# Taking an organisational approach to quality improvement

**Authors:** Robert E Klaber[A] and Ralph A Critchley[B]

ABSTRACT

**The challenge for all healthcare organisations is to develop and implement an approach that will enable improvements to the quality of healthcare to happen. This case study describes some of the thinking, design and learning from Imperial College Healthcare NHS Trust, on the early steps of our journey to create a culture of continuous improvement across the organisation.**

**KEYWORDS:** Culture, learning, organisational improvement, quality improvement

## Introduction

Quality improvement (QI) can be described as a method for designing, testing and implementing changes. It is more than just a theoretical framework against which innovations can be introduced; it is about a rigorous, patient-centric approach to the design and delivery of care.[1]

The focus on improving quality within healthcare is not a new concept[2,3] and it was the work of Darzi[4] and others[5] that began to define how healthcare systems need to be underpinned by a central focus on delivering high-quality care for patients. This includes work around making care safer,[6,7] as well as a focus on value for patients and the taxpayer.[8] More recently, Berwick and colleagues have evolved the focus onto the 'triple aim' of improving the experience of care, improving population health and reducing per capita cost of healthcare.[9]

The challenge for all healthcare organisations, including our own, is to develop an approach that supports these improvements while confronting the operational and financial challenges of today. This case study encompasses some of the thinking, design and learning from Imperial College Healthcare NHS Trust on the early steps of our journey to create a culture of continuous improvement across the organisation. By way of background, the trust comprises five hospitals working with Imperial College London and other partners as an academic health science centre. The trust employs over 10,000 staff and, as well as a wide range of nationally commissioned specialist services, plays a significant role in delivering healthcare to the 2 million people who live in north-west London.

**Authors:** [A]consultant paediatrician and associate medical director for quality improvement, Imperial College Healthcare NHS Trust, London, UK; [B]head of quality improvement programme, Imperial College Healthcare NHS Trust, London, UK

## Our approach

The Imperial College Healthcare NHS Trust QI programme launched in October 2015 on the back of a staff-led project to renew our trust values and behaviours, which sought to understand, from both staff and patients, what the organisation stood for and meant to them. This work, and an approach focused on delivering 'better health for life', strongly underpins the QI programme.

The aim of the programme is to build a culture of continuous improvement across the organisation, which we recognise as a long-term strategy and journey.

This aim is underpinned by four key drivers, which are illustrated in more detail in our working 'driver diagram' shown in Fig 1:

1. Build capacity and capability through a programme of QI education and training to enable staff to lead QI activities and initiatives within their teams.
2. Engage with staff and patients to ensure everyone knows about QI and feels empowered and energised to get involved in improving care.
3. Develop a cohort of QI Champions across the organisation who have the leadership capacity and capability to enable others to get involved in QI.
4. Support teams to deliver QI projects and programmes that are co-designed with patients, service-users and the public.

Over 10 months we have engaged with nearly 6,000 staff and patients as part of the QI programme through a diverse range of events and communications mechanisms, including an animation (**https://vimeo.com/140641715**). In parallel, we have developed a broad ranging education and coaching programme and have participated in 138 pieces of work with staff and teams looking at a variety of issues and opportunities to improve quality within our services. Of these, 10 are being actively supported as strategic QI projects (trust-wide initiatives); 44 are being actively supported as service-led QI projects; and 84 have been supported as discrete consultancy work. We have begun to transform our approach to patient, public, citizen and carer involvement and how we collaboratively approach system-wide change. This work is being led by a small Quality Improvement Hub (consisting of 12 people; four of whom are clinicians on an educational fellowship).

As well as a focus on the methodological rigor of 'improvement science', our work is equally focused on people, teams, relationships and engagement – what one might call the 'art of improvement'.

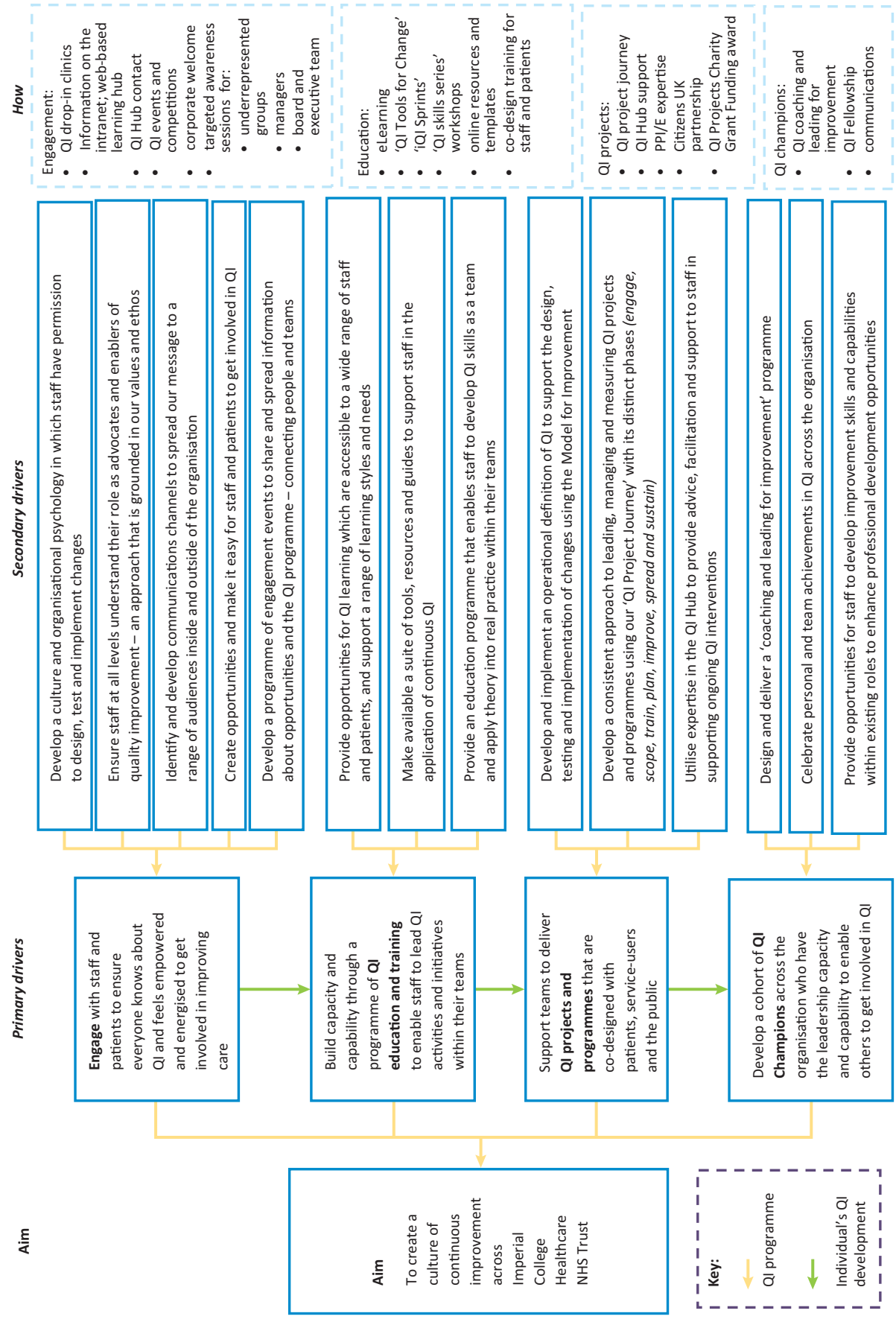


**Fig 1. Quality improvement (QI) programme driver diagram**. Reproduced with permission from Imperial College Healthcare NHS Trust.

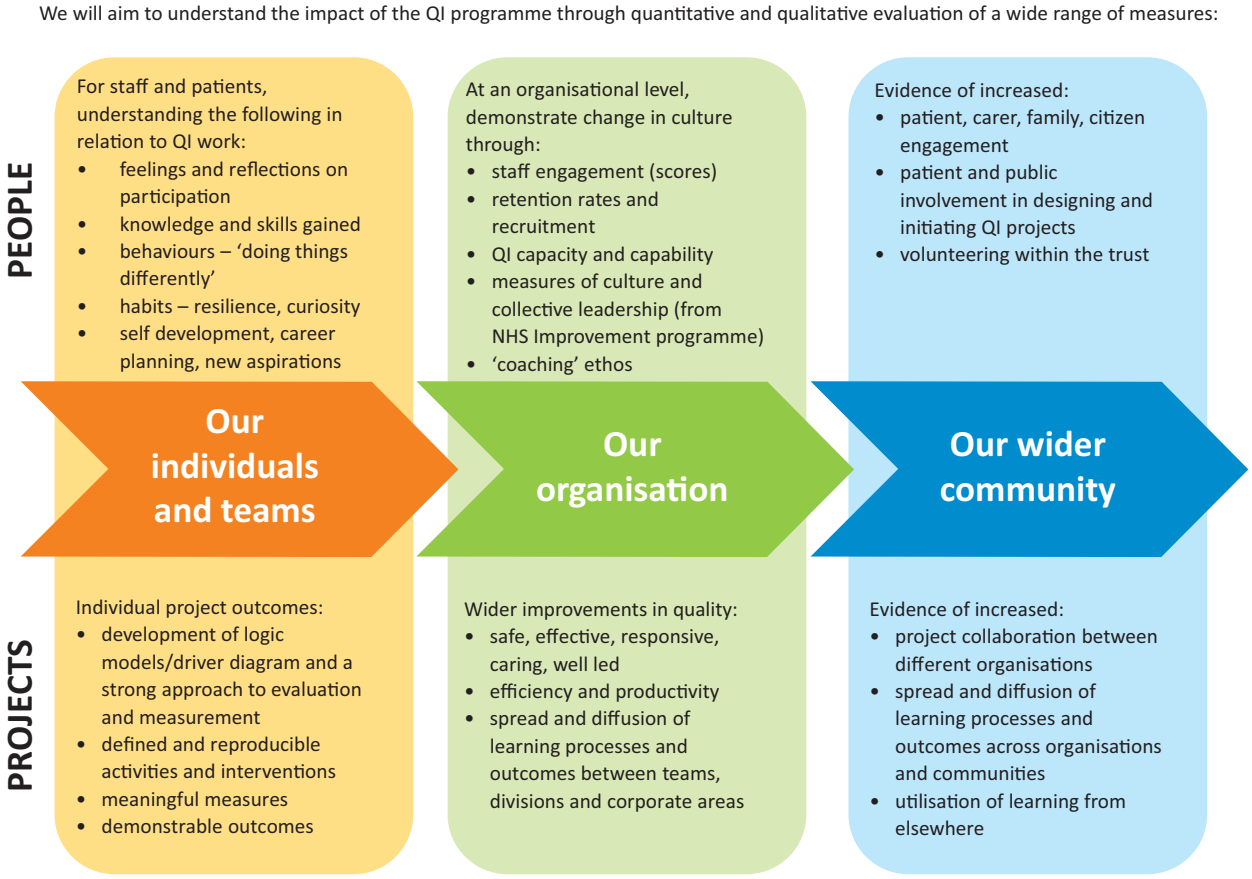


**Fig 2. Evaluation Framework**. An evaluation framework for the quality improvement programme at Imperial College Healthcare NHS Trust. Reproduced with permission from Imperial College Healthcare NHS Trust.

## Evaluating benefits and impacts

An improvement programme needs to plan from the outset how to evaluate the benefits and impacts of the work being carried out. While NHS and other healthcare system leaders would acknowledge that this programme is likely to take 10 or more years to achieve its main aim, there is also a recognition that shorter-term impact needs to be achieved to build confidence and provide 'cover' for the longer-term goals. It is essential that the programme is constantly looking to learn and adapt, both from internal experiences and through being connected to other initiatives and programmes in other healthcare systems.

Fig 2 illustrates the evaluation framework that we have developed for our programme. It gives equal weighting to the value of developing improvement capability in people as to the outputs of projects. It encourages measurement at the level of the individual or team, at an organisational level and across the wider communities we work with and serve.

To date, we have been working with a number of teams whose projects are showing meaningful improvements, others where it is too early to measure any significant changes and some where the project has not been successful. The key here is to properly understand why a project has not achieved measured impact and to ensure the learning from this process is shared and spread. Fig 2 also indicates some of the measures we are beginning to use to evaluate the impact of the programme on our people.

The final angle to consider is the role of narratives, case studies and stories in describing the impact of QI work. This approach can be a powerful way to celebrate the successes of individuals and teams, while reaching out to engage those who are yet to be involved.

## Conclusions and next steps

Reflecting on the first few steps of our organisational improvement journey, there are a number of lessons worthy of noting and sharing:

1 **Organisation-wide improvement is all about people.** The different approaches we have used to engage, teach and train our staff have focused on the importance of team-based experiential learning. Long-term capability and culture need to be built through programmes that focus on developing skills in coaching and leading for improvement.
2 **There is a lot to be gained by systematically doing the basics well.** An improvement methodology such as the Institute for Healthcare Improvement's 'Model for Improvement'[10] provides staff with an approach that can be consistently applied

to plan, test implement and evaluate small tests of change. Within the first 6 months of our journey, we realised the value of designing, testing and implementing our own operational definition of QI: our 'QI project journey'.

3 **We need to be braver about involving patients, carers, citizens and our wider communities in working in partnership with us to improve the quality of healthcare.** This won't just happen; it needs strong leadership, investment in some supporting infrastructure and a co-produced strategy and implementation plan. Crucially, it requires lots of engagement and stories of early successes.

4 **We need to move from 'measurement for assurance' to 'measurement for improvement'.** In assurance, the near total use of data is for reporting 'up' with limited clinician involvement. In improvement, clinical and operational teams have regular interactions with data that allow them to design and evaluate frequent small tests of change. The priorities are to make data available to teams, develop a common data vocabulary and to develop measurement capability across the organisation.

5 **Any central QI team/hub needs to sit itself in the 'middle'.** This means working with front line teams to frame their improvement ideas against the strategic priorities of the organisation; it means looking back at short-term successes and failures while also setting the long-term direction for the decade ahead; and it means building capacity within the organisation while connecting and learning with and from outside. This requires significant time and dedication to develop the internal capacity and capability for QI.

6 **We need to reflect faster on the lessons from things that don't work, and spread the learning from those that do.** The 17 years it is reported to take for research findings to translate into practice[11] means we have to find different approaches to share and implement new ideas and innovations.

QI is as much an art as a science, and this is often forgotten by healthcare leaders when, for example, they bring in external help to their organisation to improve performance. There is undoubtedly a critical need for QI work to be rigorous and methodologically sound but, without a focus on harnessing the energy, kindness, motivation and passion of staff and patients, it is hard to see that these sorts of programmes will have the required impact. ■

## Conflicts of interests

REK is an editorial board member for *Future Hospital Journal*.

## Acknowledgements

We would like to thank Lauren Harding, Fran Cleugh, Chris Harrison, Shona Maxwell, Julian Redhead and the QI Hub team at the trust for their ideas and inspirational work in co-designing and implementing this programme.

## References

1 Klaber RE, Roland D. Delivering quality improvement: the need to believe it is necessary. *Arch Dis Child* 2014;99:175–9.
2 Deming WE. Quality, productivity, and competitive position. Cambridge: Massachusetts Institute of Technology, Center for Advanced Engineering Study, 1982.
3 Defeo J, Juran JM. Juran's quality handbook: the complete guide to performance excellence, 6th edn. New York: McGraw Hill, 2010.
4 Darzi A. *High quality care for all: NHS next stage review final report.* London: Department of Health, 2008.
5 Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press, 2001.
6 Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. *BMJ* 2001;322:517–19
7 Kohn L, Corrigan J, Donaldson M. *To err is human: building a safer health system*. Washington, DC: National Academy Press, 2000.
8 Porter ME. What is value in health care? *N Engl J Med* 2010;363:2477–81.
9 Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Affairs* 2008;27:759–69.
10 Langley G, Nolan K, Nolan T. *The improvement guide*, 2nd edn. San Francisco: Jossey Bass, 2009.
11 Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. *J Roy Soc Med* 2011;104:510–20.

**Address for correspondence: Dr R Klaber, Imperial College Healthcare NHS Trust – Paediatrics, 1st Floor Bays Building, Off South Wharf Road, London W2 1NY, UK.**
**Email: robert.klaber@imperial.nhs.uk**