative. And we've kept on top of it since. We've had an incredibly challenging target this year and we've kept to it, just: If someone had told me five years ago that we'd be allowed to have just 21 cases a year, I'd have laughed. So it embeds the change in practice.' – Pete Turkington, Medical Director

A number of CQA-led projects have achieved recognition at improvement conferences both in the UK and internationally. The programme has also enabled the trust to develop a generation of new clinical leaders who understand and use QI methods and have the skills to lead and sustain change in a complex environment.

There is also a recognition within the trust that investing in capability has yielded important long-term financial gains, as Assistant Director of Quality Improvement Siobhan Moran points out: *'There's a clear belief by the board that our successes around cardiac arrest, pressure ulcers, C.difficile and MRSA and so on, and the culture shift that's come with it, allow you to safely reduce costs.'*

Nonetheless, the QI team is keen not to overstate what the trust has achieved over the last seven years, or to ignore the scale of the challenge ahead.

Advice for other organisations

- Ensure that robust governance and performance structures are in place, as well as appropriate funding, before embarking on any improvement capability work. Any programme needs to be built on strong corporate foundations or it will fail.
- Ensure that there is strong and consistent support for the programme at executive and board level from the start. Without this support it will be a struggle to engage people or persuade departments to release people to take part in training or carry out improvement work.
- Recruit a small team of experts to coach others and help facilitate improvement. They should be people with a strong conceptual understanding of improvement theory and methods, and who have the time and motivation to develop their skills over time and to reflect on the impact of their work.
- Get an early win on a topic that is important to staff and make sure that the success is publicised across the organisation. Put substantial resources into it, get everyone on board and do something in which they can all take pride.
- Resist any pressure to do too much too quickly. Build experience and knowhow by doing one thing well. Even if it doesn't deliver immediate results, resist the urge to experiment with other projects and concepts too soon.
- Ensure at the start that there is a shared understanding among staff of what the problem is and why it needs to be addressed. Deciding what approach to take without knowing what the problem is will undermine the impact of the work.
- Pick the right approach for the right problem and don't be tied to one method. Be flexible and have a range of methods at your disposal as the programme matures.
- Be prepared to teach skills around data and measurement over and over again at all levels within the organisation.

Case study: Sheffield Teaching Hospitals NHS Foundation Trust

Introduction

Sheffield Teaching Hospitals NHS Foundation Trust (Sheffield) manages all five of the city's adult NHS hospitals and community health services for the city. The trust's A&E department and many of its specialist medical and surgical services are based at the Northern General Hospital, one of three major trauma centres in the Yorkshire and Humber region. Other specialist services, including neurosciences and haematology, are provided at the Royal Hallamshire Hospital. The trust also runs specialist maternity, cancer and dental hospitals. Serving a population of more than 550,000, the trust has a workforce of in excess of 16,000, making it the second largest employer in the city. With an annual turnover of almost £1bn, the trust is also one of the largest NHS providers in the UK. It became a foundation trust in 2004 and, as a teaching hospital, works closely with Sheffield's two universities. The trust has been named 'Hospital Trust of the Year' in the *Good Hospital Guide* three times in five years.

Sheffield's quality improvement journey began around seven years ago with the creation of a small service improvement team. After successfully helping a number of departments with service redesign, the team secured funding to open the UK's first Microsystem Coaching Academy (MCA) in 2012. Using a methodology pioneered by the Dartmouth Institute Microsystem Academy in the US, the MCA aims to build improvement capability across the trust by training more than 200 coaches to support improvement work within their respective microsystems. The trust has also developed capability through its organisation level improvement programmes, such as Flow Cost Quality (funded by the Health Foundation) which has transformed the way it provides care to frail older people.[19]

Why did they start working on improvement?

Sheffield's first attempts at quality improvement were small-scale and iterative. The trust's Adding Value programme team, which was tasked with delivering efficiencies using a traditional project management approach, was asked by the then medical director to look at outpatient service performance. In doing so they worked with consultant rheumatologist John Boulton,[20] who was interested in using QI methods to improve outcomes. This first foray into QI was only partially successful, in part because *'they had little ownership of the solutions,'* according to Head of Quality Improvement and Senior Coach Steve Harrison. It did give the team a platform on which to build, however, which, says Harrison, *'prompted us to really think differently about how we help the team themselves to understand the problem rather than us doing it.'*

The team's next project with the falls service, in which they worked collaboratively with teams to map the service and carry out small tests of change, proved more fruitful. Crucially, it also brought the renamed Service Improvement Team, into contact with Tom Downes, a Consultant Geriatrician who had recently returned from a Health Foundation funded Quality Improvement Fellowship

19 For details about the Flow Cost Quality programme, see the Health Foundation learning report, *Improving patient flow.* www.health.org.uk/publications/improving-patient-flow/

20 John Boulton went on to become a Health Foundation Quality Improvement Fellow at the Institute for Healthcare Improvement.

at IHI. Downes has provided much of the driving force and expertise behind Sheffield's improvement and capability building work.

Sheffield's approach has been an iterative one which has grown organically, although it was considered integral to the trust's corporate strategy implementation. Executive level support has been important in helping to encourage progress and overcome obstacles, but the main impetus has come, rightly the trust believes, from the frontline.

What did they do?

Created a service improvement team

In its early days, Sheffield's service improvement team had only one full-time member of staff, Steve Harrison, who focused on facilitating quality improvement. The rest of the team used a more traditional project management approach to drive change. Aside from attending some Lean workshops run by Sheffield Children's Hospital, most of Harrison's skills were self-taught: '*When we did the falls clinic work, I'd literally have the Quality by Design book open before each meeting and was learning as we went.*' Sheffield's Service Improvement Director, Suzie Bailey, a Health Foundation GenerationQ Fellow, was very supportive of this early quality improvement work: *'she allowed us to test a lot of things out',* said Harrison, *'and after the falls work, I started working with other teams, who all started to get somewhere and we realised we were on to something*'.

Encouraged by this success, the trust decided to try to scale up its QI approach by applying microsystem coaching methods across its outpatients services. The service improvement team invested in additional coaches, the success of which persuaded the team to put together a proposal for building improvement capability more systematically. *'With three or four coaches working there in the organisation and results from their work beginning to come in,'* Harrison explains, *'we developed the confidence to put in a bid to the Health Foundation to create an academy to build improvement capability across the organisation.'* The trust also made a further wave of investment at this point, with a number of additional coaches employed to support improvement work focused on surgical pathways, using the same quality improvement methodology.

Gained some early wins

Early success in improving service performance using QI methods was vital in securing clinical support and building an appetite at strategic level for a more scaled up approach to QI. Harrison notes that the falls service project, which reduced a full-day clinic to a half-day one, largely by keeping patients in one place instead of requiring them to walk from one part of the department to another, was an important breakthrough: *'It got people interested. It was only a small clinic, with 10 staff on a Friday afternoon, but that's how we started the journey. It was incredibly small and really under the radar.'*

First they understood the problem through techniques such as process mapping, patient shadowing and spaghetti diagrams, and then they identified and analysed small tests of change at weekly meetings. They employed this method successfully with a series of services.

Developed a Microsystem Coaching Academy

The initial impetus for pursuing a microsystems approach came from Tom Downes, who had met Paul Batalden and Margie Godfrey from the Dartmouth Institute during his year with the IHI. *'What we liked about it',* Steve Harrison explains, *'was the coaching approach. It also focuses on the team dynamics and things like effective meetings, which we found was always the hardest bit – the human dimension rather than just the QI tools.'*

Funding from the Health Foundation's Shine 2011 programme for a haematology system redesign project had given the trust an opportunity to send two people on Dartmouth's coaching programme and to test out the approach on a live improvement project. After working with the haematology service to develop an ambulatory care model, the coaches went on to support microsystem projects in other areas, including the trust's antenatal and pulmonary vascular services.

However, the team realised that there was a limit to what they could achieve with a small central team of service improvement coaches. To spread the microsystem approach across an organisation with over 16,000 staff, the team estimated that they would need 125 coaches which was clearly not feasible for a central team. Consequently, they decided that the most practical way forward would be to develop the coaching capability of the trust's existing staff.

Helped by expertise from the Dartmouth Institute led by Margie Godfrey and in partnership with the Sheffield's Children's Hospital the Microsystems Coaching Academy (MCA) was launched in September 2012. The core funding for the academy was provided by a Health Foundation Shared Purpose programme grant worth £420,000 over three and half years.

The academy aims to train and support 25 to 30 new coaches, from all parts of the organisation, every six months. Each coach is expected to go on to develop an improvement microsystem in their own area.

The programme is currently managed and delivered by a team of seven, consisting of Clinical Lead, Tom Downes, Senior Coach Steve Harrison, four improvement coaches and a project officer.

The team's approach has evolved over time as they grappled with the challenges of training and supporting coaches in a large and disparate organisation. They learnt a great deal in particular from the experience of supporting their first cohort of 30 coaches.

To prepare the ground for the academy coaches, the team introduced a two-day introductory quality improvement course for staff across the organisation. Prominent support for the programme from key executives including the trust's finance director, who signed up to be a coach in the first cohort, also helped to raise the profile of the microsystems approach. As Steve Harrison says, *'It sent out a strong signal that this is important.'*

External interest too, has helped to boost awareness of the MCA internally, with around 120 people from around the country, some of them senior, attending their MCA showcase day. *'Successful events and the scale of external interest in the academy have also helped generate interest within our organisation,'* says Project Manager Patrick Richmond.

Pursued organisational level improvement work

Projects involving multiple microsystems, such as the Flow Cost Quality project (funded by the Health Foundation) have played an important role in building improvement capability within the trust. This project sought to improve the emergency care pathway for frail older people. Using techniques such as the Oobeya, or 'big room' process[21] to bring together stakeholders from multiple specialties and departments in a bid to understand and tackle constraints within the wider system, they have achieved some impressive, and sustained, outcomes: *'When you do this work across multiple areas, then you start to see outcomes such as significant reductions in length of stay, readmissions and mortality,'* Richmond says.

What impact have they made?

As a result of the efforts of the Service Improvement Team and the academy, more than 100 teams in every care group across the trust have now received coaching. Many of these teams have delivered significant improvements in areas ranging from cystic fibrosis to generic outpatients clinics to hospital wards. *'The spread model we have used is passive, through corridor conversations, when one clinician tells another "we've been doing this work and it's going really well, have you thought about doing something in your area?"'* explains Harrison. Spread has also been greatly supported by many operational and clinical leaders who have seen the value in the approach and enabled staff to have the time and space to get involved.

In other areas, however, the approach has not grown to the same extent yet. For growth to become uniform, ways of embedding quality improvement into the system and culture of the organisation will need to be identified so that it is seen as essential rather than optional. This is the trust's next challenge.

21 The Health Foundation. *Improving patient flow*. The Health Foundation, 2013.

Advice for others

- Identify improvement enthusiasts and work with them to create a good news story and build momentum. Start small and show people that the approach works.
- Prepare the ground for improvement. Provide basic quality improvement training at an early stage and get people used to thinking about improvement and using improvement tools.
- Get middle managers on board. Their support and commitment is crucial in ensuring that frontline teams feel that they have 'permission' to try new things and to work in a different way.
- Engage with as many people as possible, at every level. Don't assume that a conversation with senior people will filter down to frontline teams.
- Ensure that teams embarking on improvement journeys have a clear understanding of what it will entail and the time and resources it will require. If people start the process without a clear idea of what it means for them or why they are there, the impact of the work will be undermined.
- Make sure people are given the time and space to attend regular team meetings throughout the lifetime of their project. If key figures consistently miss meetings because of other commitments, enthusiasm in the team will wane and progress will be slow.
- Ensure that quality improvement is seen as part of the core business of the organisation.

Key components of Sheffield Teaching Hospitals NHS Foundation Trust's Microsystem Coaching Academy programme

A five-month action learning course, including:

- five learning sessions with lecture materials, handouts and workbooks
- individual and group coaching mentorship experiences
- action learning – the coaches learn by actively coaching the team
- accessible and timely academic and technical support

Social networking tools and the academy website are used to enable access to teaching materials and provide a framework for outcome measures, reflection and peer support. A network of coaches has also been established.

Case study: South Eastern Health and Social Care Trust

Introduction

South Eastern Health and Social Care Trust (SEHSCT) came into being in 2007 following the merger of the Ulster Community and Hospitals Trust and the Down Lisburn Trust. One of six trusts in Northern Ireland (including the Northern Ireland Ambulance Service), it is an integrated organisation which provides community, social care and acute hospital services. The trust serves a population of around 350,000 in Ards, North Down, Down and Lisburn, a region which contains some of the wealthiest parts of Northern Ireland as well as pockets of deprivation. It has five hospital sites, the largest being the Ulster Hospital in Dundonald. SEHSCT employs around 10,000 staff and has an annual budget of more than £500m.

SEHSCT made safety, quality and experience (SQE) a corporate priority in 2011. It did so to help deliver its SQE approach which aims to nurture a culture of inquiry and a quality improvement approach to address locally identified indicators of safety, quality and experience. To help realise this culture, the trust set up a capability building programme in 2011 through which staff learn about QI methodology and work on a live improvement project. To date, more than 250 staff have completed the programme and in excess of 70 projects have been undertaken. At the start of 2014, SEHSCT opened a Quality Improvement and Innovation Centre to build upon a range of organisational initiatives that currently focus on ensuring patient/client safety, improving quality and testing the service user experience on a trust-wide basis.

Why did they start working on improvement?

When SEHSCT was set up in 2007, it inherited from its predecessors an organisation that had some quality improvement experience and expertise. However, while good work had been done, not least through the Safer Patients Initiative,[22] the trust's vision was to embed quality improvement into the culture and fabric of the organisation. For this to take place, the trust's executive team decided to make quality and safety an organisational priority.

The driving force behind this move was SEHSCT Chief Executive Hugh McCaughey, a long-term advocate of safety and quality improvement. A critic of the 'top down' NHS performance management system and its reliance on 'clock-based targets', he wanted to develop a 'bottom up' approach that empowered frontline staff to develop their own indicators for safety, quality and experience. McCaughey explains that what they tried to do was *'to turn the performance management system on its head and create a system where every service and service team takes responsibility across our three parameters: assuring the service is safe; having areas of quality which they need to improve; and improving the experience of care.'*

Further impetus as well as valuable skills came from senior staff who had been on the Scottish Patient Safety Fellowship programme and patient safety and clinical microsystems courses run by the IHI and the Dartmouth Institute. They recognised that having only a few staff with advanced skills was not enough:

22 The Health Foundation. *Learning report: Safer patients initiative*. The Health Foundation, February 2011.

a larger-scale capability building programme was required in order to drive and sustain change across the organisation.

What did they do?

Ensured all parts of the organisation are aligned with the safety, quality and experience (SQE) approach

After making safety, quality and experience a priority corporate objective, the trust took steps to ensure that all its structures and activities were aligned with it and geared towards fostering a culture of continuous quality improvement.

A range of departments worked with frontline teams to help them develop improvement action plans and measure and monitor progress against the safety, quality and experience indicators they had identified. This allowed frontline staff to use local intelligence to identify relevant indicators and targets for improvement. Facilitation was provided to develop improvement plans based on continuous monitoring of data. Open clinics and workshops have been put in place to support staff during their improvement journey. Linda Kelly, Assistant Director for Safe and Effective Care, explains that the aim was *'you'd be able to walk into any treatment room in the community or any ward and be able to ask any member of staff what their safety priority was and what they were measuring and monitoring.'*

A safety and quality leadership committee chaired by the chief executive was set up, and leadership walk-rounds began to focus on the safety, quality and experience priorities in each area. Every directorate is expected to align clinical audit activity with local quality indicators, while accountability and performance management reviews now include safety, quality and experience. Success is measured using indicators that are relevant to the service, staff and users, not on clock-based targets developed elsewhere. The aim is to ensure that every arm of the organisation is playing its part in helping to deliver a safer and better service.

Secured staff support for the SQE approach

SEHSCT's 'bottom up' model, designed to recognise the expertise of frontline staff, has helped to secure widespread clinical support for its SQE approach. One of the first areas to buy into the approach was the trust's emergency department.

'We wanted them to take the lead and say what does quality look like in an emergency department? They didn't really buy into the four-hour target. They set a different set of parameters and it's helped to drive up standards. Our results on clinical standards and outcomes would now compare very favourably regionally and nationally which we don't believe would have been achieved had we solely focused on the top-down targets. Furthermore, our staff buy into it, because they are being measured against something that matters to them and the quality of what they do for the patient.' – Hugh McCaughey, Chief Executive

Developed an improvement capability building programme

The SQE capability building programme was conceived and designed internally, principally by the trust's Head of Patient Safety Improvement, Brenda Carson, and its Associate Medical Director, Dr David Hill. The programme they developed provided a blend of didactic classroom-based learning and experiential learning. As Brenda Carson says, *'Just to go into a room and hear people talking about improvement methods and tools wasn't sufficient: only when you begin to try and apply it do you really begin to understand it.'*

Delivered over nine months, the programme consists of three core elements: monthly tutorial and learning sessions; online learning through the IHI's open school modules; and participation in a team-based improvement project using a structured approach based on the IHI's model for improvement.

During the monthly sessions, some of which include presentations from an external expert, participants explore a key safety, quality or experience topic, such as measurement for quality improvement or human factors. These sessions also provide participants with a chance to share the learning from their improvement projects and get feedback and advice from their peers, mentors and members of the coaching faculty.

At the end of the programme each improvement project team presents their work to a judging panel comprised of senior executive staff. The panel then selects projects to present at a final event attended by the health minister and other invited guests from across health and social care. Project teams are then supported to showcase their work at external events, awards and conferences locally, nationally and internationally.

With much of the programme management and face-to-face coaching delivered by staff in existing posts, the cost of the programme has been relatively modest, with the principal expenses the purchase of IHI Open School licences and the financial support for attendance at conferences.

Interest in the programme has grown steadily each year, from 50 participants in the first year to 140 in the current cohort. People can sign up to the programme either as individuals or as teams. Initially, mainly individuals signed up, but in recent years more teams have come forward, often with a particular improvement problem that they want to address.

'I was one of the first to participate in the programme. I didn't know what to expect. I was the only Occupational Therapist (OT) and I was put into a team and guided towards a project. What I've done to date is to encourage other OTs to participate. In the second year there were four and this year there are 17. And now OTs go onto the programme with a specific issue in mind that they want to work on.' – Karen Canning, Occupational Therapy Service Lead

As well as encouraging their peers to sign up, many of the early participants have gone on to mentor teams in subsequent cohorts. There are now 50 mentors in total.

The programme has evolved over time in response to feedback from each cohort. In the second year, for example, the team worked with the IHI to develop online training modules tailored to fit the nine-month timeframe of the course and meet the needs of the range of staff attending. The team has also worked hard to find speakers and develop content which is appropriate for the needs of a social care audience.

'There's been very little work done anywhere else taking the methodology from IHI and applying it to social care. This is the bit we've probably struggled with the most. Over the past four years we have found it hard to identify session speakers with experience of using improvement methodology in a social care setting.' – Brenda Carson, Head of Patient Safety Improvement

Steps to help teams to sustain their improvement projects once their time on the SQE programme has come to an end have also been taken. Many of the projects continue as part of an improvement journey and, as Linda Kelly notes, *'that's where you begin to see some sustainability and it's why people begin to see the value of the programme.'*

Created a physical hub for improvement activity

The Quality Improvement and Innovation Centre (QIIC), which opened at the start of 2014, has given staff a dedicated space in which they can work together to develop new ideas and to gain advice and support on how to deliver and sustain improvement. As well as providing an important resource for existing SQE programme participants, it has given previous cohorts the means to build relationships.

'Every few months they meet in the innovation centre for a curry and talk about what they've been doing and re-energise themselves and avoid the risk of becoming isolated within the organisation. They spark ideas off each other and also there's now a sense that they can call on each other's skills.' – Hugh McCaughey, Chief Executive

It has also enabled the trust to generate additional revenue by making the centre available to external organisations.

What impact have they made?

Over the four years of its improvement journey, SEHSCT has seen a steady shift in staff perceptions of the trust's commitment to improving quality and safety. In the 2012/13 national staff survey, around two-thirds of staff thought that the trust saw patient care as its top priority and that its managers were committed to delivering a quality service compared to just over half of staff in the previous survey in 2009/10. In both cases, SEHSCT is now outperforming the regional and national average.

Ensuring that the programme is able to cater for both its hospital-based staff and its social care and community-based staff has been a challenge, but the trust has managed to secure buy-in for its approach in both areas.

'We are building up a social care movement and giving social care staff a basic knowledge of QI. We have wins in terms of outcomes and processes which have helped to build belief among staff on the ground. The gains we've made in social care have also been sustainable and the projects are owned by the workforce.' – Conor Campbell, Governance and Patient Involvement Manager

SEHSCT believes that the SQE programme has also made them more attractive as an employer. It has been particularly successful in attracting junior doctors who have already had a taste of the SQE approach. McCaughey points out that *'quite a number of F1s and F2s are choosing to come back to us as they feel it's an environment in which they're supported to do safety and quality work.'*

The individual projects undertaken by the participants have led to improvements in the safety, quality and experience of services.

A checklist brought in for the management of patients with acute kidney injury, for instance, has led to improved diagnosis, care and outcomes for patients. Post-partum haemorrhage rates following childbirth and number of falls among older people have also been reduced. And improvements in users' experiences have been seen everywhere from childcare case conferences to learning disability day care attenders.

The quality of the improvement work carried out through the SQE programme has been recognised both by international safety and quality conferences and journals and by other trusts in Northern Ireland: a small number of staff from other providers are now enrolled in the programme. The programme is also playing a growing role in helping the trust to meet its corporate objectives around safety, quality and experience. Each team has the licence to develop its own improvement goals, but teams are also encouraged to think about how their project might help the trust to achieve its overarching goals.

Nonetheless, the trust recognises that it is still on a journey and that there are still challenges ahead. It has yet to really engage non-clinical staff such as cleaners and porters in the programme, for example, and some of its corporate teams have only been marginally involved.

Funding, too, is an issue, as the trust does not have the same financial freedom as foundation trusts in England to fund capability building work. The staff who plan and deliver the coaching and training all have other jobs and responsibilities, and some participants find it hard to free up time to attend sessions and do the work. Financing any further roll-out of the programme will require careful planning and possibly support from an external body.

Advice for others

- Make sure core experts with the right QI skills are involved at the start and ensure they are embedded into the organisation and are part of an improvement network. For experts to make a difference, a fertile QI culture where people are empowered and can flourish is needed.
- Ensure senior leaders are engaged and supportive from the start and demonstrate the commitment necessary to isolate and eliminate any resistance to change within the organisation.
- Embed the capability building programme into a wider organisation-wide improvement approach and ensure their goals are aligned.
- Evaluate the capability building approach regularly to ensure it is continuing to meet the needs of the workforce and the organisation.
- Provide programme participants with the opportunity to share their successes and their methods within their organisation and beyond. Celebrating success is important to maintain momentum.
- Financial stability is important at the start along with an absence of any pressing performance challenges. If difficult finances and red flag issues are major preoccupations, it becomes more difficult to launch new programmes and get people's attention.

Annexes

Annex 1: Health Foundation programmes and publications

Current Health Foundation programmes

5,000 Safety Fellows: The Health Foundation is working with NHS England to develop an ambitious initiative that will connect and support people with safety and wider quality improvement expertise across the UK. The initiative will help share effective improvement ideas throughout the health care system.

www.health.org.uk/areas-of-work/programmes/safety-and-quality-improvement-initiative/

GenerationQ: This is our part-time, fully-funded leadership programme for senior leaders from health care policy and practice, and the charity sector. It is delivered in partnership with Ashridge Business School and Unipart Expert Practices.

www.health.org.uk/areas-of-work/programmes/generationq/

Innovating for Improvement: Through this programme we provide funding to project teams to develop innovative ideas and approaches to improve health care and put them into practice.

www.health.org.uk/areas-of-work/programmes/innovating-for-improvement/

Scaling Up Improvement: Through this programme we provide funding to teams to take successful health care improvement interventions and deliver them at a larger scale.

www.health.org.uk/areas-of-work/programmes/scaling-up-improvement/

Shared Purpose: This is the part of our Closing the Gap improvement programme. Between 2012 and 2015 we are supporting nine teams to develop and implement ways for corporate support services and clinical teams to work together to improve quality of care.

www.health.org.uk/areas-of-work/programmes/shared-purpose/

Completed Health Foundation programmes

Flow Cost Quality: This programme focused on the relationship between patient flow, costs and outcomes in two NHS hospital trusts. Delivered between 2010 and 2012, it examined patient flow through the emergency care pathway and developed ways in which capacity can be better matched with demand, to prevent queues and poor outcomes for patients.

www.health.org.uk/areas-of-work/programmes/flow-cost-quality/

Shine 2011: Through this programme we invested in 14 projects which aimed to find new approaches to delivering health care that reduce the need for acute hospital care while improving quality and saving money.

www.health.org.uk/areas-of-work/programmes/shine-eleven/

Quality Improvement Fellowships: Each year between 2004 and 2014 we gave up to five senior clinically-qualified NHS professionals with a track record of achievement in quality improvement the opportunity to spend a fully-funded year at the Institute for Healthcare Improvement (IHI) in the USA. The aim of the programme was to give fellows the time and space to think deeply about how to improve the quality of health care, backed up by rigorous academic and practical learning.

www.health.org.uk/areas-of-work/programmes/quality-improvement-fellowships/

Key Health Foundation publications on quality improvement

Quick guide: Quality improvement made simple, 2013: This guide provides an explanation of some common approaches used to improve quality, including where they have come from, their underlying principles and their efficacy and applicability within the health care arena. It is written for a general health care audience and is most useful for those new to the field of quality improvement, or those wanting to be reminded of the key points.

www.health.org.uk/publications/quality-improvement-made-simple/

Evidence scan: Improvement collaboratives in health care, 2014: This scan explores research about whether collaboratives help to improve quality in health care and the factors that may be key to their success.

www.health.org.uk/publications/improvement-collaboratives-in-health-care/

Evidence scan: Spreading improvement ideas, 2014: This scan provides examples from the published empirical literature of techniques for spreading innovation and improvement. The focus is on identifying practical things that teams and organisations can do to publicise and spread new ideas and ways of working.

www.health.org.uk/publications/spreading-improvement-ideas/

Evidence scan: Quality improvement training for healthcare professionals, 2012: This scan explores types of training on formal quality improvement techniques for health professionals and looks at the available evidence about the most effective methods for training clinicians in quality improvement.

www.health.org.uk/publications/quality-improvement-training-for-healthcare-professionals/

Research: Skilled for improvement, 2014: This report provides a detailed exploration of four improvement projects and draws out lessons from them. The authors identify three sets of skills that they found to be essential for successful improvement.

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

Research: Overcoming challenges to improving quality, 2012: This research report provides a synthesis of learning from 14 of the Health Foundation's improvement programme evaluations and sets this learning in its wider context.

www.health.org.uk/publications/overcoming-challenges-to-improving-quality/

Learning report: Using clinical communities to improve quality, 2013: This report introduces an approach – the clinical community – used by the Health Foundation's Closing the Gap through Clinical Communities programme to support and secure improvements in health systems across multiple sites.

www.health.org.uk/publications/using-clinical-communities-to-improve-quality/

Learning report: Lining Up: How do improvement programmes work?, 2013: This report looks at lessons from the Health Foundation's Lining Up research project – an investigation into interventions to reduce central line infections. It explores the reasons why potentially promising improvement programmes might fall short when implemented in a new setting.

www.health.org.uk/publications/lining-up-how-do-improvement-programmes-work/

Learning report: Effective networks for improvement, 2014: This report presents the lessons from an evidence review and case study work undertaken by McKinsey Hospital Institute. The review drew on the literature and empirical evidence about effective networks to describe the component parts of a successful improvement network.

www.health.org.uk/publications/effective-networks-for-improvement/

Learning report: Leading networks in health care, 2013: In 2011, the Health Foundation launched an improvement programme to support networks in health care. This report captures the experiences of the programme participants as they began working together, highlights key learning and early insights, and examines how all this relates to what the research evidence tells us about running networks.

www.health.org.uk/publications/leading-networks-in-healthcare/

Annex 2: List of case study site interviewees

East London NHS Foundation Trust

12 December 2014

Amar Shah, Associate Director for Quality Improvement and Consultant Forensic Psychiatrist

15 December 2014

James Innes, Head of Quality Improvement Programme

Tsana Rawson, Quality Improvement Clinical Fellow

Genevieve Holt, Quality Improvement Clinical Fellow

18 December 2014

Robert Dolan, Chief Executive

Jonathan Warren, Director of Nursing

23 December 2014

Kevin Cleary, Medical Director

Royal Devon and Exeter NHS Foundation Trust

18 December 2014

Angela Pedder, Chief Executive

Bernadette George, Lead Nurse Patient Safety and Risk

Em Wilkinson-Brice, Chief Nurse/Chief Operating Officer

Tracey Reeves, Deputy Chief Nurse and Midwife

Martin Smith, Head of Service Development

Salford Royal NHS Foundation Trust

15 December 2014

Siobhan Moran, Assistant Director of Quality Improvement

Emma Donaldson, Clinical Lead for Quality Improvement and Gastroenterologist

John Bellerby, Senior Quality Improvement Lead

Paul Hughes, Quality Improvement Lead

19 December 2014

Pete Turkington, Medical Director

Sheffield Teaching Hospitals NHS Foundation Trust

19 December 2014

Steve Harrison, Head of Quality Improvement and Senior Microsystem Improvement Coach

Patrick Richmond, MCA Project Manager

Nick Miller, MCA Manager and Microsystem Improvement Coach

South Eastern Health and Social Care Trust

16 December 2014

Hugh McCaughey, Chief Executive

18 December 2014

Linda Kelly, Assistant Director for Safe and Effective Care

Brenda Carson, Head of Patient Safety and Improvement

Nicola Gullen, Quality Improvement Coordinator/Quality Improvement and Innovation Centre Manager

Julie Hall, Patient Safety Support

Richard Corry, Consultant Anaesthetist

Karen Canning, Occupational Therapy Service Lead

Aveen McCraith, Coordinator in Outpatient Services in Physiotherapy

Liz Campbell, Safe and Effective Care Manager

Jane Patterson, Patient Safety Officer

Conor Campbell, Governance and Patient Involvement Manager

Monica Merron, Infection Control Lead

Pauline Thompson, Social Care Governance Facilitator

Pat McAulay, Social Care Governance Facilitator

Annex 3: Other sources of support

The following organisations provide information and case studies on improvement approaches.

1000 Lives Plus

The Welsh national improvement programme, supporting organisations and individuals to deliver the highest quality and safest healthcare for the people of Wales.

www.1000livesplus.wales.nhs.uk

Advisory Board Company

A leading US healthcare consultancy that provides comprehensive performance improvement services to the healthcare and education sectors, including operational best practices and insights.

www.advisoryboardcompany.com

Institute for Healthcare Improvement

A US-based independent not-for-profit organisation that seeks to improve healthcare worldwide through building the will for change, cultivating promising concepts for improving care, and helping healthcare systems to put them into action.

www.ihi.org

The King's Fund

A UK charity that seeks to understand how the health system can be improved, and works with individuals and organisations to shape policy, transform services, and bring about behavioural change.

www.kingsfund.org.uk

National Institute for Health and Care Excellence (NICE) Evidence Services

A suite of services that provide online access to authoritative evidence and best practice. The services cover health, social care and public health evidence.

www.evidence.nhs.uk

NHS Improving Quality (NHS IQ)

Part of NHS England, NHS Improving Quality (NHS IQ) brings together quality improvement knowledge, expertise and experience from across the NHS.

www.england.nhs.uk/ourwork/qual-clin-lead/nhsiq

Quality Improvement Scotland

A health body that aims to support healthcare providers in Scotland to deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise those services to provide public assurance about the quality and safety of that care.

www.nhshealthquality.org

Social Care Institute for Excellence

An independent charity that aims to identify and spread knowledge about good practice to the large and diverse social care workforce and support the delivery of transformed, personalised social care services.

www.scie.org.uk

The Health Foundation is an independent charity working to improve the quality of health care in the UK.

We are here to support people working in health care practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, fund improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change.

We want the UK to have a health care system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

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Registered company number: 1714937

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