

Report of the review of the application of the Framework for Improving Quality in our Health services: Learning to guide future approaches.

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1. Background / Rationale

In 2016, the HSE National Quality Improvement Division (QID) published Part One of the *Framework for Improving Quality in our Health Service* (henceforth referred to as the “Framework”). The Framework was developed as a response to a need to orientate the planning and delivery of healthcare away from crisis management to proactive service improvement. The Framework provides a strategic approach to improving quality at all levels, from front-line to national level. It aims to foster a culture of quality that continuously seeks to provide safe, effective, person centred care. The Framework is comprised of six drivers, which give a structured approach for improving quality in services. The combined force of the drivers working together creates the environment and acceleration for quality improvement. The six drivers are:

1. Leadership for Quality
2. Person and Family Engagement
3. Staff Engagement
4. Use of Improvement Methods
5. Measurement for Quality
6. Governance for Quality



At time of publication, it was acknowledged that the Framework would require testing in order to examine how each of the six drivers translates in different levels and settings. The Framework Review herein was commissioned as part of the overall evaluation of the implementation of the Framework to date.

2. Purpose

The purpose of this Review was to:

- Summarise the implementation approaches, achievements, and challenges to implementing the Framework in four different settings;
- Gather and analyse key learning to inform future approaches to successful and sustainable application of the Framework;
- Highlight key lessons learned and make recommendations to inform subsequent programmes addressing Framework implementation as well as Part 2 of the Framework resource.

3. Methodology

The review applied a sequential exploratory approach, commencing with a qualitative questionnaire method (Appendix 3) followed by qualitative one to one interviews with service leads (Appendix 9 & 10) to illuminate the findings from the initial stage. A review tool was developed by key QID leads in order to gather the necessary information for this review (Appendix 3 of main document). The tool was circulated to demonstration sites / programmes QID leads capturing four different settings, including:

- Two hospital services: Mayo University Hospital (MUH) and the National Rehabilitation Hospital (NRH)
- One National Safety Programme - Pressure Ulcers to Zero Phase 3 (PUTZ3)
- One Social Care Division Programme - whereby QID supported staff in residential services for adults with intellectual disabilities

In total, there were five templates submitted for inclusion in this review. A comparative analysis was undertaken to analyse where the similarities and differences in approaches occurred and to illuminate areas of practice that worked and areas that proved more challenging.

A literature review was also undertaken on relative research concerning the implementation of quality improvement Frameworks internationally and recommendations on future approaches to applying the Framework for Improving Quality across our health care services are made.

A challenge to the methodology of this review was as follows: while some sites and services were at an early but progressive stage of implementation of programmes of work, the progress at this point of review did not fully support the stage of application of the Framework specific to these settings, in addition not all sites were ready to conclude work regarding the application of the Framework on the completion of this review.

4. Significant Findings reflecting the successful application of the Framework for Improving Quality

The achievements of the four programmes were many and varied. This review has determined that the key success factors included:

- The identification of **key planned areas of work** at the outset in partnership with the services contributed to the successful and shared application of the Framework. This enabled a clear and consistent vision, mission and goals to be agreed and worked towards in a planned and comprehensive manner.
- Applying a **co-design approach** whereby sites took ownership and leadership of the work so as sustainability and spread were achievable, while QID providing consistent key support. This was crucial in enabling the site to take the leadership and governance role of this work and navigate the various stages of change so as to embed new ways of working within the culture of the service.
- **Due consideration and time allocated to planning** for the application and implementation of the Framework in partnership with the sites, with written plans and a core consistent working group. A significant amount of time concentrated on the preparation stage in partnership with site leads, staff and patient and family inclusion, to support a culture in their readiness for change and continuous quality improvement.
- Effective **communication, coordination and engagement** between QID and the sites/services, as well as communication to wider audiences e.g. staff and service users; ensured that each test of change using the IHI model for improvement was coordinated, manageable and consistent.
- Access to **resources, skills and knowledge** pertaining to the six drivers from other driver teams within QID, in a coordinated and pre-agreed manner. This reflected the support of the organisation to ensure each driver had appropriate supports at each stage of application and with equal emphasis in its approach. No driver across the Framework for Improvement (2016) superseded another, which subsequently resulted in a comprehensive application of the Framework in its entirety where the application of the Framework was successful.

5. Significant Findings reflecting the challenges to applying the Framework for Improving Quality

- A recurrent challenge across both demonstration sites and programmes of work was the **lack of guidance** from the outset regarding the application of the Framework drivers in a consistent and guided manner. Specifically the many and varied ways in which drivers were perceived both by QID staff and the site lead was a challenge in terms of measuring the outcomes of all of the drivers.
- Applying the Framework as a focused service priority among **competing demands** required the positive momentum for change from both service and QID leads to ensure the completion of this work.
- **Time management and scope creep** were difficult to manage resulting in delays in completion of works.

- **Communication, coordination and shared learning** within QID was identified as a challenge as each site and programme of work progressed in parallel to each other, with no opportunity to link and share experiences and learning.
- Staff turnover within sites was identified as a challenge and the readiness of the site to participate in high level **reactive change** where the culture was in crisis compounded the challenges.

6. Discussion with relevance to the application across identified sites and services.

Planning stages

The application of the Framework required extensive planning, negotiation, review and collaboration with each of the services involved.

Planning approach: Each approach both demonstration site (MUH & NRH) and programme of work (ID Services & PUTZ3) differed in its application of the Framework. Reasons for this include the fact that sites differed in their stages of readiness and also there was a lack of guidance to support applying the Framework with the services. Successful implementation of the Framework was accelerated where there was preparation which shaped and helped progress the implementation of each driver. Key processes included shared leadership, clear governance and ownership, working collaboratively with services and applying shared resources; the completion of project charters; undertaking focus groups; and conducting effective team meetings all supported a positive approach to applying the Framework.

Programme aims and objectives: In each of the programmes reviewed, the approach to implementing the Framework had a planned aim. It is also evident that having clear, measurable programme objectives contributed to the successful application of the Framework. While the aims and objectives largely reflected an intention to improve the quality and safety of the service using all six drivers, some drivers required more attention than others to initiate this work on a site by site basis. The use of all six Framework drivers, however, was essential to anchor specific areas of work and embed a sustained continuous improvement of quality within the services. Successful implementation was more evident where all six Framework drivers were given equal emphasis; and where emphasis was placed on one or two drivers more than others, implementation of the overall Framework in an integrated way was more challenging.

Working agreements: Agreement between QID and the services as regards partnership working arrangements varied along the spectrum from informal verbal agreements to written formal contracts. Written agreements resulted in a greater focus on programme goals, and assisted in solidifying the roles and responsibilities of both the sites and QID. Verbal agreements, although useful, proved challenging to keeping the focus of work to the fore, managing expectations, and sustaining partnership between teams.

Programme governance: The governance of each of the programmes varied. Governance structures mostly involved senior management within the sites and key leads in QID. Where joint partnership of the work was established at the outset between QID and site leads, senior management had a sustained role in programme governance. Where strong leadership and commitment to implementing the Framework stemmed from within the service, there was a greater sense of local ownership and incremental gains in the progression of work. In most cases, at the outset of a programme, QID had an active role in driving and governing the work; this later developed a role of support and guidance. Where sites depended on a partnership between QID and senior managers alone, it proved more challenging to obtain agreement and overall implementation of the programme of work throughout the service.

Framework Application

Priorities: In the main, priorities for applying the Framework were identified by the designated programme working group, which had an oversight role. A co-design governance structure appears to be a successful contributor to achieving outcomes. Programmes that used a site readiness checklist were able to identify priorities using each driver.

Measurement: All four programmes incorporated measurement into their approaches, in order to ensure that improvement could be evidenced. All four programmes considered a comprehensive approach to measurement, using both qualitative and quantitative approaches, and included the views of programme team members, service staff and service users to varying degrees.

Support from QID: Support from QID varied across the sites and was based on the identified needs of services at specific times. Where leads and supports from specific drivers were accessed, this contributed to a more successful experience in applying the Framework and using all six drivers to underpin programmes of works.

Resources: There were over 50 resources developed to support the application of the Framework across the programmes (excluding the total number for the safety programme).

Shared learning: The approach to sharing learning across sites and services has been diverse, using a range of methods and media. Most sites are at a stage where learning can be shared using a suite of transferable resources or illuminating experiences through networking events and poster campaigns. A few sites, however, are not at the stage where sharing of learning can occur as yet.

Scale of work: Across the four programmes, the intention and scale of work applying and using the Framework differed significantly. The services involved were at varying stages of readiness, and had different understandings of the purpose of the Framework. Some services viewed the Framework as an integrated approach using all six drivers, while others targeted specific drivers individually depending on the need as they saw it at that time. In the absence of concrete guidance for applying the Framework, and an agreed approach, progress and achievements were dependent on individual ways of working, differing approaches to measurement, and incrementally agreeing the next stages of work rather than adhering to a fixed long-term project plan. Expected outcomes at the commencement of the programmes were continually revisited, assessed, and amended, keeping in mind the context of the work and its development pace.

Timeframes: Some of the projects experienced delays delivering to agreed timescales, even with a co- designed approach. On reflection, some of the initial timeframes proposed may have been ambitious to achieve, as they were initially proposed without the benefit of a baseline to work from. Another factor appeared to be related to staffing, both in the services as well as QID staff supporting the programmes. Where senior management posts in services were unfilled, there were delays in the commencement and progression of work.

Sustainability: Mechanisms for sustainability should be considered at the outset of programme work to ensure improvements are embedded within the service. Some programmes have sustainability plans, although they are dependent on the continuation of an oversight governance group and strong leadership at all levels. Various efforts have been identified to promote sustainability, including the development of toolboxes and continuous education and training by local and national champions for QI.

Lessons Learned

To date, there have been many achievements across all areas of work applying and using the Framework; likewise there are has also been challenges. Approaching the application of the Framework for Improving Quality (2016) should be undertaken in a coordinated, planned, organised and agreed manner with services. While the Framework has been applied using both a scheduled and responsive approach to a crisis, it is preferable that it is applied in a pre-agreed planned manner with services and sites. In instances where the services welcome and support the scheduled application of the Framework for Quality, outcomes were likely to be achieved in an effective and timely manner. Effective communication with all stakeholders from the outset and throughout the process of application should be agreed. A co-designed approach is recommended with clear roles and responsibilities from both service site and QID. This is necessary to ensure that QID provide the best support and that the site takes ownership and lead with the agreed changes. Supporting service leads to identify the governance and ownership of this work at service level strongly supported the successful application of the Framework. Key to successful outcomes were the development and implementation of effective ways of working and applying tried and tested templates

between QID and site leads. In particular, having a project charter and ensuring the effective running of meetings in a structured way enabled the identification and management of scope creep. Each implementation plan needs to consider the best way to engage patients and families so as to maximise their input to the planning and implementation of the Framework, at all levels within the system. A significant proportion of time should be allocated to addressing the assessment and planning phases of the Framework. The commitment, patience and resilience of the team need to be encouraged to achieve the goal, particularly in the context of challenges of implementation. While some attention is paid to ensuring the inclusion of patients and families, the commitment of the planning and application of the Framework needs to reflect a true partnership approach at every stage of the process between the NQID and service leads. Leadership is crucial here, in particular to influence the challenges and support the changes which lead to successful outcomes. Applying and utilising information and data to drive quality needs to be easier to transfer and spread learning across the services. A sustainability plan needs to be considered from the outset and the best mechanism to support sustainability needs to be embedded as a process of work.

7. Discussion with regard to Current Literature

While there is a growing interest in researching quality implementation internationally, there is relatively little detail on the implementation of quality Frameworks or models (Meyers et al., 2012; Domitrovich et al., 2010; Durlak and Dupre, 2008). Suggestions regarding implementation approaches, however, have offered a foundation for success (IOM, IHI, Rogers, 2003).

Use of a Quality Implementation Framework

Applying an implementation Framework enables the review of key characteristics, enablers and challenges which promote implementation (Flaspohler et al., 2008). Meyers et al (2012) have proposed a Quality Implementation Framework (QIF) which focuses on the critical steps and actions necessary to achieve quality implementation. It identifies four phases of implementation and 14 critical steps to successfully implement a Framework for Quality. The four phases include: 1) initial consideration regarding partner service setting, 2) creating a structure for implementation, 3) on-going structure once implementation begins, and 4) improving further applications. This four phase approach assists in identifying when and where to focus quality implementation attention and efforts. While there is no one size fits all approach, the QIF is a tool which provides a series of steps to guide and contribute towards successful implementation.

Achievements of the QID programmes discussed in this review are comparable to the four phased approach to varying degrees. Where key steps and associated questions related to each step were addressed, this contributed largely to successful outcomes for application of the Framework, particularly those that attended with some emphasis on planning. However, where critical steps on this journey were outstanding, this had negative consequences for the overall application of the Framework.

It is worth considering applying the QIF approach when implementing the Framework, and allowing greater emphasis of time and resources on the preparation stage to identify assessment strategies, capacity building, and creating a structure for implementation which may result in a more successful implementation of the Framework. Meyers et al. (2012) also suggest that documentation of effective implementation is critical to building and sustaining success across services.

Leadership

The Institute of Medicine (2002) identifies leadership as a key factor in facilitating a team to flourish and realise its potential to deliver successfully. This is achieved when leader's act with commitment to the missions, values, goals and expectations that promotes quality and performance excellence in the service. A patient focused mission, vision, values and goals of an organisation is best integrated into all aspects of management through effective leadership. Leaders, particularly in health care organisations, have the ability to create the infrastructures which promote the development and role of champions, continuous quality improvement of services and programmes and utilising expertise to assist the team, particularly at

the early stages. The role of leadership in preparing for change and determining organisation readiness is essential. Therefore, identifying leadership support for quality, promoting staff engagement and ensuring that there is an ability to manage change, provides the context for an effective QI programme to develop overtime. Where leadership was evident in sites where implementation occurred, change was managed in a consistent, shared and agreed manner. A challenge to some sites was the inability to provide consistent visible leadership. This was evident through the turnover of staff across both service sites and support to the programme of work, dependency on single agents and the unavailability of resources to lead and develop the implementation.

Team Process

Key to all implementation discussions is the identification of quality improvement as a team process. It is suggested that this is most effective when complexity is evident, issues are addressed as a collaborative effort, a co-designed approach is in place and spaces to be creative are encouraged. In addition, the commitment of staff and their willingness to engage is crucial. Where the application of the Framework, and applying its use to underpin specific works, was more successful there was a clear demonstration of effective team processes and in particular a willingness to engage by the sites in a meaningful way to achieve the outcomes.

Climate of Support

In addition to ensuring leadership and effective team processes, fostering a supportive climate is another feature where steps to implementing a quality Framework needs consideration. Critical steps include engagement and the opinions of key leaders and decision makers regarding innovations, needs and benefits; aligning the innovation with broader service mission and values; identifying policies that create incentives for innovation use and reduce barriers to innovation use; and identifying champions who will advocate and support the innovation. A key consideration discussed in the literature is identifying the organisation's will to shift from providing standard of care paradigm to continually improving their performance. This needs to be the key considerations and reflections of the management team's position prior to proceeding with QI implementations of the Framework for Improving Quality (2016).

8. Recommendations

1. QID should consider adopting an evidence-based implementation approach to applying the Framework to guide and support the process of application and evaluation, such as the four phased approach suggested by Meyers et al. (2012).
2. The key factors that have contributed to success in planning and implementing the programmes outlined in this report should be reflected on and adopted by current and future programmes. In particular, consideration should be given to a realistic timeframe for implementation in the context of a complex ever changing health environment, with particular attention to planning and resources.
3. While the Framework is applicable across all health service settings, its implementation needs to be centrally coordinated by QID so that resources are applied in a consistent and integrated manner, and expertise from relevant driver teams is maximised. In line with this, QID as a division/team needs to improve its coordination and mobilisation to provide a defined central resource to services and sites implementing the Framework. This should include:
 - a. Attention to shared communication and commitment from QID to work in a more integrated way to ensure a consistent approach to working with sites.
 - b. Improved communication within QID to share learning and resources for implementing the Framework. This could include dedicated QI Talk times/QI clinics focused on key areas that matter to sites in relation to the implementation process.
 - c. Capabilities within QID need to be marketed as a resource to services to support the application of work regarding any specific driver, and contributing to an integrated approach to implementing the Framework.

- d. Resources and templates developed and tested across programmes should be accessible by all teams within QID.
 - e. Provide formal structures and forums for incremental QI capacity building for participants and teams locally.
 - f. Clarity to all services that the role of QID is to support and advise, rather than provide, inspection, research, or management services.
 - g. QID should identify where existing capability regarding QI approaches and methodologies exist within the health service to support the application of the Framework (outside of the QID team). For example, service providers with QI capability and services such as the academic partners can support evaluation, education, and innovations in existing programmes of education.
4. The development of Part 2 of the Framework should be accelerated, including the provision of online resources and tools to support implementation. Each of the six drivers requires clear measures to support existing descriptions, and to provide clarity on what implementing the Framework looks like in different settings. This should include identified measures to demonstrate each driver's effectiveness and contribution to the overall Framework.
 5. Improved collaboration and commitment between QID and service/site partners to improve the likelihood of successful outputs and outcomes.
 6. Sustainability of improvements must be a focus from early programme planning stages, and revisited regularly in the implementation process.

9. Conclusion

This Review has reflected achievements, challenges, resources, templates and lessons for future considerations to Framework implementation in health services. It is worth considering the Quality Implementation Framework tool (Meyers et al., 2012) which offers a guided phased approach to match actions and resources to support the overall implementation plan. The recommendations made should be considered in the context of future implementation approaches.