The role of improvement during the response to COVID-19: insights from the Q community

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Contents

Summary of key lessons for improvement

COVID-19 placed unprecedented pressure on the health and care system. Improvement, which offers systematic approaches that can help adapt to change, would be expected to be a useful asset in the response to the pandemic. We asked Q members, a community of over 4,000 people skilled in improvement about the role of improvement tools, methods, approaches and mindsets in supporting change during COVID-19. This paper summarises their responses and shares key findings and recommendations for action.

Key findings

1

Improvement played an important role for respondents during COVID-19. Many perceived its role to have increased on individual, team and organisational levels. Improvement was used most extensively for rapidly reviewing and improving processes and for engaging staff in change work. However, considerable challenges were seen in applying measurement for improvement in the crisis context and respondents reported relatively little use of improvement approaches to engage patients.

2

Improvement took a distinct form in response to the crisis context, providing a profound opportunity to learn for the future. Our analysis shows that improvement during COVID-19 was organised around short-term goals, with methods used flexibly and sometimes in a partial way. How individuals drew on their improvement expertise and mindsets to apply key principles was valued more than specific technical or rigid improvement methods. While this approach allowed improvers to work responsively to support teams to achieve improvement goals at pace, some respondents raised concerns about the longer-term sustainability and effectiveness of the changes made.

3

Our findings suggest that **improvement played a more important, valuable, and strategic role during COVID-19 in organisations that had a well-developed approach to improvement pre-pandemic**. Those with better developed individual and organisational improvement 'muscles' were able to use their skills with greater rigour and intentionality in the crisis context and are now in a stronger position to build on positive changes made.

Recommendations for action

1

Improvers and those who support them **should build on the positive momentum from the pandemic and ensure that improvement plays a central role in the recovery**. In particular, the power of improvement to engage a wide range of staff perspectives, to enable collaboration and to ensure buy-in for change will be critical. Organisational and system leaders must ensure that they continue to provide an enabling context through empowering leadership, resources and a commitment to building improvement capabilities and positive cultures for the long term.

2

Improvers locally and nationally should **reflect on which ways of working and specific solutions developed during the pandemic should continue**. This should seek to balance the benefits of the more accessible and flexible approaches that were appropriate in a crisis context with the need for sufficient rigour, for example in measurement and patient involvement, to underpin effective long-term change.

3

During the next phase of the pandemic, **improvement needs to be embedded in core ongoing work in ways that are relevant and accessible to those on the front line**. This can be achieved by simplifying language and consolidating methods, and by more intentionally adapting improvement approaches to fit existing organisational constraints. Improvers should also **galvanise their efforts around shared system priorities** for the next phase of pandemic recovery and longer-term service transformation.

Introduction

COVID-19 has precipitated unprecedented changes in service delivery and ways of working across health and care. From the start of the pandemic, competing narratives emerged about the role of improvement in these changes. Some suggested it was improvement's moment to come to the fore whereas others reflected that certain core elements of improvement were being bypassed.[1,2,3] To understand the role of improvement in more detail – and to ensure that individual improvers and those supporting them learn the right lessons for the future – we undertook an online survey and in-depth interviews to explore Q members'* experiences.

Existing research on improvement highlights the important interplay between context, culture and skills,[4,5] and the wide-ranging capabilities needed to undertake improvement successfully.[6] Our work sought to explore: the effect of the crisis context on these factors; which features of improvement or skills were most useful and why; and to highlight learning for the practice of improvement or the system conditions in which it can thrive.

In section 1, we outline the overall role of improvement, how it was used specifically to support change during COVID-19 and the key enablers and barriers that underpinned its use. Section 2 considers how we can interpret these more specific findings to ensure we learn and apply the right lessons in the future.

*Q members are diverse and include people with specialist improvement roles or interest working in NHS organisations at all levels, in acute hospitals, mental health and community settings, as well as third sector organisations, private companies and as patient representatives.

Method

An online questionnaire (using Qualtrics) was emailed to all Q members (3,880) between August and September 2020. It included a combination of 29 closed and free text questions, receiving 225 analysable responses. Respondents were broadly representative of Q membership overall in terms of primary role type, organisation type and country of the UK and Ireland. Quantitative analysis was undertaken using R and qualitative analysis was undertaken through developing inductive codes and applying thematic analysis directly in Excel and Word.

We published a working paper[7] in November 2020, to test the emerging findings with Q members and partners. To explore individual experiences and explore the emerging findings in more detail, 12 semi-structured depth interviews were conducted in November and December 2020 with a sample of respondents. The interviews were conducted by one of a panel of seven Q members and Health Foundation staff, transcribed and analysed collaboratively.

Limitations include the relatively low number of responses to the questionnaire and requests for follow up interviews, which restricted our analysis by different groups of respondents. There is also the possibility of a non-response bias with more engaged members likely to be over-represented. In order to include a wide range of experiences, 'improvement' was treated as encompassing 'tools, methods, approaches and mindsets'. At times, this broad framing surfaced some ambiguities due to different interpretations.

Definition

'Quality improvement' or health and care 'improvement' mean different things to different people. We use 'improvement' to describe a systematic approach that uses specific tools and techniques to improve quality, experience and outcomes.[8] For ease of expression, the term 'improvement' is used as shorthand for this broad definition throughout this paper although it is stated if a particular aspect of improvement is being referred to. In this paper we also use the term 'improvement mindset' which describes an approach or way of working and thinking, that builds on improvement skills and training, to shape how people respond to specific challenges.

1 Findings and analysis

This section summarises what we heard from respondents about the role of improvement during the initial response to the pandemic, how it was used, and the key enablers and barriers.

Key findings

Improvement played an important role for respondents during COVID-19.

Improvement took a distinct form in response to the crisis context, providing a profound opportunity to learn for the future.

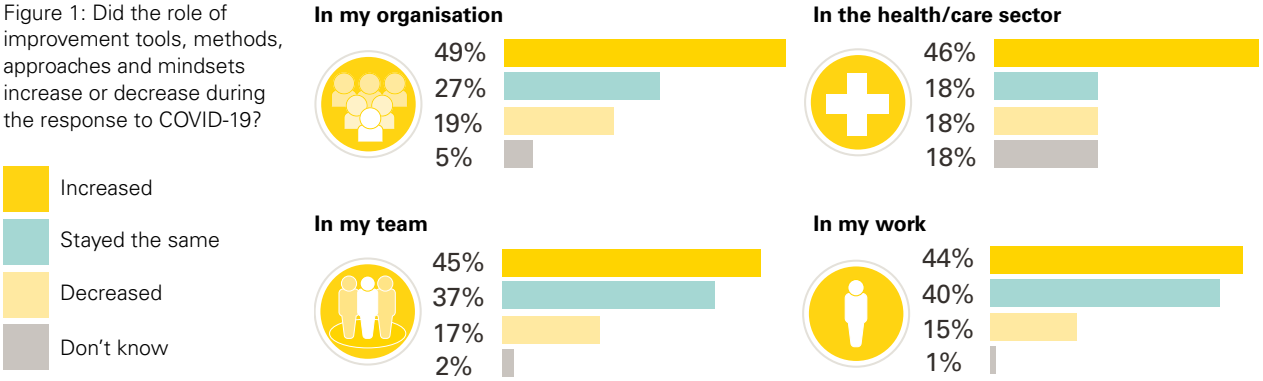
Improvement played a more important, valuable, and strategic role during COVID-19 in organisations that had a well-developed approach to improvement pre-pandemic.

The role of improvement

Our survey analysis found that half (51%) of respondents felt that improvement had been very important in health and care generally during COVID-19, with 82% feeling it had been moderately or very important.

Figure 1 shows that more respondents said that the role of improvement had increased during the response to COVID-19 than said it had decreased or stayed the same.

Figure 1: Did the role of improvement tools, methods, approaches and mindsets increase or decrease during the response to COVID-19?



The interviews revealed the variation in experiences this encompasses, which is influenced by the individual's role and the context within which they were operating. The interviews showed that when existing improvement activity (strategic improvement programmes, projects and training) stopped so that resource could be redirected to different aspects of the pandemic response, many improvement staff were redeployed or reallocated. For some, this meant they lost key 'improvement allies' across the organisation to support their activity; and importantly, it was perceived to send a message that improvement wasn't important:

"I'm a quality improvement nurse, but […] you're valued more for your hands than you are for your quality improvement expertise"

(Interviewee)

"When COVID hit, they said, 'QI stop, everything stop.' […] There's a little bit of that at board level where you just think QI is seen as a sort of luxury where we can put a few people in post to say we're doing it. It's a luxury that can be stopped if there's something more important, which strikes me that therefore we haven't got complete buy-in".

(Interviewee)

For others, the importance of improvement was felt in how they were individually able to apply their improvement capabilities in redeployed or changed roles. This was founded on a personal motivation and mindset to apply improvement in all their work, combined with individual and organisational recognition of the value of these approaches to the rapid changes occurring. As will be discussed in more detail later, existing organisational improvement capability, the respondents' position in the hierarchy or autonomy to act, and supportive leadership are important factors that facilitated this individual response.

"[When COVID-19 hit all our big-ticket improvement activities stopped] So, what we're really trying to do is be as bloody helpful as we possibly can which is why we ended up with QI teams running silvers [commands] so that the leadership of those other care orgs who don't really know us, get to know us as capable and useful people."

(Interviewee)

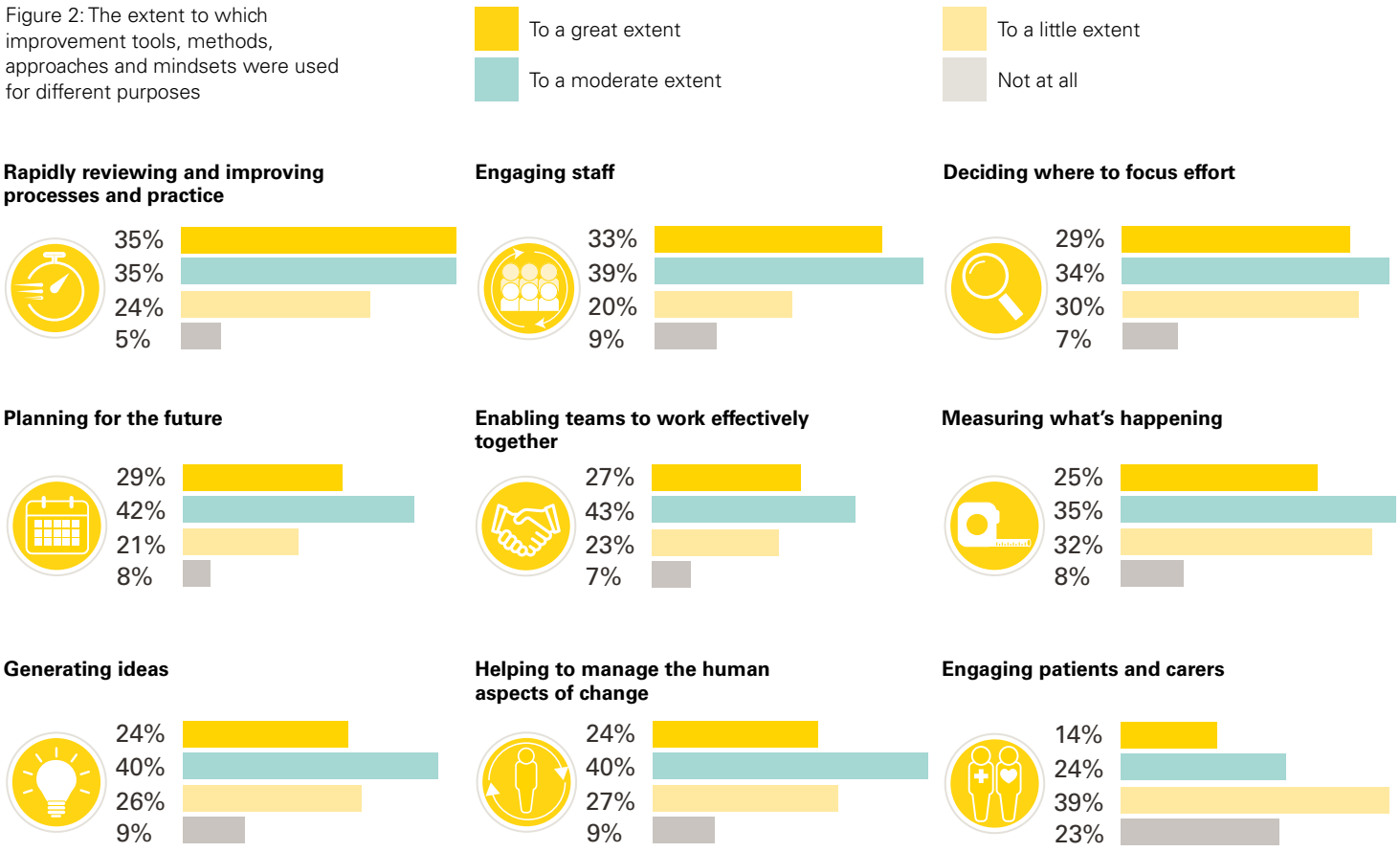
"People have taken their skills and those principles and used them to address the challenges that are in front of them and done that well. […] We used our improvement skills to do different things, and not the things that this time last year we expected to have been using our skills to improve."

(Interviewee)

How improvement was used

As can be seen from Figure 2, improvement tools, methods, approaches, and mindsets were used to meet a wide range of purposes.

Figure 2: The extent to which improvement tools, methods, approaches and mindsets were used for different purposes



The following four areas stood out from respondents' experiences.

1. Rapid review and process improvements

Perhaps unsurprisingly given the extent of the rapid changes the pandemic prompted, improvement was used extensively for rapidly reviewing and improving processes and practice (70% to a great or moderate extent). The Model for Improvement[9], specifically PDSA cycles, was the most cited tool for this. Their simplicity was valued, with one respondent describing the method as 'easy to adapt and use during COVID'. However, others discussed how PDSAs were applied incompletely with some stages missing due to the pace of change and access to, or availability of,

data. Although some pre-existing evidence[10] suggests that even before COVID-19, PDSAs were often applied in an oversimplified way, many respondents felt that this had increasingly become the case during the pandemic response.

"The way that my brain works, is [to follow a PDSA cycle]. So, we, kind of, went from P [to] A, you know, we planned and acted, but what we couldn't do is study in the middle."

(Interviewee)

The interviews draw out that for many, even if the improvement tools and methods were not always applied completely, there was value in how they provide a systematic structure to work rapidly and engage others.

"The big challenges to the programmatic work […] was the fact that, you know, no-one's in their regular role. […] However, people have taken their skills and those principles and used them to address the challenges that are in front of them, and done that well."

(Interviewee)

2. Engaging staff

Respondents also frequently used improvement for engaging staff (72% to a great or moderate extent). They stressed the importance of this application to support change at speed and engage those who were required to deliver change as quickly and substantially as possible. Tools that supported staff resilience, psychological safety, rapidly adapting ways of working and responding to change, were seen as particularly useful.

"We experimented with a whole range of different approaches that brought structure, energy and intention to [daily] team briefing spaces. So, gradually, looking at getting that better and better, so that the team is checking in for half an hour a day, but that time is really productively used, and people leave with a sense of energy and joy."

(Interviewee)

"One of the really valuable things that QI does is give people the energy and the validation to say, "I hear you when you say it's not as good as it could be and I'm listening to you when you tell me what you think might be helpful to change".

(Interviewee)

3. Measuring change

The majority of respondents (60% to a great or moderate extent) used improvement to measure what was happening. As much statutory reporting had been put on hold, this presented an opportunity for some to focus their efforts on gathering useful and meaningful qualitative data to support in-service changes. However, respondents highlighted many challenges to effective measurement for improvement. Some of these challenges existed before the pandemic – such as too much focus on data for compliance rather than improvement – but the crisis inevitably exacerbated others. This included: difficulties in systematically measuring variation due to the unpredictability and lack of control over variables in a chaotic crisis context; a short-term focus on rapid changes needed rather than longer-term outcomes; limited access to data, and restricted staff time available to collect or analyse data.

> *"The focus is just on getting this 'done' rather than systematically planning change and measuring the difference."*
>
> (Survey respondent)

4. Engaging patients and carers

Improvement was less frequently used for engaging patients and carers – with less than two-fifths (38%) using it for this purpose to a great or moderate extent. Some positive examples of remote engagement with patients and carers were offered by respondents. Yet it was clear that this element of improvement was often missing, which respondents suggested was due to the required speed of change, the dependence on tools that had been designed for face-to-face engagement and a lack of commitment for this as essential. For one interviewee, the decision to stop requiring patient experience data was seen as emblematic of a lack of commitment to engaging patients, carers and the public at this time:

> *"The NHS wants to be person-centred. To do that, you have to understand patient experience, but right at the moment when we had the biggest public health crisis for a century, […], the NHS, NHS England said, 'Okay, folks. We don't need to collect data on patient experience anymore.' […] That just seemed like, 'Hang on, isn't this the very moment when we do need to hear from patients and the public' because understanding their experience of this whole thing is vital to how we [develop a response]."*
>
> (Interviewee)

Factors that enabled or inhibited improvement

The questionnaire responses and interviews showed that there were a range of enabling and inhibiting factors that shaped the success of improvement efforts across different contexts.

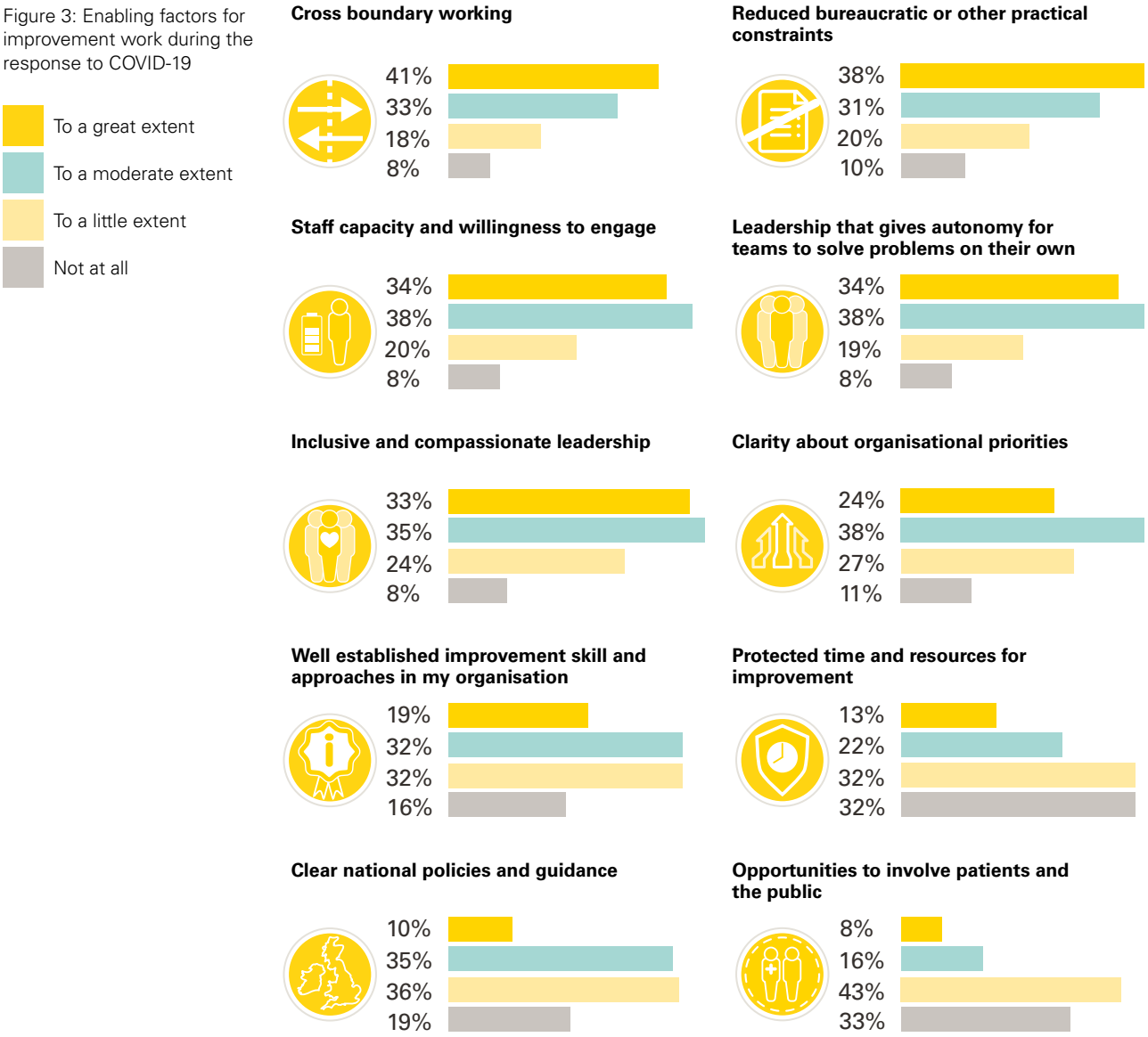
1. Remote working

There were competing perspectives around the potential for digital and remote adaptations of improvement tools. Some respondents reflected that remote working was a barrier to improvement and felt that it was 'second best' to face-to-face engagement. Others felt that it could be as good as, or better than, face-to-face in the longer term as it removed geographical boundaries and allowed for more flexible engagement. Indeed, some respondents had successfully adapted tools such as Liberating Structures[11] and huddles to work remotely during COVID-19, and some of this work was done pre-pandemic. For this to be more widespread and to enable all improvers to capture this potential, improvement tools will require further adaptation, and this needs investment in both platforms and staff training.

2. Fidelity to tools and processes

Overall, many respondents described how improvement took on a distinct form during the COVID-19 response: characterised by short-term goals and reactive or opportunistic activity. Improvement tools and methods were often used with flexibility and sometimes applied in a limited or partial way. Some found this flexibility helpful to achieve improvement goals at pace and to diffuse improvement concepts across the organisation. Others questioned if this may undermine the longer-term sustainability of the changes made.

Figure 3: Enabling factors for improvement work during the response to COVID-19



3. Leadership

As can be seen in Figure 3, leadership emerged as an important enabler of improvement during the pandemic, either by providing autonomy to teams (72% to a great or moderate extent), or by being inclusive and compassionate (68% to a great or moderate extent). The experiences of respondents resonate with the characterisation made in wider Health Foundation work[2] of 'top-down clarity and bottom-up agency' (p7).
The enabling role of leadership should be considered alongside other factors prompted by the urgency of the crisis response, such as reduced bureaucratic constraints, quicker decision making, fewer financial and procurement hurdles, clarity of purpose and shared priorities. As one of our survey respondents described, there was "permission to try new things rapidly without having perfected the approach."

In contrast, those who had faced greater challenge in drawing on elements of improvement often described a 'command and control' style leadership in their organisation. The interviews illustrate that 'command and control' was not always thought to be the wrong approach, given the pace of change that was needed. The challenge was the extent and length at which it had been in place and the effect it has had in stifling improvement cultures. For individual improvers, the effect of this was felt differently depending on where they sat in the organisational hierarchy.

"There were lots of, kind of, political things in play that dictated what I could do on the [testing] sites. So, I couldn't, kind of, then say, 'Well, actually, to improve our testing rates, I can do this, this, this and this.'"

(Interviewee)

Despite the survey results supporting the wider positive narrative of the emergence of more enabling leadership during COVID-19,[1,2] the results also make clear that there were many examples where this was not the case. More constraining forms of leadership persisted in some contexts and, in some cases, were intensified.

"We were just building confidence in some parts of an organisation that had struggled for years and then we went straight back to command and control. […] It's bad for the psychological safety of the people on the shop floor."

(Interviewee)

4. Pre-existing level of improvement

As well as the broader enabling conditions described in Figure 3, improvement appears to have played a more important, valuable and strategic role for those respondents who said their organisation had a well-developed approach to improvement pre-pandemic. Firstly, these respondents were more likely to have used improvement tools to plan for the future and decide where to focus efforts. Secondly, they were more likely to report using it for staff engagement and to enable their teams to work effectively together. Finally, they were also more likely to agree that they had been able to make use of their personal capabilities, and that their team had applied a systematic approach.

"I think the organisation has put some really good improvement structures in which are now, sort of, in the bricks, and has been able to feel confident to change those or adapt those for the situation and the crisis that they find themselves in."

(Interviewee)

"The manager of the site tasked me and a couple of others, very early on actually, to somehow catalogue what was happening. […] I, with the help of our QI infrastructure, pulled together a team to do that […] so that was reusing the QI crew in a different way."

(Interviewee)

The experience of interviewees suggests that this capability alongside leadership support meant it was easier for improvement teams to pay at least some attention to the sustainability of changes and longer-term improvement goals, in addition to, or rather than solely delivering short-term, reactive changes. Interviewees' experiences also suggested that this may make it easier to restart paused improvement activity – even if it is initially limited.

"So it is much more rapid improvement than we have done, than was previous. At the same time, we're trying to keep an eye on medium and long-term goals of improvement around building capacity and capability […] Our job is not a rapid response team. We're having to be a rapid response team but our job is also to build capacity and capability and confidence in the system."

(Interviewee)

2

Learning the right lessons

The section considers how we can interpret these findings to ensure we learn and apply the right lessons in the future. We reflect on the findings through the lens of a 'crisis standard' of improvement, and the analogy of an improvement 'muscle'. We also make recommendations for how to meet the future priorities for, and challenges facing, health care.

Recommendations for action

Improvers should build on the positive momentum from the pandemic and ensure that improvement plays a central role in the recovery.

Improvers should reflect on which ways of working and specific solutions developed during the pandemic should continue.

Improvement needs to be embedded in core ongoing work in ways that are relevant and accessible to those on the front line. Improvers should also galvanise their efforts around shared system priorities.

Was an effective 'crisis standard of improvement' applied?

Drawing inspiration from Fitzsimons' call for quality improvement to contribute to adopting a crisis standard of care during COVID-19[12], we explored whether our respondents had applied a 'crisis standard' of improvement. The crisis standard of care can be a divisive concept for clinicians, and no respondents described explicitly applying 'a crisis standard'. However, we believe that using this framing can help inform our assessment of what 'good' improvement during a crisis is. By integrating the crisis constraints into our judgements – such as the speed of change, the high level of uncertainty and remote working – it allowed us to make a more sophisticated assessment of different forms of improvement during the crisis.

This framing acknowledges that, although the partial and limited application of different forms of improvement may have represented good practice given constraints during the pandemic, this does not necessarily mean it is something to aspire to outside of the crisis response. Furthermore, this framing can help us to learn from those who applied a more effective 'crisis standard' than others. The responses draw attention to three areas in particular:

- Given the crisis context, some approaches to measurement for improvement – such as capturing long-term outcomes – were simply not possible. However, some respondents described substantial and systematic measurement of engagement, service quality and staff feedback.
- Similarly, patient and public engagement was relatively low during COVID and some clearly felt that meaningful participation was just not possible. Yet others innovatively and proactively engaged patients and adapted their tools, achieving a higher 'crisis standard' of patient and public involvement in improvement.
- Finally, the responses leave an open question as to what the most effective 'crisis standard' of the Model for Improvement was and the implications for sustainable change. As previously stated, some applied the model very flexibly and successfully to their COVID-response work, whereas others felt that if the application becomes too partial and limited then the value is lost – a concern that is supported by existing evidence.[10]

Were improvement methods, mindsets or 'muscles' more important?

In our analysis, we also explored the importance of how people applied formal improvement tools and methods compared to broader improvement approaches and mindsets. As has been discussed, some respondents drew heavily and successfully on specific improvement tools. However, the dominant view amongst respondents was that broader improvement mindsets and principles were most important in supporting positive change. Indeed, some felt that more technical, rigid, and niche improvement methods were not useful at all during COVID-19.

In attempting to understand the findings around the methods-mindset tension, and to integrate the earlier findings on the importance of a well-developed approach to improvement pre-pandemic, we argue that it is also useful to frame improvement as functioning like a 'muscle'. As survey respondents said:

> *"what was encouraging was that you could observe methodologies being used, almost as a heuristic, rather than through any planned desire to follow a strict methodology."*
>
> *"there simply wasn't time to devote to ensuring accurate measurement or implementation or even plan - but it was as if muscle memory kicked in for a lot of the team."*

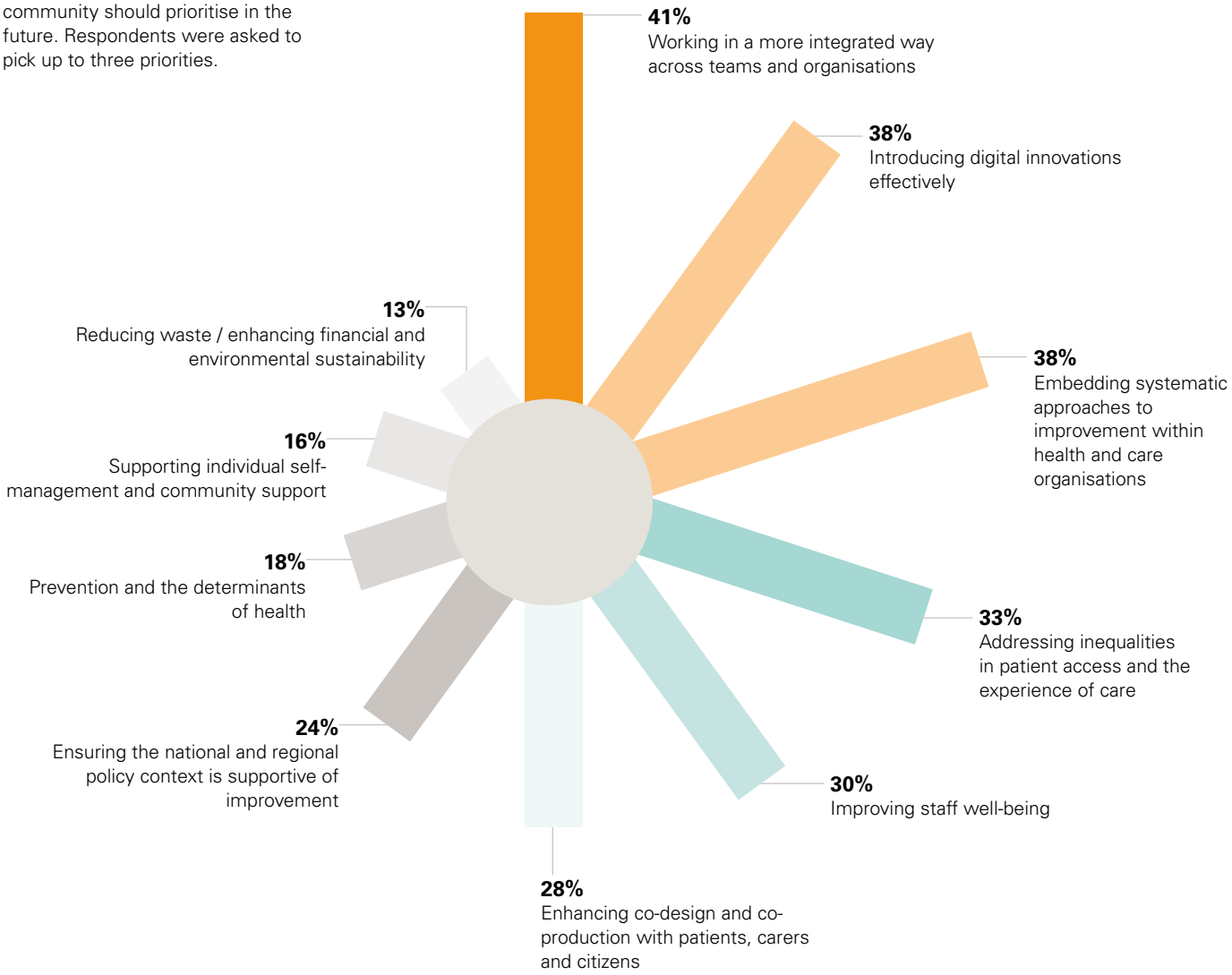
This framing can help us learn the right lessons from the pandemic as it highlights the benefits of building improvement capabilities of people at all levels of the system. By investing in and supporting people to learn and be able to apply improvement tools and methods in practice, it builds the improvement 'muscle' that can then be flexed more easily and with more suppleness to respond to different contexts – both in the COVID-19 crisis and in the longer term.

Future priorities for improving health and care

Supporting wider emerging evidence on the importance of shared purpose to achieving positive change during the pandemic,[2,1] our analysis draws attention to the need for improvement to actively contribute to mainstream system priorities during the recovery.

When asked specifically what future system priorities the improvement community should contribute to, survey respondents picked out working in a more integrated way across teams and organisations (41%), introducing digital innovations effectively (38%) and embedding systematic approaches to improvement within health and care organisations (38%) as the top three (Figure 4).

Figure 4: Issues that the improvement community should prioritise in the future. Respondents were asked to pick up to three priorities.



Upcoming challenges for improvement practice

The responses also provided rich insights around future challenges to the practice of improvement and its role in supporting the health and care system's recovery over the next 12 months and beyond. Some of the challenges pre-date the pandemic, whereas others have taken on a new colour and prominence during COVID-19. Focusing on five areas over the months ahead is likely to be important in securing the greatest long-term impact and benefit from improvement activity.

1. Re-establishing measurement rigour

Some concerns were raised that certain measurements may no longer be valid given the changed context: data may not be available or data may provide a skewed picture because the changes are related to COVID-19 or the different social context. This makes the job of improvers – to question and challenge whether change is an improvement, and advocate for evidence-based decision-making – much harder. As one interviewee reflected:

"It's, sort of, fallen back on anecdotes again. Where the data is not underpinning, then you're just back into the workshop anecdote – 'Let me tell you about my anecdote' – there's an awful lot of that back again."

(Interviewee)

2. Supporting staff engagement and resilience

There are capacity challenges within improvement teams to pick up paused work alongside new programmes as well as the widespread challenge of staff engagement and enthusiasm after an extended period of relentless change and uncertainty. Improvers need to both wrestle with this reality and capture the opportunity for improvement to contribute positively to workforce and morale challenges through boosting staff engagement, resilience and wellbeing.

"One of the biggest challenges is resilience in the system. We put some things in really quickly. It would be really nice to learn about them but I think, because there is still more change, people don't have the resilience to look back. They don't have the resilience to learn because there's more change coming, more change coming."

(Interviewee)

3. Making improvement more accessible

The experiences we captured suggested that improvers need to be proactive to capture this profound moment of change to make improvement tools, methods and approaches more easily understood and applied. This means capitalising on the potential of digital: ensuring tools are fully adapted, that resources are devoted to technology and that staff capabilities in remote work are built. Responses also stressed the need to simplify the language of improvement and consolidate approaches that are more easily understood and applied – especially where there are multiple tools that may appear distinct but are, in fact, based on very similar fundamentals.[13]

4. Embedding improvement as mainstream activity

The experience of improvers who were able to use their skills and capabilities most effectively during COVID-19, highlights the benefits of embedding improvement at the core of health and care rather than operating on the fringes or being seen as non-essential. Respondents outlined that this should be underpinned by building improvement capabilities across teams; offering protected staff time; having improvement-friendly regulatory, governance and data systems; and having clear expectations around the role of improvement from leaders.

5. Fostering conditions for rapid change

To achieve this, leaders and decision-makers need to understand what conditions have made rapid change possible during COVID-19. While this is something that is being given attention at strategic level –for example by NHS England and NHS Improvement[14] – there were fears that these conditions were already regressing. Respondents cited the reintroduction of competitive models of operation at the expense of positive collaboration, the return of managerial approaches over enabling leadership, and a drying up of some of the financial and staff resources that have been made available as examples of this. Indeed, our work suggests that for many the nature of support for, and the context of, improvement has changed over the course of the pandemic. More work is needed to understand precisely how this played out and to continue to observe how these conditions shift throughout the next stages of the pandemic response and recovery.

> *"To build improvement capacity it needs to be integrated culturally and systematically. Needs to be a national mindset that improvement work is not an optional extra delivered by passionate staff in their own time but a core part of work."*
>
> (Survey respondent)

Conclusion

This report has explored the experiences of Q members to understand the role of improvement during COVID-19. It is crucial that the right lessons are learned from this moment of profound change.

We heard that improvement played an important role for a wide range of purposes but that it took a distinct form in the pandemic response, often organised around short-term goals and applied flexibly. We found that improvement played a more important and strategic role in organisations that had a well-developed approach to improvement pre-COVID-19.

As the next phase of the pandemic unfolds, there is positive momentum around improvement. Improvers and those who support them must build on it to ensure that improvement plays a central role in COVID-19 recovery and into the future, balancing the benefits of more accessible and flexible approaches with the rigour that is needed for long-term effectiveness and sustainability. This won't be possible without the key enablers of improvement that Q members identified through the pandemic response: empowering leadership, resources, capabilities, and positive cultures are all vital to making this a reality.

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About Q

Q is an initiative connecting people, who have improvement expertise, across the UK and Ireland. It is delivered by the Health Foundation and supported and co-funded by partners across the UK and Ireland.

Visit us online or follow us on Twitter (@theQcommunity).

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