

BOARD MEETING

26th July 2018

Paper Title:	Quality Improvement
Section:	Public
Lead Director:	Medical Director
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Agenda Item:	10
Presented For:	Approval
Paper Category:	Quality

Executive Summary:

Quality Improvement (QI) is a systematic approach to improving health services based on iterative change, continuous testing and measurement, and empowerment of frontline teams.

We have a duty to strive to continuously improve the quality of care, provided by the trust, and QI approaches have an important role to play in this.

A growing number of trusts are using QI and some are achieving impressive results, especially those who have sustained the approach for a number of years.

Research by the King's Fund shows that building an organisation-wide commitment to quality improvement requires courageous leadership, a sustained focus over time, and efforts to promote transparency, evaluation and shared learning across the organisation and beyond.

From the outset, it is vital to build board-level commitment to the principles of QI and support for the rationale to shift the emphasis from assurance to improvement.

QI requires leaders to engage directly and regularly with staff and, critically, to empower frontline teams to develop solutions rather than imposing them from the top.

Doing QI at scale requires building an appropriate infrastructure, including a robust support structure for frontline teams and mechanisms to spread learning across the organisation.

Fidelity to a chosen methodology helps to sustain and embed QI in ways of working and in the organisation's culture.

Fundamentally, QI rests on an understanding that those directly involved in giving and receiving a service are best placed to improve it, provided they are given the right tools and authority to do so **.

** *The King's Fund, Quality Improvement in Mental Health, July 2017 (Ross & Naylor).*

The trust recently commissioned an external expert to undertake an analysis of our needs, in respect of QI, and to recommend the next steps we should take.

The clear, and evidence-based, recommendation is that we use a QI approach based on 'Lean' (the Virginia Mason Production System being the most health-oriented version of that method) and that, via an appropriate procurement route, we should seek expert support to help us implement such an approach.

Recommendations:

That the Board:

- Agrees to implement a QI methodology across the Trust;
- Agrees that our chosen approach should be based on 'Lean' methodology; and
- Approves the development of a service specification with a view to procuring external support for our implementation

Governance/Audit Trail:

Meetings where this item has previously been discussed (please mark with an X):					
Audit Committee		Quality & Safety Committee		Remuneration Committee	Finance, Business & Investment Committee
Executive Management Team	x	Directors		Chair of Committee Meetings	Mental Health Legislation Committee
Council of Governors					

This report supports the achievement of the following strategic aims of the Trust: (please mark those that apply with an X):	
Quality and Workforce: to provide high quality, evidence-based services delivered by a diverse, motivated and engaged workforce	x
Integration and Partnerships: to be influential in the development and delivery of new models of care locally and more widely across West Yorkshire and Harrogate STP	
Sustainability and Growth: to maintain our financial viability whilst actively seeking appropriate new business opportunities	

This report supports the achievement of the following Regulatory Requirements: (please mark those that apply with an X):	
Safe: People who use our services are protected from abuse and avoidable harm	x
Caring: Staff involve people who use our services and treat them with compassion, kindness, dignity and respect	x
Responsive: Services are organised to meet the needs of people who use our services	x
Effective: Care, treatment and support achieves good outcomes, helps to maintain quality of life people who use our services and is based on the best available evidence.	x
Well Led: The leadership, management and governance of the organisation make sure it's providing high-quality care that is based around individual needs, encourages learning and innovation, and promotes an open and fair culture.	x
NHSI Single Oversight Framework	

Freedom of Information:
<p>Publication Under Freedom of Information Act</p> <p>This paper has been made available under the Freedom of Information Act</p>

Quality Improvement

1. Background and Context

This paper sets out recommendations regarding the development of a systematic approach to Quality Improvement (QI) at BDCFT.

This paper sets out some thoughts on what the main components might be in the establishment of a systematic approach. This is a long term piece of work and we should get started soon, but be realistic that significant results will take time. However, if we get the early stages right around this agenda we will create a sense of momentum around this work that will be difficult to stop.

In our early discussions as the most senior leaders of the organisation we should be prepared to consider whether we are prepared for this journey and to take on a personal commitment to lead from the front, meaning:

- a. we must be prepared to make some key decisions (with the support of the senior clinical and managerial leaders) and stick to them,
- b. be visibly behind this,
- c. develop a high level of skill ourselves in whatever methodology we adopt,
- d. enhance our coaching skills,
- e. promote a culture of devolved or collective leadership
- f. role model
- g. hold to account
- h. celebrate success.

Why do this?

The Board has already expressed its desire to see the development of a systematic approach to QI. This has been reinforced in the Trust's response to the recent CQC report. The Trust has also had a number of recent experiences of adopting QI practices in specific projects and pieces of work in pockets with good successes.

The Trust has also recently embarked on the first stages of the development of a new 5 year organisational strategy. This will set a clear vision of the future, making sense of the world around us and the part that BDCFT will play in this. This strategy will clearly set the tone for the way that we as the most senior leaders need to develop the organisation and create the right culture for success, however we define it in the new strategy.

This is the main reason we should adopt a QI approach; to galvanise the organisation behind the Trust's strategy and to create a culture that embraces quality and gives all staff the encouragement and skills to improve their work. The reason they will be fully behind this is because the focus of everything we do should be clearly linked to improving patient experience and outcome. We hope our new strategy will make this clear. Our job as leaders is to make the connection between Trust policies, procedures, projects, training

and anything else we ask people to do and the mission of improving patient experience and outcomes.

Collective commitment

There are several organisations that have undertaken a similar enterprise and not sustained the initial enthusiasm. It is important that as part of our early work we are clear that we as the most senior leaders are “bought in”. We need to feel free to express our hindering thoughts and coach ourselves through this, offering support and indeed challenge where we feel we need to. We will also need to work through the risks and issues that undoubtedly we will discover together.

We will need to think carefully about our communications and engagement strategy. Our new CEO will be the overall sponsor of this work, but we need to all be highly visible through various media and channels. We must all be out as much as possible with staff, listening to them, coaching them and challenging them to take on the initiative in their areas.

The successful implementation of QI requires a leadership style that embodies respect and trust in staff to do their jobs. This means that the role of leaders is to coach people to be the best they can be for the benefits of the care we deliver (including staff in corporate jobs). Staff must expect to be held to account if they do not deliver, however we must not blame and should always try to find positives and learn lessons (in managerial and also clinical matters).

Through this approach, the adoption of a tools based approach to QI will allow us to develop our people to drive their own improvements. If we create the right environment and culture, they should be able to identify clear improvement priorities and with a range of QI tools, manage through process improvements that allow them to focus on delivering great care or supporting the delivery of great care.

In some companies that use ‘Lean’ they do not have job descriptions, staff are aligned to the purpose of delivering a service or product, trained in multiple roles and committed to continuous improvement. This is collective leadership and commitment. Everyone sees quality improvement as their job. No matter where they work in the organisation, what their level of seniority is or how potentially small their part of the overall process might feel to them. This idea of collective leadership and commitment (and not of no job descriptions!) could really help us to empower and unleash improvement potential in the Trust.

If we are to agree to adopt this way of working we will need to:

- Have really clear communications about what we are trying to achieve in our new strategy
- Have an explicit conversation (two way) about values, behaviour and expectations
- Give a clear statement that people have the power to act and the responsibility to deliver and be held to account
- Ensure our leaders (including us) have the right solutions focussed coaching skills to untap the potential

- Target QI training specific to Executives, medics, senior clinicians and operational and function managers, admin and experts by experience
- Be clear what success looks like – expressed in outcomes, built into our strategy and what everything we do should hang off.

Thinking and Planning

Following the, NHSI-led, development sessions for Board members, senior clinicians and senior managers we commissioned an external expert to narrow down the specific methodology and help prepare us to tender for a partner to help us skill up.

If we are really serious about embedding QI then we need to think about how this will work across the organisation. As mentioned above, if the end is improvement in patient experience and outcome then we will need to think how this links to our:

- Business planning and priority setting process
- Performance improvement system
- Financial forecasting and costing programme
- People development system
- Clinical pathways
- Technology transformation programme

As we shape our new organisational strategy we will need to be clear about our metrics. We can use driver diagrams or logic models to get to these. We will probably need to work toward a relatively small number of key outcomes potentially linked to:

- Access
- Quality
- Patient Experience
- Money/Value

From the beginning we should look to engage and involve people in how we develop this. Staff and service users can help us to identify the metrics, be involved in ideas generation and be part of the priority setting. They will be front and centre on delivery.

The Trust has already made great strides on this sort of thinking and, for example, we might want to consider using i-Care as part of the branding for our QI methodology.

Issues for Consideration

- Identify a method and delivery partner
- Be honest and clear about what we can afford to invest
- Set up an Improvement Office (consider involving PMO, Clinical Audit, Organisational Development, Patient experience and PPI expertise, Patient Safety, Expert by Experience)
- Pull together our coaching development expertise and supplement with training from outside where needed (budget dependent)

- Executive Accountability Visibility Wall – key metrics and KPIs set out around strategic priorities, improvement work linked to the priorities, start reporting out and role modelling
- Establish a “Guiding Team” or Transformation Board (small group) to lead the thinking, reading, horizon scanning, ideas generation and strategic QI priority setting
- Consider training focus and products
- Identify some early QI priorities for “model cell/team” work
- Engage with senior staff initially – clear on reason why, clear on their role and expectations, clear on the gives and gets in shifting the power and being accountable.

This is not an exhaustive list and there will be lots more to consider.

2. Proposal

In searching for a suitable methodology we have considered the following key areas for consideration (as highlighted in the NHS Change Model) as criteria:

- Leadership for change
- Spread of innovation
- Improvement tools
- Rigor
- Transparent measurement
- System drivers
- Engagement across the organisation

The main methodologies for consideration are:

- Business process re-engineering – this methodology involves a fundamental rethinking the organisations central processes. This leads to a restructuring of the organisation around these processes rather than specialist functions. This moves organisations from silo working and allows waste to be identified. This approach needs to be driven top down by a visionary leader.
- Experience based co-design – this requires patients and service users to work with staff to design services. Data are gathered through an in depth set of interviews and observations and discussions. Analysis is presented back and staff and patients work together to undertake service improvements. This is more project specific (and not organisation-wide) and not based on a tools based approach. Several NHS organisations have used this for large scale service reconfiguration.
- Lean – a quality management system adapted from car manufacturing. The system is based on defining value, reducing waste to maximise value and involving those who do the work (and the customer) in improving their processes. The methodology is based in a collective ownership of the improvement agenda and is aligned to strategic deployment of the organisations strategic priorities. There are a number of key tools including standard

work (allowing the scaling and repeatability) of improvements. Improvement is sustained through measurement and routine reporting.

- Model for improvement – the method deployed by the Institute for Health Innovation (IHI). This promotes improvements that are tested in small plan, do, study, act (PDSA). The method uses statistical process control run charts to pin point priorities for improvement. Fundamental questions guide each piece of work: what are we trying to achieve? How will we know that a change is an improvement? What changes can we make that will result in improvement? The method is a way of organising improvement work and is an enabler to delivering a broader quality strategy.
- Six Sigma – this methodology is about reducing and eliminating defects. It is based on establishing the voice of the customer in identifying these defects and uses statistical methods to develop standards for variation in quality. The methodology is strong on customer value and challenging waste. However, through statistical analysis it is philosophically prepared to tolerate some defects in processes. It was developed within the electronics industry with Motorola being a high profiler adopter of this system.
- Theory of constraints – this method assumes that any process or chain is only as strong as its weakest link. The approach involves identifying the constraint or bottleneck and tackling it. The methodology will then attempt to level capacity to meet through address the bottleneck. This method is a process improvement methodology that can be adapted to address the quality improvement agenda. This methodology is widely used by district health boards in New Zealand.

As an organisation embarking on its QI journey it is important that the weighting of the criteria used to judge the most appropriate methodology is on the ability to identify an overarching QI narrative that can be adapted to Bradford. This means (i) that it becomes a key enabling system to support the delivery of organisational strategy, (ii) that it can engage lots of staff and service users, very quickly, (iii) that there is training in QI techniques and tools that can be rigorously deployed to meet organisational priorities and (iv) that it can demonstrate sustainability through the use of measurement.

For these reasons, it is recommended that Lean is adopted as the preferred methodology.

There are other, clear advantages to choosing Lean in that the new CEO has been using this particular method for many years which could save us a lot of time and money and also that it is becoming the most commonly used (and supported) method in the NHS with NHSI's own QI support programme being based around this method.

Virginia Mason Production System (VMPS) is a form of Lean that has been developed specifically to suit the healthcare world and it is, therefore, recommended that we procure support from someone using a UK-grown derivative of it.

What about other local trusts?

Leeds York Partnership NHSFT and South West Yorkshire Partnership NHSFT are both about to adopt the Model for Improvement working with IHI. This is a potentially expensive

approach and is not systematic. It will sit as part of a wider range of tools and techniques to deliver the quality strategy. There is no particular advantage in adopting the exact same methodology as other organisations in the system. The various methodologies have similar DNA, so working together should not be harmed through adopting a different approach to them. There is only one other Mental Health NHS organisation that we know who has adopted the IHI Model for Improvement, East London NHSFT (ELFT). This has been very successful. QI at ELFT is very widely spread across the organisation. It works on members of staff suggesting schemes. It deploys the methodology to work across multi-disciplinary teams to improve the service.

The Model for Improvement does not link in the same way to policy and strategy deployment. It is something that is used to successfully solve a problem, it does not lead to the embedding of a collective commitment to everyday quality improvement in the same way that Lean does.

3. Next steps

We should now start the process of identifying delivery partners who can:

- Develop our board's knowledge and skills in the strategy and policy deployment aspects of the method
- Develop our Quality Office capabilities and expertise
- Contribute to the development of a Collective Leadership Strategy (to be Trust driven and the partner to advise) and training package
- Help us to develop a range of training materials for use across the organisation
- Train and coach a number of leaders in the methodology to a level of expertise, where they can teach and train others
- Help develop solutions focused training skills for all staff across the organisation
- Set out a clear exit plan that establishes the Trust as a self-sustaining QI driven organisation
- Set out options for a future ongoing annual sensei review and advice relationship

In addition, by the end of September we need to have scoped the likely internal and external resource impacts including the staff associated.

4. Implications

4.1 Legal and Constitutional

None.

4.2 Resource

National benchmarking suggests initial support costs in the region of 200k per annum are a reasonable estimate with high returns, in terms of quality of services, staff engagement and efficiency gains, delivered for as long as fidelity to the model is maintained and leaders are unswervingly committed.

4.3 Quality and Compliance

- The implementation of a formal QI methodology will help us to radically improve the quality of all our services, delivering improved CQC ratings along the way.

5. Risk Issues Identified

Risk	Likelihood High/Medium/Low	Implication	Mitigation
Failure to realise quality and efficiency gains despite significant financial and human resource investment	Low	Poorer outcomes / reduction in services / efficiencies to be gained via other, unidentified methods / serious reputational damage	High quality service specification Identify capable, experienced support partner Board all fully committed to 'living and breathing' methodology Remaining faithful to the chosen methodology

Board will be aware of a number of organisations where QI has failed. We can learn from these examples; they typically tried to invent their own method without expert external support, leaders were seen to doubt the method, trusts did not maintain fidelity to the model when the going got tough and some felt that QI was a panacea for all ills.

On the other hand, a small, but growing, number of trusts have successfully implemented QI and are now reaping huge rewards in terms of the quality of their service offer, external recognition (e.g. CQC Outstanding) and staff satisfaction. It is these organisations that we should look to emulate.

6. Communication and Involvement

A full communications plan will be developed once our support partner has been identified.

7. Monitoring and review

Should Board agree to proceed with the procurement of an external support partner for Lean / VMPS, it will need to return to this proposal in September to assess progress, including the identification of likely internal and external resource.

8. Timescales/Milestones

Aim to commence procurement in September, following our Board meeting, with award as quickly as procurement method allows.

9. Summary

The Trust has started to do some deep thinking about the development of a systematic approach to QI and now has a clear recommendation about the best way forward.

This is a fantastic opportunity but this is very much the start of the journey. If we get this right we can make huge strides in improving experience and outcomes for service users and make BDCFT a really enjoyable and satisfying place for people to work.