IMPROVEMENT

NHSProviders

In partnership with

Q is led by the Health Foundation and supported by partners across the UK and Ireland

Improvement survey 2023

Date: August 23

Number of respondents: 129

Number of trusts: 95 (45% of trusts in England)

Summary

Trust level

- 22% of respondents said they have largely implemented, embedded and sustained a systematic, trust-wide improvement approach over a number of years, 50% said implementation at their trust was underway and they have made progress but there is a need to mature their approach, and14% said their trust was just underway.

- 7% reported that they have made a commitment to a systematic, trust-wide improvement approach and are thinking about where to begin, and 5% reported that frontline teams in parts of the organisation are using structured improvement methods and approaches, but have yet to make a commitment to take a systematic, trust-wide approach.

- Three quarters of respondents (75%) said their trusts approach to quality improvement is fully or mostly aligned with the five components outlined in NHS Impact.

- At trust level, the top three barriers' respondents experienced in progressing a systematic approach to improvement was operational pressures (75%), the challenge of engaging over-stretched staff (68%) and lack of workforce capacity (64%).

- Respondents indicated that at trust level they would most like to receive support on developing leadership behaviours for behaviours for improvement (64%), investing in culture and people (58%) and building shared purpose and vision (53%).

- Of the named enablers of improvement, health inequalities was the top area where respondents would value support. This was true both at trust level (64%) and across their provider collaborative (63%).

Provider collaboratives

- It's early days in terms of shared approaches to improvement at provider collaborative level with 5% of respondents saying they have largely embedded a shared approach to improvement and are seeing impact, 17% that their shared approach to improvement is underway, and 38% that they have just started on this journey.

- 25% of respondents said their approach to quality improvement across their provider collaboratives is fully or mostly aligned with the components outlined in NHS Impact.

- Across provider collaboratives, the top three greatest barriers respondents experienced were lack of robust shared systems in place, such as IT and shared data systems (50%) lack of workforce capacity (44%) and operational pressures taking precedence (43%).

- Respondents indicated that across their provider collaboratives they would like to receive support on developing leadership behaviours for improvement (66%) embedding a quality management system (60%) and building shared purpose and vision (58%).

Other key messages

- How people rate their progress is clearly subjective, with different levels of understanding of what embedded and systematic approaches to improvement means in practice. Additional clarity on the milestones and what good and great looks like would be beneficial.

- Whilst resource and capacity for improvement is a struggle at both trust and provider collaborative level, organisations are at very varying levels of maturity. A differentiated approach will be essential in providing support for embedding NHS Impact – one size will not fit all.

- The long-term and ongoing nature of embedding improvement across organisations is underlined by member responses. Many noted that creating the right cultural conditions takes time. Trusts who've had improvement approaches in place for a decade still believe there is

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scope to mature it to become fully systematised and integrated into clinical and operational processes.

Survey findings in detail

Where are members on their trust-level progress on improvement?

- 22% of respondents said they have largely implemented, embedded and sustained a systematic, trust-wide improvement approach over a number of years.

- 50% said implementation at their trust was underway and they have made progress but there is a need to mature their approach.

- 14% said their trust was just underway.

- 7% reported that they have made a commitment to a systematic, trust-wide improvement approach and are thinking about where to begin.

- 5% reported that frontline teams in parts of the organisation are using structured improvement methods and approaches but have yet to make a commitment to take a systematic, trust-wide approach.

- 2% selected 'other' in answer to this question.

- 75% said their trusts approach to quality improvement is fully or mostly aligned with the five components outlined in NHS Impact – 32% fully, 42% mostly. 22% reported being partially aligned with NHS Impact.

Those at the beginning tell us...

- They lack alignment between quality and financial improvement and struggle to come up with coherent organisation-wide improvement programmes.

- Examples from trusts at the early stages of their improvement journey include one organisation currently undertaking a baseline diagnostic assessment of organisational maturity and readiness for the adoption of a trust-wide quality management system. Another is in the process of taking proposals for an NHS Impact-aligned programme through their governance.

Those whose trust-wide approach is just underway tell us…

- Initiatives are underway to relaunch improvement approaches where work involved to create the right cultural conditions was under-estimated originally or de-railed by the pandemic.

- Some report having a number of staff with skills to drive programmes of change and improvement, established programmes and capability building, but they don't yet have a systematised and embedded cross-organisational approach.

- Examples from trusts include: an organisation linking their trust-wide EPR implementation with a renewed focus on continuous improvement; a trust bringing together key teams into a single improvement team to better coordinate improvement efforts; one trust is testing out methodology to take a more robust approach in the future; another organisation is in the process of developing a clinical strategy and has appointed a QI team to support trust-wide improvement.

Those whose approach is underway and has made some progress, but there a need to mature their approach, tell us…

- Trusts in this category highlighted a wide variety of time spans for their improvement journey so far, ranging from 1 to 10 years, and different stages of progress from systematically rolling out improvement methodology to wards and departments to deployment of a quality management system. A number of trusts have had an approach in place for a decade but believe there is still scope to mature it to become fully systematised and integrated into clinical and operational processes.

- Examples cited include: one trust highlighting that the pandemic had hampered their progress in terms of training teams, but demand is growing again. One trust reported that their well-embedded improvement progress withstood the challenges of the pandemic, as there was a clear culture of improvement, so the focus is now more on aligning improvement priorities to strategic priorities and challenges and using the QI team to facilitate improvement. A 'strategy on a page' is being seen as a way to raise awareness of continuous improvement.

Those who have largely implemented, embedded and sustained a systematic, trustwide improvement approach over a number of years tell us…

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- Not all trusts placing themselves in this category consider their approach to be fully aligned with NHS Impact.

- Examples from organisations in this category included: a focus on coaching senior clinical and operational leaders to adopt leadership behaviours that nurture a culture of continuous improvement; one trust that has recently implemented a 12 week improvement sprint methodology to gain traction on key trust priorities; a trust that focused on annual cultural surveys as one way to measure their progress; and an organisation that has a mature and embedded improvement approach in most of the organisation that has recently merged with another organisation with a less mature and embedded approach.

Where are members on their progress in improvement through provider collaboration?

- It's early days - 5% of respondents at provider collaboratives said they have largely embedded a shared approach to improvement and are seeing impact, 17% that their approach to shared improvement is underway, and 38% said they have just started on this journey.

- 25% of respondents said their approach to quality improvement across their provider collaboratives is fully or mostly aligned with the five components outlined in NHS Impact.

Themes in comments included:

- Work is underway to begin to drill down to the operational components needed to support the strategic intentions already agreed by the partners and how to focus the collaborative on what adds most value.

- Links between transformation/improvement teams are being made and some have established networks and improvement collaborative training programmes across organisations. One respondent said that they are working on aligning all provider approaches to NHS Impact, but that this will take time.

- Resource and capacity constraints are a challenge in delivering impact. Other challenges cited include CEO turnover across trusts, and working across multiple ICS and/or several provider collaboratives where progress is at different stages.

- One respondent felt there is more thinking on improvement between the NHS trusts in the system than by the system itself. Identification of OD needs at ICS level for transformation and

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improvement, including identification of key roles and alignment of skills was cited by another respondent as critical in moving from plans to delivery.

Perceived barriers and support needs at trust level:

- The top three barriers' respondents experienced in progressing a systematic approach to improvement was operational pressures taking precedence (75%), the challenge of engaging over-stretched staff (68%) and the lack of workforce capacity (64%).
- Respondents indicated that at trust level they would most like to receive support on developing leadership behaviours for improvement (64%), investing in culture and people (58%) and building shared purpose and vision (53%).
- Building improvement capability was the least common area of support with less than half of respondents (43%) selecting this option relating to trust level.

Perceived barriers and support needs at provider collaboratives level:

- Across provider collaboratives, the top three greatest barriers respondents experienced were lack of robust shared systems in place, such as IT and shared data systems (50%) lack of workforce capacity (44%) and operational pressures taking precedence (43%).
- Respondents indicated that across their provider collaboratives, they would like to receive support on developing leadership behaviours for improvement (66%)
- Embedding a quality management system (60%) and building shared purpose and vision (58%).
- 67% of respondents indicated they would most like to participate in workshops to help their boards accelerate the adoption of improvement with an equity lens, closely followed by peer learning webinars (64%).

Themes in comments included:

- NHS Impact is very helpful in reinforcing the work being done at trust and provider collaborative level, and NHS Providers' offer provides 'external' validation of the importance of

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systematic approaches to improvement which it's helpful to point leaders and corporate teams to.

- There was a call for published guidance/tactical advice on how to adopt NHS Impact locally and regionally.

- Some noted there is limited resource to deliver NHS Impact at any great pace and scale. It is not straightforward to manage capacity of the day job and time to think creatively outside of the box for others.

- Further clarity and support on the selection of a common improvement method was considered helpful, as would collaboration on developing those capabilities in a financially strained environment.

- Culture and behaviours was a recurring theme and considered vital, including aligning improvement behaviours across provider collaboratives, creating shared purpose, building trust and ceding power, partnership relations.

- It was noted that it can be difficult to disentangle what is needed at trust level, collaborative and ICB level, and there is a need to engage more broadly than the NHS.

- Other requirements noted included integrated budgets, mandated shared services, less in-house provision, new metrics and performance systems, whole system accountability at senior levels and a national digital repository of evidence-based uec solutions.

- Other practical enablers mentioned included business case models, ready reckoners, new performance measures, and skills/cultural change programmes. It was noted that performance metrics can still dominate.

- Implementing EPR was mentioned numerous times, including how alignment with NHS Impact can support the EPR implementation journey. There was also a call for common and integrated digital, data and technology at board and ICB level. Digital maturity and pace of progress to shared EPRs was seen by one as a significant barrier.

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Confidence in board skills, capability and capacity to deliver NHS Impact at trust level and across provider collaboratives:

- Three quarters of respondents (76%) said they are confident that their trust board has the skills, capability and capacity to fully align with NHS Impact, trust wide (20% very confident, 56% confident).

- A quarter of respondents (25%) said they are confident that their trust board has the skills, capability and capacity to fully align with NHS Impact through their provider collaborative(s).

Themes in comments included:

- Concerns about capacity were by far the most frequently raised issue, both in reference to leaders and clinicians.

- The challenge is how to view this as a way to help with immediate operational issues whilst allowing time to mature your approach.

- Skills need to be developed at board level include digital and building strength and depth and maturity across all disciplines in NHS Impact.

- Lack of confidence in the skills at ICS to support this work.

How do members view inequalities in their improvement work?

- Of the named enablers of improvement, health inequalities was the top area where respondents would value support. This was true both at trust level (64%) and across their provider collaborative (63%).

- For some embedding this in QI is just starting and is an evolving piece of work, and although there is commitment, moving from strategic priority to how it translates to improvement practice for all projects can currently be unclear.

- It is recognised that this is a challenging and long term ambition, with a need to collaborate across the many stakeholders responsible for the social determinants of health.

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- Collaboration is viewed as essential to better communicate with the whole population, with a need for the ICB as it matures to better share information and have input in designing outcomes.

- It is recognised as a complex area with cross overs in many areas including digital transformation. One respondent queried how far boards are able to influence this agenda when the factors inherent within it are outside of their control.

Themes identified to help embed equity in all QI work at trust level:

- Clarity on the role of the board in supporting delivery and 'first steps'.

- Better use of data and how to bring it together to aid improvement e.g. data transparency, sharing and analysis; understanding local demographics; identifying what needs to be measured; embedding data and measurement that reflects differences across population groups within standardised reporting; the role of the board in its delivery including identifying good practice on how to incorporate this into performance discussions as part of standard work; using data to evaluate services and inform transformation work to mitigate structural discrimination; monitoring progress.

- Digital mapping of deprivation, health inequalities, new (non-hospital) clinical pathways, contact points between providers (including and especially primary care).

- Aligning system wide initiatives, including alignment with local councils vision and services with adequate funding for identified local needs.

- Interest in good practice/ideas for initiatives that help support rapid improvements and how to engage staff and local communities in issues, as well as more support for practical implementation and embedding in QI.

- Keen for support on implementation of WRES and PSIRF, research into what is affective e.g. alternative UEC pathways, standard practice in applying equity in practice across waiting lists and UEC pathways/triage and shared QI approaches.

- Ways this is being put into practice at board level include: equity being a key theme within integrated performance reports; equity of access, delivery, and outcomes a regular part of quality committee agendas; reframing the role of middle leaders as crucial in ensuring a whole organisation approach; a focus and commitment to become an anti-racist organisation, and a

refresh of the EDI Strategy, including key elements of health inequalities and improvement. One respondent called for mandated objective alignment to EDI across the board.

- Next steps mentioned include further engaging staff at all levels and across the diversity spectrum in improvement programmes, connecting improvement more explicitly to health inequalities work, and embedding EDI in NHSE board development programme.
- Barriers identified include data quality, capability in co-design and co-production, and the flexibility in systems to adapt. Also, the role of historic commissioning organisational boundaries and existing service specifications from commissioners that prevent redistributing resources to tackle inequalities.
- Other barriers mentioned include the ability to clearly describe the needs and inequity of the population and what that means for the trust, and as a partner, then translating that into all improvement work. A feeling that the new ways of working to support reducing inequality may not be as well versed at acute level as in the community. The lack of integrated health and social care budgets was also cited as a barrier.
- This work is in a much earlier stage with provider collaboratives. Comments identified that they need a set of focused programmes to drive together across the collaborative, as well as open dialogue on the best approaches to deliver impact.

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