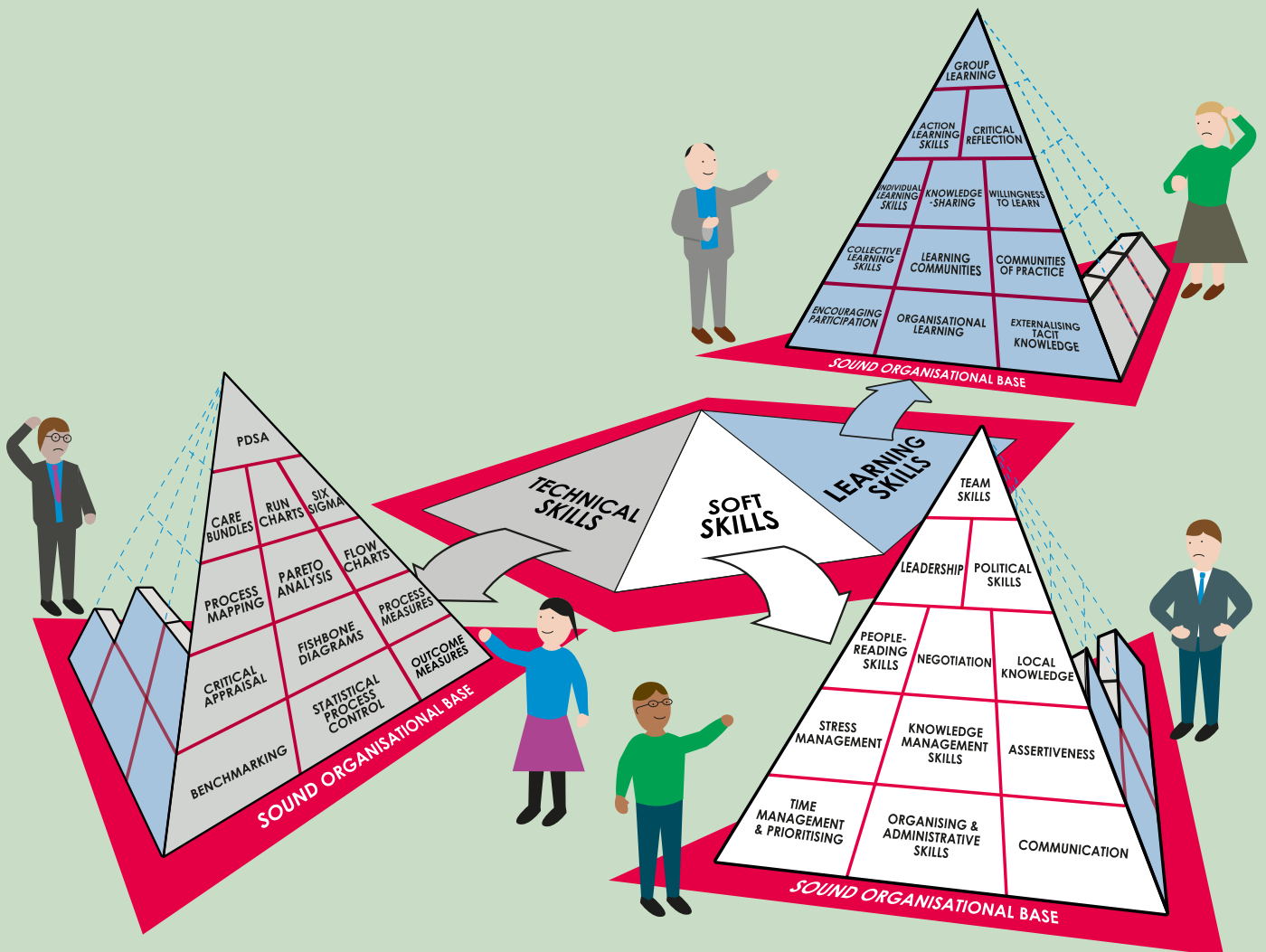


Skilled for improvement?

Learning communities and the skills needed to improve care: an evaluative service development



This project was commissioned and funded by the Health Foundation to help identify where and how improvements in healthcare quality can be made.

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We are all still learning together ...

Anonymity

It is always problematic to write an account of this sort while holding to one’s assurance to participants that the data would be kept anonymous and unattributable. We have done our very best to maintain anonymity by giving the sites fictional names and using false names for specific individuals; but inevitably some readers will still be able to identify the sites. We hope that participants will accept that anyone who recognises one or other site will probably already be close enough to them to be well aware of most of the matters we raise, and that no harm will result.

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Executive summary

Introduction

The Learning Communities Initiative aimed to explore the use of organisational techniques such as learning communities and communities of practice. It set out to work with selected improvement groups in the NHS to help them learn collectively about proven improvement methods ('improvement science') and to examine how the learning process – and hence the enhancement of quality – could be better deployed in future improvement initiatives. The work was carried out in 2010–12 in two sites, which we have named 'Dansworth' and 'Furnhills'; each had a strong track record of working to improve quality and investing in learning and development to support this work.

Each site selected two specific improvement tasks in different clinical areas. Dansworth chose (i) medicine for the (hospitalised) elderly and (ii) the hospital care of patients who have dementia (we have named the projects Danelder and Dandem respectively); Furnhills chose (i) the care of people with chronic obstructive pulmonary disease (COPD) and (ii) community dementia services delivered by the memory clinic (Furncop and Furndem respectively).

The Health Foundation project team, comprising four senior academics with a long history of health services and organisational research, aimed to work with four 'improvement groups' to delineate clear improvement tasks and to help them function as learning communities to undertake those tasks.

Methods

After a short period of intensive orientation based on interviews and document review to probe each organisation's structure and culture, we undertook a (mainly telephone) interview survey of a snowball sample of the key players associated with each task until

we reached saturation (n=9–13 per group). The semi-structured open interviews were designed mainly to elicit interviewees' concerns about the services being provided but also what they thought were the successes. We also explored their understanding of improvement methods that might be used to deal with their concerns.

Having analysed the results, using a method based on 'fourth generation evaluation' that we called systematic prior interview-based analysis of claims and concerns (SPIBACC), we fed them back to the four improvement groups. Using a version of nominal group technique that we called subsequent open prioritisation, we facilitated the groups in prioritising topics for the first of an intended series of three 'learning events'. These were designed to help fill agreed gaps in knowledge or skills needed to accomplish the improvement tasks. Further learning topics were to be chosen in the light of the first event and subsequent rounds of interviews, evaluation and prioritisation. There were nine learning events altogether (four in Dansworth, with two for each improvement group; and five in Furnhills, four for the first and just one for the second group), all of which were facilitated and/or observed by members of the Health Foundation project team.

The findings – including from some 35 further interviews during the fieldwork, and from observations of the nine learning events and a similar number of other group meetings – were analysed qualitatively as the projects unfolded to produce descriptions of the improvement and learning processes (or lack of them) across the four improvement tasks. The final analysis also included information from a further 33 follow-up interviews between three and nine months after the individual projects had ended, to establish subsequent progress with the improvement tasks.

Findings

The four improvement groups proved very different in terms of their characteristics, cultures and processes, and the extent to which they achieved their improvement tasks. This report presents a detailed picture of the four contrasting improvement stories – which, in effect, proved to be a natural experiment – and analyses the reasons why there were such significant differences in what they achieved and how.

The Dansworth elderly care improvement group set itself the objective of improving the system of estimated discharge dates (EDDs) to help minimise unnecessarily long stays in hospital. Led by an able and well-trained ‘improvement fellow’, and with experience of using quality improvement (QI) techniques such as plan, do, study, act (PDSA) cycles, the group functioned well as a learning group both internally and in terms of spreading the learning that it generated more widely. Despite a recent restructuring of the service, which had proved very stressful, the group surpassed its objectives. They felt well supported by, and made good use of, the wider improvement structures and culture in Dansworth, where the principles of ‘improvement science’ were well established and fostered by senior managers.

That culture had not, however, spread to the domain of the second Dansworth improvement group (the one working on dementia services), or to its partner organisations involved in dementia care. Due to a welter of external and internal pressures on service managers, it did not prove possible to establish a learning community around the dementia group’s originally intended task. However, a wide and disparate cross-sectoral group was brought together for the first time ever in two learning events around a related topic – the development of staff training schemes to improve dementia care – and this did much to foster better cross-disciplinary and cross-sectoral understanding that helped to develop an agreed work plan.

The Furnhills COPD improvement group, which chose to improve the management of COPD in the community, held four learning events. These covered: improving group members’ interpersonal skills; the techniques of social marketing (to help ‘sell’ to patients and clinicians the idea that COPD is a treatable condition that should be properly managed); an introduction to the principles of improvement science; and a subsequent follow-up event to help put those principles into practice. These last two events inspired the improvement group to completely alter their approach to helping primary care teams improve the management of COPD. However, despite their

senior manager (a GP on the executive board) strongly advocating implementation of this new approach to improvement, it proved inimical to the performance management culture that was prevalent in Furnhills and, as a result, made little headway. However, Furnhills’ targets for patients with COPD were met.

The other Furnhills project, which set out to help restructure the memory clinic service, stalled for nearly two years for a variety of internal political reasons, including a stand-off between key parties and managers’ preference for improving services by means of commissioning and planning structures. One learning event was finally arranged at the end of our time there. Despite anticipated resistance, the event opened up a dialogue between key parties who had not previously come together to discuss the difficulties surrounding community dementia services; this led to significant changes in care pathways, including more GP-led care, supported rather than led by memory clinic staff.

In common with other researchers in this area, we found factors in all four improvement areas that affected their receptiveness to change. These included:

- the external environment (for example, reorganisation vs stability, multiple targets, cross-cutting national programmes)
- internal organisational culture (for example, the prevailing managerial approach to QI, the degree of penetration of that approach, leadership styles, internal wrangles, degree of mutual trust)
- resources, structures and processes (for example, staff time and conflicting priorities, educational systems, QI systems) that might help or hinder the work of the improvement groups and their appetite and capacity to learn.

We discerned three different types of skills – technical, soft and learning skills – as being essential to the work of the improvement groups, and found that difficulties ensued when any of these were inadequate. What all four projects had in common, therefore, was their reliance on knowledge, skills and techniques that included not only the technical skills usually associated with improvement science (such as Lean methodology, PDSA cycles, run charts and care bundles), but also others that were clearly the fundamental *building blocks* without which improvement could not happen. These organisational or ‘soft’ skills included assertiveness, communication, negotiation, time management, stress management, leadership and team skills, administrative and political skills, educational and knowledge-handling

skills, and local knowledge. The third set of skills involved the art of collectively *learning* how to improve services. These learning skills enabled the improvement groups to learn from each other and also to develop a broader learning community; they appeared to play a key role in the extent to which each group was able to achieve its objectives. The evidence, management, and parallel development of each of these three skill sets were demonstrated differently in each improvement group, leading to contrasting learning outcomes. This report provides an analysis of what those three skill sets actually mean in practice, explaining why it is important to engage all three skills sets when leading even relatively straightforward improvement work at all organisational levels, especially where that involves cross-team working.

Conclusions

Part of the reason why quality improvement is so hard to achieve may be that those involved in leading QI programmes need to deploy three different but interrelated types of improvement skills: technical, soft and learning skills. A lack of skills in one area will constrain progress, irrespective of the team's strengths in other skill areas. We have illustrated this with the analogy of a pyramid that requires all three faces to be equally high if its summit is to be at the desired elevation (see Figure 3 on page 56).

In practice, therefore, all three skill sets need to be carefully assessed and developed in QI initiatives; employing the techniques of improvement science is not sufficient. Developing these skills (including the ability to learn collectively as a group) needs to be recognised as a central function of managers and practitioners; it should not be regarded as an optional 'add on', but should be institutionally supported (culturally, financially, and inter-personally) if QI initiatives are to succeed.

Quality improvement requires strong and unambiguous central support (covering administration, strategic planning and resourcing, among other elements). The pyramid also requires a broad organisational base, strongly sponsored by senior staff. But securing such support throughout the organisation cannot be taken for granted; even where there is strong management and executive backing for improvement work, the degree of common understanding between different parts of the organisation may be deceptive. Even in apparently high-performing organisations, it is crucial to understand and take account of the range and depth of skills possessed by individuals and project teams

when planning and managing improvement projects. Those responsible for commissioning improvement programmes must therefore balance ambitious ideas with grass-roots, nitty-gritty operational matters. It is essential to ascertain the current state of improvement capability on the ground, possibly by conducting a full and candid assessment of the extent to which the three skill sets are present. We recognise that this would take time, but our findings suggest that it is vital to capture the whole picture – not just the view from the top of the organisation but whether the capability for implementing improvement projects is present on the ground – and this should include an assessment of all the three sets of skills that we have highlighted. Such an assessment should shed light not only on the espoused organisational culture for improvement but also the actual cultures and subcultures; not only the formal structures and processes but also the workings of the informal ones. Clarity of purpose, apparent and shared by all, is vital.

Organisations will benefit from actively investing in developing a wide range of skills in those tasked with or willing to get involved in improvement projects. Improvement work should not underestimate the influence of key individuals who have the potential to either drive projects forward or hinder them, whether at the grass roots or higher up the organisation. Projects need enthused, motivated, trained and empowered individuals to drive them forward. Improvement work requires that these individuals be identified and trained in technical skills, soft skills, *and* learning skills.

Another crucial aspect of improvement work and the learning associated with it (the mortar that holds the bricks in the pyramid walls, to pursue our analogy) is the organisational, professional and personal politics involved. The level of mutual trust and cooperation must be probed, understood and taken into account in projects of this type – for example, by fostering new or better dialogues between the main parties. This also entails recognising the crucial place of interpersonal relationships and personal emotions in encouraging or inhibiting learning for improvement. All four improvement groups demonstrated the significant value of bringing together people with similar concerns, who did not usually interact professionally, and simply giving them the opportunity to talk to and learn from each other in a carefully facilitated and supportive environment. One might even make the case for this being a prerequisite (or at least a valuable support strand) for an effective, reliable and predictable level of cross-team working.

Linked to this is the problem of continuity of management. Organisational change can disrupt improvement work, not least because it upsets the dynamics and politics of organisational, professional and personal trust and understanding (as happened in the upheavals at Furnhills, in contrast to the very stable environment of Dansworth).

Finally, the report makes recommendations about the methods used to carry out projects of a similar nature in future. These include, first (as above), the need to conduct a thorough assessment of the capacity for improvement among staff at all levels, including middle managers and those directly engaged in delivering patient care, and this should inform any improvement project planning. Second, the SPIBACC (systematic prior interview-based analysis of claims and concerns, see page 59) method that we developed proved to be a very useful and adaptable way of designing and delivering a collective learning programme for organisations engaging in quality improvement work. Third, such projects need to be capable of adapting any pre-designed programme to suit the evolving needs of the improvement group. Fourth, the report raises important questions about how far the neutral facilitation traditionally recommended for such work is adequate for underpinning organisational learning processes. It suggests there may be a place for a directive and content-led style of facilitation.

Chapter 1:

Introduction

The origins of the Learning Communities Initiative

The Learning Communities Initiative was initiated in 2009 by senior members of the Health Foundation. Their intention was to explore the use of organisational techniques such as learning communities and communities of practice to introduce a greater awareness of knowledge and skills in proven improvement methods ('improvement science') among the NHS workforce. Their ideas stemmed from the conviction that improvements in the quality of healthcare are often impeded by two factors: a lack of knowledge of the most effective improvement techniques, and weaknesses in the capacity of healthcare organisations to provide an organisational environment conducive to learning and applying those techniques. By providing funding and expert facilitation through the initiative, the Health Foundation aimed to help groups of staff (local 'improvement groups') bring about specifically agreed improvements. By studying and evaluating the processes involved, the initiative aimed to draw lessons for wider dissemination that would enable others to become more adept at delivering improvements in quality.

The report

In Chapter 1 we briefly outline the concepts and terms that underpin this research project. Chapter 2 details how the two sites were selected, and how the four improvement tasks and groups were identified, as well as the methods that were used to carry out the project (see also Appendix 1). Chapter 3 then sets the scene for the stories of the four improvement tasks by describing the organisations in which they took place. Chapters 4-7 describe the experience of each improvement group in turn, highlighting the strengths and weaknesses of the processes involved. Based on a comparative analysis of

the experience of all four groups, Chapter 8 elicits the main themes and lessons that emerge from the data and presents a model of improvement learning. Chapter 9 reflects on how the project was conducted and links it to recent work on improvement science at the Health Foundation and more widely. Chapter 10 summarises the conclusions and implications.

Theoretical context

Organisational learning, learning communities and communities of practice

The Learning Communities Initiative was predicated on the notion that learning is not merely an individual act but a social phenomenon with collective and collaborative dimensions. Since the 1970s, social psychologists and educationists have reached a consensus that practical learning within organisations is not just conducted and passed on by individuals; it occurs mainly through participative interaction between those individuals within the context of their work. This means that new knowledge about practice is not simply stored and handed on unchanged, but is continually created and recreated in a *change process* of 'organisational learning'. This term should not be confused with the commonly used term 'learning organisation', which denotes certain characteristics – such as seeing the organisation as a whole, being open and questioning, willing to make mistakes, and to work with people who are different from oneself to build a widely shared vision while continually learning from experience – that are usually exhortations to senior managers about how their organisations should behave. In contrast, 'organisational learning' tends to be the focus of investigations that try to understand *how* organisations, or groups within them, behave when they are learning. As the project team, our intention here was to do just that with the improvement groups we were working with.

The term ‘learning community’, which the Health Foundation used from the start to describe this project, has a variable meaning in the literature. We use it here almost synonymously with ‘community of practice’. Both terms imply that the improvement groups could be expected to learn collectively (but not necessarily formally) as a group. They also entail the idea that people learn a great deal through social relationships, sharing knowledge by watching and discussing each other’s practice in a safe environment – one where there is mutual respect and trust. (The ‘teacher’ in a learning community, if there is one at all, does not play the role of expert, but rather stands back and helps to shape the safe environment. It is a process that can be uncomfortable for some participants – especially where there are tensions or competitiveness – so facilitation needs to be well executed.)

‘Communities of practice’ were fundamental to the Learning Communities Initiative as the building blocks of collective learning, the medium for organisational learning. The term denotes informal groups that come together because of a shared set of problems and concerns about their practice, and a desire to learn from each other. As the group members interact, they reveal insights (often about crucial aspects of their practice) that are difficult to teach formally. This helps them to solve problems themselves and hence improve their practice, and their situation, and also usually gives them a sense of shared identity that in turn helps to bring about further improvements. Awareness of the crucial role of communities of practice is becoming widely recognised in health and social services;¹ they are increasingly being formed (either voluntarily as part of an organic process, or created deliberately by senior managers) with the aim of getting people together to develop best practice, implement new knowledge, or reshape old knowledge for new practices so that people might do their everyday tasks better. The expectation is that success in achieving those aims should lead to improvements in the quality of the service being provided to patients.

Quality improvement

The Health Foundation regards ‘quality’ as the degree of excellence in healthcare. This excellence is multidimensional and the Health Foundation works to a framework of six dimensions of quality; safe, effective, person-centred, timely, efficient and equitable. With regard to ‘quality improvement’, the Health Foundation describes it as “a systematic approach that uses a defined method to improve quality, with regard to better patient experience and outcomes achieved

through changing the behaviour and organisation of healthcare providers.” The key elements in this definition are the combination of a ‘change’ (improvement) and a ‘method’ (an approach with appropriate tools), while paying attention to the context, in order to achieve better outcomes.

The Health Foundation uses the term “improvement science”, which underpinned the original design of the Learning Communities Initiative, to mean the application of a range of basic and applied sciences, delivered through a partnership of researchers and those who work in and use health services, with the aim of creating new knowledge and promoting strategies for the implementation of evidence-based healthcare, leading to improved healthcare processes and improved health outcomes for patients and populations. The aim of the Health Foundation in developing and promoting improvement science is to:

- help build a practical and accessible body of knowledge about what does and doesn’t work to improve healthcare
- help those working in healthcare to translate this knowledge into practice to deliver the best possible care.

Two techniques that are referred to several times in this report, and are widely accepted as proven methods of implementing quality improvement work, are plan, do, study, act (PDSA) and ‘Lean’. PDSA is a continuous improvement approach that calls for improvements to be made using small tests of change and is now widely used in the NHS. Lean originates in the scientific statistical approaches used to improve industrial manufacturing, led by pioneers such as Deming² and Juran³, further developed in Japanese car manufacturing and now applied widely across many types of industry including healthcare (see also Boaden *et al*⁴).

The PDSA approach to continuous improvement links the cycles of testing change with three key questions:

- ‘What are we trying to accomplish?’
- ‘How will we know that a change is an improvement?’
- ‘What changes can we make that will result in improvement?’

Each cycle starts with hunches, theories and ideas (preferably based on sound evidence) and helps them evolve into knowledge that can inform action and, ultimately, produce positive outcomes.

The Lean quality management system focuses on five principles: customer value; managing the value stream; regulating flow of production (to avoid quiet patches and bottlenecks); reducing waste; and using 'pull' mechanisms to support flow. Using 'pull' means responding to actual demand, rather than allowing the organisational needs to determine activity levels.

The project team used a relatively broad definition of quality improvement for this project, but made four assumptions: (a) that organisational learning is crucial for quality improvement; (b) that learning communities and communities of practice might help bring that about; (c) that it should be possible to encourage the improvement groups to use the tried and tested methods of quality improvement sometimes referred to as 'improvement science' (which incorporates techniques such as PDSA and Lean); and (d) that by carrying out continually evaluated development work with improvement groups, the Health Foundation might draw some useful lessons about this whole approach to quality improvement.

Aims

The four key questions to be addressed by the project were as follows:

1. What are the factors that help communities of practice and learning communities in health organisations to absorb, share and implement lessons from improvement science in quality improvement programmes? What are the factors that hinder them from doing so?
2. What can we learn about this process from those who are working together in learning organisations that are promoting education and training in the field of health service improvement?
3. How can we best understand and develop learning about improvement across the health service?
4. What lessons can be drawn that will help the Health Foundation to invest strategically in learning about improvement, including the possibility of undertaking larger-scale work in this field?

The project team

The project team commissioned to carry out the work consisted of two recently retired professors, one of public health (JG) and one of nursing (ALM), both with a long history of working in and with the NHS on how to apply best evidence to policy and practice. They brought in two colleagues, a professor (CC) and a senior lecturer (JHK) from the Southampton Management School, both of whom have extensive experience in applying management science, knowledge management and systems approaches to improving the delivery of healthcare.

Chapter 2:

Methods

Site selection

The Health Foundation and the project team selected two local health economies that they identified as high-quality learning organisations. Before tendering for this project, the Health Foundation had already decided to seek out field sites that had a strong track record in working to improve the quality of healthcare within and across sectoral boundaries, and that were investing in learning and development to support this. The organisations selected would either have, or actively aspire to have, certain characteristics of learning organisations identified from the literature (see Box 2.1). The Health Foundation had already earmarked one site, ‘Dansworth’, as meeting those criteria; but according to the design set out in the original tender document, three more sites were required in order to include a range of types and size of service organisation. The Foundation had already invited suggestions from 26 of their contacts, including staff and governors, selected suppliers, award holders, and the Department of Health.

As the design of the study matured and the project team began work, it was agreed that “a ‘deep’ investigation [was] likely to generate more knowledge and benefit for participating sites than a ‘broad’ study and... to achieve an in-depth understanding of change processes”. This meant selecting fewer sites than originally anticipated; from the suggestions submitted by the Health Foundation’s contacts, just one more site (in England) was now needed.

Box 2.1: Health Foundation desiderata for Learning Communities Initiative field sites

- “a clear vision and mission about quality, aligned to strategic and organisational development plans. This vision will be owned by all members of the Board and Executive and embedded in such a way that it survives the departure of any one individual
- a strong belief in the potential of their staff to improve, empowering their teams to do so and a willingness to invest in this development
- a joy in celebrating success
- a willingness to be open, transparent and outward-looking, and to share its learning with others
- a willingness to constantly question and challenge
- an ability to tolerate ambiguity and uncertainty
- a desire to learn from experience and from mistakes and a willingness to ‘unlearn’ unhelpful attitudes and behaviours
- a willingness to operate a high level of trust and take calculated risks
- an ability to reflect on and learn about how they learn

Other desired characteristics

- have been pursuing a quality improvement strategy for some years
- are investing in learning and development for improvement at all levels (undergraduate/pre-registration, postgraduate and continuing professional development)
- have developed partnerships about learning and development for improvement with healthcare professional education providers
- not already being heavily researched
- not in financial difficulty
- not in the process of applying for Foundation Trust status or otherwise experiencing major strategic distractions.”ⁱ

i Throughout this report, the use of double quotation marks (“...”) denotes a quote noted in the fieldwork or written source.

Nine health economies (“partnerships”) were recommended for consideration, and a further 11 single acute trusts, seven primary care trusts (PCTs) and five mental health trusts. Many of these were recommended by just one of the Health Foundation’s contacts. (Furnhills appeared on the list twice: it was recommended by one person for the work of its whole health economy, and by another for its work as a mental health trust.) Each of these partnerships or trusts was sent an invitation letter. The Health Foundation project team shortlisted three of the responses received; after further discussion with JG and ALM and a telephone interview, it was agreed that Furnhills was clearly the outstanding candidate, and was therefore selected to join Dansworth as the second study site.

Overall approach

The Learning Communities Initiative approached its exploration of the four key questions in this project (see ‘Aims’, page 3) based on the following assumptions:

- Attempts to improve the quality of healthcare are more likely to succeed when health professionals learn how best to apply proven improvement techniques.
- Communities of practice and learning communities are likely to be an effective way to facilitate that learning, especially if they are working in the conducive culture of a learning organisation.
- It is important to deepen our understanding of the nature of these processes of learning and how the wider organisational culture influences them. Therefore, a project that closely observes and facilitates learning communities in favourable health service organisations might yield useful findings that will strengthen our understanding of how best to incorporate proven techniques into quality improvement initiatives.

The project team worked with key staff on two separate ‘improvement tasks’ at each site. All four tasks were designed to bring about specific changes in practice to improve the service provided to patients. The team’s remit was:

- to elicit from local participants their perception of the problems that needed to be overcome in order to bring about the desired improvements, and to identify their collective learning needs in terms of improvement techniques

- to design a series of learning events to meet those needs, based wherever possible around specifically convened improvement groups comprising the key actors who would be encouraged and helped to work as communities of practice or learning communities
- to use an “action approach” (combining action research and action learning) where the project team, while working with the participants to facilitate the flow of knowledge and learning among the improvement groups, would also draw wider lessons about the organisational learning process and its place in health service improvement initiatives.

The question of ethical approval was discussed with the chairs of the relevant research ethics committees, who decided that the work was to be considered as service development rather than research.

Fieldwork

The work took place over a two-year period (2010–12), which was longer than planned due to unanticipated problems at three levels: the macro level (major NHS reorganisation); the meso level (internal reorganisations and other changes); and the micro level (the staff involved in the improvement groups). While the project team had always been cognisant that modifications would inevitably occur as the projects and improvement tasks unfolded, the differences between what was planned (see Appendix 1, ‘The agreed original project plan’) and what ultimately occurred turned out to be quite major. The consequent evolution of the study design and methods yielded important lessons that inform the fourth key question (see page 3) about the Health Foundation’s future investment in learning for improvement, which are discussed further in Chapter 9. This report describes the project as it was actually carried out; as we discuss in more detail in Chapter 9, it was neither research nor consultancy, but four very different case studies of localised organisational development – facilitated and continually evaluated – using specific techniques that we adapted for the purpose as events unfolded.

The first stage for the project team was to familiarise themselves with the organisations we would be working with and to agree the improvements tasks and the staff groups that would be involved. To that end, JG and ALM spent several days in each of the two sites in August and September 2010 conducting an ethnographically informed, interview-based assessment of the structure and culture of each organisation. Most

of the discussions (which amounted to approximately 15 hours at each of the sites) were with senior staff – around an hour per interview. We also gathered baseline documents, began the process of negotiating acceptance and clearance to undertake the work, and negotiated the respective roles and relationships of our project team, the Health Foundation, and key personnel in each organisation; this included staff who were going to be directly involved in the improvement tasks and others who were likely to have less direct involvement but were nonetheless likely to influence what could be achieved (such as senior managers in all relevant parts of the organisation).

The four improvement tasks eventually selected (and to which we attach specific names derived from the site and service, for ease of reading) were:

- Furncop:** Improving **Furnhills'** uptake and delivery of appropriate long term care for patients with chronic obstructive pulmonary disease (**COPD**)
- Furndem:** Optimising **Furnhills'** community **dementia** services by reorganising the way in which services of the memory clinic were delivered
- Danelder:** Improving services provided by **Dansworth's** hospital's "medicine for the **elderly**" (MFE) service, with particular reference to reducing unnecessary lengths of stay
- Dandem:** Improving the care provided to patients who are in **Dansworth's** hospitals and who have **dementia**.

The next stage was to elicit participants' main concerns about the chosen improvement tasks and to reach consensus on the topic for the first of a series of learning events. We used a method we have since called SPIBACC (systematic prior interview-based analysis of claims and concerns, discussed in more detail on page 59). We based this on key elements of Guba and Lincoln's "fourth generation evaluation" technique,⁵ taking an interpretive, constructivist approach to arrive at a consensus about the matters to be resolved. The technique involved the project team interviewing (usually by telephone) a snowball sample of the key actors and other stakeholders for each of the four improvement tasks until saturation was reached (that is, no further useful information was being elicited). The semi-structured telephone interviews focused on:

- claims about the improvement tasks (that is, aspects of the tasks that they felt were relatively successful)
- concerns (their own perceptions regarding the execution of certain tasks, including difficulties and weaknesses that they felt would also be generally acknowledged by their colleagues)
- issues (any perceived concerns that they felt others would probably not share). In the event, participants identified very few issues; these were only included in the syntheses fed back to participants if more than one person mentioned something as an issue.

In addition, and where possible, we enquired about participants' sources of knowledge of 'improvement science' or – if they were not familiar with that term – about improvement techniques they were already using, and hence tried to explore with them their learning needs about quality improvement methods. In the event, many of the early interviewees found it difficult to articulate coherent answers about this, or even to grasp what the questions meant (in fact, we soon realised that the term 'improvement science' was alien, if not alienating, to most participants, so we subsequently used it much less frequently). Early interviews were recorded for re-checking of the content during the analysis, which would be chiefly based on notes taken during the interview. As the project proceeded and the telephone interviews became more focused, a sample of interview notes was quality checked against the recordings (which were not transcribed) and it was agreed that it was no longer necessary to record these interviews.

The SPIBACC method then involved the project team collating and analysing each full set of interviews in order to structure each of the four improvement groups' collective perceptions of their task and to help them subsequently work through the identified problems. This process involved what we have called subsequent open prioritisation, in which, after feeding back findings from each of the four separate thematic analyses as a 'synthesised construction',⁵ we facilitated them in prioritising the topic for the first learning event, and potentially for the remaining events. We also discussed with them the optimal design of the learning events, and how they might structure their work, including any action plans for making progress with the improvement task between learning events.

The original intention was that each improvement group would have three learning events involving the key actors and stakeholders, at roughly quarterly intervals, each informed by the SPIBACC process. As it turned out, there were fewer learning events than anticipated,

and they were held at irregular intervals: Furncop had four, Danelder had three (one of which was held on three separate occasions to maximise attendance), Dandem had two, and Furndem had only one, right at the end of the fieldwork, in April 2012. (For further details on this and subsequent modifications to this aspect of the fieldwork, and why they occurred, see Chapters 4–7.)

We ensured that the learning events were all based at least partly on the principles of action learning, where participants learn from each other's knowledge and practical experience. Most of the events were interactive and although there were sometimes elements of didactic input, all the events gave the opportunity for reflective, usually facilitated, discussions between participants that allowed at least some degree of action learning. (The more formal action learning technique of structured commitment to future action and reporting back was, however, only practicable in a minority of cases due to the disjuncture between the learning events.) Some but not all of the learning events involved external contributors who were asked to provide specific expertise. With two exceptions these were found not, as originally intended, from the Health Foundation's network of experts, but from within the expertise already available to each project site's own networks.

Where appropriate, we held face-to-face discussions with the participants about the progress and design of the learning events and related topics. Sometimes this necessitated additional field trips or teleconferences to elicit views and galvanise action. Where possible and appropriate, the project team also engaged in participant observation at meetings and discussions relevant to the improvement task and/or to understanding the immediate organisational culture. We also conducted feedback surveys by email about the impact of the learning events on subsequent practice.

Further SPIBACC activities, as well as the learning events themselves, were intended to give the improvement groups the opportunity to identify further learning needs and find ways of meeting these needs, feeding back their experience and reflections at the next meeting. As things turned out, however, this rarely happened. As mentioned, Furndem, for instance, had only one learning event. In Furncop, there was little scope for identifying further learning needs because a surfeit of topics for the full programme of learning events had been generated by the second round of interviews; moreover, the continuing dialogue with an expanding range of key Furncop participants did not elicit further pressing topics for inclusion but instead did much to refine and prioritise those that had already

been identified. In some cases (Dandem's first learning event and Furncop's fourth and final event), the event's outcome laid the entire foundations for the next one.

The project team repeatedly offered the opportunity to hold a final cross-site learning event at which all four improvement groups could share their experiences and learning with each other. However, there was no practical way for busy staff to take the time needed to attend such a meeting, nor frankly any sense among the participants that it would be a worthwhile use of their time. Although the geographical distance between the sites may have played a part in this, there was also no demand for exchange of learning between the two improvement groups within each site; we also heard that fact-finding visits from Furnhills to nearby exemplar sites had been shelved because "the austerity and hard evidence culture" made it seem a luxury in the face of so many competing priorities on the relevant people's time. This was part of a general sense that, even though people recognised the validity of learning by such means, it was not a core part of their jobs and might be frowned upon as "time away from real work".

Follow-up review

After the learning events were completed, we undertook semi-structured telephone interviews with a sample of the stakeholders across all four improvement groups to ascertain the degree to which they:

- a. were on course to achieve their original improvement task
- b. continued to make use of the improvement techniques or other new knowledge and skills they had acquired during the project
- c. had found the Learning Communities Initiative useful (or not).

To maintain continuity and consistency, one member of the project team (ALM) conducted all but one of the 33 follow-up telephone interviews, which took place between three and nine months after the last learning event for each improvement task. One other interview (with the Danelder lead) was face-to-face and was conducted jointly by ALM and JG. Three of the key telephone interviews with the project leads also included JG as a joint interviewer. Two people who declined to be interviewed answered the questions by email, and 10 did not respond at all (most of whom had left the organisation). The interviews, the last of which was conducted in January 2013, were then thematically analysed. The findings about each group's

subsequent progress in achieving the improvement tasks contributed to the findings as reported in Chapters 4–7. The generic findings about participants’ reflections on the Learning Communities Initiative, and the role of the Health Foundation and the project team, informed the conclusions in Chapter 10.

Analysis

Throughout the Learning Communities Initiative, the project team met frequently to review the emerging findings. The meetings doubled as reflective ‘co-counselling’ and tactical reviews of the possible ways forward for each project and also as analysis workshops to help make sense of the emerging events. This dual approach reflects the innovative nature of this work, which was not quite research and not quite consultancy (see ‘The nature of the intervention: crossing boundaries?’, page 58). Summaries of our deliberations were shared at quarterly review meetings with the Health Foundation Learning Communities Initiative Steering Committee.

Towards the end of the projects, each team member led the process of writing up the experience of the project for which they were team lead (Furncop – JG; Furdem – CC; Danelder – ALM; Dandem – JK), and contributed to the editing and writing of the interim report submitted to the Health Foundation in May 2012. In August, after the projects had finished, the team held a half-day internal analysis workshop to explore and test the ideas and models emerging from the agreed findings in the interim report, and to help plan the follow-up interviews. The meeting was recorded, and detailed notes used to map out an agreed structure for the concluding chapter of this final report, to ensure that it took into account the subsequent findings from the follow-up interviews.

Chapter 3:

The case studies

The organisational culture in which the improvement groups were working

Furnhills

Furnhills was chosen because its record suggested a strong learning and quality-oriented environment. The PCT, which served the whole city, was formed through a merger some years earlier and had rapidly become a force for change. Led by a visionary and high-achieving chief executive officer (CEO), it was ranked among the top five PCTs for “world class commissioning”, and over two years had improved its Annual Health Check performance ratings for quality and use of resources from “weak” to “good”. Furnhills had since established a multi-agency Quality Improvement Academy, which we were told was now driving a consistent approach to quality improvement, identifying key improvement and cost-saving projects across the health community, strengthening governance arrangements, and developing leadership capability in partnership with private providers, academic institutions and social care.

“Meaningful clinical engagement” was described as “a central objective” around which there were several initiatives. These included high-profile clinical summit meetings, with some 50 senior clinicians from primary and secondary care working on system-wide problems such as admission avoidance (which included a major project on COPD and some work on dementia). Furnhills had invested in various learning programmes – for example, a leadership skills course, a programme designed to promote and develop practice-based commissioning, and a large-scale structured programme of “protected” education for GPs, which provided clinical updates on a wide range of topics.

During our first visit to Furnhills, the project team learnt that, based on the impending Health and Social Care Act, the PCT was to be radically transformed and then phased out so that commissioning could be taken over by local clinical commissioning groups (CCGs). Nevertheless, the PCT was still running a large number of innovative initiatives. Their “bold” top team recognised that their prowess in commissioning (which was very much geared up to dealing with a projected deficit of over £20m, approximately 2% of the budget) needed to be matched by improvements in quality; they also knew that to accomplish, for example, the ~80 QIPP (the NHS-wide Quality, Innovation, Productivity and Prevention scheme) projects, they would need to become much better at engaging doctors in programmes of change. They spoke of the need for cultural change to be driven from the centre of the organisation, largely through a much-vaunted suite of “Clinical Programme Areas”. There was some success in getting “board-to-board cooperation” between the PCT and foundation trusts, despite the exceptionally hard-nosed contract-driven relationships, the financial squeeze, and the frequent discussions about the need to radically reduce the health economy’s over-reliance on hospital beds rather than community care.

One senior manager suggested to us, though, that while some might claim that the clinical programme areas were innovative, others might describe them as “loose groupings of previously unmanaged projects” and others admitted that they had been difficult to establish and had achieved only “patchy” and relatively minor success. Moreover, we found that some of the boards’ other key ideas about quality improvement appeared not to have penetrated further down their organisations. Process mapping was a fairly familiar technique in Furnhills, but although “a small handful” of senior and middle managers were trying to promote proven improvement methods – mostly using Lean, some process mapping,

and “patchy” PDSA (see page 2) – we were told that most staff were unaware of that approach and, moreover, that it was generally unconnected with the work of the Quality Improvement Academy. When asked how far the organisations in the local health economy could be described as ‘learning organisations’, using a scale of 1–10, interviewees tended to answer 5 or 6; some even went so far as to describe their organisations as “dysfunctional”. One trust’s chief executive even suggested that the Quality Improvement Academy was “all plans and no action”, and had instituted a completely different quality improvement programme in his own trust.

In short, the impression gained from the orientation visits to Furnhills – confirmed by subsequent observations of key meetings and by the events that ensued during the improvement tasks – was that the PCT-driven quality initiative was informed by an approach to improvement based on the PCT’s exceptional prowess in commissioning, contracting, and above all, target-led performance management. This was in stark contrast to the “bottom-up” approach that some senior managers claimed to be the model on which the Quality Improvement Academy and the clinical summits were based. In fact, as the PCT was metamorphosing over the following year, the Quality Improvement Academy was – as a senior manager told us – “put to sleep peacefully” and the clinical summit meetings, which had aimed to produce improvement initiatives led and owned by clinicians, petered down to one meeting a year. (It was, however, to rise again as an active, more inclusive, cross-sectoral scheme in the year after our fieldwork had finished.) But QIPP, a method of improvement founded in top-down target-led performance management, remained robust throughout our time there, not least because the Furnhills PCT was itself subject to rigorous performance management by the higher echelons of the NHS.

While Furnhills was achieving considerable and tangible success in improving its services, its impressive path to continual improvement seemed to be driven chiefly by rigorous and sophisticated commissioning. It was evident to us from the start that while Furnhills was working hard to achieve clinical engagement and ownership of target-led improvement, its improvement culture bore little resemblance to the philosophy of ‘improvement science’ underlying the Learning Communities Initiative.

Dansworth

Dansworth, in contrast, was strongly inculcated with the values associated with ‘improvement science’ (see page 2). Responsible for planning and delivering all health services for a population of nearly 400,000 living in relatively small towns and rural areas in Scotland, Dansworth’s senior managers considered their organisation a major national, even international, player in the field of quality improvement. The CEO had been running performance management for NHS Scotland when, over 12 years ago, he had been appointed to turn Dansworth’s poor performance around. He had arrived with a declared sentiment that has now evolved into a mantra that we heard often during our orientation visit: “we have to focus on the 95% and not the 5%”. This refers to the notion that staff should not dwell on the problems at the margins (for example, the current requirement to make a 5% saving – £30m – on the budget) but should focus instead on the “core business of quality improvement” (a much-repeated phrase in Dansworth) across the bulk of its work. While turning the organisation around, which was “a difficult two years”, the CEO deliberately set about “building the capacity and capability” (more buzzwords that we often heard) to concentrate on quality and performance. One feature of the Scottish NHS is its relative stability and low turnover of senior staff (who are a small, closely knit community), so the executive team that he brought in initially were in for the long haul of inculcating that philosophy. They continue to be so.

The CEO and the director responsible for organisational innovation and change told us that, recognising that people tend to learn best by doing rather than by formal training, Dansworth has used coaching, mentoring and “masterclass” models to instil its quality improvement philosophy and methods. Dansworth was closely involved with the Institute for Healthcare Improvement (IHI) in the USA. Key people, including the head of the improvement team, had spent time at the IHI, whose methods (especially PDSA) were actively promoted at Dansworth; a core of local enthusiasts had imbibed and applied the IHI ethos and methods. The wards were all supposed to have “run charts” and/or “dashboards” (showing the percentage of achieved targets in, for example, care bundles that all have measurable outcomes), although when we were visiting the wards, we did not always see such charts on display. Standardised Early Warning Systems (SEWS) were also widely promoted. The IHI tools of improvement science were by no means the only ones in use: Dansworth employed a range of approaches to improvement – “whatever works best”, as they would say. They were

using Lean a great deal, and in an illuminating spin, the Scots had dropped the Lean term “The Productive Ward”, widely used in England, and called it instead “Releasing Time for Care”. We heard mention of Six Sigma (often linked with Lean in the NHS), Kaisen (linked with Lean, and for whom Dansworth was an early Scottish pilot working on “small scale change”), and a range of models for personal development.

When participants were asked how they would score Dansworth as a learning organisation, using a scale of 1–10, the usual response was 7 or 8; interestingly, an external consultant told us that when he had arrived a couple of years earlier, he would have said 3, but it was now 7 or 8 “in terms of learning to learn”, and that “the void is at middle-management level, where they are still fire-fighting” and that there was still “a real need to develop capability and capacity”.

Much of that development was being done by a central improvement team, which had over 20 staff who worked as much as possible out of the office to spread the skills and to allow selection and nurturing of talented staff who were handpicked as “improvement fellows” and plucked out for this role – sometimes to the dismay of their line managers, who did not want to lose them from their own teams. There were also several other sources of internal support for improvement work, including a Practice Development Unit for nurses and allied health professionals, an audit team and Clinical Governance Unit, and the Patient Safety Unit – all of whose work, while pursuing their own different approaches, overlapped with the improvement team. There was, in short, a wealth of structures and processes to promulgate their approach to quality improvement (QI), which was in principle based loosely on improvement science, but these tended to be centred mainly on the hospitals.

Among the many examples of successful improvement programmes we heard about, the most recent had been carried out with the help of outside consultants who, following a false start two years earlier, had been asked to provide a train-the-trainers course for a team of “modernisers” who had since gone on to train others. This snowballing of skills was generally regarded as having been a great success, and had enabled a new improvement scheme to proceed apace. The result was a suite of ambitious improvement projects that were highly prominent in the management of Dansworth and were being reviewed weekly by the executive team. One of the walls of their open plan office was covered with up-to-date progress charts for all the scheme’s projects.

In summary, Furnhills’ successes with quality improvement stemmed mainly from its outstanding prowess in commissioning and performance management and, with minor exceptions, was not based on methods from ‘improvement science’. Dansworth, in contrast, was an organisation driven by the executive team’s enthusiasm for QI using an approach explicitly borne out of ‘improvement science’ that had already demonstrated many tangible local successes.

The projects in brief

The four improvement groups proved very different in their characteristics, culture, processes, and the extent to which they achieved their improvement task (see Table 1 on page 13). The following four chapters present the details of the four contrasting improvement stories, which in effect proved to be a natural experiment; Chapter 8 analyses why they differed so greatly.

The Furnhills COPD improvement group (Furncop), whose chosen task was to improve the management of COPD in the community, held four learning events. The first three dealt with group members’ interpersonal skills, social marketing techniques (to help “sell” to patients and clinicians the idea that COPD was a treatable condition that should be properly managed), and introducing the principles of improvement science, while the fourth event focused on how to put those principles into practice. These last two events inspired the improvement group to completely alter their approach to helping primary care teams improve the management of COPD; but despite their senior manager (a GP on the executive board) strongly advocating their new approach to improvement, this proved inimical to the performance management culture that was prevalent in Furnhills, and the group made little headway as a result. This did not, however, prevent Furnhills from meeting its specific COPD targets.

The other Furnhills project (Furndem), which set out to help restructure the memory clinic service, stalled for nearly two years for a variety of internal political reasons (including a stand-off between key parties over various financial and professional tensions) and managers’ preference for improving services by means of commissioning and planning structures. One learning event was finally arranged at the end of our time there. Despite anticipated resistance, the event succeeded in opening up a dialogue between key parties who had not previously come together to discuss the difficulties surrounding community dementia services; this has, in the relatively short time since, led to significant changes in care pathways, including more GP-led care that was now supported, rather than led, by memory clinic staff.

In Dansworth, the Danelder project aimed to improve the system of estimated discharge dates (EDDs) for elderly patients to help minimise unnecessarily long stays in hospital. Led by an able and well-trained “improvement fellow”, and already used to using QI techniques such as PDSA, the group functioned well as a learning group both within its membership and in spreading the learning more widely. Despite a recent restructuring of the service, which had proven extremely stressful, the group more than achieved its objectives in overcoming the problems around the system of EDDs. They felt well supported by, and made good use of, the wider improvement structures and culture in Dansworth, where the principles of improvement science were well established and fostered by senior managers.

That culture had not, however, spread to the organisational domain of Dandem – the second Dansworth improvement project, which focused on improving dementia services – or to its partner organisations involved in dementia care. Due to a welter of external and internal pressures on service managers, it did not prove possible to establish a learning community around the task originally agreed by the group. However, a wide and disparate cross-sectoral group was brought together for the first time in two learning events around a related topic – the development of staff training schemes to improve dementia care. These did much to foster better cross-disciplinary and cross-sectoral understanding, which helped to subsequently develop an agreed work plan.

Table 1: The four improvement projects summarised

Project (Team lead)	Danelder (ALM)	Dandem (JHK)	Furncop (JG)	Furndem (CC)
Original aim	To improve the use of estimated date of discharge for elderly hospital patients	To improve the care of people with dementia in hospital	To improve uptake of “Level 1” care for COPD patients (esp. diagnosis and rehabilitation)	To improve memory service by redesigning dementia pathways
Eventual aim	As above	To agree cross-sectoral dementia training for “Level 3” staff	As above, but using “small tests of change” and “improvement conversations” with “the willing”	Wider, well-supported GP dementia care
Leader	Jane (physiotherapist and ‘improvement fellow’)	Richard (nurse consultant, dementia) then with Nigel (old age psychiatrist)	Mary (PCT nurse consultant) , then Jocelyn (lead GP and CCG exec member)	Paul (old age psychiatrist and dementia service director)
Learning events	2 (one of which was repeated 3 times)	2	4	1
Outcome	Surpassed original aims	Agreed new approach to Level 3 staff training, but not yet acted on it	COPD care improving but group unable to use desired improvement methods to achieve even more	Significant changes in care pathways, including more GP-led care supported by clinic staff
Organisational environment	Fully supportive improvement structures and culture appreciated and used by the group despite recent restructuring, which had proven stressful	No real connection with prevailing improvement culture and structures in parent organisation, nor with each other (partners’ improvement cultures vary)	Organisational upheavals; different approach to improvement (tackle “bad apples”/ performance management/ commissioning)	Stand-off between key parties; worked mainly through commissioning and planning structures as means to improvement
Improvement science?	Embedded in the project and fostered by the organisation	Not used, although potentially available from the main organisation	Enthused the group but not accepted by their managers	Not used here (but parallel project used pathway redesign methods)
Learning community? subjectively rated 1*-5* + comment	***** (both the group itself and wider community of staff)	** (only during the facilitated learning events)	**** (the core group, but not more widely)	* (only during the facilitated learning event, when resistance melted)

Chapter 4:

The Danelder project: integrating Medicine for the Elderly across sites and improving discharge from hospital

Preliminary work: identifying the task and the key people

This case study describes the creation and workings of the Dansworth Medicine for the Elderly (MfE) improvement group. When we first visited the site in August 2010, we were told that it was a particularly challenging time for the MfE service, where longstanding turf battles had just erupted. These involved deeply embedded cultural differences – between traditional physicians and the “elderly physicians” (the new term for geriatricians), between some of the acute hospital wards, and between them and a smaller nearby hospital that had a dedicated assessment unit and a rehabilitation unit staffed by “elderly physicians” and specialist nurses.

During the spring and summer of 2010, just before our initial visit, the clinical service manager, ‘Christine’,ⁱⁱ and her team had started a visionary programme of improvement that entailed a comprehensive review of MfE services. This programme (The Dansworth Better Care Programme – Improving Older People’s Services) aimed to reduce “wide variation in practice across the service and a number of queues within the system” and aspired to “implement a standard patient pathway, align practice and identify opportunities to create an enhanced patient centred service”. The programme comprised eight workstreams that included discharge planning, inpatient management, intermediate care, social work redesign and staffing profiles. Most staff had recognised that care pathways could be greatly

improved; among other problems, they had attempted to tackle the anomaly that patients tended to be treated differently depending on where they happened to be treated. There had initially been great eagerness for change, but after the first phase of the programme, the old tensions had suddenly resurfaced. The initial enthusiasm had quickly turned to anger and dismay among staff, patients and the local press and public when (largely misleading) word had got out that the programme’s aims would be achieved mainly by closing some elderly care wards in the smaller of the two main hospitals and changing or amalgamating others.

However, the Better Care Programme was still going ahead and most people supported most of what it was trying to achieve, despite many staff feeling very bruised. (“We are in counselling mode with lots of 1:1 meetings.” “A lot of the identified need for change has been met, and most people – even the opponents – say it’s great except for this bit or that bit.”) Worse, some influential “elderly physicians” were simply refusing to cooperate with their consultant colleagues who were championing the changes. However, senior staff felt that once the dust had settled, there would be a great need to work with ward staff and others to help them achieve the desired improvements, which was where the Learning Communities Initiative was seen as being potentially very helpful. But the improvement group could not begin its work until the organisation had recovered from the immediate fallout of the ward rearrangements.

ii Names of project personnel are fictional to protect identities.

The Danelder project therefore started later than the other three so as not to interfere with that controversial restructuring. During the months before the planned start of the project, Christine continued to work with the leads for each workstream. She stayed in close touch with the Health Foundation project team (represented by ALM), hoping that a by-product of the Danelder project would eventually be an improvement in relations and communications across the service. When the time seemed right (January 2011), Christine met a small group of staff to identify the specific improvement task for the project. This meeting (to which we were not privy) chose the estimated date of discharge (EDD) as Danelder's improvement task, reflecting the hospital's problems in assigning an EDD to patients across the specialty, and ensuring that the various multidisciplinary teams responsible for each patient's care enabled patients to be discharged by the EDD whenever possible. Daily meetings to focus on preparing patients for discharge were already the norm in some but not all of the wards across the MfE specialty; but they did not always use or update an actual EDD.

The idea of focusing the project on the problem of EDDs came from a senior occupational therapist, and complemented the work being undertaken by the discharge planning workstream in the Dansworth Better Care Programme. The fact that this workstream already existed within the organisational structure was no doubt a positive feature, and enabled the Health Foundation project to slot more easily into the everyday workings of the organisation. This stream had been led by a physiotherapist, 'Jane', who went on to be given responsibility for taking forward the Danelder project. By then, Jane – now one of Dansworth's trained improvement fellows – had been redeployed from her clinical role to become pathways coordinator (and quality improvement intern). In February 2011, the clinical services manager, Christine, convened a core group of four people – herself (although she subsequently withdrew from the everyday workings of the group), the occupational therapist who originally proposed the idea for this improvement task, an elderly care consultant, and Jane, in her new role as pathways coordinator.

Once the core group had met, they invited other key stakeholders to attend a preliminary meeting and nominated Jane to take this task forward, primarily because of the nature of her role as pathways coordinator. When the improvement task was agreed, Jane, the occupational therapist and ALM discussed the project regularly by phone, in person, and by email.

Setting up a learning community

Once the task had been selected, the core group invited more key people to join the improvement group (see box). This membership remained more or less constant during the group's first full year of functioning and was only expanded after the final learning event in March 2012 (see section on 'Follow-up' below). The group membership covered all wards in the unit: all group members had shared responsibility for disseminating information and actions needed to their respective wards, teams and professions.

Box 4.1: Membership of improvement group

Senior charge nurses	6/7
Senior physiotherapists	2/3
MfE medical consultants	2
Pathways coordinator	1
Senior occupational therapists	2/3
Speech and language therapist – joined later	1
Discharge team member – joined later	1

At the group's first meeting (March 2011), the occupational therapist who had proposed the idea (now designated "clinical lead") discussed the problems surrounding the inconsistent use of EDD, and stated that the overarching aim of the improvement group was to "explore the concept of EDD and identify improvement opportunities for this to be used to support the patient pathway". The group quickly agreed their aims.

Box 4.2: The aims of the Danelder improvement group

1. To achieve a consistent approach to setting estimated date of discharge (EDD)
2. To share good practice
3. To share and cascade information and involve all staff
4. To ensure that all members of the multidisciplinary team follow evidence-based practice to improve patient flow so that all patients have appropriate access to MfE services at the appropriate time

One of the medical consultants who had responsibility for liaison across all consultants in the MfE unit agreed to compile evidence around the use of EDDs. The group agreed that EDDs would be defined as:

[an] anticipated discharge date where the period of hospital assessment is complete for the individual patient. This is a fluid date based on the patient's needs. The EDD should be set

within 48 hours of admission unless the patient is [too] unwell and has not undertaken MDT [multidisciplinary team] assessment. Patients who are admitted on a Friday must have an EDD set by the Monday.

They then adopted a PDSA (plan, do, study, act) approach to guide their improvement: to *plan* an agreed way of implementing their EDD parameters into practice as a small test of change (*do*) before their next meeting, in which they would *study* the results of their actions and *act* on any changes needed. It is important to note that PDSA was already a commonly used improvement technique in Dansworth.

The group met regularly every 6–8 weeks to continue their improvement discussions and actions. Minutes were always taken and circulated to members, as well as the Health Foundation project team and other potential stakeholders (for example, heads of nursing, physiotherapy, occupational therapy and allied health professionals, all MfE medical consultants, and the MfE clinical service manager). Once established, the group was self-motivating and continued to use small tests of change and PDSA cycles to progress their work towards the instigation of “Board Rounds” – daily ward briefings clustered around a whiteboard – during which staff reviewed the progress of all patients against their agreed EDD.

Identifying the learning needs for the improvement task

Approximately two months after the group began its work, we undertook a round of telephone interviews (using the SPIBACC method – see page 6) to identify participants’ claims, concerns and issues related to the project. Thirteen people were interviewed by phone or email. We elicited 20 success claims, including the fact that the Danelder work was seen to create a more critical and uniform approach to EDD, that it showed that EDD was usually very simple to do, and that it brought doctors – even those who had initially been sceptical – into the process while also involving families more; participants also suggested that the PDSA approach worked well in practice. They expressed nearly 30 concerns, which we placed into six categories, as follows.

- **General**, including shortage of staff both in the hospital and community settings; poor infrastructure (for example, badly designed buildings); and problems in predicting EDD for the full patient journey, especially across organisational and specialty boundaries.

- **Liaison with other hospital staff**, such as speech and language therapists who were under-resourced/ unable to be properly involved, whether in the hospital or the community; the rotation (moving on) of experienced junior therapists; and the need for patients/relatives and the whole multidisciplinary team (including pharmacists and speech and language therapists) to be more involved in setting and reviewing EDDs.
- **Attitudes and behaviours of hospital staff**, whereby, for example, some doctors (and other professionals) still needed to be persuaded to take EDD seriously (some even actively resisted it); some juniors were over-reliant on their seniors; some hospital staff were more risk/discharge averse than others; and others were over-optimistic about how much they could improve a patient’s ability to live independently at home.
- **Liaison with community services**, including problems in getting community services (especially social care) activated on time, and hence the need for better communication with the community workforce to work differently, and/or for them to attend patient flow meetings more regularly or send deputies; and the need for GP education to realign their working methods.
- **Admissions processes** – effective EDD relied on better admissions criteria and processes (including earlier full assessment on admissions ward), which itself required experienced rehabilitation staff (not just doctors) to make assessment on admission; and the need to be better at communicating expectations to patients and their carers.
- **Learning** to be better at sharing experience and learning across the group; the need to focus on learning from, not competing with, each other; and the lack of a strategy for rolling out the learning on EDD across the specialty and beyond.

In May 2011, these findings were fed back to participants in a prioritisation focus group, which consisted of members of the core improvement group and several other key staff. We used a prioritisation exercise based on nominal group techniques to help the group rank their key concerns. The box below shows the most common concerns according to the number of votes each received.

Box 4.3: Danelder improvement group's concerns, in order of priority

1. Needs community workforce to work differently (10 votes)
2. Juniors are over-reliant on senior involvement and need to be more independently proactive to keep up momentum. (Based on the above: "Attitudes and behaviours of hospital staff") (7)
- 3= Problems in getting care managers and social services mobilised in time (6) (later linked to 1 above)
- 3= Patients/relatives need to be more involved with setting and review of EDDs (6)
- 3= All multidisciplinary team need to be involved in setting and reviewing EDDs (6)
6. Problems in getting community services (esp. social care) activated on time (5) (later linked to 1 above)

After further discussion, the improvement group agreed that the learning events should focus on two key concerns:

1. the need for the community workforce to work differently, including getting care managers and social services mobilised in time;
2. the over-reliance of juniors on the involvement of senior staff, and the need for juniors to be more independently proactive to keep up momentum in working towards a patient's discharge.

The focus group decided that the second concern – which was essentially about helping junior staff assert their views when decisions were being made about discharge dates – should be addressed in the first learning event. This choice was partly because of the perceived urgency of rectifying that problem in relation to achieving their goal of improving the EDD system, and partly because the main concern about the community workforce was regarded, at that time, as "unachievable"; the group could not see how they could reasonably move such a far-reaching concern forward into a learning event that crossed organisational (health and social care) boundaries and disciplines. However, the Health Foundation project team resolved not to let the problem rest there, and later ensured that the group returned to deal with it.

Meanwhile, the improvement group, together with the Health Foundation project team, began to organise the first learning event. It soon became clear that a large number of staff needed to attend, and so it was repeated over three afternoons to maximise its potential in "up-skilling" key workers assigned to each patient to manage their discharge.

The first learning event

The first event aimed at rectifying the lack of skills such as assertiveness and negotiation, and the ability to question decision making at EDD board rounds, which the improvement group/learning community perceived as a major limiting factor in consistently achieving EDDs. The Health Foundation team (ALM and JG) put together a range of practice-related stories highlighting the part played by the lack of these key skills. The stories were based on examples given by the improvement group at a meeting in late August 2011 and on our observations of board rounds – one each on two acute wards and two rehabilitation wards – during that same week. These observations were not intended to confirm or refute the stories we had gathered, but rather to help us understand the environment from which they emanated and thereby make the scripts realistic. We wrote the stories up as scenarios to be acted out at the learning event using a technique known as Forum Theatre – a method of interactive learning based on the dramatic construction and reconstruction of problematic events.⁶ First, the audience watches the actors portray an event that highlights where improvements are needed; then, the audience tells the actors how to improve things; and finally, the actors act out the improved story and invite further reflections from participants.

The event took place on three occasions during one week in September 2011, each for a whole afternoon. Up to 60 junior staff from a range of disciplines (as far as possible the entire complement of staff for the relevant wards) were encouraged to attend, but fewer than half that number did so; there were 23 nurses, occupational therapists and physiotherapists, together with eight members of the MfE learning community – 31 in all.

Two members of Dansworth's central team responsible for organisational development and improvement supported the event by introducing (in lecture format) several techniques, including transactional analysis, which the participants could then apply in the Forum Theatre exercise. The scenarios portrayed instances where:

- junior members of staff felt unable to give information in the board rounds for fear of contradicting their seniors, or felt too intimidated to speak out
- seniors from one discipline were experiencing problems in confronting those from another, where staff had their valid views overruled at the board round for no apparent reason

- confusion over dates and plans for discharge led to patients being discharged inappropriately or with insufficient support
- medical staff failed to listen to the views of nurses and allied health professionals.

After working through the scenarios, we gave participants a chance to grasp the problems and suggest potential techniques for solving them, and to try to improve their confidence in making their voices heard at team meetings, so that all aspects of the patient's care might be properly considered. The participants put forward techniques based not only on concepts suggested by the introductory presentation and the Health Foundation project team, but also most notably (as might be expected in a community of practice/learning community) from the experience and knowledge that participants shared with each other.

During the broader reflective discussions that we encouraged at the end of each session, concerns emerged about a further suite of possible structural and cultural deficiencies in the system. We fed these concerns back to the MfE learning community, emphasising that they were only impressions that may need further investigation. They included the following:

- The lack of a sense of collective belonging to one MfE service. There was still a “them and us” feeling between staff at the two hospitals. We did not, however, detect such “tribalism” between the professions, which was a great bonus.
- The lack of effective communication channels – about general concerns rather than individual patients – across the sites and between wards, particularly at junior levels.
- The need to make better use of the procedure for feeding back difficulties such as inappropriate transfers, so as to systematically gather evidence that would highlight the causes of such events and help deal with them generically.
- The lack of any mechanisms for junior staff to be able to communicate with or receive feedback from the forum recently established for senior staff. Most front-line staff did not even know that the forum existed.
- The lack of knowledge among staff about how other parts of the MfE system worked – for example, the relative roles of the acute MfE wards and rehabilitation wards.

We suggested that the MfE learning community follow up these matters, as they were likely to be influential in helping the group to achieve the intended improvements. They were discussed at the next meeting and some actions were taken forward, such as creating leaflets that explained the differences between the wards. The fact that these broader concerns were dealt with as part of the improvement task was an important part of the process.

Our follow-up interviews, about seven months after this learning event, suggested that although it was generally felt to have been successful, what may have helped junior staff more in asserting their views during board rounds was also to have some role models among their peers to show them how to do so successfully. The improvement group was still working hard to help juniors develop their assertiveness skills, not least because there was a continual turnover of such staff. They had also been working to make the board rounds “slicker”. Different wards had customised the board rounds to best meet their needs. For instance, as deemed appropriate, they invited staff from other disciplines (such as social work and other health districts) to take part; some included a new section on the board to reflect patients' own discharge goals in addition to the team's goal for that patient. Overall, they told us that the board rounds had now improved communication across the multidisciplinary teams, enabling them to feel more integrated when working on the wards. This was not a universal success, though; at the time of the follow-up interviews, one consultant was still refusing to attend any board rounds. In other feedback, respondents emphasised the importance of the Learning Communities Initiative in helping them to develop a better understanding of the work of colleagues in different sectors across the service, breaking down the “them and us” feel that had previously prevailed. This outcome was also related to the second and final learning event that took place in March 2012.

The second learning event

The shape of the second and final learning event was becoming clearer as early as September 2011, coincidentally very soon after the first event. Dansworth had been allocated new funding from a Change Fund for the 2011/12 financial year to focus on community services, and it was anticipated that projects from that programme would impact on the effectiveness of discharge from hospital. This allowed us to reintroduce the prime concern about the role of community

services, which the improvement group had earlier categorised as “too hard to handle”. We encouraged the group to sketch out a rough structure for the half-day event in order to share information about new developments in relation to the Change Fund projects and other community resources. The learning event would aim to produce a list of areas where services still needed to be improved to enable effective discharge planning. The group delegated the planning of this event to a senior physiotherapist and a senior occupational therapist.

The event took place in March 2012 and was planned as a showcase of the main services and initiatives available to help achieve an improved EDD system. About 25–30 people from different organisations and disciplines were expected to attend, but on the day more than 50 arrived (including Dansworth’s Chief Operating Officer who unexpectedly stayed throughout and contributed to the closing panel discussion). The remarkably high turnout and the “buzz” at the meeting confirmed that we had been right not to let this concern about community services slip, but to encourage the group to confront it openly and constructively. The event became principally an information-sharing one, between the improvement group and the many other staff who had attended unexpectedly. It closed with a panel session to discuss problems and suggest ways forward – these were written up on flip charts to be followed through by the MfE learning community.

There was an inescapable air of enthusiasm during the tea break and afterwards; there were several comments that it was unheard of to get people from all these sectors in one room, and how useful it was. One of the consultant physicians from the MfE learning community prefaced her presentation by saying that a year ago she had thought a meeting like this would be impossible.

So what made it happen? There are a number of possible reasons, including:

- the setting up of a core improvement group that functioned not only as a service development team/catalyst but also as an improvement group/learning community
- having a designated leader whose job it was to run that group, and who was linked to (and trained by) the Dansworth improvement team
- the pressure to achieve EDDs as part of a general push to reduce hospital stays
- the Health Foundation project team’s role in helping the improvement group to identify the key problems they needed to tackle in order to improve the EDD system and to find ways to overcome those problems
- the fact that we insisted that the group return to this problem, which they had identified as a priority concern, even though they had backed away from it because they thought they could not achieve any change
- the Health Foundation adding kudos and lustre (and a little pressure from not wishing to let the side down, we were told), which encouraged people to contribute to the event
- the hard work of the key players to make sure the event happened.

The improvement group evaluated the event using an evaluation form on the day. The feedback was overwhelmingly positive, ranging from how important it was to find out what is available in the community and getting updated on all the initiatives that were going on, to interacting with relevant professionals one would otherwise not have had the chance to meet, and resolving specific misunderstandings (about who provides what equipment, for example). The few negative comments were either about the lack of space and time to get the best out of the meeting, or the lack of representation of key players such as GP practices and patients.

As a result of this event, and after the Learning Communities Initiative had ended, the improvement group went on to organise a stakeholder meeting that included many of the key participants across the MfE service and community services; this meeting was characterised by “enthusiastic information sharing” across the sectors and an agreement to meet again in September 2012 (which they did, and then again in November) to determine areas for a joint improvement initiative. These included “in-reach” from the community rehabilitation team, medication concordance, occupational therapists using small tests of change to determine if people can go home with less support, and district nurses “dropping in” to the hospital wards to share communication and advice.

The learning community outputs

Achievements

As the project formally closed, Jane (the project leader) led the core improvement group in writing a review of the work associated with the Learning Communities Initiative, which highlighted their many outputs (see Box 4.4) and successes. They were clear that they had achieved their first three aims; moreover, their review (subsequently confirmed by our follow-up interviews) showed the team's work had extended beyond these initial aims and was continuing to develop not only within the original MfE improvement group but now alongside staff from the community which, just a year earlier, had been deemed too difficult a problem to tackle.

Box 4.4: The Danelder learning community's main outputs

- A definition of EDD that can extend beyond the project
- A review of evidence to support the introduction of improvements in the use of EDD
- A standard operating procedure
- Decision trees
- Small tests of change that could be tried in other units
- "Sharing Practice" outputs (eg, patient information leaflets)
- Reviewing their own success in their improvement journey report
- Disseminating the report to all who attended the community showcase
- Taking their experiences and practices beyond the boundaries of MfE and into other wards
- An extended learning community involving community colleagues, with new tasks to work on

years – small tests of change” there was agreement when reviewing the claims that the “PDSA approach seems to work in practice”.

At an early stage, the group was focused on learning about rolling out best EDD practice across all the wards. But, not least because they were emerging from the difficult and painful service upheavals mentioned earlier, the group had initially had concerns about the potential difficulties of learning through sharing experiences; they were concerned that they might compete with, rather than learn from each other, which is indeed a recognised hazard of learning communities that lack skilled facilitation.⁷ At the follow-up interviews, in contrast, the work of the group was described as having been “healing”. Five of the 14 Danelder respondents said it had reduced the feeling of an “us and them” culture; 12 reported the value of forming a group to share ideas and/or described the group as reducing differences in understanding; and there were many comments about a renewed sense of ownership of the changes (in contrast to the “sticker afternoons” of other improvement projects). They also recognised how inclusive this project was and how it succeeded because it did not point at the poor performers.

In short, with careful facilitation and good management, the group appeared to have functioned well as a learning community/community of practice and succeeded in achieving its goal of improved practice as a result.

Learning about improvement

At the start of the project, interviewees suggested that they learnt how to improve services from each other or from going to specific events either hosted by external agencies or internally. One interviewee learnt by accessing an improvement website. One suggested that, in contrast to our project, they had previously been used to others coming in and “doing things to us” even during “sticker afternoons” (a term she used disparagingly for workshops run by outside consultancies, who always seemed to ask them to write ideas on Post-it notes). Although only one person talked about specific improvement techniques, saying that they had “used the PDSA system for the last couple of years and so recognise it as familiar – we’ve done this for

Chapter 5:

The Furncop project: improving services for patients with chronic obstructive pulmonary disease (COPD)

In contrast to the experience of the Danelder project, where a learning community was formed within an organisational environment that was conducive to its intended improvement method, constant organisational tensions and turmoil created a much more complex story for the Furncop project, where a clash of managerial and improvement cultures led to mixed results.

One of Furnhills' five main programme areas, COPD was a cross-sectoral initiative driven by the PCT. It was in need of closer collaboration across the city and across different professional and geographical "tribes" if it were to succeed in changing deeply ingrained patterns of practice and rectifying unacceptable disparities in clinical quality. The problem was that too few patients with COPD were being appropriately managed in primary care, leaving them unnecessarily vulnerable to exacerbations of bronchitis. Infections were only a small part of most exacerbations, but primary care clinicians as well as patients tended to have undue faith in antibiotics "curing" them. Moreover, there was a tendency, particularly among elderly patients, to regard a chronic cough as a natural part of old age, about which nothing can or need be done.

Primary care practices needed to be persuaded to manage patients more effectively (and help patients manage themselves) during the quiescent part of this chronic disease, and so avoid exacerbations. In particular, it was important to diagnose the patient's illness properly (using, for example, spirometry) and to refer them for pulmonary rehabilitation, which the PCT, in line with NICE recommendations, had recently invested in.

A team of public health respiratory nurses, led by 'Mary', a former respiratory nurse consultant, had been designated the task of managing this change by working with GPs and practice nurses; but they had been having difficulties and the targets for reduced hospital admission were not being met. The team sensed that GPs had little faith that pulmonary rehabilitation would do much to alleviate what many GPs and their patients saw as an inevitable part of being old (and poor) in Furnhills. A renewed effort to improve the quality of primary care for COPD was therefore needed, and this would benefit from the development of a learning community.

Preliminary work: identifying the task and the key people

Mary's aim was to completely restructure respiratory services. Her key message, which was in line with NICE guidance, was that better care at level 1 (GP and community nurse care of patients with underlying COPD) would be much more clinically effective and cost-effective than the current emphasis on level 2 (treating exacerbations of the illness) and level 3 (hospital care for patients with serious exacerbations). Once patients get to level 2, they are not easy to treat and often suffer further lung damage. She therefore wanted her team to go through GP records to identify patients with COPD and help primary care staff to diagnose them properly using spirometry, and to refer them as needed to pulmonary rehabilitation and other services designed to improve their overall lung function and minimise exacerbations. Yet even her own team were not fully engaged with this strategy and tended to devote a lot of their energies to level 2 services. The intended shift to level 1 was happening only "patchily".

Mary had done a thorough job, both at the level of backroom public health (including reviews of demography, epidemiology, evidence-based guidelines) and managerial and structural change (including process mapping, redesigning pathways, reallocating staff and resources, establishing new services). She had given presentations on that work to many different groups, but her audiences were not appreciative. She admitted, "...we are now a bit stuck in terms of getting things to happen in the front line. We still need to capture the hearts and minds of GPs and nurses". Our impression was that while part of the difficulty was the bewildering plethora of problems, ideas and goals she was grappling with, another part was the lack of credibility that her epidemiological/managerial approach had with some influential clinicians.

Under pressure from the top-down, performance-led managerial style of her PCT managers, Mary's approach was to set and monitor well-specified performance targets for primary care, such as the number of patients undergoing spirometry, or rates of referral to pulmonary rehabilitation. But this, she told us, was leading to resentment and resistance from managers and front-line staff ("they say it's that control freak from the PCT again"). Moreover, a key to this target-led PCT strategy was to focus on "hotspot practices" (that is, the poorest performers that were well below the COPD targets for level 1 care) as this would help to reduce inequalities. Yet these were the very practices where the public health nurses were having a tough time trying to win over the GPs and practice nurses. This was, perhaps, another reason why Mary's team were flagging in their efforts to bring about change.

Underlying this tension was not only a difference in philosophy but also a major structural change in the local NHS. Furnhills was in the vanguard of the controversial Health and Social Care Bill that would dismantle PCTs. There were already strong locality based consortia, which were growing in stature and asserting their new powers as they moved towards becoming clinical commissioning groups (CCGs). A senior GP called 'Jocelyn' was an enthusiastic and knowledgeable lead on COPD across all these local consortia, and she disagreed strongly with Mary's entire approach. Mary was therefore caught between the top-down, performance-led managerial approach of the PCT, and the assertiveness of clinicians who resisted her approach, backed by their own emerging power base that now even included some of her own staff, since some of her team were now technically employed by the consortia rather than the PCT.

For her part, Jocelyn, when we interviewed her, was in fact arguing that there was too much emphasis on the *wrong kinds* of level 1 care and on performance measures that she felt were clinically inappropriate. She – and, indeed, most GPs, and even sometimes Mary's own team – preferred the option of sending patients to the (voluntary sector) "Breeze" sessions and to yoga, not just to the evidence-based physiotherapy and respiratory nurse-led rehabilitation centres that the PCT had recently invested in. Mary naturally felt obliged to insist upon the latter, not least because the fact that so many patients were being referred to Breeze meant that the new rehabilitation centres were at risk of being closed down, which would have represented a considerable waste of resources.

By September 2010, the PCT's high-profile COPD initiative was teetering on the brink of collapse due to these internal wrangles. Mary had found it increasingly difficult to make progress. She felt undermined and could not understand why clinicians were so reluctant to turn to a new pathway.

Setting up a learning community

During September and October 2010, we interviewed most of Mary's team of nine public health nurses, and also some of the key staff at the PCT who were involved with the COPD programme (see Box 5.1).

Box 5.1: The first round of interviewees

Public health nurses	8
PCT managers	2
Hospital consultant	1
Practice-based commissioning manager	1

The interviews were designed (using our SPIBACC method – see page 6) to elicit participants' 'claims' and 'concerns' about improving the COPD service. They generally confirmed the situation described above, but the picture that emerged was also rounded out with considerable optimism and enthusiasm. The long list of claims about successes, when analysed and presented back to a meeting with Mary and her team, came as a pleasant surprise to Mary, who (visibly nervous) had been expecting to hear that she had been lambasted in the interviews. The positive points, which overall suggested that things were going much better than Mary had feared, included comments about better engagement of local primary care teams, the great potential for improvement in "hotspots" that had been identified, some pulmonary rehabilitation targets actually being met, a good feeling of teamwork within and across teams (with experienced nurses passionate about the task and

better communications between key parties), increasing support from the top (in some consortia) in dealing with difficult practices, and the more effective use of IT by some practice nurses in screening patient records.

The mood of the meeting lightened on hearing these success claims, and as a result the group were happy to talk more openly about the longer list of ‘concerns’, which we presented under the following seven headings that had emerged from our SPIBACC analysis of the interview data.

- **Overall:** the focus on targets set by the PCT rather than by primary care practitioners themselves was contentious; the work was going too slowly, with too many distractions from the main task.
- **Engagement:** the difficulty of engaging GPs and busy practice nurses, who did not regard COPD as a priority; a frequent sense of rejection/hostility “in the lions’ den” of GP practices; defensive clinicians unconvinced that pulmonary rehabilitation was worthwhile or that they needed to change their practice; it was hard to sell the ideas to patients, especially if their GP and public health nurse were not convinced of the benefits.
- **Outcomes:** “discrimination” against practices keen to work with public health nurses but who were refused help because their performance was insufficiently poor to warrant intervention; misclassification of some practices as “hotspots”.
- **Teamwork:** sometimes there was poor communications about the project (within the team and to practices); over-hierarchical relationships within the team (doctors; nurses; band 7 nurses; band 6 nurses); tendency to be told what is happening rather than being involved; poor balance between clinical and management activity among band 7 nurses.
- **Organisational support:** being caught in the middle (PCT/consortium; practice nurses/GPs...) as to how COPD care should move forward; disjointed changes in project direction; poor GP and lead nurse leadership in some consortia; lack of support from the top of some consortia.
- **Technical support:** poor quality data in practices.
- **Further concerns:** more experience of direct patient care needed to maintain public health nurses’ credibility with practice nurses when showing them new techniques, while maintaining a balance that enables the practices themselves to conduct the work in a sustainable manner.

The meeting that was held to feed back success claims and concerns – which was facilitated by ALM and JG and subsequently described by Mary and the team as having been exceptionally helpful and constructive – appeared to bring the team closer together with a shared purpose. At this stage, we therefore felt that we had the beginnings of an improvement group that had the potential to become a learning community.

Identifying the learning needs for the improvement task – I

That initial discussion produced a shortlist of topics to be considered for future learning events. Using nominal group technique, we helped the team identify three main areas for further learning to enable the COPD improvement task to develop successfully:

1. The public health nurses needed more experience of direct patient care *whilst* maintaining a balance that enabled the practice staff to do the work sustainably

Mary readily agreed to deal with this concern through internal management arrangements; this was a very welcome development for the rest of the team, for whom this had long been a major bone of contention. We took this as an indicator that the Learning Communities Initiative was helping the team to learn about each other’s concerns and to function better as an improvement group.

2. How best to deal with GPs and practice nurses who are difficult to engage (techniques for engaging and negotiating with resistant, sometimes even hostile, primary care teams)

This was agreed as the topic for the first learning event, aimed exclusively at the public health nursing team.

3. How best to “sell” (eg via social marketing) the idea of the COPD programme to practitioners, the public and patients who either don’t know what COPD is (ie a treatable disease, not a normal part of old age) or who resist getting involved in rehab for one reason or another

This was agreed as the most likely topic for the second learning event. The team identified a further 20 or so key individuals to be interviewed in preparation for a subsequent, much wider, learning event about this topic.

The first learning event

The learning need was about how to deal with the stresses that the public health nurses experienced when going into a primary care practice and, as they put it, having to explain to GPs and nurses “how they need to improve because they weren’t caring for COPD patients properly”. Unsurprisingly, this message was not always readily received; all of the public health nurses in the team had experienced various degrees of hostility from practice staff, which they admitted made them sometimes reluctant to press forward and therefore slowed their progress in meeting their targets for increasing level 1 care. They felt strongly that they needed to strengthen their assertiveness and negotiating skills; more training was needed in negotiating some acceptance of their role and in “selling” the suggested improvements, so this was to be the focus of the first learning event.

The event was arranged a few weeks after these discussions to be run by a facilitator/trainer identified by the Health Foundation. The interactive session was introduced but not observed by the project team (which would have been intrusive and counterproductive), and the immediate feedback was positive. The team reported that the session had met their needs in providing them with useful techniques and behaviours. Moreover, in the subsequent prioritisation of concerns, this no longer emerged as an area for concern.

When, six months later, all but one of the team were interviewed about the lasting effects of that first learning event, they reported that they had learnt helpful and relevant conflict management and negotiating skills, which they were continuing to use in their day-to-day work. Several interviewees unexpectedly reported that the functioning and morale of the team had also improved as a result. Not only was there higher job satisfaction and a better sense of achievement, but they were able to be more assertive with each other in constructively discussing their different approaches to the job. Although we were not able to test this claim formally, Mary’s team seemed to be not only more cohesive (despite now being formally managed through a number of different locality groups) but more willing to learn informally from each other.

Identifying the learning needs for the improvement task – II

JG and ALM’s second round of interviews in November and December 2010 was with 25 key people involved in the COPD improvement task – some as suggested by Mary’s team, others reached by snowball sampling (see Box 5.2).

Box 5.2: Interviewees for second learning event

Public health nurse 1 (+8 earlier discussions)	9
Practice nurse	2
PCT manager	5
Practice-based commissioning manager	2
Community nurse lead	3
GP	2
Respiratory consultant	2

Notwithstanding the fact that Furnhills’ COPD services were at last beginning to meet some of the key improvement targets set by the PCT, the interviews revealed many concerns that went beyond the topic – how best to “sell” the idea of the COPD programme to the public and patients – that Mary’s team had identified the previous October. Our analysis revealed 30 concerns that we emailed to all the interviewees in an electronic voting exercise in order to identify the wider community’s priorities for the subsequent learning events. The votes indicated that two problems should be provisionally addressed by learning events aimed at a much wider constituency than the first had been.

- (= Learning event 2) How best to handle the fact that patients (and some clinicians) commonly see COPD not as a treatable disease, but as a normal (if perhaps stigmatised) part of old age, and often fail to get involved with the available services such as rehab for one reason or another.
- (= Learning event 3) How to build a sustainable improvement programme given the multifarious and often conflicting stakeholders who are involved in the attempts to improve COPD services in a fragmented and tumultuous organisational environment.

The remainder of the Furncop project was essentially directed at ensuring that the second and third learning events were appropriately designed to meet the expressed needs. As there was no link between the topics or, to some extent, the target audience of each event, there was no call for further exploration of claims, concerns and issues around the COPD improvement task in between the two events.

However, the arrangements were initially hampered by events at the PCT. There were extraordinary new pressures and insecurities due to the upheavals that staff were having to cope with (restructuring in preparation for CCGs to take over the PCT role; change of chief executive; changes of priorities; financial deficit; ambitious initiatives to significantly reduce hospital bed numbers; GPs taking on new responsibilities; new programmes and clinical committee structures; a plethora of meetings and rival educational events; and so on). The COPD improvement group feared that it would be swallowed up by the PCT's new programme of generic chronic disease management (a fundamental philosophical shift away from pathways designed for single diseases, reflecting the large number of patients with more than one chronic condition). In another development, Mary announced her retirement, which left Jocelyn, the joint consortia's lead GP, now able to take charge without being constrained by the former tensions between herself and Mary, and with a clearer brief as to the relationship between the PCT and the GP consortia. This meant that there was less of a sense of conflict around the project and it was able to proceed apace, only now without the PCT-driven sense of target-led urgency.

As regards the Furncop project, the senior PCT manager with responsibility for the COPD programme (which had now been subsumed by the ambitious chronic conditions programme) had little or no commitment to the project, and our original site liaison manager had been drawn full time into other priority areas. Both of these developments slowed the project's progress, but eventually the baton was passed to a new site liaison manager, 'Ellie', who proved indispensable: had "Electric Ellie" not been so committed to the Health Foundation project and been able to make enough time to deploy her managerial spark to galvanise and organise the learning events, there is little doubt that the project would have ground to a complete halt.

The second learning event

A planning team for the second learning event was gradually assembled, including the Health Foundation team, Ellie, Mary (until she left), and staff from the health promotion department, aided where possible by a public health nurse. No GP was able to take part in the teleconferences arranged to organise this event. The topic quickly crystallised around social marketing, and an outside organisation – 'The CC Agency', which specialises in this field and was already working on other campaigns in Furnhills – was invited to provide the requisite expertise.

The invitation letter, signed by the highly influential GP chair of the PCT's professional committee, stressed that this event was part of a project (for which Furnhills had been chosen as an exemplar site for the NHS in England) that aimed to help practitioners learn more about "the art and science of service improvement". It explained that local clinicians and managers had highlighted the problem of patients and professionals alike not taking seriously the need to identify COPD early and ensure appropriate treatment at every stage of the "patient journey". The event was billed as "a unique opportunity" to develop the skills needed to engage people more effectively in the delivery and uptake of care, which was applicable to COPD but also to everyday practice across all disciplines and specialties.

Forty people signed up to attend the second learning event, "Making the most of every opportunity", which took place in July 2010. The chief disappointment was that only two GPs signed up to attend, neither of whom was among the 33 people who actually attended on the day. The lack of GP involvement was explained away by the suggestion that in the current climate, and given the still relatively low profile of proactive COPD care relative to other contractual requirements for GPs, this was a very low priority for them. Even the lead GPs, including those who had signed the invitation letter, were unable to come. Indeed, another senior GP who had been pressed into giving a brief introduction to the session left immediately after speaking.

The main aim of this second learning event was to help participants – mainly community nurses and COPD specialists – raise the profile of COPD care. A patient with severe COPD spoke eloquently to convince the audience how much better his life had been since attending pulmonary rehabilitation. A local film, which Jocelyn had already commissioned, poignantly reinforced that view. Specially-made COPD postcards (see Figure 1 overleaf) listing the principles of behaviour change were distributed for participants to pass on to their colleagues.

The techniques of social marketing were explained by specialists brought in by Furnhills PCT, both from within their own ranks and more particularly – and very ably – by the CC Agency, which was brought in for this event. They led open discussions to explore the barriers to greater uptake of level 1 care, and especially pulmonary rehabilitation (including its rather off-putting name). They and the Health Foundation team facilitated round-table work based on the CC Agency's "Behaviour Change Grid". The event was also linked to another PCT initiative that entailed individuals making

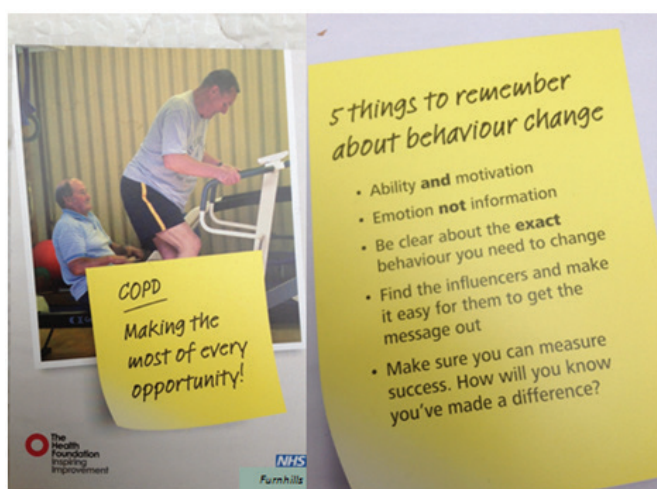
pledges to improve health in Furnhills; indeed, one output of the learning event involved attendees publicly making their own pledges to alter some part of their approach to COPD in line with what they had learnt (see Box 5.3). The CC Agency produced a “glossy” report afterwards, which was circulated not only to the attendees but to other key influencers in Furnhills.

Box 5.3: Second learning event: examples of pledges made by participants

Practice nurse	Give patients more opportunities to discuss factors that may be influencing their health behaviour
Case manager	Encourage uptake of pulmonary rehab
COPD nurse specialist	Sell pulmonary rehab more effectively and encourage patients to support each other

Some months later, when the first flush of enthusiasm was likely to have died down, we sent a follow-up email to those who had made a pledge at the event to get a more measured assessment of any lasting impacts it had had. Only five people responded, all indicating some lasting impact, from being more aware of the need to refer patients to pulmonary rehabilitation (and actually doing so), to following up on social marketing and behaviour change, to changing their own approach in dealing with COPD patients. For four of the five, their most memorable recollection was the patient stories about the impact of COPD and rehabilitation.

Figure 1: The social marketing postcard (showing both the front and the back)



The third learning event

The second event had generated a good deal of enthusiasm among the key players, including Jocelyn who had heard good reports, as they set about planning the third event aimed at helping them, in a changing organisational environment, to build a sustainable improvement programme given the multifarious and often conflicting stakeholders involved in COPD services. The Health Foundation team suggested inviting Gerry Marr, the Chief Executive of Tayside – a Scottish health economy with close links to the Health Foundation and an outstanding reputation for improvement work grounded in improvement science.

Around 18 people attended the third learning event, held in December 2011 – mainly public health nurses, practice and community nurses, GPs, managers (PCT) and a respiratory consultant. It began with Jocelyn presenting long lists of the achievements and remaining challenges concerning COPD in Furnhills. As guest speaker, Gerry Marr gave an account of the way in which his organisation had used tried and tested improvement methods to bring about radical changes that led to sometimes major but always measurable improvements in care. He was pragmatic, down to earth and persuasive. At first, there was palpable concern (an observation later confirmed by what people told us about their reactions) that Scotland was a very different context. But as he described how they had achieved such significant improvements in care, the audience seemed to perk up as it became clear that the kinds of interventions he was describing were not context-dependent. He gave good examples of remarkable changes that had initially seemed unachievable, but which they had managed to bring about using these proven improvement methods.

Later, there was some informal discussion about another important factor – namely Gerry’s leadership style, which was very different to that of the participants’ managers. Some members of the public health nursing team commented that, attractive and convincing as it was, the Tayside approach would go completely against the grain of what they were expected to do; they were struggling to see how it could be done under the current regime (see Table 2). Another nurse – reflecting again the concern she had expressed in the first round of interviews – later commented that they had “wanted instinctively to use that sort of approach, especially to work at first with the willing who would then help spread better practice by example and peer influence”. However, she stated that the PCT, through Mary, had always insisted that they work with the (often hostile)

laggards so as to improve the figures. “But we do try to have a conversation rather than a top-down target setting judgement-type approach, and it’s taken years to be able to do that with some practices”.

Table 2: Differences in the approach to improvement between Tayside and Furnhills

Tayside’s improvement approach	Furnhills’ improvement approach
Work with the willing/early adopters	Work with the poor performers/laggards
Use clinicians’ own data	Use PCT data
Mutual problem-solving “improvement conversation” (“we’re on the same side”)	Contract-based “judgement conversation” (“we’re here to push you to change, as adversaries if need be”)
Focus on one or two key agreed problems	Set multiple improvement targets
Do small tests of change and adjust as you go	Try to bring about change across the board
Show just enough evidence to make the point	Provide lots of evidence to support change
Develop ideas of improvement with the clinicians	Provide evidence-based guidance to clinicians
Get buy-in through early wins and natural spread	Use incentives and sanctions to change practice

Following the third learning event, we circulated a summary of the points that seemed to us, as facilitators, to be the most salient (see Box 5.4 overleaf).

Despite the local barriers to using this new approach, some were keen to try it. Group discussions led to action plans to try small tests of change in three areas of COPD care: one to look at the way patient care plans were being deployed; one to work with a willing general practice and see what could be done to improve the conduct and interpretation of spirometry; and one to look at why GPs record COPD patients as exceptions in the Quality and Outcomes Framework (and hence do not refer them on for care). Our follow-up enquiry found no more mention of the first of these. The second eventually became subsumed by the third, in that it moved towards investigating only why spirometry was or was not being done, rather than trying to improve how it was done, and even this was rather low key. The person leading that work regarded it, five months later, not as a step change to a new way of working, but as merely a continuation (albeit now more legitimate) of the work she had always done with primary care practices. In short, little had changed.

The fourth learning event

Jocelyn was keen to encourage this new approach to improvement more overtly, and contacted Gerry Marr to try and set up a presentation of these ideas to the executive of the CCG that was replacing the PCT. Busy timetables – and possibly reluctance from some of her senior management colleagues – made this difficult. (Despite a continuing declared interest, the visit has still not been arranged at the time of writing.) Jocelyn therefore decided to pursue a parallel track. She was now the chair of the COPD Special Interest Group – a small informal group of local consultants, respiratory nurses and members of the public health nursing team that met regularly over dinner sponsored by a drug company. Mary had once told us that this was the nearest thing there would be to a city-wide community of practice on COPD, but the group had not previously engaged with the Learning Communities Initiative. Now, however, Jocelyn invited us to their next meeting in March 2011.

Following our presentation there, which focused on the implications of the key points from the third learning event (as outlined in Box 5.4 overleaf), they agreed to run an exercise in which they would carry out a small test of change using the new improvement principles that had inspired them. They decided to work with a small handful of willing practices from two of the CCGs, to engage them in a “conversation” about how those with low exceptions manage it (rather than those with high exception levels who needed to change their way of doing things) and then agree some small changes to implement and monitor over a short period – all based on the principles absorbed at the third learning event. Talking late into the evening after we had left, we were later told, members of that informal group saw this as a breakthrough and agreed to ask the Health Foundation to hold such a session as a fourth learning event. Then, if it all went ahead, they wanted to have a fifth event subsequently where they would showcase the work to demonstrate to senior managers how well this new approach works. Jocelyn had come to the conclusion that the only way to be able to use this new approach was to actually try it out and then use any successes to help inculcate it at the top of the organisation, as well as spread the ideas among her colleagues.

Box 5.4: Key points circulated to registered participants after Learning Event 3

- that the key was to work with clinicians by having “an improvement conversation” that begins with evidence that there is a problem – usually practice variation – that they will want to help solve; “clinicians need to know we’re on the same side, not adversaries”
- that the evidence should preferably be their own evidence, not data presented by managers
- that there is therefore little to be gained by managers bringing what Marr called ‘judgement data’, (when the response will sequentially be (a) “the data are wrong” (b) “they’re not my data” (c) “it’s not my problem”
- the need to focus on three things:
 1. *people’s will to change*, (“work hard on working out what makes it attractive for the person to change their behaviour”, he said) rather than
 2. *ideas* (“you don’t need more ideas – there are too many already”)
 3. *evidence* about the changes that are needed (“but you don’t need to gather masses of data to prove that things need to improve”)
- the necessity of working with what Everett Rogers calls the influential early adopters, not with the laggards who are the worst performers and the least willing to cooperate. The latter, of course, was exactly where Furnhills had been putting most of its COPD efforts to date on the assumption that this was where the most inequalities would be ironed out and the most cost savings made. But, as he [Marr] emphasised, “not if they won’t cooperate!” Work instead, he insisted, with the early adopters who will show how things can work better and will then spread the word
- don’t set them a target but work with them, he said, to get them to suggest at most three things (“a bundle of care”) that one could do to achieve change in the direction of the desired improvement. This could be based on “driver diagrams” but also on other techniques
- don’t try taking on too many changes at once – “spray and pray” approach, which will always fail (i.e. tackling a wide range of targets at once, as Furnhills did)
- implement those few changes with the willing adopters and make sure the results are measurable with a small and focused bit of data collection, not major longwinded audits
- the measurements, which are an essential part of the improvement process, should be based on the underlying “theory of change” (which is simply a statement of the sort: ‘we are making these adjustments in care because we expect them to lead to these outcomes’)
- use those simple measurements (from “small tests of change” over a short period of weeks) to show if the changes, and maybe their expected consequences, are happening and adjust accordingly, (eg the PDSA approach)
- gain confidence and buy-in through early wins and then use the successes of that process to spread the word via the early adopters themselves.

The fourth learning event was stalled for four months for a variety of reasons, including the difficulty of coordinating the availability of the key players and Jocelyn’s long-term sick leave, during which her deputy consortium manager – who had never engaged with the improvement project and was strongly wedded to the performance management approach – tried several times to re-focus the event on the laggards despite advice from ourselves and various colleagues that the aim of this event was to design small tests of change with the willing practices. The fourth learning event, which was attended by 15 participants (mainly primary and community care nurses, a GP and some PCT staff), began with a presentation from the PCT of data that showed the large variations in local exception reporting and other aspects of primary care for COPD. We then reminded them of the key points of the Tayside improvement method that Jocelyn was keen to use (Table 2). The majority of the

meeting was then spent in small group discussions (see Box 5.5) that led to a set of agreed small tests of change that would be taken forward.

Box 5.5: Group tasks in the fourth learning event

1. Review the data on the current high rates of exception/exclusion (ie, where COPD patients who might be considered eligible are not being entered into the appropriate care programmes).
2. Examine (in unthreatening reflective discussion groups) the reasons for exception reporting in patients with COPD; agree new criteria for inclusion/exclusion.
3. Design a small test of change in which a small group of relatively willing practitioners will try using the new criteria for several weeks, and plan a method for reviewing that “small test of change” using objective measures to assess its impact.

The agreed action plans, with measurable outcomes, included:

1. “Making a **personal individualised approach** (eg by phone) to all COPD patients who do not respond after three invitations to attend for a COPD check-up to find out reasons for dissent (and maybe detailing consequences, etc)”
2. “**Someone being responsible for managing/monitoring** the process of COPD appointments/recalls/chasing up.” (This was agreed to be a general managerial matter but could be introduced via the small tests of change by having someone run those as a small test of this new management arrangement)
3. “**Encourage practices to join up to having a protocol** about COPD exemptions” ... (Step 1: get a couple of practices to devise (or adapt an existing) protocol, work to it and see difference using PDSA approach. Step 2: make top tips from it and share good practice across GP associations, etc)”

Participants volunteered to ensure that these tests were tried in their own or selected practices, and to report back in time for a final “showcase event” later in the year. However, despite regular reminders, the work did not proceed as planned and no such event took place. The follow-up interviews, held some six months later, revealed that little progress had been made. For example, the GP who had volunteered to pilot the third small test of change towards using a protocol had found her partners surprisingly resistant to the idea and had therefore backpedalled. She did, however, manage to get her colleagues to review patients before accepting them as exemptions, and also discovered a coding problem that had overestimated the level of exception reporting. The nurse volunteers for the first two small tests admitted that the structural upheavals of the NHS had taken precedence and pushed these changes off the agenda for the time being, although they were still hopeful that the situation might change. However, there were also suggestions that senior managers from the PCT were quietly but actively making this new approach difficult to pursue. Although we could not ascertain how true this allegation was, several interviews with the relevant senior managers corroborated it. Even if untrue, the very fact that such sabotage was so widely suspected revealed that the tensions between the two contrasting approaches to improvement at Furnhills (Table 2, page 27) remained unresolved.

The learning community outputs

Achievements

Early achievements included strengthening the interactional skills (especially assertiveness and negotiation) of members of the core improvement group, which also improved the inner workings of the team, bringing it more into line with what tends to work best in a learning community. The morale of the team continued to improve, as did Furnhills’ QIPP targets for COPD (though it is not possible to say if those two outcomes were causally connected).

Later in the project, there was a very well-received event that aimed to impart social marketing skills as a means of changing the mindset of healthcare staff and patients about the nature of COPD. But it also had direct educational value in alerting participants to aspects of COPD that they had not necessarily understood. In particular, it alerted many of those present to the importance of listening to patient stories, and to the importance of pulmonary rehabilitation. Most participants felt moved to make a “pledge” to change the way they dealt with COPD, and although the follow-up survey several months after the event had a low response rate, the responses about the event’s impact were uniformly positive.

The visiting speaker at Furncop’s third learning event had sparked a radical change in the mindset of many of those responsible for improving COPD care. But ultimately they proved unable to work against the organisational grain in taking those ideas further – despite the main protagonist, Jocelyn, being in a very senior position in the new structures. The renewed enthusiasm and commitment from the fourth learning event, which was designed to operationalise the new improvement methods in small and easily achievable tests of change, also foundered in the subsequent months of organisational change. Six months after Furncop’s fourth and last learning event, the key players in the original team of public health nurses were being reallocated, mainly to primary care.ⁱⁱⁱ They were still doing the same jobs, aiming to meet COPD targets set by the PCT while struggling to clarify their roles in the new structures. Jocelyn, meanwhile, was still trying to get her fellow members of the new Furnhills executive team to take seriously the suggestion of hearing more about the Tayside approach to improvement, not just for COPD but more generally as a way of working

ⁱⁱⁱ This move involved a continuing fight over the very first concern that we had identified with them more than two years earlier – namely the level of direct clinical work to be included in their job descriptions.

for the new GP-led organisations. Convinced that the CCG should adopt the “improvement conversation” approach as opposed to the performance management one inherited from the PCT, she was frustrated by the slowness of getting her vision accepted, but determined to continue trying until it was.

Meanwhile, the figures for pulmonary rehabilitation referrals, having been very poor in 2010–11, surpassed their target during 2011–12. Another of Furnhills’ QIPP measures of success was a reduction in COPD emergency admissions, and in 2011–12 there were 133 fewer such admissions than in the previous year with a calculated QIPP saving of nearly £200,000, net of the investment in the service. Confirmed figures for 2012–13 continued to show a sustained improvement on previous years.

Learning about improvement

The core improvement team of public health nurses learnt from each other as a ‘proto-community of practice’, but this functioned much better after the Learning Communities work got under way with the first focus group and first learning event. The first round of concerns revealed a strong need for support to develop crucial interpersonal skills that proved very helpful both in the improvement task and also in the functioning of the core improvement team. The identification of concerns and consequent learning needs led to a well-targeted event on behaviour change through social marketing, some of which may have had some lasting impacts. The potentially major shift in learning about improvement came with the third learning event, where a fundamentally different approach struck a chord with many of those present (Table 2). However, follow-up after the fourth and final learning event showed that this was unable to have any lasting impact in an environment whose culture was generally inimical to the improvement methods, promulgated by the Health Foundation and advocated at the final learning events, that the COPD improvement group wished to introduce.

Chapter 6:

The Dandem project: caring for people with dementia when they are admitted to hospital

This chapter describes a project in Dansworth that was slow to get off the ground due to a welter of other commitments calling on the time of the key staff involved, and which – when it did finally get going – switched from a focus on the dementia friendliness of acute hospitals to the question of staff education about dementia. Nevertheless, the two heavily facilitated “last minute” learning events contributed to a much-needed and valued exchange of knowledge and ideas across relevant sectors, which had not previously been working collectively on this topic, and therefore still helped indirectly to shape an improvement in dementia services.

Dementia had been a “Cinderella” among Dansworth’s quality improvement work and had been peripheral to the suite of mental health projects that were part of the organisation’s Lean-based improvement programme. When the Learning Communities Initiative was starting in mid-2010, ‘Richard’ had just been appointed as nurse consultant in dementia and had been asked to take on two main programmes of work: to develop services for dementia in the community (in line with the then two-month old Scottish dementia strategy); and to improve the experience of people with dementia who, for whatever reason, were admitted to hospital.

At this stage there was also an external enquiry under way, following a serious complaint, into the way people with dementia were being treated in Dansworth. The results of that enquiry (not yet concluded at that time) would doubtless add to the length and complexity of the first of Richard’s overall programmes. We therefore agreed to work with him on the second, which was more circumscribed.^{iv} The early discussions left it unclear

exactly how the Learning Communities Initiative would fit in, but Richard was keen in principle to engage the Health Foundation in helping make the acute hospital more “dementia friendly”.

Preliminary work: identifying the task and the key people

During the months that followed our initial contact, Richard identified for us a number of key players who would be involved in helping improve acute care for patients with dementia (see Box 6.1). They included representatives from all NHS functions relevant to the acute care of patients with dementia (including geriatrics, psychiatry, nursing and pharmacy), as well as functions outside the NHS. Some had chosen voluntarily to participate. This loose group was in its infancy in March 2011 when, as part of our SPIBACC method (see page 6), we interviewed them to elicit their ‘claims, concerns and issues’ surrounding the care of people with dementia in hospital.

Box 6.1: The first round of interviewees

Consultant psychiatrist for old age	1
Occupational therapy (OT) service manager	1
OT (dementia consultant)	1
Nurses (Director of nursing; associate director of nursing; liaison nurse; consultant nurse)	4
Pharmacist	1
Commissioner for older people’s services	1
Doctor (consultant)	1

The 10 interviewees felt that it was too early to make any claims concerning their achievements, so the interviews focused on their concerns. It was notable that interviewees did not find it natural to focus specifically on the acute care context; their concerns often related to matters that applied in non-acute contexts too. Care homes, in particular, were commonly mentioned.

^{iv} Interestingly, the care of dementia among acute hospital admissions was the same topic that the Furnhills dementia project lead had initially suggested but then moved away from because it might not happen within our timescale. And as it turned out, the Dandem project was also eventually to move away from this topic.

We obtained a long and disparate list of concerns, including:

- the scale of the problem
- poor understanding of dementia/delirium/depression
- dementia not being diagnosed, or being inappropriately or misdiagnosed
- where people with dementia were treated (when and why hospital/acute wards?)
- the roles of allied health professions and of voluntary staff
- the use of anti-psychotic drugs and their alternatives
- conflict between needs of patients with dementia and needs of other patients
- discharging patients with dementia
- training – quantity, quality and focus (eg, practical rather than theoretical)
- not sharing good practice
- the process of change
- stress levels among staff.

Our SPIBACC yielded a synthesis of 25 key concerns, and we negotiated an opportunity to meet the interviewees and other key people involved in dementia care to discuss them. This opportunity was a short designated slot in a three-hour dementia workshop that Richard convened in May 2011, sponsored by the local health economy's commissioner for older people's services.

In total, 22 people attended this meeting from across the Dansworth health and social care economy. JHK and JG, representing the Health Foundation project team, summarised interviewees' claims and concerns. The presentation stimulated the workshop participants to spend time producing a prioritised list of areas that could form the focus for the improvement task and the development of a learning community (see Box 6.2).

Box 6.2: Dandem's prioritised list of areas for potential improvement tasks

1. Education
2. Diagnosis
3. Ward environment
4. Exchange of information across sectors
5. Discharge planning to reduce lengths of stay
6. Implementation and change management
7. Pathways
8. Improved coding
9. Explaining the legal framework to carers

Following the event, Richard used this list of priorities to develop a dementia improvement plan, which was ratified by the local health board. Another event took place to develop a hospital pathway for people with dementia from admission to discharge. His own work was growing, not least because the enquiry that resulted from the serious complaint had led to urgent demands for an overhaul of dementia services, with many demands suddenly placed on him. A new action plan was developed, which included the main priorities from the first action plan. Over the year, three different strategic steering groups were set up by the health board to focus on dementia. While Richard welcomed the new enthusiasm to improve dementia services, he found himself juggling with a long list of priorities (see Box 6.2), which he described later as having "swamped" him with "a huge wave". Hence his communications with us became rare and the Dandem project all but came to a halt.

In addition, Richard now had to begin implementing the Scottish government's Promoting Excellence Framework⁸ – a document setting out the knowledge and skills required by staff and volunteers working with people with dementia. The Health Foundation project team met Richard in September 2011 to discuss how rebooting the Dandem project might help him take forward part of this overall workload. At this meeting it became clear that the need for improved education, as prioritised by the earlier workshop, dovetailed with the aspirations set out in the government's new framework, and he saw this as an opportunity to use our project to "kill two birds with one stone". It was decided, therefore, to craft the improvement task, the learning community and the learning events around the new educational requirements of Promoting Excellence – which was not limited to acute settings.

The improvement task had changed and now centred on finding a workable way of improving the knowledge and skills of staff and volunteers working with people with dementia in accordance with the government's new framework. The learning events were to be used to enable participants to adopt the framework and localise it to their geographical area. At the September meeting, a plan was formulated wherein the first learning event would bring together everyone concerned with adapting and localising the framework, to decide what generic and specific skills all relevant staff would need to have and to establish who already had (or should have) those skills. The first learning event would deliver an action plan detailing a realistic pilot scheme for implementing any resultant educational programme. The pilot would then be undertaken and evaluated, with the findings

presented at a second learning event in order to help the group plan the further roll-out of the programme. A third and final learning event would bring together the health economy's extant four dementia workstreams to share experiences and explore where there were overlaps and opportunities for better joint working. The education and training workstream group would bring together the results of the first two learning events as part of their contribution to this final event.

Predictably, this carefully laid plan did not turn out as anticipated.

Box 6.3: Richard's main accomplishments while the Learning Communities Initiative was in gestation

- Two "dementia friendly wards" set up as a pilot for Dansworth's main acute hospital, with a successful application for a two-year plan, and an application for a three-year plan to roll it out across all of Dansworth
- Basic delirium training (how to recognise and deal with delirium) provided for very large numbers of staff and well received as part of a wider dementia educational drive
- Development of person-centred training, now to be mandatory, as an e-learning package due to be launched shortly
- Roll-out of *This is me* (a leaflet produced by the Alzheimer's Society to make professional carers in any setting aware of people's needs and preferences), with some 3,000 leaflets distributed via community and nursing teams
- Introduction of the Butterfly system (using a butterfly sticker in the notes or on the bedside, as a symbol to tell staff that the patient has dementia), starting in three wards of Dansworth's County C Hospital
- A scheme for 22 Dansworth staff to undertake the national training programme to become "Dementia Champions"
- Setting up four "work streams" on dementia, responding to NES (NHS Education Scotland): pharmacy; nutrition, education and training, and professionals.

Setting up a learning community

It was expected that members of the education and training workstream group would form the core of the learning community. However, it became clear that there was little chance of moving things forward for Dansworth as a whole, so when the events were being re-planned in January 2012, Richard thought it best to work only in County C, an area of Dansworth that was substantially ahead of the other localities in terms of commitment to addressing the problems in dementia care. Valuable work had already started there, with some momentum

already established. Richard asked 'Nigel', a very proactive consultant in old age psychiatry in County C, to plan a series of learning events with him. They decided to invite a range of professionals from different sectors and disciplines to the first learning event. Guided by the newly appointed local project coordinator, they invited health professionals and managers from most of the relevant sectors across health and social services in County C, as well as representatives from the voluntary sector and private residential care.

The learning events

JHK met Richard and Nigel to determine the detail of the first two events scheduled in March 2012 but agreed to leave the logistical preparations to the local team. It was not considered feasible at this late stage to undertake another (topic-focused) schedule of SPIBACC (see page 6).

The government's Promoting Excellence Framework was to be the backdrop to both events. It identified four levels of knowledge and skills relevant to people working with individuals with dementia. In County C, substantial work had already been completed to identify the kind of knowledge and skills required at the first level (baseline knowledge required by "all staff") and the second (those who have "direct and/or substantial contact with patients with dementia"). The fourth level clearly applied to those who were expected to possess specialised expertise in dementia and dementia care. It was the third level – the "*Expertise in Dementia Practice Level*" – that was proving problematic, and which the two learning events were designed to address. The County C group needed help to identify what kind of personnel constituted level three, what kinds of skills and knowledge they required, the extent to which they might already possess such skills and knowledge, and how any additional skills and knowledge they needed might be developed. In effect, this built on the first prioritised concern identified with the Health Foundation project team four months earlier (staff education about dementia), adjusted to the emerging needs of the County C group.

The first learning event

The aim of the first event, held in March 2012, was described in a flyer for participants as being to "identify the knowledge and skills requirements for workers at the Enhanced Dementia Practice Level ('Level 3') in County C". There was a detailed design for the workshop, but in practice, the structure of the afternoon differed from the plan as the needs and

wishes of the group became evident. It also became clear in subsequent feedback that little had been done to brief participants about the context of the event within the Learning Communities Initiative. (Some apparently believed that the Health Foundation was involved because it had helped formulate the Scottish government's Promoting Excellence Framework. It had not.) More importantly, participants were not sure exactly what was required of them and seemed reluctant, at first, to accept the value of a relatively open information-sharing discussion. However, after a relatively sticky beginning, the workshop developed into a highly productive discussion, facilitated by the Health Foundation team (JHK, JG and ALM), which produced consensus on a number of key principles related to the knowledge and skill levels of staff working with people with dementia; these were not always exactly as suggested in the government's framework, but were agreed to be more feasible locally (see Box 6.4). This was not, however, achieved without having to resolve some notable differences, confusions and arguments that had not previously been voiced, let alone addressed in such a forum.

Box 6.4: Dandem's first learning event: consensus on the principles for dementia training

No patient should ever come into contact with any member of staff who has not been trained to at least level 1.

- Any substantial personal, psychosocial or clinical interactions should be with staff trained to at least level 2 (sometimes with additional skills/knowledge); but...
- Such staff should always be able to call immediately for help from someone from their own discipline who has level 3 skills if the patient requires it.
- All staff involved frequently in specific dementia-related interventions should be trained to at least level 3.
- The crucial requirement is that any given facility (such as a ward) should be adequately covered to the required level, rather than training every individual member of staff working in the facility to that level.

The second learning event

The second learning event, held one week later, was primarily intended to discuss the education and training implications of the conclusions of the first event for County C and possibly also, by inference, for the rest of the local health economy. Most of those who attended this event had also attended the first one the previous week, except for replacement staff from two organisations.

At the beginning of the event, some participants suggested that educational packages currently being developed at NHS Education for Scotland (NES) and elsewhere – similar to the work already undertaken locally to design courses for levels 1 and 2, which were soon to be launched – would provide the answer to local training needs for level 3. However, this suggestion caused a lot of consternation and the meeting required considerable facilitation; some participants had clearly decided that further discussion was likely to be a waste of time while others were unhappy with having an externally formulated education programme thrust on them, whether from NES or elsewhere. The debate eventually led to the conclusion that, while these other resources would be useful – both directly and as a useful model for designing County C's level 3 training – they would be extremely unlikely to provide the entire solution. The group eventually agreed that there was therefore still much scope, and need, for further local thinking about how best to take things forward bearing in mind these external resources, and the discussion then proceeded apace. They debated the nature of level 3 requirements, concluding that they were the training needed for “doing” such things as diagnosis, assessment and post-diagnostic care, whereas level 2 was merely about “understanding” these aspects of care.

When considering the likely pathway of clients/patients with possible dementia, it became clear that training staff to follow such a pathway was not just a matter of imparting certain knowledge and skills that the staff member could put in their “dementia care passport”. It also requires *embedding key elements of care into daily practice*, including: (i) a dementia-sensitive culture with a particular set of values and attitudes; (ii) a set of processes (such as continuing professional development, re-registration and re-validation) that takes full account of the needs of people with dementia; and (iii) a dementia-friendly physical environment. This led the group to produce a long list of features of a dementia-sensitive culture and a dementia-friendly organisational physical environment. In the process, they recognised that GPs, who were crucial to this change, were insufficiently involved. Only one GP in County C was identified as having a special interest in dementia, and there were no GPs in the learning community.

The crucial need was to spread not only specific knowledge and skills but also to bring about a shift in organisational culture; the improvement group – by now working well together and with good morale – concluded that in order to do this there would need to be a very varied set of educational resources (weaving

together a whole “tartan”, as they dubbed it, of training approaches and resources). The best approach to achieving this would be:

- a preliminary piece of work to firm up the numbers of likely target staff
- mapping available educational and training resources (from which to “pick and mix” education and training), including didactic materials such as modules, course booklets, information packages, in-service training packages, up-skilling by individual practical tuition, and shadowing
- firming up the identification of suitable trainers in County C (and others who might be involved in delivering training), including identifying those individuals’ own needs for up-skilling to carry out the required educational work. In particular, trainers would need skills in assessing the competence of trainees
- agreeing suitable mixes of the components of training, including mixed educational events spanning modular courses and one-to-one training, face-to-face and distance learning, and assessment and certification methods.

The intention was to carry this work forward as an improvement task in its own right, and to bring in some of those who should be important players but had yet to be involved – especially GPs – at a third learning event. However, Richard left Dansworth shortly afterwards for an academic job outside the NHS, and Nigel was appointed to a more senior management position that removed him from direct involvement in dementia planning. The group that had been assembled for the learning events had no sense of being a learning community now that there was no one to lead it as such. Yet there was a manager in County C, who had attended both events, who was responsible for rolling out education about dementia – indeed, that was why Richard had chosen to run the Dandem project there. The follow-up interviews revealed that manager’s frustration that Richard had brought us to County C with so little prior consultation and preparation, and therefore so little connection with their existing work. While he had much appreciated the unique opportunity for exchanging knowledge and ideas at the two learning events, he had decided that the work on dementia education would continue outside of any improvement group linked to our initiative. Our follow-up interviews also confirmed that although there had been great progress in rolling out the level 1 training (which had

not been the main subject of the learning events), the joint design of level 3 education, and the involvement of GPs in that design, had stalled.

The learning community outputs

Achievements

Richard reported that although he admitted that he never took the opportunity of using a learning community to achieve the necessary improvements, the Health Foundation’s involvement in his first dementia workshop in May 2011 (where we had helped to prioritise and focus the work among a diverse group of stakeholders) had given him greater credibility to develop the action plan to improve hospital care for patients with dementia. This enabled him to run another successful workshop to that end, following which he felt able to take the agreed plan to Dansworth’s executive committee, which ratified it. This was the first acute hospital action plan for Dansworth, and was frequently referred to and adapted.

The County C group only acted as a learning community during the actual learning events. Those events, however, gave the first ever opportunity for key people from many relevant sectors to come together in one room to discuss how to shift the whole culture around dementia care in health, social services and the voluntary sector. This turned out to be a broader purpose than the original task, but was, in retrospect, regarded by participants as a big step forward. Being given the opportunity to express their differing perspectives and to see them accommodated into an agreed plan was a revelation. The follow-up interviews (four, plus one email response) all demonstrated that the primary contribution of the Learning Communities Initiative had been to bring together the key people across all the relevant sectors and facilitate an open discussion in which all voices felt they were being heard. But the lack of GP involvement, given their key role in the care of people with dementia, was a major drawback; this was not subsequently rectified despite the agreed intention to include GPs at a third event, which never materialised.^v

In the learning events, the group had begun to address the Scottish National Dementia Strategy, noting that several of its aims were impracticable in the short-term climate, but approving these aims as legitimately

^v This was disappointing if only because the first two events had gone such a long way to bridge the chasms between the various hospital, community services, local authority and voluntary sector participants, and one might have hoped that GPs were not going to be a bridge too far.

aspirational. By articulating the care pathways for dementia across all the main sectors, the group had collectively begun to rework some of the ambitions of the strategy into locally achievable goals (in particular, the group had modified the aim of level 3 training for all personnel in particular categories, and had agreed on a short-term goal of training for a suitable proportion of such personnel). The group had also begun to formulate specific plans for developing an education and training package suited to County C's particular needs. As one interviewee later put it, "potential size and full context of the task" became clearer from this exercise. The manager who had led on the implementation of the training also remarked in a follow-up email nine months later that the Health Foundation's involvement "provided more of a comprehensive list [of training requirements and potential trainees] for levels 3 and 4", but had chosen at this stage to focus on rolling out the level 1 training to all staff "including bus drivers", and on piloting level 2 training in County C. Thus, the agreed aspirations and plans were not brought to fruition in the months following the learning events.

Learning about improvement

The Dandem improvement group was diverse; many people had not even met each other before. Thus it brought together a range of perspectives not only on dementia care, but also of approaches to improvement techniques. Richard had to tread delicate paths across a wide range of organisations, including the Dansworth Community Health Partnerships, which were relatively unfamiliar with Dansworth's quality improvement philosophy or with improvement science more generally. Richard himself was relatively unexposed to the work of the Dansworth improvement team. He felt that some of the main priorities from the cross-sectoral dementia improvement plan did not fit in with the health board's overall improvement philosophy, and made no attempt to avail himself of Dansworth's formal improvement resources and techniques for the Dandem task. It is notable, however, that the notion of an "improvement conversation" – a big part of the Dansworth philosophy – was prominent in the discussion about altering the organisational culture.

Richard and Nigel were both very enthusiastic about the improvement group's aims, and their enthusiasm was (eventually) reflected by many of the group members at the two learning events. However, while Richard had hoped that the improvement task would lead to the development of a learning community that could be sustained over time, the participants in fact functioned more as a temporary group with a task to complete.

There were several reasons for this. First, despite their evident keenness to continue with the tasks they had set themselves, they found it difficult to see where these ideas fitted into the working practices of their respective sectors. Second, in the final learning event, a perception arose that many parallel and overlapping dementia-related initiatives were currently under way in the same locality, that different members of the group only ever knew different parts of the story, and that these lacunae rather undermined what individual participants were able to achieve. This gave rise to a sense of uncertainty about the group's purpose. Third, whilst most stakeholders were represented, many had never met beforehand. Fourth, participants had not readily understood, from Richard's invitation, quite what each meeting was intended to achieve, which in any case differed from the tasks that emerged once the group began working.

This confluence of adverse factors presented a challenge to us as facilitators; we therefore used a fairly directive style and did much to help shape the outputs. After the initial reluctance, most participants contributed actively and seemed to function in a constructive way, accepting not only the plurality of viewpoints but also the need to develop consensus about how to improve knowledge and skills for dementia care. To some extent, this goes against much of the conventional wisdom regarding such facilitation,^{9,10} yet it is hard to see how progress could have been made in the time available had we not taken such a directive and often content-led (as well as more conventional process-sensitive) approach. Thus, the Dandem learning events highlighted the question of how far one's facilitation style can and should be adapted to meet the specific needs of a certain group – a matter which would benefit from further study and is discussed briefly in Chapter 9 (page 59). Certainly, the follow-up interviews emphasised that participants recognised how valuable the facilitation had been. They told us that we "really helped" because we "were outside the established power of the organisation" and had "managed to get each voice heard" and "generate open discussion".

Nevertheless, the fact remains that nine months after the second and last learning event, little had happened in terms of the level 3 training that was its main focus. External pressures had ensured that attention had been devoted instead to levels 1 and 2. However, there was still the intention that the outputs of the learning events would be used later when attention eventually turned to the development of level 3 training.

Chapter 7:

The Furdem project: improving the memory clinic services for patients with early dementia

At Furnhills, as at Dansworth, the dementia improvement task for the Learning Communities Initiative remained persistently low on the agenda of the key personnel, who never formed a learning community. The Furdem project began in an environment of poor communication, alienation, and even resentment, which was to lead to reluctant, token engagement by the key actors, who were otherwise very keen to improve aspects of their service. One learning event was eventually held, however, and proved important in bringing together stakeholders (some of whom had never met before) to discuss a way forward. Following that event, the agreed improvement task, which had hitherto been controversial, was successfully implemented.

At the start of the Learning Communities Initiative, the Furnhills site liaison manager told us that our involvement would be welcomed by the team that was grappling with multi-sectoral problems in the dementia services as a key part of the “Clinical Programme Areas” for care of the elderly. We later learnt that this suggestion had come from a subgroup of the clinical summit (Chapter 3, page 9) working mainly on the over-75s programme area, a committee of 20 or so clinical directors, nursing leads, and PCT and CCG leads. When we met ‘Paul’, the consultant in old age psychiatry who was clinical director for dementia services, we found that he was unsure why dementia had been “rather hurriedly” chosen, why no one from the PCT had discussed it with him or his team, or what the Furdem project was supposed to be about.

Most of that first discussion was therefore taken up by reassuring him about how the Learning Communities Initiative would work, and by gleaning that communication between the organisations was not good and that the improvement work on dementia had barely started. Nevertheless, Paul seemed pleased that dementia might at least be taken seriously as part

of the quality improvement process. There were already some “small initiatives” on Paul’s inpatient wards (eg the Lean-based “Productive Ward” scheme led by the NHS Institute), but nothing that dealt with the whole system in the way that he would have liked. He cited examples of how a recent, much-celebrated attempt to improve care of the elderly had, in his view, actually made things worse for patients with dementia.

After surveying a number of possible improvement tasks, there was no clear front runner, so this was further explored at a second meeting a month later, which was also attended by our PCT site liaison manager. Underlying tensions and poor communication between the PCT and Paul’s trust were very evident at this meeting. The PCT manager produced a list of 17 objectives for dementia, which the PCT had based on the national dementia strategy, but Paul and his colleagues, who were responsible for managing dementia services, claimed never to have seen it. The discussion turned instead to two specific areas for which Paul was responsible – the hospital’s medical assessment unit and the memory clinic service – that might be suitable as the focus of the Furdem project. The first of these (and much the more important according to Paul and his immediate boss, as well as the chief executive whom we interviewed later) was about the way in which medical patients were admitted to the acute hospital wards. However, improvement work on this topic was dependent on a major tranche of funds being agreed by the relevant acute trust boards, and was not guaranteed to be forthcoming within the time frame of the Health Foundation project. Paul therefore agreed that, all things considered, the best area for the Learning Communities Initiative was probably the memory clinic service. This service, run mainly from two community-based clinics, was designed to assess and diagnose people in the early stages of dementia so that they could be referred to the appropriate services.

There followed a lengthy, sometimes tetchy discussion about undertaking new quality improvement work to improve the memory clinic service. Why, Paul only half-jokingly quipped, should he take this on when the last time the dementia team had made efficiencies to reinvest in other parts of their service, the PCT had clawed all the savings back to help with their acute services deficit? He did, however, recognise that the memory service needed a complete overhaul, as the waiting list was already nine months and growing fast. The ensuing discussion, confirmed and amplified by our subsequent interviews with senior managers, alerted us to some of the likely difficulties ahead. These included:

- “the sheer complexity” of the cross-boundary work between the primary care, community, hospital and social care sectors
- the “sheer amount of other work”, such as QIPP, which was “a fundamental must-do”
- probable lack of staff capacity to undertake the overhaul that was needed
- the lingering concern that any resultant savings would be “swallowed up” and not used to improve dementia services
- possible reluctance on the part of staff working in the memory service to dismantle what many regarded as “a Rolls-Royce service” so as to “build Fords for the masses”.

Nevertheless, Paul came round to the idea that it would be useful to work with all the key players to redesign the memory service, using process mapping, Lean (in which there was some in-house expertise), and other improvement techniques, and that this would be helped by being part of the Learning Communities Initiative.

Preliminary work: identifying the task and the key people

The principal role of the memory clinic services, offered at two sites, was the early assessment of patients with memory loss. The service claimed to have hit its performance targets to a high standard; for example, it had recently been nationally accredited – a significant achievement. Patient and carer feedback – often describing it as a “Rolls-Royce” service – was reported as “excellent”. However, the long waiting lists (initially reported as nine months, but in actual fact being four and 11 months respectively for the two clinics) were acknowledged by all stakeholders as requiring attention.

Our preliminary discussions with Paul suggested that despite its achievements, the memory service had four interrelated problem areas:

- difficulty in achieving more primary care-led follow-up care of patients
- deficiencies in the psychosocial support group interventions for carers
- unsatisfactory transport arrangements for patients visiting the clinics
- the risk of duplication in assessment processes for patients entering the care pathways at different points.

Each of these might impact on the primary problem – the growing waiting list – and the improvement task was therefore defined more broadly as “trying to improve the performance of the memory clinics” within the context of a “beleaguered” community of service providers who felt that their clinical contribution was “under-valued and misunderstood”.

Setting up a learning community

Besides Paul, other key actors included the managers and staff of both memory clinics. However, while it was clear that those staff took the opportunity (through their respective managers) to share localised knowledge, no obvious existing or potential learning community was evident for the Furnhills dementia service. Notwithstanding this, and with Paul’s help, we identified potential interviewees who might help us to discover what would need to be learned such that the service might be improved. That process was a protracted one in which no sense of community was able to develop from the point of view of the Learning Communities Initiative. It was only at the very end of the Furndem project that anything approaching an improvement group for the project’s task (let alone a learning community) was put in place at all.

At Paul’s behest, a parallel track of improvement work based on process mapping, aimed specifically at reducing the waiting list, was undertaken outside of the Learning Communities Initiative. Although we later learnt that this process mapping appeared to have stalled, as had the development of some sort of “business plan” related to that activity, it may well have contributed to the clinics’ eventual success in reducing waiting times. However, we will not refer further to the process mapping here as Paul kept it completely separate from the Learning Communities Initiative.

Identifying the learning needs for the improvement task

We carried out nine interviews at the end of 2010 and early in 2011. In identifying the interviewees (see Box 7.1), we tried to draw upon a sample that reflected the range of views about the broad problems referred to above. Each interview lasted for about one hour, and broadly followed the ‘claims/concerns/issues’ SPIBACC framework (see page 6). Although we reminded interviewees of the four broad areas Paul had initially identified in relation to the waiting times, they were free to focus on those aspects of the service that they knew best, or felt most strongly about.

Box 7.1: The first round of Furndem interviewees

Clinical director	1
Memory service manager	1
Memory clinic manager	2
Clinical psychologist	1
Occupational therapist	2
Performance manager	1
GP (commissioning lead for the elderly)	1

Our aspiration to capture a range of views for our SPIBACC was well met. Some respondents claimed that the difference in waiting times between the two clinics was down to practice differences, while others put it down to demographic factors; some argued that there were shortcomings in the current medication-based treatment, while others cited controversy over the current emphasis on the very labour-intensive psychosocial group activities.

Everyone seemed to agree that change was needed at the operational level, but there was no clear perception of who was responsible for explicitly driving such change. Despite the various initiatives Paul had put in place, interviewees had little awareness of any ‘quality improvement projects’ as such, but some awareness that other people were “doing things”. On the one hand, staff appeared protective of their position, and “precious about what they do”, while on the other they complained that “GPs should be able to do more”. GPs, though, were reported as having little or no incentive; follow-up and care plans often appeared inadequate, and processes slow. The perception among respondents was that dementia was seen in the wider organisation as relatively “low priority”.

Our SPIBACC method revealed long lists of around 40 claims and 60 concerns. We placed both into the same six categories (see Box 7.2 overleaf).

There appeared to be a lack of structured dissemination of strategic learning. The most telling feature was that there was no sense of ‘a project’ (or in our terms an ‘improvement task’) towards which all interviewees were contributing. For example, in answering direct questions about their role in quality improvement, or the ways in which good practice is shared, views expressed were typically operational – “we need more resources”, “GPs need to do more”, etc – rather than reflecting on aspects of a bigger quality improvement picture. Faced with a long waiting list, those who felt themselves under pressure seemed, perhaps understandably, to point to other parts of the service where changes might help relieve some of that pressure.

We found no sense of a group identity or ownership, which a quality improvement project might have helped forge. Interviewees spoke of their expectations of other service providers, but there appeared to be no forum for any such shared learning. Everyone seemed to feel that they knew what (and sometimes where) the problem was, but their perceptions were held in isolation from those held by other parts of the service. It is precisely these sorts of tensions that the Learning Communities Initiative sought to surface, so we looked forward to a series of meetings in which the differences between the perceptions of (for example) the memory service staff and GPs might be explored.

By this stage we had identified several factors that were impeding any sense of a learning community. They included:

- this being a service under pressure, fearful for its future
- an apparent mismatch between clinical and psychosocial objectives and targets
- demarcation lines (between different parts of care provision) not being well understood
- a culture where an appetite for change was espoused, but with little evidence of appetite for its application.

Box 7.2: Examples of claims and concerns from the Furndem SPIBACC interviews

Overall service performance

- **Claims included:** “fabulous” feedback from patients/carers; clinics meet (or exceed) their contracted targets for assessment; other parts of the service are enthusiastic about what they do; teams are well managed.
- **Concerns included:** long waiting lists for first appointments; access is poor – need for a generalised care plan rather than “gold standard” service; tensions between what they are commissioned to deliver, and what they feel (as professionals) that they could/should do; fears of compromising (perceived) professional standards.

Different perceptions of the possible role(s) of the service

- **Claims included:** the underlying model of service is “Assess-Treat-Educate”; GPs able to take on some of the assessment.
- **Concerns included:** is the service’s role just assessment, or should they also be developing treatments (eg, interventions)?; role of memory service not sufficiently understood by GPs and primary care teams; need for “learning opportunities” about dementia for GPs who tend to pass everything back to the memory service; memory service is often required to undertake follow-up work not always appropriate to its role; staff feel “drained” by the caring experience.

Relationships with other care providers

- **Claims included:** good relationships between GPs and other agencies.
- **Concerns included:** relationships with other care providers; poor sharing of data (eg, diagnostic); no incentive for the trust to manage the data (which would be beneficial for commissioning); being stuck on a register, but not followed up; GPs need a more systematic approach to care plans; use of community nurse to identify “at risk” patients; direct access (via GP) to quick CT scans, followed by care plan, could improve patient experience.

Ways in which good practice is shared, at national, local and interdisciplinary levels

- **Claims included:** national accreditation has raised self-esteem and raised awareness (and knowledge) of “external” ideas; accredited individuals could act as “champions”; accreditation “chat pages” raise plenty of discussion about good practice; various regular operational meetings provide good knowledge-sharing fora, and encourage dissemination of service improvement ideas; city-wide shared protocols.
- **Concerns included:** not disseminating our strengths and successes very well; little knowledge of “chat rooms” for memory service; uptake of weekly continuing professional development not always good due to clinical pressures and uneven attendance; information-giving service differs across sites; dementia workshops operate differently (different practices) across the service.

Operational practice such as the relationship between GPs and other care providers, and the streamlining of performance regarding these relationships

- **Claims included:** relocation to a single site would improve whole service.
- **Concerns included:** GPs could do more of the memory clinic’s work; need to develop an “education programme” for primary care staff; other parts of the service need to take their share of assessment tasks; the need for the consultant/senior clinician to confirm diagnosis leads to bottlenecks; having two sites is potentially divisive but also a good medium for knowledge exchange.

General change management

- **Claims included:** PCT supportive of the business plan for the service; everyone’s “up for change”; could use “the productive community” as a catalyst to engage all staff.
- **Concerns included:** ownership of change is needed; process mapping was a tension-filled process with no feedback; repetitive assessment of patients, because information is not shared; some staff cannot see what is wrong with the existing service; staff are precious about what they do, do not want to “let go” of aspects of the service – “giving away our business”; minimal contact with some ethnic groups.

We therefore urged the senior players in Furnhills to get influential GPs around the table (with our help, if necessary), together with the clinical directorate team and staff with experience of pathway redesign, to discuss how to get to the next step. The first such meeting took place in March 2011 and apparently considerably improved awareness of the need to work together to address the ‘improvement agenda’. We agreed not to attend this meeting, as there was a feeling that our participation might be inhibiting in the light of some of the sensitivities between, for example, the PCT and the memory service. However, further meetings between the memory service and GPs did not materialise, and there was no response from Paul to any of our requests to help move the project forward. There was therefore no opportunity at this stage for us to feed back the results of our SPIBACC or to help the group prioritise them so as to develop an appropriate programme of learning events.

In the hope of injecting some momentum into the process, we proposed three ways in which the Learning Communities Initiative might assist. The one that was most warmly welcomed was a face-to-face facilitation event engaging “as many GPs as possible” to focus participants’ attention towards some consensus around the most compelling concerns.^{vi} Our intention was to use that as a starting point to open up debate with GPs, possibly by reconciling – or at the very least recognising – their own concerns with those of the memory service team, with a view to developing a learning community that could begin tackling the problems. However, it seemed increasingly difficult to bring together key stakeholders in any of the suggested fora, perhaps again underlining the low priority they accorded such activities. Eventually, just one opportunity for such a consensus-building meeting materialised, but not until September 2011 – nearly nine months after the first stage of our interviews had concluded.

Meanwhile, notwithstanding the stalling of the Learning Communities Initiative, considerable operational improvements appeared to be happening under Paul’s leadership. The waiting lists at the two clinics, which had peaked at around 30 and 48 weeks respectively, were more than halved to 12 and 19 weeks due to the redesign of some of the pathways into the service, and a streamlining of the assessment process. However, this improvement in assessment, our interviewees told us, was brought about at the cost of diverting staff from follow-up. Some were worried that any improvement was likely to be temporary, as this reallocation had led

to a bottleneck in follow-up care, which they said could probably only be addressed by shifting resources away from assessment and back to routine follow-up – unless, that is, GPs could be encouraged to undertake such work.^{vii}

In sum, at this stage, there was still no recognisable learning community relevant to the Health Foundation project but – perhaps partly due to the parallel process mapping initiative that now seemed to have run into some difficulties – improvements had been made in one part of the system, albeit at the likely expense of other parts.

However, Paul still seemed reluctant to buy into the Health Foundation improvement project, partly because of more compelling day-to-day pressures (some of which he put down to the financial cuts that his unit was experiencing, which needed immediate and urgent action) and partly because he was pursuing the other operational improvements. While all the key people would subscribe to the spirit of the broader Furndem improvement task via a learning community, there was no key supporter who seemed prepared to invest effort in building such a community. This left the Health Foundation project team with three choices: should we more actively ‘drive’ the creation of such a community, withdraw altogether, or continue to gently encourage, more in the role of observers than instigators? We chose to continue in the latter (mostly observing) mode on the grounds that the unfolding events would reveal lessons about how improvement tasks and learning communities are interrelated. (The first option, actively driving the work, would in any case have been beyond our remit.)

Still identifying the learning needs for the improvement task

In June 2011, we again asked the memory service team to identify how they might best use the Learning Communities Initiative as an opportunity to help engage with GPs, since the bottlenecks would continue unless they took on more of the routine assessment and follow-up work. From an improvement perspective, much of the success of these activities would depend on the level of engagement by the memory service team, and on their relationships with the GP community. But the signs were not encouraging, so we pressed to be

vi See Chapters 4–6 for examples of how we achieved this elsewhere.

vii Although the PCT’s “preferred direction of travel”, informed by senior and influential GPs, was that follow-up should be part of holistic primary care for patients transferred back to the GP from the memory service, it was controversial. Some GPs saw it as unpaid extra work, despite detailed modelling from the PCT that showed it applied only to a small handful of patients per practice.

invited to present the Learning Communities Initiative at two existing meetings in September 2011. The first was a memory service management group meeting; it was attended by a subset of the interviewees together with other service managers, including two key senior consultant psychiatrists who expressed surprise that Paul had not informed them about our project, thus confirming our view that he had been downplaying it. From the long list of concerns already identified (see Box 7.2 on page 40), those present agreed three priority concerns and interrelated learning needs (see Box 7.3), and asked for the ‘*who is responsible for what?*’ question to be addressed at a Health Foundation learning event that would help to cast further light on the care pathways concerns.

Box 7.3: The Furdem group’s priority concerns

- Service boundary issues, both internal (how different parts of the memory service interacted in their care-giving) and external (eg, the extent to which GPs understand the nature of the ‘memory problems’). Both of these might be exemplified by the ‘pass the parcel’ syndrome, precipitated by an unclear picture of *who is responsible for what?*
- The role (and extent) of the memory service, in particular the relationship of ‘psychosocial assessment’ with other activities.
- The ‘waiting list’ problem, and in particular how this might be viewed (and used) by third parties, particularly in the light of the new commissioning arrangements and possibly also changes in the directorate.

A few days later, we attended a second meeting at which the prioritised concerns were due to be raised. Two people who attended – ‘Anthea’, the PCT strategy and specification manager, and ‘Tara’, the practice-based commissioning manager – subsequently proved crucial to moving the project forward. Initially, most of those present had little if any idea why we were there at all. The hope had been that GPs would be strongly represented at this meeting, since one objective was to impress on them the need to engage in this improvement task and secure their agreement to the offer of consensus building at the agreed learning event together with memory service staff – given that they and the GPs were still, as Paul told us, “a long way apart”. As it transpired, the only GP present was a lead GP for commissioning, albeit one who turned out to be decisively influential in subsequent events. The meeting agreed to hold the “who is responsible for what?” event, so we set out to prepare it, working not only with Paul and the lone GP but also with the PCT.

Despite the meeting’s evident enthusiasm for such an event, little progress was made on setting a date. Were it not for the forceful and persistent intervention of ‘Electric Ellie’, our new site liaison manager at the PCT (see Chapter 5, page 25) who, by January 2012, had made it a point of principle to salvage this project, it would probably not have gone ahead. By then, Anthea and Tara were running Furnhill PCT’s dementia improvement work, and without consulting us, they went enthusiastically ahead with arranging a programme of training events using their own design of didactic lectures, which they labelled as the Health Foundation learning events. Taken aback, we again explained the scope, philosophy and timeline of the Learning Communities Initiative, after which Anthea and Tara readily agreed to an interactive event that was more in line with the initiative’s principles. This would focus on raising and reconciling stakeholders’ differing roles and perspectives, with a view to jointly improving the care pathway across the different sectors. They eagerly set about arranging such an event, suggesting that its action points would then feed into their lecture series, which they would now run as a separate but complementary programme.

The learning event

There were 25 attendees, including five of the original nine people who had been interviewed more than a year earlier. The participants included representatives from primary and secondary care, the PCT, the city council, social care, psychiatry and psychology. There were clear differences of perspective during the presentations given by Paul and the lead GP respectively, but these were well handled and began to be resolved during the subsequent open discussions. ‘Charles’, a very enthusiastic GP who had not previously been involved in the project but was now pushing the ideas forward, also emerged at this meeting as an enthusiastic champion, and was subsequently to take a large leadership role in helping to shape the changes that followed the meeting.

The day was deliberately interactive, with discussion focusing on four key areas, each consistent with the concerns that had been previously prioritised and with the proposed improvement task. The areas were:

1. **The challenges in mapping the care pathways:** mapping of any single pathway would always be contentious, as there were different types of pathway and it was impossible to legislate for the many differences between clients/patients; the service suffered from poor communication within and between organisations and between service users

and providers; there was a lack of knowledge of the range of services and their connectivity; a lack of clarity about when diagnosis of memory problems/dementia needs an intervention; and lack of understanding of how such interventions can best avoid overlong stays in acute services.

2. **Functional mapping of services across the city**, recognising responsibilities and areas of concern (building on point 1 above) across a wide range of services; each different part of the service needed to understand more about what the others provided; the usefulness of having this rare chance to do so across so many relevant sectors simultaneously; the paucity of information exchange between services, both electronic and manual, and its lack of clarity. An “**issue-based mapping of services**” made many participants aware of (inappropriate) “crisis reactions”, often leading to avoidable acute hospital stays followed by complex discharge processes.
3. **Gaps in skills, knowledge and resource**: what services exist and how to access them; the scope of non-pharmacological interventions; the potential role of “alternative to restraint” policies and of Mental Capacity Act and Deprivation of Liberty Safeguards as used in learning disability services.
4. **How agencies can work more effectively together**, broken down into three strands.
 - **Organisational**: developing working relationships between professional groups; integrating physical and mental health, and social care; shared care delivery via co-location; ways to increase the visibility of partner agencies; the possibility of relocating the memory clinics to a single site, with direct access; making better use of community resources like shops, libraries, churches and pubs.
 - **Communication**: how to access services; how services connect; all agencies needing access to contingency plans and to shared understanding of eligibility criteria used by the city council; increased knowledge, and better signposting, of “Furnhills Help Yourself” and resources like Map of Medicine.
 - **Misunderstandings/shared common goals**: it would be better not to have to wait for the dementia “label” before accessing services; more clarity needed regarding service improvement plans for diagnosis, memory service and follow-up in primary care.

The suggestions agreed by the end of the meeting are summarised in Box 7.4.

Box 7.4: The Furndem learning event outputs

Suggestions for service improvement

- Remove the need to have the dementia “label” to be able to access services.
- Reduce the number of steps in the pathway to diagnosis (taking straightforward cases out of the memory service and following them up in primary care with nurse support).
- Improve communication and co-provision of care between agencies.
- Make more information available about the acute hospital’s dementia pathway.
- Pool some budgets.

Agreed actions

- To continue to meet to foster cross-agency conversations, and improve communication, via, for example, the “Dementia Services Panel”, and possibly forming a cross-agency subgroup to ensure a clear mandate for change.
- To prioritise the above suggestions, including raising awareness of why dementia should be a priority for all parts of the health service.
- To ensure that service redesign is undertaken by people working in the service, and be aware that changes might have knock-on effects for other services, which will need to be kept informed.

Further events were now outside the timescale of the Learning Communities Initiative, but Tara and Anthea volunteered to take the work forward and organise such events as appropriate. Charles continued to take a strong interest in the subsequent events. He helped Anthea, Tara and Paul organise a large dementia “Protected Learning” event, based on the outcome of the Health Foundation’s learning event, which was scheduled for June and aimed largely at GPs. He also undertook to pilot the new ways of working in his geographical patch.

Above all, Charles’ leadership helped calm the storm that erupted among some GPs when the new arrangements were proposed. As we learned from our subsequent interviews and other correspondence with nine of the key players, following on from the learning event there was strong debate (variously described to us as “meltdown”, “cathartic” and “healthy”) among some influential GPs who were concerned about workload implications. Nevertheless, the CCG’s decision-making body approved changes to the memory clinic service as part of its business case for dementia. These improvements freed up more clinic capacity for diagnosis and more specialised work among the more

complicated cases of dementia; this was achieved by assigning to GPs the routine monitoring of patients with stable dementia, including (via the Local Enhanced Service scheme) those that live in care homes. These changes were disseminated at a large education event in June 2012 attended by 210 GPs and practice nurses – a defining moment in the development of the new service.

Following all the debates, an experienced mental health nurse began working in the community in September 2012 to support the service transitions that had been decided on, including addressing the learning and development needs of key primary care staff. By early January 2013, the scheme had already discharged back to the community around a third of people who were suitable for GP care but were being followed up by the clinics, and was on track to continue with the rest. The new GP commissioners were also contemplating follow-up clinics supported by a dedicated service that would enable GP practices to provide information and advice to their follow-up patients and to people worried about their (or a relative's) memory, who would be able to “drop in” following publicity about the new service in their local area.

The learning community outputs

Achievements

Among those responsible for dementia care in Furndem (who, in the face of widely acknowledged problems and difficulties, saw themselves as beleaguered and undervalued), cross-service conversations about change had been seen as a low priority. The fact that the learning event eventually brought together members of a nascent dementia care community was a significant achievement in itself; it helped key stakeholders to recognise how improvement conversations could be initiated and sustained. The learning event outputs (see Box 7.4) embraced activities far beyond the (narrower) scope of the memory service that had originally formed the focus of the much-delayed Furndem improvement task.

The long delay meant that the Learning Communities Initiative was unable to provide further help in developing this new improvement theme. Nevertheless, in so far as it went, our model of working was “useful and formed a bedrock” for the proposed improvements, as one of the subsequent project leaders put it. Most of the eight follow-up interviewees found it useful to attend a group to share problems and solutions, to network and to meet people from other relevant sectors they had never engaged with before despite working with the same patient/client group. They also

appreciated the time that it gave them to reflect. The learning event did appear to act as a catalyst, and this was aided by the facilitation style, which according to one interviewee said “allowed us to all be part of the conversation”. However, the subsequent change in service provision (described at the end of the previous section), which might be viewed as one of the successful outcomes of the Learning Communities Initiative, was dependent not only on the readiness of key staff to recognise the need for (and embrace) such change, but also on the capacity of an individual GP, Charles, to drive the change forward. We will return to the need for this blend of ‘organisational’ and ‘personal’ skills in the next chapter, which discusses how people learn the art of improvement science within the context of their particular organisation.

Learning about improvement

An improvement group, and more especially a learning community, becomes such through a sense of belonging, not just a shared aspiration to improve the service. For Furndem, such a sense of belonging was hard to identify. At the interview stage, it had been clear that some internal mechanisms were in place for potentially sharing knowledge (for example, regular operational meetings, liaisons between the managers of each of the two sites, monthly continuing professional development meetings). However, these were often explicitly meetings to discuss business matters rather than a forum for knowledge sharing.

The learning event confirmed our perception. It was evident that although many of the participants from the different sectors interacted with each other over operational and (occasionally) strategic matters, the learning event was the first opportunity they had ever had to discuss their concerns constructively in such an open forum. When it finally took place, therefore, the event sowed the seeds of a learning community, drawn from the different geographical areas, sectors and specialties of the service, which might take the important next steps to meet the agreed improvement task. Nine months later, however, no such learning community had developed. Instead, the changes to practice that were identified during the learning event appear to have been driven through largely thanks to an enthusiastic and enlightened GP, who has since emerged as an influential opinion leader within the new CCG. He was prepared to pilot new practices and share the results in a way that convinced his colleagues to do likewise. Dementia is now described in Furnhills as “a huge strand” of the PCT/CCG's improvement programme.

Chapter 8:

Discussion (I): Learning about the art of improvement science in an organisational context

The purpose of the Learning Communities Initiative was to explore what helps communities of practice/learning communities to absorb, share and implement lessons from improvement science when trying to improve the services their organisation provides – and what hinders them from doing so. The detailed case studies describing the four projects undertaken have highlighted some clear and important lessons, both about the processes of learning and about applying the skills of improvement. The very fact that the improvement groups often found those processes so difficult allows us to develop a broader analysis to help understand just how and why improvement groups did or did not achieve the intended programme of work (ie, to develop what Dixon-Woods *et al*¹¹ would call a “programme theory”). However, we must first examine what the participants learnt, and why.

Improvement science: techniques, tools and skills

Were these projects undertaking or learning improvement science? Where that means (in Health Foundation terms) “the application of a range of basic and applied sciences, delivered through a partnership of researchers and those who work in and use health services, with the aim of creating new knowledge and promoting strategies for the implementation of evidence-based healthcare” (see Chapter 1, page 2), then – whatever the successes of the four projects – we saw little or none of that happening in the Learning Communities Initiative. If, on the other hand, we were looking for the application of methods developed through improvement science, including tried and tested techniques and tools, to implement healthcare interventions based on solid scientific research, then this certainly occurred in the Danelder and Furncop projects (Chapters 4 and 5). In Danelder, for example, some of the key work using the PDSA cycle helped to implement well established methods for optimising the

early discharge of elderly patients from acute care. And the Furncop group was always striving to increase the uptake of interventions such as spirometric diagnosis and pulmonary rehabilitation that are founded on good research evidence, and was always using objective process and outcome measures to assess progress.

Moreover, both of those improvement groups developed into a learning community whose members were learning, from each other and from others in different parts of their organisation, how best to enhance the quality of patient care. This included not only exchanges about the contributions, practices and constraints of the different professions and sectors involved in the care of the relevant patient group, but also help and advice on overcoming personal and organisational obstacles to improvement, as well as about improvement techniques, and the value of learning such things collectively as a community. It was not always easy or possible, however, to implement the new ideas that were learnt. For example, the leaders of the Furncop improvement group were inspired to bring about a radical shift in the organisation’s whole approach to improvement based on what they had learnt from the Tayside speaker, whose approach was steeped in improvement science; but by the end of the project, they were still striving unsuccessfully against the odds to make that transition.

As for Furdem and Dandem, (Chapters 6 and 7), the protagonists’ main efforts to introduce improvements, which did achieve tangible results, were being strongly pressed forward by individuals or processes that were outside of the Learning Communities Initiative. Both of the dementia improvement groups, with their time and energies absorbed by those other tasks, took a long time to get to the point of holding a learning event (or events) around the agreed improvement tasks within this initiative. When those events finally took place, they did give hitherto disengaged participants an unprecedented chance to begin a dialogue and learn from each other

about the best way to improve services for patients with dementia. In both cases, important bridges were built. The events did, therefore, help to steer their improvements in a well-founded direction, but they did not centre upon anything recognisable as improvement science. Nor did those groups establish any continuing sense of being a learning community or community of practice.

What all the projects had in common, however, was their reliance on knowledge, skills and techniques that may not immediately be recognised as improvement ‘science’, but which were clearly fundamental building blocks without which any such improvement could not happen. Indeed, one might argue that, just as Maslow suggested that people must fulfil a hierarchy of (personal) needs before they achieve ‘self-actualisation’,¹² there was also a hierarchy of organisational skills that needed to be fulfilled before one could even begin to expect the improvement groups to learn improvement science in anything like the manner that the Learning Communities Initiative had originally intended. We do not imply any strict hierarchy of such skills, but draw this comparison only in the sense that the need for certain basic skills must be satisfied before a quality improvement initiative project can succeed.

Box 8.1: Examples of the personal and organisational (‘soft’) skills necessary for improvement science to be successfully applied

- Communication
- Assertiveness
- Negotiation
- Time management and prioritising
- Stress management
- Leadership and team skills
- Organising and administrative skills (management)
- Political skills (understanding the system, managing vested interests, navigating and exploiting power bases, “people reading”, timing interventions shrewdly, listening to and taking into account other people’s views)
- Local knowledge
- Educational and knowledge management skills

Box 8.1 lists some of the wide range of knowledge and skills that emerged throughout the Learning Communities Initiative as essential prerequisites for any improvement intervention to succeed. They range from basic skills of self-management through to interpersonal skills, and the simple capacity to organise effective meetings; from the application of appropriate team skills, structures and processes,

through educational principles, to the subtleties of political manoeuvring and understanding all the relevant aspects of one’s organisational environment. We witnessed those essential building blocks being successfully used, and also saw a great deal of learning about them, as well as many instances where their absence, and/or the failure to learn them, hampered the projects. Sometimes, the participants themselves recognised the need to learn those skills – such as the Furncop and Danelder improvement groups choosing to focus their first learning event on developing assertiveness and negotiation skills. It is also noteworthy that these were the only two groups that recognisably functioned as learning communities and achieved tangible improvements as a direct result of the Learning Communities Initiative. Other examples include the focus in the Furdem and Dandem learning events (as well as the final Danelder event) on learning more about the contributions, values and problems facing staff in other sectors with an input to the service.

Sometimes the need for people to develop these organisational and personal skills became very clear, not only from our interviews, but also our observations of the learning events and their consequences – as in the third Furncop event, for instance, in which the project resolved to change the whole culture and mindset of the organisation to bring about real and lasting improvements based on methods derived from improvement science, and explicitly realised that they would have to maximise their political skills to do so. Sometimes, though, the protagonists did not recognise that the improvement project might have achieved more, and more quickly, had there been a better deployment of communication, time management, leadership and political skills, for example.

It may seem surprising to see educational skills listed among the building blocks for improvement science to be successfully applied, but we have included them because we found wide variation in participants’ appreciation of the value of interactive learning as an educational approach that underpins improvement initiatives. In some of the environments we were working in, the typical style of educational events would be relatively formal and didactic, with clear learning outcomes, as this still tends to be the way that ‘knowledge’ is typically exchanged (or rather imparted) in organised events, especially among clinicians. Participants, used to that style of education, often expected the Learning Communities Initiative, including the associated learning events, to take that form rather than seeing it as an opportunity to exchange/share knowledge through an interactive

process where the learning outcome(s) might be very uncertain. Some participants, however, reported that attending our style of event had opened their eyes to the benefits of simply sharing and debating knowledge and skills in an action learning or problem solving setting.

A clear example of the lack of interactive educational skills was how the fact-packed lectures given to educational meetings by the original lead of the Furncop project had been unhelpful, even counterproductive, in helping to achieve the desired improvements in care (Chapter 5, page 22). Another example was the entirely didactic, lecture-based design of the event that the Furndem leaders had independently organised as part of the improvement initiative. In contrast, when we encouraged them to organise more interactive events, they recognised the advantages of that approach. So, palpably, did the participants. Another example of the Learning Communities Initiative helping group members realise the value of community learning skills was the initial resistance we experienced when facilitating the Dandem learning events; this only dissipated when participants began to recognise the value of simply exchanging and sharing their differing perceptions of the problems to be solved. A final example was the stumbling block in Furncop, where the protagonists (and more particularly the senior managers) did not see learning from elsewhere (either by undertaking visits or even inviting external experts to share their experience) as the best use of people's time given all the other competing priorities. This may have been related to the expectation, as discussed, of a clear didactic structure for educational events; mere informal knowledge exchange with an uncertain outcome might not be seen as an efficient use of time or resources, particularly in a risk-averse organisational culture.

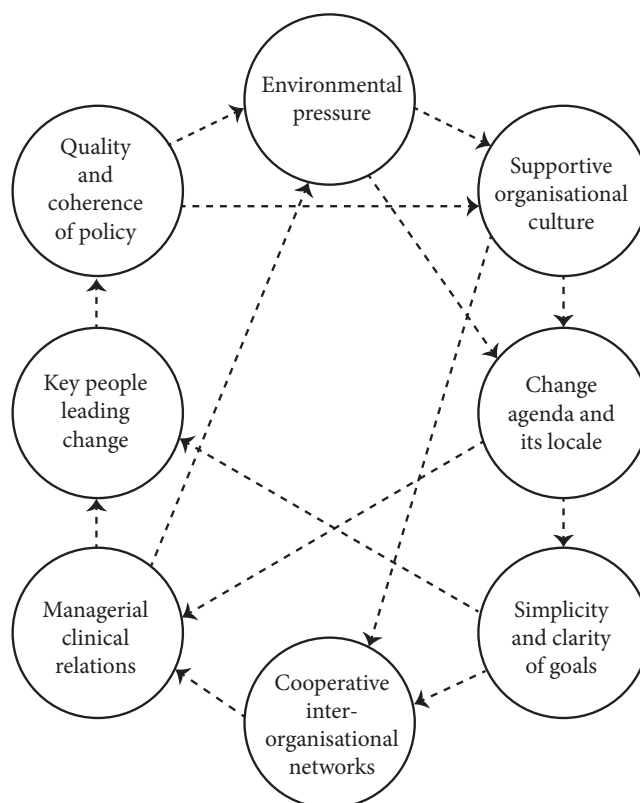
In the final follow-up interviews, a key theme across all the improvement groups was to emphasise our impression that participants felt they had learnt something from the other members of the group about the service they were providing and how it could be improved. Another common theme reinforced the above finding that participants felt they had learnt about the value of such learning – that is, they became aware through the Learning Communities Initiative how useful it was to be brought together to discuss problems and service improvements with others who shared the overall aim of improving services. This was true whether or not the groups showed signs of becoming learning communities/communities of practice. Later in this chapter, we return to this question of learning about learning; but first, we briefly address the question of why the personal and organisational skills described here were so fundamental to the Learning Communities Initiative.

The organisational environment for learning about improvement

It should come as no surprise that achieving change through the application of improvement science requires successful navigation through the complexities of the systems and institutions involved as well as the individuals within them. The organisational environment within which each improvement journey takes place inevitably has a profound impact on its success. If the improvement be considered an innovation, then many of the findings about the factors that affect the spread of innovations – such as the “outer context”, the internal organisational structures, and “system readiness” – would be expected to play their part.^{13–16} This is often referred to as being either a receptive or non-receptive context for change; but of course every organisational environment, and certainly those we encountered through the initiative, has elements of both. A recent Health Foundation review by Fulop, Robert and Waters (unpublished) summarises the literature on the contextual receptiveness for improvement, suggesting that it relies not only on the structural but also the psychological features of the context for change at what they classify as the micro, meso and macro levels. Some of their features go beyond what Pettigrew¹⁷ and others have long highlighted as the essential features of receptivity (see Figure 2 overleaf), to include factors such as the type or range of services provided or the degree of patient involvement in care.

Our aim here, however, is not to explore the context in its own right, but to focus on how the organisational environment of each project was related to the learning needs of the improvement groups we worked with. In this section, we discuss the immediate organisational environment of the improvement groups – or the micro/meso-level context, to use Fulop *et al*'s terminology. We focus on the culture, structures and processes, leadership styles, local politics and relationships, and educational milieu in turn. However it must be borne in mind that these features are all inextricably interrelated. The culture gives rise to the structures and processes that in turn help sustain that culture; the local politics, shaped of course by those very structures, both dictate and are nurtured by internal relationships; the leadership styles that grow out of those relationships, and also foster them, provide the basis of the culture that is sustained by the educational environment that reproduces it... and so on. Nevertheless we must deal with these factors separately, in turn.

Figure 2: The classical view of the factors for receptive and non-receptive context for change



Source: Pettigrew AM, Ferlie E, McKee L. *Shaping strategic change: making change in large organizations: the case of the National Health Service*. London and California: Sage Publications, 1992.

External environment

Before considering how internal organisational features affected the progress of the improvement groups, we must also note the wider external environment – the macro-level context – within which the two health economies existed, including the NHS reorganisation, national professional bodies, or the geopolitical locality, some of which arguably had an almost overpowering impact on the Learning Communities Initiative. The upheavals to the NHS brought about by the Health and Social Care Bill – which led to unprecedented disruptions for the PCT during our work in Furnhills and directly affected the employment of most members of the Furncop improvement group – made a radical difference to the progress of the Learning Communities Initiative, given that the initiative had been taken on and run by the PCT, which was subsequently abolished. A contrasting example is how the smaller, more intimate and more stable Scottish NHS had allowed – in a manner that is inconceivable in England – a consistency of managerial philosophy and structures to develop over a whole decade in Dansworth. Without that steady external environment, Dansworth’s distinctive and deeply embedded improvement culture and its

attendant resources could never have come about, and the Learning Communities Initiative would have fared very differently there.

There were also, however, examples where the external environment was more directly relevant to the specific improvement journeys that we observed. For example, the fact that the Furnhills culture of improvement through target-led performance management was completely in line with the prevailing policies of the Department of Health had a profound influence on the Furncop project. This was felt not just through cultural consonance but also through tight monitoring by the strategic health authority and Department of Health of Furnhills’ overall targets and “must-be-dones”. The project ended in a stalemate in which the prevailing national climate undoubtedly strengthened the resolve of those resisting the improvement group’s desire to bring about a very different micro-climate of improvement methods.

In Dansworth too, the Scottish government’s Promoting Excellence Framework and the shock of an adverse enquiry into local dementia care, not to mention the hostile local publicity that it provoked, illustrate how aspects of the external environment directly

influenced the Dandem improvement task, positively and negatively. The consequent workload hit the project leader like a tsunami that swept away any chance of him giving our project priority. But when we pointed out how it could help him deal more effectively with yet another externally driven priority that his managers were now pushing him to achieve, alongside all his existing ones (Chapter 6, page 32), our project was suddenly up and running again.

Before exploring the impact of the organisational environment in which the improvement groups were working, we should emphasise that the internal and external environments are by no means distinct entities but are inextricably related. Furnhills and Dansworth were not simply drifting passively in the NHS, tamely receiving policy guidance and instructions. They were actively contributing to that broader environment – not least because both sites were often held up as national exemplars for many of their activities, including the excellence of some of their managerial practices (commissioning, process mapping, service redesign, practice development, systematic improvement programmes...) that were achieving excellent results in some services. Moreover, many of the senior personnel from both sites were influential at national level; they were pioneering new ways of doing things that influenced NHS policies that in turn shaped – or “enacted”^{18, 19} – their own services.

In that sense, the external environment was not just closely linked to the internal one; the two were often mutually constitutive. And even where they were not, it was usually difficult to discern whether an environmental factor affecting the improvement groups was internal or external in nature. For example, the Dandem improvement group’s attempt to improve dementia training – based on a local plan that drew on a national one – was made much more difficult by their finding themselves among so many initiatives, schemes and resources with similar aims – some from within the locality and some from beyond. That environmental turbulence did much to inhibit the group’s development of a working identity and sense of purpose.

Internal organisational culture of improvement

Furnhills and Dansworth were selected as the two sites for the Learning Communities Initiative because they were initially thought to have a strong improvement culture; however, once we began the fieldwork, we found a range of cultural or subcultural approaches to improvement. This variety was serendipitously helpful to

the overall aim of the initiative – namely to gain insight into the process of learning about improvement. If, as originally intended, all the groups we worked with had been uniformly steeped in an environment conducive to improvement science, we would not have had the opportunity to see, in what became almost a natural experiment, how their approaches to improving services varied in accordance with the culture of the internal organisational environment.

Some of that variety was due to the inevitable disparity to be found between the approach to improvement espoused by managers, and that found among clinical and other staff especially in the far reaches of the organisation. Even at Dansworth, where improvement science had been actively woven into the fabric of the top management team for a decade and was widely encouraged across many parts of the health economy (as the Danelder project exemplified), that culture had not penetrated very far into the minds and actions of those directly involved in the Dandem project in County C, still less their partners in primary care and other sectors jointly delivering dementia services.

There can be no doubt that this difference in subculture played a very large part in the disparities between the Danelder and Dandem projects in terms of their processes and their outcomes. The Danelder improvement group, despite still licking its wounds after coming through a painful and controversial restructuring of its service, was nevertheless minded to use an improvement project to work together across boundaries; they judged that the time was now right to do so. Their cultural mindset was to use the Learning Communities Initiative as an opportunity to restore good working relationships and rebuild the service. They were not afraid to link the specific goal of improving the estimated date of discharge (EDD) system with broader concerns about the infrastructure and culture, rather than trying to circumscribe it as a detached task. And, having been steeped in Dansworth’s improvement culture, they accepted the project leader’s improvement ethos, expertise and guidance. Their acceptance may also have possibly been because she was one of their peers rather than from another subculture, a factor that was also evident in the final stage of the leadership of the Furndem project, when the new GP enthusiast was able, unlike the PCT or the memory service doctors, to engage his GP colleagues in the changes needed. The Danelder group were quickly able to agree a clear process for improvement, to manage the project efficiently, to use tools such as PDSA, to measure progress, and so on – all techniques familiar to them because of the pervasive improvement culture.

In contrast, the Dandem project leaders, who had not (as one senior manager had put it) “had their brains rewired” for the local improvement culture, were slow to recognise how the Learning Communities Initiative could help their group deal with the many demands for service improvement that they were being required to handle. Nor did they avail themselves of the many resources available both within Dansworth and from the Health Foundation that might have helped. And after the learning events had eventually thrashed out a way forward for dementia education locally, the group were unable to build on that momentum.

In Furnhills, we encountered a rather different version of the impact of culture. While Furnhills had a much-deserved reputation as an innovative health economy that was well able to bring about service improvements and was outstandingly successful by many standards, its management culture and systems were set up in a way that was not at all receptive to the (improvement science-based) culture of improvement that those running the Furncop project – now themselves senior managers in the new order – wanted to introduce (Table 2, page 27). This continual tension between two contrasting approaches to improvement characterised the project even before the third learning event threw them into sharp relief. The public health nurses had, for example, been very stressed by having to work (against their better judgement) with poor performers and imposed targets; they had instinctively wanted instead to spread improvements through what, after the third learning event, they came to call “improvement conversations” beginning *with* willing clinicians who would help spread the word, rather than immediately working *on* recalcitrant ones. The lead GP had been at loggerheads with the original project lead from the PCT, precisely because of this same difference in philosophy, as she later came to realise, between the PCT and the practising clinicians. That cultural conflict remained unresolved to the end because the original PCT managers were still able to promulgate their performance management philosophy. Even though the improvement group was now led by a senior GP who was on the new Furnhills CCG executive board, she was not able to make any headway with her insistence that the “improvement conversation” approach could work better than top-down target setting.

The dementia projects at both sites were strongly affected by organisational subcultures too. In Furnhills’ dementia project, Furndem, staff working in the memory clinics lacked any collective sense of the need to improve the service. Our interviews revealed a defensive pride in their “Rolls-Royce” memory

service and self-justification stemming from insecurity about possible restructuring as a consequence of their growing waiting list. The tendency was to blame others (especially GPs) for the problems, leading to a stand-off between the memory service staff and GPs. Hence the clinic practitioners and managers appeared to have little enthusiasm for an improvement task that was intended to work with key staff across all the relevant sectors. One could speculate that this underlying culture partly explains why they kept the Learning Communities Initiative at arm’s length for so long while undertaking separate internal work to rectify the waiting list problem, although the ostensible reason was that they were just too busy. Another possible underlying cultural factor was the team’s overt suspicion about the motives and the manner of the PCT’s selection of dementia as a topic for the Learning Communities Initiative (Chapter 7, page 37). As for the Dandem project, although the delayed start was largely explained by the “tsunami” of demands on the key manager, its ultimate failure to progress along the agreed lines after the second learning event was rooted in the apparent cultural chasm between those who had been at the meeting and GPs who, although vital to the improvement task’s success, had somehow not been invited or involved.

GPs were the most prominent example of the way that differences between various sectors and disciplines participating in an improvement task could have a profound impact. In three of the four projects (the fourth being Danelder, where GPs did not need to be involved), a major difficulty for the groups was to get more than a few enthused GPs on board. There are several possible reasons for this, but the GPs’ many competing priorities, lack of time, and the absence of any contractual obligation (or incentive) to join improvement groups were cited most often. Whatever the reason, the reluctance of most GPs to take seriously the improvement approach promulgated by NHS managers proved to be a key problem. Primary care had a very distinctive culture (or set of subcultures). Apart from a few managerial enthusiasts, few GPs were willing or able to cross over to what they saw as the managerially led approach embodied in the improvement tasks. Even the second Furncop learning event about social marketing, which was designed to help participants tackle a common and serious illness that Furnhills’ GPs deal with every day, failed to attract a single GP among the 33 health service personnel who attended.

The above examples of the impact of organisational subcultures on improvement are an indication of why such a range of organisational and personal skills (as listed in Box 8.1) was fundamental to the work of

the improvement groups and such a crucial part of learning about improvement. It is self-evident that these skills (including communication, assertiveness, negotiation, political manoeuvring, time management and prioritising, stress management, leadership, and organising and administration) were vital in dealing with the constraints of an adverse culture, capitalising on what could have been a very supportive improvement culture, or sometimes perhaps just avoiding being sucked into activities seen (at Furnhills, for example, by memory clinic staff as well as GPs) as someone else's priority. It follows then that if such skills were weak or absent, then the projects were never going to be able to make the most of the improvement science approaches and techniques that the Learning Communities Initiative or even (in Dandem) their own organisation could have offered. Moreover, it is worth noting that the two most successful projects (Danelder and Furncop) both explicitly sought to use the Learning Communities Initiative to help them acquire interpersonal skills to help change their own organisational subculture so as to effect the desired improvements.

Resources, structures and processes

We have seen that organisational culture had a vital effect on the work of the projects, but culture is an abstraction that is notoriously difficult to define, let alone isolate or manage.²⁰ One way forward is to identify the effects it has on concrete resources, structures and processes, and we now consider some examples of these, which worked for and against the execution of the improvement tasks.

The projects were undertaken at a time when resources were under pressure. Furnhills was tackling a £20m (2%) deficit in its budget and aiming to radically reduce acute hospital bed numbers by transferring work to the community. Those financial constraints affected the two Furnhills projects, mainly by intensifying the pressure to meet performance management targets. Dansworth was also under financial pressure, striving to save £30m (5% of its budget) per year, and it too was aiming to drastically reduce acute hospital beds in the longer term. But this in itself had no noticeable effect on the two Dansworth projects, other than to intensify the general pressure to continually improve services. Moreover, a decade earlier it had been precisely when Dansworth had faced massive deficits that the CEO had used that opportunity to drive forward his philosophy of improvement (“Never waste a good crisis”) by redesigning services both to improve quality and to reduce costs. Thus while it was always necessary

to consider how financial constraints might affect the Learning Communities Initiative, their impact was not predictable. Indeed, ironically, while three of the four projects – Furncop, Furndem and Danelder – were predicated on reducing unnecessary hospital care to free up resources for more appropriate primary and community care, one constraint on their progress was the fact that resources were so inextricably tied up in the hospital infrastructure.

The more direct resource problem for the improvement tasks was not, in fact, money but rather staff time, in the sense both of allocating sufficient time to the work involved and of finding times when everyone could meet. Many of the crucial Furnhills personnel were in a state of flux caused by the NHS restructuring; it was clear that the staff involved in the improvement projects were finding their time and energy exceptionally stretched by that shake-up. Even the lead GP who was the driving force behind the fourth Furncop event – which was so vital to the COPD improvement agenda she was now in charge of – was forced to miss it because it clashed with a meeting about establishing the new clinical commissioning group. And the key staff members who did attend that fourth event told us later that the turmoil of negotiating new employment contracts and job descriptions had left them without the time, stability or backing to lead the small tests of change they had agreed to.

It was generally easier to move forward with an improvement project when the task coincided with other workstreams – as in Danelder and Dandem – and harder if it did not. The Furncop group, for example, mostly saw the subsuming of COPD into a more general “long-term conditions” strategy as inimical to their cause (unless and until they could transform that whole strategy to their way of thinking, which seemed unlikely). Those arguments took energy away from their desired improvement path. This was part of a more general problem at both sites: with the exception of the Danelder project, the improvement group leaders had too many other priorities to deal with, some of which (eg, for the Furndem and Dandem projects) cut across the very things their improvement tasks were aiming to achieve, and therefore inevitably interfered with progress. The Danelder project, in contrast, was led by a person for whom the improvement work was a core part of her role and her organisational objectives, and whose training had explicitly equipped her with the requisite knowledge and skills. This was undoubtedly a key reason for the project's success, but one that only existed because her role was institutionalised as part of the structures and processes that Dansworth's improvement

culture had assembled over recent years. The skills that the Danelder project lead showed – in structuring the project management, ensuring the breadth and constancy (in both senses) of the membership of the improvement group, running its regular steering meetings, attending to the detailed administration, monitoring its activities against its goals, and using appropriate tools such as PDSA, among other skills – all set Danelder’s improvement journey apart from the other three projects. And those skills all stemmed from physical resources and structures that Dansworth had put in place precisely for this kind of improvement work – not least the well-funded central improvement team, the internal resource for training and consultancy with which the project lead was closely linked. Indeed, one could argue that the project lead, one of a cadre of improvement fellows trained by the organisation, was herself an embodiment of Dansworth’s improvement culture.

Furnhills too had put in place formal improvement structures in the shape, for instance, of the Quality Improvement Academy, but this turned out to be what some called a “toothless talking shop” that made little impact and was later quietly dropped. Similarly, it took a long time for the high-profile, well-organised and well-attended clinical summits to achieve any results. We can only speculate as to why Furnhills’ improvement structures made relatively little headway compared with Dansworth’s, but it is notable how stark the contrast was between the achievements of two sets of structures.

Furnhills’ improvement structures were intermittent, stage-managed gatherings sitting atop a strong, elaborate apparatus built on the power of commissioning, contracts and target setting, where relatively few core clinicians seemed to be helping to drive the agenda (at least in the meetings we observed). Indeed, we heard overtly cynical comments about the superficiality of the discussions in the face of the vast top-down upheaval the organisation was experiencing during 2010 (although by 2012, towards the end of the project, we were told that such attitudes were changing, and the clinical summits were finally championing some quality improvement initiatives). Dansworth’s core structures, in contrast, had long formed a well-established and continual hub of training and consultancy designed to drive the “bottom-up” skills and mentality of quality improvement at every level of the organisation. Moreover, improvement work was at the heart of the agenda of the Dansworth executive team who, with the progress charts pinned on their office walls, monitored and measured the projects’ progress weekly. Yet even Dansworth’s structures did not go as deep as the senior

managers would have wanted, failing to reach some of the further flung parts of the health economy or even the majority of local GPs.

In short, the experience across the four projects suggests that investing in the right kinds of structures and processes makes a very big difference to what improvement projects can achieve. One cannot draw firm conclusions, but the structures that were designed to directly help spread the skills, tools and attitudes needed for quality improvement appeared to be the most conducive to the Learning Communities Initiative. The Dansworth structures had taken many years to put in place, but perhaps their key characteristic (which enabled them to be so effective) was that they were designed to operationalise the core prevailing improvement culture, and to give staff the practical wherewithal to make the improvements that they themselves felt would work best, which the improvement structures at Furnhills were not able to do.

Leadership

Sustained leadership from a CEO steeped in a particular approach to improvement was of course the *sine qua non* of Dansworth’s culture, structures and processes, but it is beyond our remit to comment on the leadership of the umbrella organisations under which the four projects were carried out. We must, however, comment briefly on the specific impact of leadership skills *within* the four improvement projects. Self-evidently, the four groups and their tasks needed good leadership, not only to manage the work effectively but to manage the organisational complexities we have reviewed above, as well as the politics and relationships that we discuss below. Such skills turned out to be in variable supply among those leading the four improvement groups.

In Furnhills, the original Furncop project leader had difficulties both in carrying her team with her and in managing the conflicting pressures that she experienced from managers and senior colleagues. In the Furndem project, the apparent lack of leadership may have been a deliberate ruse to hold things back, which continued until the time came for the project leader to hand over to new leadership, after which time the brakes suddenly came off and the project’s one and only learning event was then able to take place. Whatever the reason, though, the project was simply not being led for much of the time, which showed how powerful the designated leader’s role can be even as a mere gatekeeper to any given change. This was highlighted when a new GP began helping to lead the changes after the learning event, who subsequently proved instrumental in

bringing other GPs on board when they had earlier been wary about managing patients with dementia. The takeover of the leadership by a member of their own “tribe” seemed to be the turning point. Another important factor was that the new ideas were able to be embedded into an existing and well-supported structure, the dementia services panel, which legitimised the leadership of the project and opened doors to resources.

In Dansworth, the work of the Danelder project was a clear display of the impact of effective leadership from a person whose knowledge and expertise, often shared by others in the team who helped lead it, fitted with the improvement task, the group’s ethos, and the organisation’s wider goals. On the other hand, Dandem was led by a person who felt swamped by other related priorities and therefore never wholeheartedly embraced the leadership of the project. Moreover, in the final rush to organise the learning events, the Dandem project lead did not manage to fully engage one of the key managers in County C, which, in view of some of the professional and broader political sensitivities, may have been a significant omission. Was that perhaps part of the reason why, when the original project lead subsequently left the organisation, that same County C manager, who succeeded him, did not feel sufficient ownership to see the project through?

Our findings suggest the need to differentiate leadership (L) from day-to-day task management (M), either of which can be weak (L-, M-) or strong (L+, M+).^{viii} Both varied independently across the four projects, and the end results arguably reflected that variation. The Danelder group, which came closest to fully achieving its aims, had strong leadership as well as good task management – not only being led towards a clear overall vision but also ensuring that the group set itself sensible goals, met regularly, stayed engaged, monitored progress, celebrated successes, and pushed on to the next set of tasks in a similarly well-managed way (M+, L+). In Dandem, which finished a long way from achieving the intended improvement task, it was difficult to discern any strong leadership of the project, and the task management was not a priority (M-, L-). In Furncop, the original project leader made full use of her managerial skills such as setting objectives, monitoring progress, and managing the workload of her team of respiratory nurses reasonably well in difficult circumstances; but found herself unable to *lead* the improvement task (M+, L-). Her successor,

in contrast, showed much more leadership in pushing the project forward, but was not in a position to manage its tasks effectively (M-, L+). The end result was success in improving outcomes but frustration in terms of advancing quality improvement processes. Finally, in Furndem, any leadership role for this specific project was actively eschewed in favour of managing other quality improvement tasks (L-, M+/-). The final breakthrough came about partly because a leading GP took on a strong leadership role (L+), while others ensured clear task management (M+) – a combination that appears to have transformed the memory service.

Local politics

Internal politics, which are always heightened when attempting to make changes that involve embedded attitudes or practices, inevitably affected the work of the improvement groups. Below, we give a few examples of how participants’ political skills were fundamental to the projects. Such skills were very much needed but sometimes insufficiently deployed to either accelerate the improvement process or remove any unwanted brakes that might be slowing progress.

The Furncop improvement task was repeatedly held back by difficulties in manoeuvring through the personal, professional and political turf battles that surrounded attempts to improve care for patients with COPD, which also echoed wider political power struggles between the outgoing PCT and the new GP-led clinical commissioning group. Even the senior member of the CCG executive who was also leading the improvement group felt disempowered and unable to take the improvement approach that they believed would work best, and was ultimately unable to overcome the political obstacles.

The inability of the improvement groups to engage GPs fully in their work – even to the point of a complete stand-off between GPs and memory clinic staff in the case of Furndem, which was only resolved at the very end of the project – is another example of where the deployment of stronger political skills earlier in the project might have led to greater success.

Finally, the political shrewdness displayed by the deftness of the timing of the Danelder project, and by the group’s subtle use of the Learning Communities Initiative to help to heal the scars and the wounded professional pride of recent political battles was one of the keys to the project’s success.

^{viii} It is important to note that this applies to the improvement project only, not to the project leader’s intrinsic qualities nor to their wider role in the organisation – a good leader and/or manager may, for good reason, choose not to lead or manage a given project.

Relationships: trust and communication

Closely linked to the impact of internal politics on the projects were the different levels and styles of communication, which in turn relates to the degrees of trust between the key protagonists – both individual and organisational. We have, for example, already noted how the lack of trust in Furdem between the memory service leadership and the Furnhills PCT probably undermined engagement with the improvement task. At the time, however, we had not fully appreciated the importance of that factor, and therefore did not deploy (or help the key protagonists learn to deploy) the skills needed to confront that mistrust. If we had, it might have brought the learning event forward by many months. Moreover, doing so could have equipped staff to deal with the subsequent mistrust between the PCT and the lead GPs, which again might well have allowed the improvement task to proceed much further and faster than it did.

The experience of all four projects demonstrates how improvement groups and learning communities must be driven by (or soundly based on) good communication. This was certainly lacking in some instances, and was sometimes clearly underpinned by a lack of trust between co-providers of care. It was manifest in the final feedback that one of the main benefits of the Learning Communities Initiative was the fact that in every project we created opportunities for newly bringing people together to exchange the different perspectives that they brought to the task in hand. This was essential to making improvements in such complex environments; it promoted mutual understanding, buy-in and consensus across different – sometimes strongly differing – services, even where there had initially been a lack of mutual respect across professions and sectors (a phenomenon we observed to some extent in all four projects). In every project, participants remarked positively on that aspect of the Learning Communities Initiative, and asserted that they had not only learnt about each other's perspectives and problems but about the importance of that (facilitated) communication process in helping them work together to achieve their improvement goals.

The educational environment

Here, we briefly consider one final aspect of the organisational environment that had an important influence on the skills required (and acquired) for the improvement projects – namely, the educational environment. The impact that Dansworth's central improvement team had on the leadership and execution of the Danelder project has already been

highlighted; the key personnel, if not already steeped in the mentality of service improvement at Dansworth, had only to apply to join one of the many courses available. But the educational environment also had an indirect, nurturing influence that made reflective discussions and joint problem-solving the *modus operandi* for most of the staff involved in the Danelder improvement group. However, even at Dansworth, this was not a universal phenomenon. Internal politics and protection of professional territories sometimes got in the way (at least one senior doctor refused to partake in the Danelder changes, for example); and cynicism sometimes crept in, as in the disparaging references to “sticker afternoons” (Chapter 4, page 20). We also found the reflective, problem-solving educational culture to be much less evident in the Dandem project than in the Danelder one.

Furnhills had also developed a leadership skills programme, but this was aimed mainly at developing practice-based commissioning. The tradition of education aimed at improving care was to hold large “protected learning events”, mainly designed to update GPs and other clinicians, largely through lectures that were followed by discussion. The clinical summits were an exception to this style; with the help of the NHS Institute for Innovation and Improvement, small group discussions took place between scheduled lectures to garner ideas from participating clinicians and managers. But these were only short discussions in 10-person cabaret-style tables with plenary feedback; they did not create a sense of community learning or educational follow through. We saw little in the way of knowledge-sharing networks for the Furnhills projects beyond the small team that formed the core of the Furncop improvement group. The Quality Improvement Academy meeting we attended was mainly a series of presentations about various quality improvement programmes across Furnhills; formal meetings like that were the only organised way (other than circulated papers and websites) by which much of that information was actively promulgated. In short, there was little evidence of an educational environment that fostered the learning style of a community of practice or other forms of learning community.

None of the improvement groups worked initially as a learning community. However, most progress and learning occurred where groups who had previously not come together to discuss the matters covered by the improvement task were enabled to do so by the Learning Communities Initiative. How such learning communities (particularly nascent ones) continue to thrive in future, whether proactively or reactively once

external support such as ours is withdrawn, will be a key challenge – especially given their informal nature, and the high staff turnover that characterises some parts of the NHS. On the other hand, where there is a supportive internal environment, learning communities may well continue to develop (as with the Danelder project, for example) at least until they have resolved the main problems they are set up to address.

The way in which the Learning Community Initiative fostered the learning style of a community of practice was an important part of the improvement process. Many participants reported not only gaining useful information from each other about improving the service, but also learning about the value of such knowledge sharing. This was not necessarily something that they perceived at the time, but was a strong feature of the feedback interviews some months later, when they had had time to reflect on their involvement.

Learning improvement skills

The previous section aimed to show why the kinds of knowledge and skills outlined in Box 8.1 were so fundamental to the success of the improvement projects, and therefore why those skills are as important to ‘improvement science’ and its implementation as the relevant technical skills and tools. It therefore also follows that an exercise designed to promote learning about improvement must ensure that wide-ranging sets of skills be carefully nurtured, and must also recognise that participants will be developing their skills in the very methods of learning that are being used to do that. Our findings led us to conclude, therefore, that one needs to distinguish three sets of skills that are crucial for improvement: ‘technical’ skills, ‘soft’ skills, and ‘learning’ skills.

Technical skills

The technical improvement skills needed to achieve service improvements (see, for example, Boaden *et al*⁴) would include critical appraisal of research findings, process mapping, flow charts, benchmarking, process and outcome measures, statistical process control, six sigma, Lean methodology, PDSA cycles, driver diagrams, run charts, care bundles, SEWS (Standard Early Warning Systems), fishbone diagrams, Pareto analysis, and so on. These technical skills may also be described as a general toolkit, as a body of theory and concepts that need to be understood, appreciated and selected for use in any given situation since they are – in so far as anything can be – context-free. We do not use the term ‘hard’ to denote such skills, since this may be

misinterpreted as ‘difficult’ (complicated though some of them may be), which would be contrary to our view that the ‘soft’ skills detailed below may actually be among the hardest to learn! (As Don Berwick, founding CEO of the influential Institute for Healthcare Improvement, has said: “Improvement isn’t rocket science... It’s *people* science, which is a heck of a lot harder!”)

Soft skills

The ‘soft’ improvement skills that came to the fore in the Learning Communities Initiative are summarised in Box 8.1. We also recognise that ‘soft’ has ‘touchy-feely’ connotations that may be misleading, given that the leadership, structures and political wrangles involved in achieving genuine and lasting improvements can call for real toughness. Nevertheless, on balance, we prefer the term ‘soft’ to ‘organisational’ or ‘interpersonal’, as the skills we are referring to are broader than those terms suggest. We have also eschewed the terms ‘know what’ and ‘know how’ because they do not correspond to the distinction we have in mind. Both technical skills and soft skills can have a ‘what’ and a ‘how’ element to them – as would be confirmed by anyone who has tried to carry out a critical appraisal of a research review, or has read a standard textbook on leadership.

Learning skills

Finally, there are the skills of learning about improvement, which include the willingness and the capacity for learning in communities of practice or learning communities. A growing body of work suggests that for technical and soft skills to be used successfully in practice in a given context,²¹ they need to be learnt in a complex cycle of collective as well as individual learning,²² and of practical as well as theoretical learning.^{23,24} Such a cycle must involve people individually internalising new knowledge, but where this consists of practical, contextual, tacit knowledge it also has been found to involve them in collectively sharing and reflecting on their experiences, for example through story swapping and observation.^{25,26} Such learning means they are not necessarily learning (and possibly rejecting or bypassing) imposed new rules and procedures, but also challenging assumptions and learning how to formalise, in their own contexts, new practices that they have genuinely agreed to.^{23,27,28} In the four projects, all of these aspects of learning new knowledge needed to be facilitated. In short, the participants also needed to learn (to a greater or lesser extent) how to learn the relevant skills.

Building the three-sided improvement pyramid

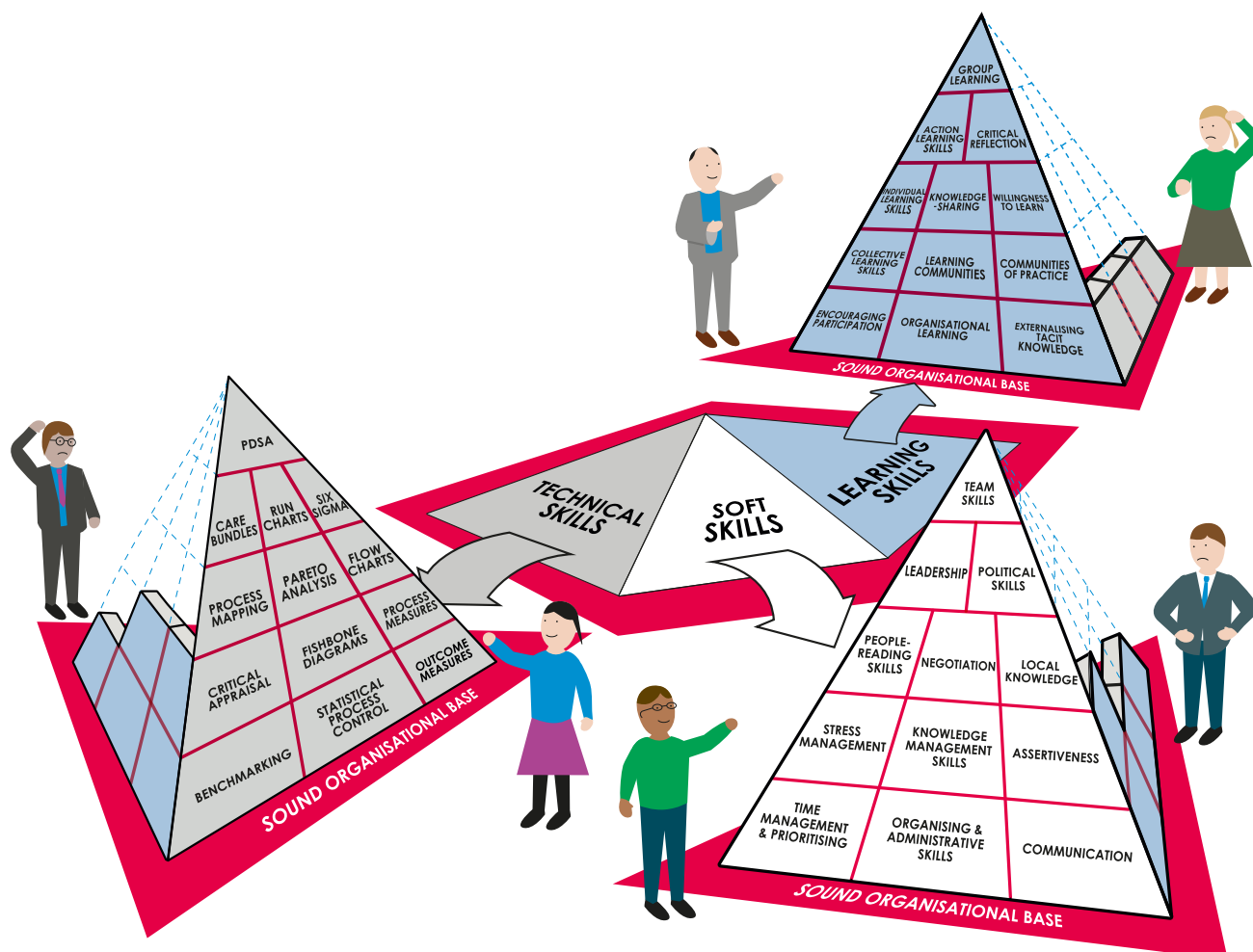
Our main point here is that all three sets of skills need to be the explicit focus of any future improvement exercise based on the principles of the Learning Communities Initiative. This finding echoes other work in this field; for example, in their landmark study of high-performing hospitals in Europe and the USA, Bate, Mendel and Robert²⁹ also found that a wide range of interrelated factors were at play when major improvements occurred in services. Their categories (physical and technological, structural, political, cultural, educational and emotional) have many parallels with the factors that emerged in the detailed stories of our four improvement groups.

A good analogy might be a pyramid (Figure 3), the apex of which is an organisation fully capable of delivering quality improvements by using the best improvement methods and principles. The height of that apex, and hence the quality of the improved

services, will depend on there being a stable base (the organisational environment) that is strong and broad enough to support the three sides (the three types of skills) to achieve maximum and equal height. The smaller that base, the lower the height of the apex that can be supported with any stability. (Compare the organisational environment that acted as the base of Dansworth's central improvement team with that for Furnhills' Quality Improvement Academy). Moreover, the apex will ultimately be lower if any one of its sides is too small to meet up with the others. Conversely, many of the skills on the highest side will be redundant if the other two sets of skills are too low to support them. The technical skills, soft skills and learning skills must all be deployed to their maximum extent – and must be commensurate with the others. If not, either the height of the pyramid will be limited to the smallest of its sides, or gaps will appear that prevent the desired heights from being safely reached, and skills and training will be wasted. One cannot construct a solid pyramid with one short face and two taller ones.

Figure 3: The three-sided improvement pyramid

Too small a base (red) will not support the three sides to any worthwhile height. If any of the sides falls short, the pyramid cannot be completed and the top cannot be reached, and the higher level of skills in the other sides will be wasted.



Chapter 9:

Discussion (II): The Learning Communities Initiative as a project

Reflections on running the project

Selecting projects and engaging participants

Comparison of the selection criteria for participating sites (see Box 2.1 on page 4) with the descriptions of the organisational environments (Chapter 3), and the subsequent unfolding of events within each project (Chapters 4–7), show that the criteria turned out to be only patchily met. This was due to inevitable differences not only between the espoused and actual organisational cultures, but also the degree of variability across the different subcultures of the improvement groups. In retrospect, we may also have been inadvertently misled by our hosts into specific project areas in their organisations that, in the event, were not the best ones to work with.

We would strongly recommend that in the final selection process for future initiatives, it would pay dividends to ascertain the state of improvement on the ground by conducting a full, rapid on-site assessment of the shortlisted health economies. This would help avoid the wishful thinking and consequent misleading impression that a well-crafted bid can convey, especially where it describes an organisation that is unquestionably excellent in some respects that turn out not to be so relevant to the improvement areas one is working with. This would enable the Health Foundation (or other supporting organisation) to see a different view from the one perceived or portrayed by the top of the organisation, since what matters for project implementation is the reality on the ground – espoused *and* actual cultures, formal *and* informal structures and processes. For example, one suggestion for selection of sites – or projects within sites – would be to conduct an initial ‘rapid appraisal’ of the organisation based on a ‘diagonal slice’ of staff at all levels in the particular

areas to be worked in. This would not only help the improvement projects in the longer term, but would also be attractive to bidders, because even if they were not selected, shortlisted organisations would receive useful feedback and guidance about their fitness for sound quality improvement programmes.

In future projects of this kind, it may also help for the Health Foundation to make available short, well-produced information sheets that can be given to all participants. We made available brief project information sheets/summaries for participants, and most of the learning events also had some tailored explanation in the invitation letter and an explanatory introduction that situated the event within the improvement project and the wider Learning Communities Initiative. However, in retrospect, it may have been helpful also to have something more substantial, which participants could read at leisure, to explain what a learning community is and how the learning event fitted into their own work.

One of the consistent difficulties we encountered was engaging GPs in the learning events. This is a common finding in such projects, and one that neither we nor the project leaders and site liaison managers were able to solve. Future projects of this sort will need to give careful consideration to this, and address it head-on in project design, the handling of local politics, and costing of initiatives (although back-fill payment for GPs was not the main issue in these four cases, as such funding was readily available but rarely called on).

The nature of the intervention: crossing boundaries?

In designing a Learning Communities Initiative that continually fostered and evaluated localised organisational development, we intentionally adopted a novel approach that was ceaselessly adapting to the changing needs of the four projects. That approach turned out to be a blend of action learning, action research and organisational development/consultancy, along with a variant that we developed of “Fourth Generation Evaluation”.⁵ It was therefore not always easy to pin down and categorise the approach we were taking in ways that readily made sense to the participants. At times, the ambiguity of our roles also made it difficult for the Health Foundation project team to forge the somewhat non-standard facilitation and intervention style that was needed (see ‘Facilitating the learning events’ on page 59).

Even at the start, the usually more straightforward matters such as research (or consultancy) ethics or governance procedures were uncertain (Chapter 2, page 5). More importantly, though, as the work got under way, the ambiguous nature of our role caused us real dilemmas in executing the projects. When the improvement process or the learning communities were stalled or breaking down, as ‘researchers’ we wanted to observe and learn from what was going wrong; but we had no research ethics approval (nor indeed ethical appetite) for this. As organisational development consultants we wanted to intervene and help put things right; but for this we had no clear mandate (nor indeed adequate resources). As evaluators we wanted to confront the participants, or their managers, with the problems they were exacerbating; but for this we did not have their full consent (and to obtain it would have changed the entire nature of our task and likely damaged the trust we had gained from the improvement group leaders). It was often a struggle to steer the right path. For example, in Dandem and Furdem, we had to press hard to bring about the learning events at all; and when the Danelder group were keen to abandon their top priority (the problems they were having with community services) as being too hard to handle, they needed to be pressed into taking it on when they had gained confidence from their successes in tackling the other priorities.

It was always a matter of fine judgement when to let groups make decisions without us being involved or when – without foisting our opinions or interventions on them – to keep close to events or push things along.

Such judgement was strongly dependent on regular contact, rapport and facilitation with the key people, including where necessary the site liaison managers.

In highlighting such dilemmas, we do not imply that such ambiguity of purpose and role was something to be avoided in future. On the contrary, one of the strengths of the Learning Communities Initiative was its multifaceted flexibility. However, funders, project teams and participants may benefit from being more explicit and proactive in thinking through the implications of that flexibility in any future initiatives. To help in that task, we now attempt to delineate what actually characterised our interventions, based not only on our own reflections but also on those of the participants.

Feedback and evaluation

The 36 responses out of 46 key members of the improvement groups who were offered interviews – elicited after enough time had elapsed for any lasting effects to be seen – show that sharing ideas and reducing differences in understanding figured most strongly among the benefits they felt. They reported very few disadvantages to taking part, but among the many challenges that each project faced, getting the right people involved and able to attend learning events was the biggest, closely followed by problems with internal leadership and communication. They also perceived our team as making a difference to the projects mainly through facilitation of the events (which included the use of the SPIBACC and subsequent prioritisation processes) and as the prompt and catalyst for making sure the projects achieved their aims. (For the full set of cross-cutting themes from the final interviews, which also informs the following sections, see Appendix 2.)

Eliciting participants’ learning needs

An essential first part of the process was to gain a working understanding of the organisational environment in which each improvement group was working. While it required us to apply our academic skills as ethnographers, this was by no means ethnographic research. We only needed to reach a level of understanding sufficient to begin what might arguably be called a consultancy process, in which we helped senior staff clarify and focus the improvement problem they were trying to solve and begin mapping a way forward by creating an improvement group. It also required us to get to the heart of why the improvement tasks were (or were not) important to participants and what the main difficulties were likely to be – difficulties that could either be intrinsic to the groups, imposed

by others in their organisational environments, or inherent to their clinical area. As the projects proceeded, our understanding of these factors grew and changed, and was greatly aided by the fact that, again using our ethnographic skills, we developed relationships with most of the key players that allowed us to ‘chat as colleagues’, not only with the improvement group members, but with senior managers and our site liaison managers who were invaluable sources of insight and stimulus.

A central part of gaining this understanding was the interview process and consensus-forming method, the SPIBACC techniques, which were the *sine qua non* of our method. In retrospect, the key features (which were not always easy to achieve) were as follows.

SPIBACC (systematic prior interview-based analysis of claims and concerns)

1. Interview all relevant individuals (snowball sampling) in a loosely structured and very supportive mode.
2. Ensure that the interviews take place at a time when the group and the topic have crystallised sufficiently for the SPIBACC to be appropriately focused.
3. Do not attempt, during analysis, to over-synthesise or over-collate the claims and concerns but rather preserve individual inputs and perspectives.
4. Use categories of claims to help limit the length of the list and make it manageably short while preserving the perspectives.
5. Collect stories (to give richness, to show that the limited categories do not mean dropped concerns; and to stimulate discussion when feeding back).
6. Present the claims and concerns in simple slides illustrated with the stories or (if by email) as an easily assimilated table.

Subsequent prioritisation exercise

1. Always focus on claims (achievements) before listing the concerns (defects) and ensure confidence building before the prioritising begins.
2. Work as a group to discuss and prioritise. (Use accepted consensus method to agree top priorities – eg, ‘nominal group’ voting, Delphi.)
3. Make absolutely sure the chosen topic reflects majority/group needs and is genuinely acceptable.

Facilitating the learning events

The facilitation of the learning events was vital to the success of the whole initiative. This was not just a matter of process facilitation (using techniques to create the right atmosphere, allowing everyone to contribute easily and feel valued, discouraging over-talkers, maintaining energy levels, and so on) nor of guiding and structuring the discussion (for example, ensuring that an agreed agenda is carried out within the allotted time, running the consensus exercise). It was also about such things as encouraging storytelling to help participants recognise progress that they themselves, and the routine monitoring techniques used by their organisation, would not otherwise have recognised. Above all, we sometimes found that – contrary to the received wisdom on problem structuring and facilitation – we needed to become deeply involved in the content; for example, in Dandem, we directly took a lead in structuring their scoping of staff education about dementia. This observation has deep implications for the process of problem structuring and facilitation. As well as upsetting one of the key assumptions of the normally accepted facilitation process (focus on process, not content), it implies that the facilitator becomes a more central figure than the empathetically neutral outsider often suggested by the literature.^{9,10}

How does the Learning Communities Initiative fit in...

...with quality improvement?

There is nothing surprising or new in our finding that the organisational environment had a major impact on these four attempts to improve quality.³⁰ A 2009 review by Powell *et al*³¹ suggests that for quality improvement to succeed, certain conditions – all of which are closely dependent on the organisational environment – are “necessary but not sufficient”. They include: provision of the practical and human resources to enable quality improvement; the active engagement of health professionals, especially doctors; sustained managerial focus and attention; the use of multifaceted interventions; coordinated action at all levels of the healthcare system; substantial investment in training and development; and the availability of robust and timely data through supported IT systems. This echoes what nearly all standard textbooks on quality improvement emphasise, namely that improvement relies not only on such technical matters as data gathering and measurement, statistical control or process redesign, but also on good leadership, team ethos, communication and the like.

In most such texts, large sections are devoted to showing senior managers how to inspire change, to revolutionise the culture, to deal with the internal politics, to build teamwork, and so on. But this is always, it seems, aimed at the top tiers of management, enjoining them to establish the right conditions for deep and lasting quality improvements. What seems to be missing in the literature is advice for those lower down the organisation who wish to bring about local quality improvements within an environment that, for whatever reason (differing managerial demands, unsupportive ethos or culture, unstable structures, multiple objectives, political or “tribal” turf battles, inadequate resourcing, understaffing...) does not make it easy to use long-established principles of Deming, Juran, Feigenbaum, Crosby and/or others to bring about quality improvement.^{2,3,32,33} Yet the problems that we encountered, where “top-down” objectives and managerial styles designed to improve services either failed to reach or actually cut across attempts at “bottom-up” quality improvement, and which have been described elsewhere,³⁴ are highly likely to be relevant in future projects of this nature, as a uniformly conducive environment is hard to find.

Furnhills and Dansworth were selected precisely because they appeared to be able and willing both to provide an organisational environment that would cultivate the improvement groups’ work and to encourage the kind of organisational learning that would nurture the groups as learning communities. Yet in only one of the four projects did this turn out to be so; even though the organisations were chosen for their excellence, the appropriate improvement culture did not always reach the parts we were working with. In retrospect, the assumption of a uniformly favourable culture may have been naive, but we did not hesitate to go ahead even when it became clear that the microclimates of the projects were not what had been anticipated. One can only agree with Powell *et al*’s conclusion³¹ (p 39) that in any given improvement programme “the specific approach (or combination of approaches) may be less important than the thoughtful consideration of the match and ‘best fit’ (however imperfect) for the *particular circumstances in the local organisations* using it” (our emphasis).

...with organisational learning?

Furnhills, riven by the NHS restructuring, was driven by performance management. The philosophy and culture that underlies performance management is, according to Deming,² and reinforced by Senge,^{35 ix} inimical to the methods of quality improvement that he advocated, and that formed the basis of the “improvement science” methods³⁶ that the Learning Communities Initiative had envisaged. For Deming, management by objectives (from which target-led performance management is derived) is a “roadblock” to the total quality approach³⁷ because it is a form of “management by fear”. He argues that it fosters short-termism, rivalry and political manoeuvring and thus damages teamwork and individual morale. Not only does this undermine the collaborative and collective “bottom-up” approach to quality improvement, but it also makes anything approaching a learning community difficult to achieve. This may partly explain why Furnhills was not a learning organisation and why we saw little evidence of spontaneous organisational learning there.

Deming also stresses the need for managerial stability over a long period of change if his methods are to succeed – a view that has been supported by subsequent evidence.³¹ Such conditions contrast starkly with the management upheavals that occurred shortly after the Furnhills projects began, which makes it entirely predictable that the Furnhills projects would have difficulty following the intended path of becoming a learning community. At Dansworth, the opposite was true – there was managerial stability and a longstanding culture that fostered organisational learning alongside a Deming-like approach to improvement, and the Danelder project thrived in that environment. The Dandem project, on the other hand, was based in a section of Dansworth where that ethos of organisational learning had not penetrated, and where the management and project leadership lacked stability and continuity.

Organisational learning was happening in most of the groups once they began sharing their knowledge and experience and working collectively towards their improvement goal. We saw examples of this happening not only in the work of the Furncop and Danelder groups but also in the learning events of Dandem and Furndem, where group members had what our Furnhills site liaison manager called “lightbulb” moments that caused them – at least for a while – to rethink how they

ix In his preface, Senge (2006; x), quoting a letter that Deming sent to him, claims that Deming “said in a sentence what I had struggled to put into 400 pages”: What Deming had written was “Our prevailing system of management [...by objectives, quotas, incentive pay, business plans...] has destroyed our people”.

should collectively approach their improvement work or change the way they learnt. These included, for instance, new understandings of the problems to be solved, of the contributions that other parts of the service could make, or of the benefits of new ways of working.

The feedback from our follow-up interviews suggests that cumulative change in understanding did, in some instances, lead to changes in processes and structures that are characteristic of true organisational learning.³⁸ In Furncop, this was confined to the core improvement group – the public health nurses – who, as a result of the first learning event, changed how they related to each other and to the difficult situations they encountered in primary care practices. After the third and fourth learning events, they had radically changed their collective view of how to approach their task, although they were not yet able to put their ideas into practice. This can be seen as a (localised) shift from what Argyris and Schön^{23,27,28} call “single loop learning” to the “double loop learning” characteristic of learning organisations. In those terms, Dandem’s new set of criteria for dementia education, which arose from the learning event, was confined to localised single loop learning. In Danelder and Furndem, however, the changes from the collective learning went beyond single loop learning in the groups themselves and were manifested as new ways of working on the elderly care wards (Danelder), and as a much-improved configuration of the memory service (Furndem). In these two cases, therefore, one could argue there was also double loop organisational learning.

...with the work of the Health Foundation?

The Learning Communities Initiative is part of a long series of Health Foundation programmes on the improvement of quality in healthcare. Several of these have worked with networks and communities in what might be seen as precursors of this initiative, including the Closing the Gap through Clinical Communities programme, which was recently evaluated.³⁹ However, there were important differences between the two pieces of work – not least the fact that unlike our improvement groups, each of their clinical communities was, although run by core teams, distributed across the UK; their members were therefore working with respected and self-selected colleagues from their own disciplines elsewhere in the country. Moreover, they were focused on action rather than learning *per se*. Thus, although those communities were, in many senses, communities of practice, as were our improvement groups, any

comparison would be difficult to interpret. Nevertheless, if one were to take the 10 desiderata set out in the Closing the Gap evaluation as indicators of a well-functioning improvement community, then it becomes clear that the Danelder group would have scored better than the other three on virtually all those criteria, and the two dementia projects would have scored the lowest, which suggests some concurrence between the findings.

The Health Foundation’s recent support for a Safer Patient Network has also been evaluated, with some important lessons for cross-site networking and learning to aid improvements in services.⁴⁰ But those networks were much less successful as communities of practice or learning communities, and again, the many differences between that programme and the Learning Communities Initiative render any comparison between them very difficult to sustain.

The Health Foundation’s extensive programme of leadership training for quality improvement has also been evaluated.⁴¹ Four of the main conclusions from this evaluation resonate well with our own findings from the Learning Communities Initiative.

- “Engagement and relationship skills are fundamentally important in leading improvement. These skills feature more prominently in reported patterns of leadership behaviour than task-related or conceptual skills.”
- “...enabling and facilitating others to make their contribution is central to leading improvement in the NHS.”
- “the complexity of an improvement initiative... is indeed a relevant factor, with greater complexity reportedly leading to greater use of certain aspects of leadership.”
- “More innovative improvement work, involving more complex influencing, is associated with combining operational management with longer-term relationship building, while keeping an opportunistic eye on the possibilities for the future.”

Our findings also support and amply illustrate the suggestion made in that evaluation report that “it will be important for the Health Foundation and other providers to decide how [engagement and relationship behaviours] can effectively be embedded into leadership development activities in a way that complements more technical QI skills.”⁴¹

Finally, the Health Foundation report, *Overcoming challenges to improving quality*,¹¹ is based on a review of a large portfolio of the Foundation's quality improvement programmes, and provides perhaps the best encapsulation of the lessons learnt so far from that body of work. It suggests that quality improvement will fare better when it is designed and executed with 10 challenges in mind, each of which the review explores in some detail. Our projects were undertaken before this review became available, but our findings confirm that overcoming these 10 challenges is indeed important and that, in the main, the more successfully they were overcome, the better our four improvement groups fared. This is discussed in detail in Appendix 3.

Chapter 10:

Summary conclusions and implications

For health service organisations

It is not our place to add to the burgeoning advice and techniques given to healthcare organisations wishing to improve the quality of health services. We would simply highlight that part of the reason why improvement is so hard to achieve may be that those involved in leading programmes need to deploy three different but fundamentally interdependent types of improvement skills: 'technical', 'soft' and 'learning' skills.

The relative absence of skills in one area will lead to a lack of progress overall, irrespective of the strengths in other skill areas. Any organisation wishing to improve quality must therefore invest in developing all three sets of skills. This principle is expressed by the analogy of the three-sided improvement pyramid (Figure 3). The pyramid also conveys the idea that for any sustained improvement, it is important for the organisational base to be consistently broad and solid enough to support the development and deployment of the three sets of quality improvement skills.

In practice, therefore, all three sets of skills, and not just the techniques of improvement science, need to be carefully assessed and developed in future projects of this sort. The development of such skills (including learning to learn collectively as a group) needs to be recognised as a central part of managers' and practitioners' roles and identities – not just as a marginal 'add-on', but through sustained institutional support (culturally, financially and interpersonally).

Unambiguous central support (administrative, strategic, resourcing, etc.) within organisations is very important. But such support throughout the organisation cannot be taken for granted; even where we found strong central and managerial backing for improvement work, the degree of common understanding between different parts of the organisation may be deceptive. Even in high-performing organisations, it is still crucial to

understand and take account of the range and depth of skills possessed by individuals and project teams when planning and managing improvement projects. For those undertaking improvement programmes, there is a need to balance ambitious ideas with the grass-roots, nitty-gritty operational matters. It is essential to ascertain the current state of improvement capability on the ground, possibly by conducting a full and candid assessment of the extent to which the three skill sets are present. We recognise that this would take time, but our findings suggests that it is vital to capture the whole picture – not just the view from the top of the organisation but whether the capability for implementing improvement projects is present on the ground – and this should include an assessment of all the three sets of skills that we have highlighted. Such an assessment should shed light not only on the espoused organisational culture for improvement but also the actual cultures and subcultures; not only the formal structures and processes but also the workings of the informal ones. Clarity of purpose, apparent and shared by all, is vital.

Organisations will benefit from actively investing in developing a wide range of skills among individuals and teams that are tasked with or willing to get involved in improvement projects. Improvement work should not underestimate the influence of key individuals who can drive projects forward or hinder them, both at the grass roots and higher up the organisation. Projects need enthused, motivated, trained and empowered individuals to drive them forward. Improvement work requires that such individuals be identified and trained in all three sets of skills. Individual champions, leaders, and facilitators appear to be fundamentally important to the success of such projects, so there may also be a need for some initial investment in developing the balance of the three sets of skills needed in those people.

Another crucial aspect of improvement work and the learning associated with such work (the mortar that holds the bricks in the pyramid walls, to refer back to our analogy) is the ability to navigate organisational, professional and personal politics. The level of mutual trust and cooperation must be probed, understood and taken into account in projects of this type – for example, by fostering new or better dialogues. This also entails recognising the crucial place of interpersonal relationships and personal emotions in encouraging or inhibiting learning for improvement. All four improvement groups demonstrated the great value of bringing together people with similar concerns, who may not have interacted with each other previously, and giving them the opportunity to talk to and learn from each other in a carefully facilitated and supportive environment. One might even make the case for this being a prerequisite or at least a valuable support for, an effective, reliable and predictable level of cross-team working.

Related to this is the problem of continuity of management. Organisational change can disrupt improvement work, not least because it upsets the dynamics and politics of organisational, professional and personal trust and understanding that impact on quality improvement initiatives, but also because it makes it difficult to sustain a consistent improvement culture with the necessary resources, processes and structures. The contrasting experiences of the four improvement groups clearly showed this.

For the Health Foundation or other organisations funding improvement projects

To help future initiatives of this kind maximise learning and achieve real improvements, we make the following suggestions.

1. The selection of sites needs to be carefully carried out, preferably including on-site initial assessments, to ensure that the immediate organisational environments in which any improvement groups will be working are conducive, as far as possible, to the success of the projects. This assessment should cover all the relevant aspects of the organisational environment (see ‘The organisational environment for learning about improvement’, page 47), specifically:
 - the external environment
 - the culture (and subcultures) of improvement
 - the resources, structures and processes

- leadership at the appropriate levels for the project
- local politics
- relationships and communication
- the educational environment.

Factors such as stability of the organisational structure and levels of staff turnover should also be considered.

2. Facilitators involved in projects designed to support learning communities to improve services should be alert to, and proactive in, ensuring that all three sets of skills – technical, soft and learning – are being developed, proactively and appropriately. Few if any such communities would have full strengths across all three skill sets at the outset; by being ready and willing to deal with deficiencies in *any* of the three, future projects would be well placed to add value in helping the groups to achieve successful improvement, no matter what their starting point was.
3. To maximise the chances of success, projects need to be capable of adapting any pre-designed programme to suit the evolving needs of the improvement group, so that the emerging improvement task is in fact co-designed. All parties must be prepared, from the outset, to accept the work being re-shaped as it unfolds.
4. The leadership of learning communities, which need careful facilitation and stewardship, should have a high degree of managerial/administrative skills *and* leadership/championing skills (page 53). In future initiatives, the Health Foundation may wish to take more steps to ensure that group leaders and site liaison managers are fully committed and are able to devote sufficient time to the project. This may require specified back-fill (ie, dedicated time bought out for the project).
5. Participation in learning communities is not usually regarded as a core part of a health professional’s job and might even be frowned on as taking up time that could be spent on “real” work. Participants need to be given credit for taking part and enough encouragement to overcome any mistaken perceptions they might encounter from colleagues. It is important to make sure that everyone involved in the learning community, including newcomers, understands its *raison d’être* – *it should be seen as a method of improvement that is itself part of the change process*. (In the jargon of improvement science, members should understand that part of the ‘theory of change’ is the learning community itself.)

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6. A further aspect of points 4 and 5 is the need to ensure that the organisation actively encourages the key protagonists to make space in their diaries for the key events – and supports their doing so!
 7. The SPIBACC method used in this initiative for focusing improvement programmes and eliciting the skills deficits to be addressed (page 59) could be usefully developed and used for future projects.
 8. To be credible and influential in supporting the improvement group to achieve its task, facilitators should have some knowledge of the content of the topic under consideration, as well as group process skills.

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Appendix 1:

The agreed original project plan^x

Stage 1

The Health Foundation and the Project Team will select two high quality learning organisations using and adapting the criteria developed by the HF. These sites will already be working across their health economies to create learning communities which are undertaking particular quality improvement tasks (henceforth the “Tasks”) that they wish to implement and which will be selected for the Study. We will first spend around two weeks immersed in the organisations in each site:

- doing (in two tranches) an ethnographic and interview-based assessment of the structure and culture of the organisations;
- ascertaining the aims, context and status of the intended service improvements and the roles and views of the key players and their likely communities of practice and selecting up to four Tasks for the project at each site (i.e. up to four Tasks and their communities of practice at each site);
- gathering baseline documents;
- beginning the process of negotiating acceptance and clearance to undertake the work;
- agreeing (particularly in the second tranche of the baseline work) the process/outcome measures for the selected Tasks [...]
- negotiating the respective roles and relationships over the following nine months of our Project Team, the Health Foundation, the Reference Group, and the key players in the organisation, both those directly involved in the Tasks and those (eg other senior managers) not involved but possibly influential (which will include the micro, meso and the higher levels of all relevant parts of the organisations.)

The outputs of Stage 1 will be:

- a rich description of the context and culture of the organisation relevant to this intended service improvement (the Tasks);
- an analysis of the (“emic”) stakeholders’ constructions of the intended organisational changes;
- commitment of the key actors to participate in the Learning Communities (including attending at least three local Learning Community Events, see below), to cooperate in its evaluative facilitation (both at the Learning Community Events and the related telephone interviews – see below), and to participate in at least one cross-site Improvement Science Learning Event with the other site. Again this will include all levels of the organisations, all of whom may be involved in the subsequent data gathering and iterative discussions;
- sufficient information to allow the project team and HF, to formulate a Reference Group of experts with appropriate skills who agree to provide expertise when requested, either by identifying relevant sources, producing written summaries of the relevant evidence or state of the art improvement science, or – where appropriate – by being present at the Learning Events to provide “masterclasses” on either improvement science, learning communities or the service developments.

Stage 2

Over the following three months the Project Team will interview by telephone/Skype the key actors in the change process, and a sample of other stakeholders involved in the changes, all of whom we hope to have met during the initial immersion visit. The focus of the interviews, based

^x To avoid confusion, one subsidiary aspect of the plan, the use of online and other techniques for knowledge sharing, has been omitted here since, as things turned out, was no place for it at all.

loosely on Guba and Lincoln's (1989) "fourth generation evaluation" techniques will be the "claims, concerns and issues" of the main players about the Tasks. We will also interview a wide range of other stakeholders, who will be selected by snowball sampling depending on the emerging issues. In addition we will gather data about the sources of knowledge about "improvement science" that the actors are bringing to bear, and also their learning needs. These findings from the interviews, which will be recorded but not transcribed, will be collated and where appropriate thematically analysed and fed back, as a synthesised construction (Guba and Lincoln, 1989), to the interviewees in a focus group one month before the first of three quarterly Learning Community Events at each site. We expect by then to have identified the main emerging claims, concerns and issues and especially learning needs. We will use these as a starting point for the design of not only the first Learning Community Event in each community, but also for structuring the work of the community between learning events (i.e. an action plan for each community of practice [n = up to 8]). The planning of all Learning Community Events will include Skype or teleconferencing to ensure full engagement of key players.

The outputs of Stage 2 will be:

- an ("etic") analysis, or construction, of the emerging issues that have been identified about the Tasks (in a format that can be used by the participants as well as the facilitators) as preparation for the facilitated Learning Community Event at each site. Each construction will then be augmented by relevant literature and where possible contributions from the experts in the Reference Group in relation to their own areas of expertise in improvement sciences;
- an initial action plans for each learning community about the Tasks ;
- the beginnings of a "map" of the key actors' sources of knowledge about improvement science;
- a preliminary outline of the networks of people with whom they exchange such knowledge (i.e. their learning community/community of practice);
- a summary of learning needs;
- interim outline plans (to be firmed up with the learning communities, the Reference Group and the HF) for the first Learning Community Events.

Stage 3

At approximately quarterly intervals we will facilitate a Learning Community Event of the key actors and stakeholders within each learning community, and

during the same visit (3-4 days) will conduct key face-to-face interviews (individual and where appropriate group interviews/focus groups), and – if possible – observe any relevant meetings or other activities relevant to the intended change in order to identify further claims, concerns and issues related to the Tasks. We will also commence discussions about the introduction of knowledge-exchange systems within and between the learning communities during this stage.

The Learning Community Event will follow loosely the tried and tested methods of an "Experiential Learning Programme" (ELP) developed over many years by one of the team to establish learning communities in public health. In brief, this developed from the principles of action learning, in which the participants learn from each other's knowledge and experience, and also learn reflectively and collectively through making informal but structured presentations about the ways in which they have, or have not, found it helpful to apply (in this case) "improvement science" to their part of their Task in hand, or similar past improvement programmes. The ELP model, which requires careful facilitation, also involves the input of experts specifically chosen to help meet the learning needs identified by the members of the learning set.^{xi}

The outputs of Stage 3 will be:

- action learning plans for the learning communities;
- focussed summaries of the implicit and tacit knowledge (and continuing learning needs) of the participants about the Tasks;
- focussed summaries of the application of relevant improvement sciences to the Tasks (produced by the participants, the Project Team and the Reference Group members);
- a summary analysis of the learning process that occurred at the Events (produced by the Project Team and fed back to the participants, Reference Group and HF);
- a short interim report of the above for the HF and (as appropriate) the participating sites.

Stage 4

After the Learning Community Events, during months 4-6, the telephone interviews will continue as before, with an additional focus on the progress of individual and organisational action/learning plans set out at the Event. The whole process will go through two further

^{xi} Detailed explanation omitted here for brevity's sake.

cycles around the two subsequent Learning Community Events, which may involve different members of the Reference Group, depending on the emerging needs.

The Project Team will also make available a range of facilities for sharing knowledge and experience [...]

The project team will be continually analysing and synthesising the emerging themes about both the content (main learning needs) and how the processes (how those learning needs are or are not being met, why that is, and how it relates to the wider culture of the organisations). As a result, the evolving pattern of learning and improvement in the uptake of improvement science can be thematically analysed, assessed and evaluated.

The outputs of Stage 4 will be:

- further sharing of implicit and explicit knowledge between the members of each Learning Community;
- (by telephone interviews and online discussions)
 - elicitation of evolving claims, concerns and issues
 - further identification of explicit learning needs and consequent planning of learning events;
- Learning Community Event products as above (eg summaries and reports – See Stage 3);
- further analysis of the emerging lessons in the context of the relevant literature on learning communities and “improvement science” (i.e. what we are learning about the learning);
- summaries of cross-community learning and discussion.

Stage 5

After the second and third Learning Community Events, which should be around months 6 and 9, the Project Team and Health Foundation will hold Cross-Site Learning Events (months 7 and 10) at which both sites will share their experiences and learning with each other and with members of the Reference Group. As well as presentations and discussion groups, these could feature a “Knowledge Cafe”, consisting of poster presentations created by the learning communities, small-group cross-organisational “peer assists”, and a large-group narrative exercise building on emergent issues from the online discussion forums conducted in Stage 4.

This meeting will include preliminary feedback from the Project Team of their main findings to date, to test these against the perceptions of the participants in the meeting. As necessary the stakeholder reactions will be followed up by individual discussion interviews. This “member checking” will help validate our findings.

We will also at this stage complete our exploration of the literature relevant to the main findings to enable us to situate the findings appropriately through later publication.

Dissemination: In addition to the above intra-project dissemination we will work with the learning communities to identify with them the most appropriate ways to disseminate their work to the wider audience of practitioners, managers and academics. We will present to these groups the various options ranging from those which capitalise on the conventions of these groups (eg publication in professional and refereed journals, conference presentations, targeted workshops/seminars) to more novel media such as You-Tube and similar options could be made available if the learning group participants and the HF so desire.)

The outputs of Stage 5 will be:^{xii}

- *an analysis of the lessons learnt from the project about the specific features of the learning communities and the process that they have undergone (aimed chiefly at the participants and their peers);
- *an analysis of the generic lessons about the use of communities of practice and learning communities as a tool for QI and about the organisational culture in which they function;
- *a possible draft outline of a tool (if feasible at this stage) that the HF might develop for assessing the learning culture and/or effectiveness of learning communities in future QI projects;
- a provisional dissemination plan, to be agreed with the HF before finalising;
- the hand-over of facilitator and moderator capacity for the Knowledge Gateway to the learning communities should they decide in Stage 5 to continue with its use in the future.

Stage 6: follow up review

Three months after the last Cross-Site Learning Event we propose to conduct telephone interviews with a limited sample of the stakeholders and if necessary to make a brief visit to each of the sites to ascertain the degree to which they are then on course for achieving the original objectives of the Tasks and to which they have (or have not) continued to make use of the improvement science input that they acquired during the project and how useful it has (or has not) been.

xii *in the final report to the Health Foundation

Appendix 2:

Cross-cutting themes from final follow-up interviews

Benefits of involvement in the project

- Being part of a group which:
 - shared ideas (18 respondents from across all sites)
 - found solutions (3)
 - developed an understanding of what it may be possible to do (1)
- Reducing differences in understanding/them and us/working together (19)
- Networking and meeting people never exposed to before (9)
- Learning from each other (9)
 - learning about small steps of change: quick wins: starting small (7)
 - learning from expert (3)
- Having time away from the coalface to stop and reflect (7)
- Provided a training/education opportunity unrelated to the process of quality improvement (6)
- Enabled us to feel more empowered/confident/raise issues to surface/work in service development and improvement (6)
- Positive emphasis, not just focusing on poor practice (5)
- Health Foundation team came with different/non-political eyes (2)
- Identified further work to do (2)
- Gave us the kick we needed (1)
- Generated specific products (lists of levels) (1)
- Focused on what we could improve (1)
- Enabled the formation of a coherent and united story to take forward (1)

- Methodology used enabled an honest view to emerge (1)
- Being able to sit down with peers and discuss data together (1)
- Keeping the need to improve practice, even when it is good, on the agenda (1)

Disadvantages of involvement in the project

- Hard to fit in with other distracting pressures (4)
- Too much time spent on project for too little gains (1)

Challenges

- The changing NHS landscape in England (5)
- Reconciling conflicting philosophies (4)
- Balancing clinical workload with involvement in project (3)
- Managing historical problems associated with individuals (3)
- Keeping going without the Health Foundation push (2)
- Fitting work in against a changing national agenda related to particular services (2)
- Shifting organisational priorities (2)
- Local changes in management involvement due to changing roles (2)
- Remaining motivated (2)
- Involving other sectors (2)
- Only as good as the person leading it (2)
- Spreading/cascading good practice/information (2)

- People not on group initially may not own work (1)
- Finding more resources to continue to meet in small group and spread good practice (1)
- Focusing on the measurement of improvement (1)
- Having people with drive (1)

The project could have been improved by...

- Getting the right people to the learning events (9)
- Better communication from project leaders in the improvement groups (8)
- Greater emphasis on following up one-off attenders (4)
- Reducing the time over which the project ran (3)
- Having a clearer idea of end product at the beginning (3)
- Having better senior management buy-in as project leader left (3)
- Using venues away from usual place of work (1)
- Having better turnout at learning events (1)
- Getting all of the right key players together at the start (1)

The perceived impact of the Health Foundation

- Facilitation (12) through:
 - creating focus
 - leading events
 - engaging all
 - getting each voice heard
 - getting conversation going
 - asking questions
 - promoting open discussion
 - being systematic
 - being supportive
 - being outside the normal organisational “power” structures
 - keeping things going
 - promoting ownership
 - having the generic know-how to make things happen

- Catalyst for ongoing work (8)
- Can't imagine it would have happened without the Health Foundation project (8)
- Got people together (7)
- Right time and right place (4)
- Laid the foundation for future work (4)
- Raised the profile of the work (3)
- Model used in project useful (2)
- Moved us on from where we were (2)
- Made us delve into problems (1)
- Gave kudos to the project (1)
- Provided funding (1)
- Helped others to learn about PDSA and small tests of change (1)
- Got people to think before the learning events about what could be achieved and how (1)
- Good relationship with the project team (1)

Feedback from the Furnhills site manager also suggested that the financial contribution, through the grant from the Health Foundation, should be acknowledged as having played an important part in helping the learning events to work; it paid for backfill, for learning materials, travel expenses, the hire of neutral venues that facilitated more relaxed discussions, and catering that made people feel valued.

Appendix 3:

How the Learning Communities Initiative fared in relation to the Health Foundation's report, *Overcoming challenges to improving quality*

In *Overcoming challenges to improving quality*,¹¹ Dixon-Woods and her colleagues reviewed the Health Foundation's portfolio of quality improvement programmes and concluded that quality improvement will fare better when it is designed and executed with 10 challenges in mind. Here we consider the four projects of the Learning Communities Initiative in that light.

1. **The need to convince people that there is a problem:** In the Learning Communities Initiative, the choice of problem to solve was mostly, with active help from us as facilitators, in the hands of the improvement groups, and the concerns to be addressed within that were the main focus of our SPIBACC method. For the Dandem project, however, the learning events were not based on the results of the SPIBACC process (which had been about getting a dementia-friendly hospital environment, and had been dealt with following our earlier intervention), but on the pressures – stemming partly from a recent public enquiry into the mishandling of a patient with dementia – that pointed to a different set of problems (which were about educating staff in conformity with new requirements). Nevertheless, the way that the learning events were run allowed the participants to focus on a problem they all recognised and wished to help solve.

Thus in all four projects, the methods of the Learning Communities Initiative all met this first challenge, but the improvement groups did not necessarily have the power to implement the changes that they believed would ameliorate the problems they

perceived. A further complicating factor, familiar within the wider 'problem structuring' literature, arises from the need not only to convince those involved that there is a problem, but also to share an appreciation of the many different (and often competing) perspectives of what 'the problem' is. This is often referred to as the need for a more thorough awareness of 'the problem situation' rather than merely 'the problem'. It thus becomes wider than just 'we are powerless to change this situation'; instead, the emphasis is much more on 'others do not understand our problem' (or more accurately perhaps, our 'perception' of the problem) at best, or 'others are the problem' at worst. We saw evidence of this at some stage of all four projects. This sharing of (or failure to share) perceptions about the problem situation, which we worked actively to rectify through our SPIBACC and facilitation, impacts on the second challenge.

2. **Convincing people that the solution chosen is the right one:** Again, this second challenge was generally met by the SPIBACC method, since the key staff were themselves choosing the solution (although in Danelder we needed to encourage them not to back away from their top priority problem and its solution – namely to tackle poor liaison with community services). But, as with challenge 1, the core improvement groups did not necessarily have control over the *implementation* of their chosen solutions. There were others in the organisation well placed to impose alternative solutions. In Furncop, for example, the PCT managers of the COPD team

ensured that the new approach to improvement was, if not stifled, then at least subsumed by their own performance-driven agenda; and in the Furndem project, the solution for restructuring memory clinic services that was catalysed by the learning event needed to run the gauntlet of a powerful GP lobby before being implemented. Had a charismatic GP leader not emerged towards the end of the project to champion it, the changes may not have happened. In other words, it is not just a matter of convincing people, but convincing the right people. It also means that the chosen solution should genuinely recognise and work towards the reconciliation of a variety of perspectives, rather than the imposition of a solution that appears to be ‘the right one’ from a particular perspective.

3. **Getting data collection and monitoring systems**

right: The Danelder group collected informal data from its PDSA cycles as part of the improvement process, including data on conformity to expected discharge dates. Dandem did not get to the stage where data collection was appropriate – it was little more than a preliminary task group to plan a new education programme. Furndem monitored the numbers of dementia patients attending different parts of the system and used those data to show progress. Furncop was very much data driven, since the figures for acute hospital admissions for COPD exacerbations and for referrals to pulmonary rehabilitation were strong drivers for the project; those data were not, however, linked to the specific changes that the core group were hoping to implement, nor designed by the group. They therefore could not be linked to the activities of the improvement task of the Learning Communities Initiative itself. One cannot draw any conclusions, but it is worth noting that the most successful of the four projects did indeed get the data collection and monitoring systems right, and that this was an integral part of the structures and processes that were so efficiently managed by the group and especially by the group leader.

4. **Excess ambition and “projectness”:** Because the goals were largely determined by the project leaders themselves and then refined through the SPIBACC processes with the key members of the improvement groups, they were not regarded as overambitious by any of the four improvement groups. In Furncop and Danelder, the work of the Learning Communities Initiative was a core part of

what the teams were, in any case, trying to achieve and did not have the appearance of being a separate project imposed from outside or above. Indeed, the Danelder managers had an additional motive of using the project to tackle some underlying political problems that still needed resolving after the recent painful restructuring. This in fact meant that the work was more sustainable for being a focused project that worked on several different levels (eg improving patient care, improving communication across teams, reducing antagonism between different professions and parts of the system; “healing” some rifts). Thus its very “projectness” may have helped its success by wrapping these aims into a coherent and integrated programme of work. Again, it is worth noting that one of the key factors in the success of this group was the group leader’s very efficient and effective project management. The Furndem project leader saw the Learning Communities Initiative project as something separate from his other quality improvement work (and possibly imposed from the PCT) insofar as he pushed this work to one side for a large part of the time, with the result that the rest of the memory clinic staff were hardly aware that ‘the project’ existed at all. However, after the eventual learning event took place, they regarded the project – those that noticed it as such – as an integral and catalytic step towards the eventual improvements in the memory service. In Dandem, there was no suggestion of excess “projectness”, since the learning events were seen as a uniquely useful way of bringing together the many different (and differing) parties who needed to engage in a task that would face them all – namely improving the education of staff about dementia. The events were not, for them, a project, but stepping stones on a much longer journey.

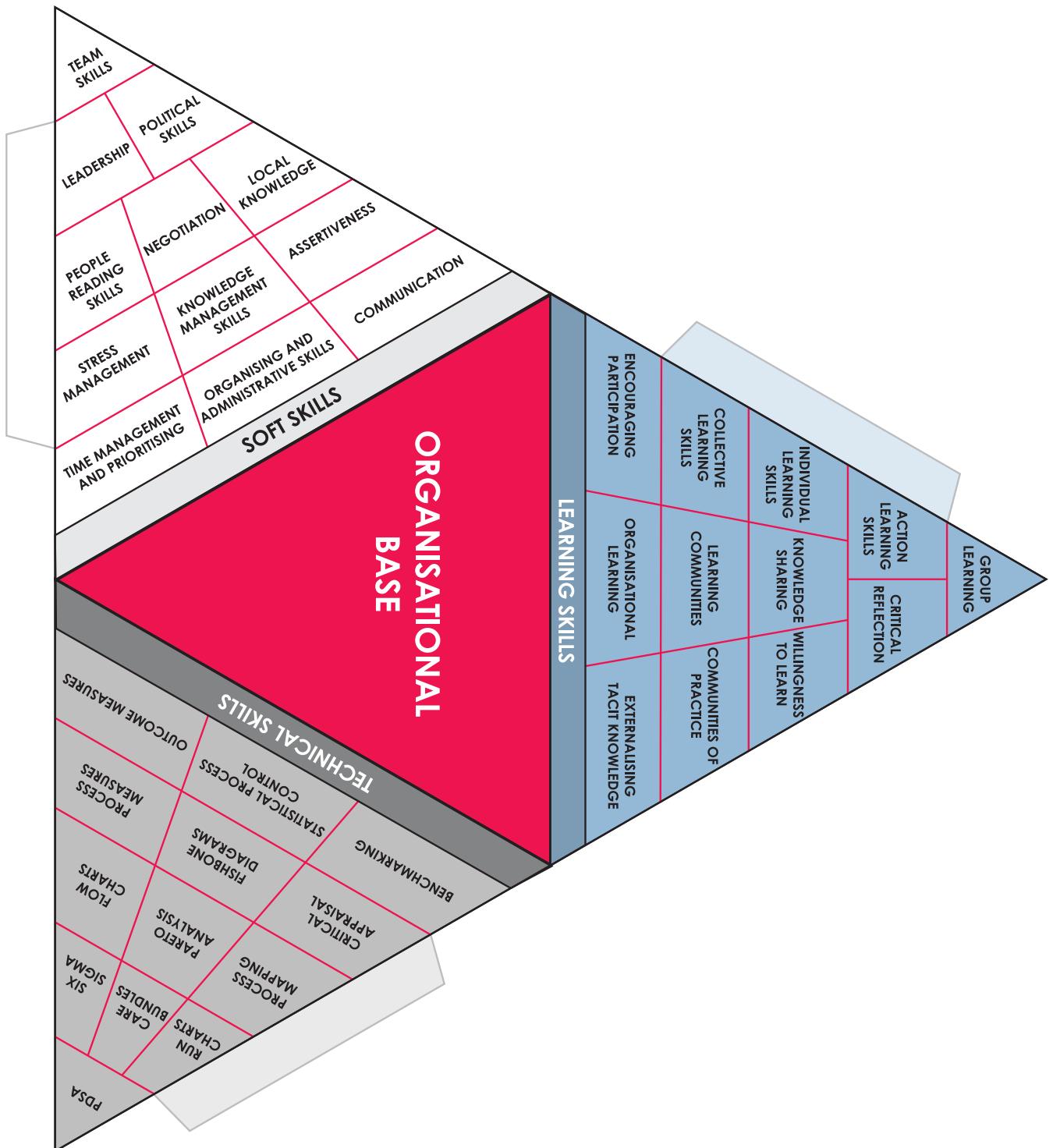
5. **The organisational context, culture and capacities:** this is discussed alongside **challenge 6**.

6. **Tribalism** and the lack of staff engagement: We have dealt with these two at length in our analysis of the impact of the environment on the projects (Chapter 8, pages 47). The main lesson is probably that a great deal of care should be taken to ensure that the environment is conducive to the desired approach to improvement, and the person leading the improvement task has the professional background, skills, motivation, priorities and power to match the agreed aims of the project, overcome ‘tribal’ boundaries, and engage the key players, which was not always the case.

-
7. **Leadership:** We have dealt with this at length in the section on Leadership (Chapter 8, pages 52–53).
 8. **Balancing carrots and sticks – harnessing commitment through incentives and potential sanctions:** This was not a relevant concern in most of the work described here, since the Health Foundation was in no position to deploy such measures. However, there were elements of such factors at play – for example, in the ways in which the balance of incentives and sanctions for the public health nurses who formed the core of the Furncop team led them to postpone implementing the changes they had signed up to. Also, as facilitators we sometimes needed to use “carrots and sticks”, as did the site liaison managers, to help move the projects along.
 9. **Securing sustainability:** Although it is still early days, the original work of the Danelder group seems now to be embedded in the ways of working for most of the wards, and the group seem to have a momentum that is carrying forward an expanding programme of improvements built on the same principles and methods. This appears to have happened partly because of the palpable success of the project at all the levels mentioned under challenge 4 and also because of the consonance of the work with, and support and resource from, the Dansworth environment, including the continued involvement of a project leader trained in improvement skills and the deployment of excellent project management skills. As for the Dandem project, there is the intention that the work of the learning events will, at some point in the future, feed into the development of dementia education for level 3 staff, and this is probably because the participants recognised that the events represented an unusual dialogue between the many parties involved and the agreed outputs would therefore have a better chance of being supported when the time comes to implement the ideas generated there. The changes that had been introduced in the Furnhills memory service (Furndem) are continuing, again because they reflect the unusual multi-sectoral dialogue that the learning event actively promoted, and which all parties recognised as important and relevant. The changes are probably also being implemented because they are supported by all those key parties, albeit after some dissent was ably dealt with by newly emerging leaders, and supported with new resource (such as the new peripatetic dementia nurse). We recognise that the injection of ‘new resource’ can sometimes cloud sustainability judgements; those involved will sometimes ‘wait and see’ how the new situation plays itself out. However, the early signs appear promising. The Furncop improvement group has been making impressive headway in altering care for patients with COPD, but not in bringing about the improvement ethos that many of them, including their leaders, are desirous to do. The reasons for this have been considered at length in Chapter 5.
 10. **Considering the side effects of change:** The term ‘side effects’ can be both contentious and problematic in any healthcare context but, although it may be too soon to tell, no untoward side effects from the project work are yet apparent. One aspect of this final challenge is that there is often a price to be paid for improvement, and it is often paid unequally. Organisational change usually causes a range of effects, and what one set of participants see as ‘side effects’, other participants in the same problem situation may see as central to their working environment and behaviour.

Three sets of skills for successful improvement – cut-out pyramid

Please visit www.health.org.uk/publications/skilled-for-improvement to download the diagram below. You can use this to cut out and create your own 'three-sided improvement pyramid'.



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