

A practitioner's codebook for the quality journey

As we collated, read, fed back and shared the organizational stories we had been told (as summarized in Chapters 2 to 8), we began to realize that despite the huge variety of solutions and strategies that had been – and were continuing – to be implemented in the organizations we visited, there were common elements or themes emerging and repeating themselves. Through our familiarization with the stories it became increasingly clear – and intriguing – to us that these high-performing healthcare organizations had all encountered similar kinds of challenges when seeking to develop their improvement systems and processes.

Although not anticipated at the outset of this research, the idea of a set of common challenges with different solutions across several contexts is far from original. This finding is referred to across the social sciences as the ‘universal but variable’ thesis, which states that there are only ‘a limited number of basic human problems to which all people at all times and in all places must find a solution’,¹ but the number of possible solutions to them is almost unlimited – hence the co-existence of similarities (common problems) *and* differences (varied solutions) between all human systems, social or organizational.^{1,2} Such variations, in our case between healthcare QI processes, stem from the infinite number of ways in which people have sought to resolve these life or, as in our case, quality challenges or problems.

The remainder of this book takes this broad ‘universal but variable’ thesis as its organizer. With this in mind, our tasks in the next two chapters are to:

- identify for practitioners what the common core challenges and practical solutions are (or may be) for QI efforts in healthcare organizations generally (Chapter 9)
- explore in more detail the similarities and differences between our case study sites in terms of their varied efforts to solve each of these challenges (Chapter 10).

In the context of healthcare QI processes, and drawing on our real-life cases, we represent this thesis here as six common challenges that are problems to which any organization will need to find solutions that will work for them in their particular context, and that if they do not do so will ultimately lead to disappointment and failure in the quality

arena. Although these six challenges are broadly similar for all healthcare organizations, the possible solutions (or, more pertinently, as we shall show in Chapter 10, the possible *combinations* of solutions) are assumed to be practically innumerable.

Furthermore, what works for one organization may not work for another: San Diego Children's Hospital (Chapter 2) does not require a Cedars-Sinai (Chapter 4) or a Royal Devon and Exeter (Chapter 3) approach. Hence, the broad advice to any healthcare organization seeking to learn from the stories outlined in Chapters 2 to 8 is to:

- a. be aware that one needs to take up each and every one of these six organizational challenges (as did our case study sites), given that they are imperatives or 'must do's', not luxuries or add-ons to a QI effort
- b. find answers to each that fit locally and are contextually appropriate (find the right key for the right lock)
- c. build them into your ongoing organizational and service improvement processes.

Our overarching thesis is simply that 'successful' organizations (in terms of quality and performance generally) will be doing (a), (b) and (c), even if only implicitly. Conversely, we propose that low performers in terms of healthcare quality will be failing on one, some or all of these fronts, although this remains to be tested empirically.

The purposes of this chapter are therefore to help healthcare managers, practitioners and researchers to:

- understand these six common challenges that every healthcare organization will need to face up to if it is to successfully implement, spread and sustain quality and service improvement processes
- establish the extent to which their own organization has risen to and been able to meet these challenges
- leverage a model and a language that allows the complex and difficult developmental issues associated with these challenges to be thought about and debated, and effort and attention to be focused on where the 'gaps' lie and where QI interventions need to be targeted.

The six common challenges

The organizational stories recounted in Chapters 2 to 8 saw all of our organizations struggling to attend to and manage the same set of core challenges, and doing so by adopting and employing a wide range of different methods and approaches.

For example, the main theme of the Royal Devon and Exeter case revolved around organizational identity and pride, concepts closely tied to *cultural processes* within organizations. Yet cultural challenges and solutions were prominent across virtually all the cases, from a similar culture of excellence at Cedars-Sinai, to the culture of mindfulness discussed in the San Diego Children's Hospital chapter, and the development of group-oriented cultures at Peterborough. Similarly, the predominating theme of a distributed leadership system in the Reinier de Graff Groep case, and of intelligent socio-technical systems design in the Luther Midelfort case, each imply *structural processes* within organizations. The Peterborough case, with its emphasis on empowerment, drew attention to *political processes* within organizations. This theme of empowerment was also present at the Albany AIDS Treatment Center, while the issue of engaging clinicians in quality efforts, which involves deep political challenges particular to healthcare organizations, was a consistent theme across all of the cases. Likewise, the Cedars-Sinai case highlighted the need to link organizational *learning* to improvement,

as did San Diego and Royal Devon and Exeter, in the form of strong mentoring by micro-system leaders, and Luther Midelfort, which dedicated 'slack' resources to support QI training and 'knowledge harvesting' from other organizations.

The Albany case was unique in its emphasis on mobilizing processes that tap into the commitments and passions of individuals at an *emotional* level. However, other cases, each in their own way, also addressed emotional processes inherent in the quality journey in the form of generating collective momentum for the quality agenda (*see*, for example, the Peterborough case) and seeking to 'move' people by inspirational leadership (for example, the San Diego case).

Finally, there were numerous references to the design and use of both *physical and technological* infrastructure throughout the narratives, including such issues as the placement of facilities and organizational units (e.g. Royal Devon and Exeter, Luther Midelfort), different roles for information technology in the improvement process (Cedars-Sinai, Peterborough), and the aesthetics of the built environment (*see*, especially, the San Diego case).

Previous studies of the quality journeys of healthcare organizations (e.g. Øvretveit and Aslaksen³) have mirrored our case-based approach but have not sought to explicitly draw out such commonalities and differences across the organizations under study. With this in mind, and driven by a desire to rise above the idiosyncrasies of each case and at the same time leave our readers with something practical, we revisited the organizational narratives and were able to pull out the six universal challenges, which in turn became the organizer for the specific sub-themes or elements that we identified in our repeated readings of the cases and which now provide the spine of the quality codebook that follows.

We have already stated the six challenges in our opening chapter:

1. **structural** – the whole challenge around structuring, planning and co-ordinating quality efforts
2. **political** – the challenge of addressing the politics and negotiating the buy-in, conflict and relationships of change surrounding any QI effort
3. **cultural** – the challenge of giving 'quality' a shared, collective meaning, value and significance within the organization
4. **educational** – the challenge of creating and nurturing a learning process that supports continuous improvement
5. **emotional** – the challenge of inspiring, energizing, and mobilizing people for the QI effort
6. **physical and technological** – the challenge of designing physical systems and technological infrastructures that support improvement and quality of care.

As already stated, every organization in our research has, to varying degrees, found different ways of meeting these challenges, reinforcing the point that there is no one best way of reaching one's goal. Because local conditions and contexts vary so much, particular solutions also need to vary, and therefore need to be locally cultivated, home-grown and situation-specific. In this sense it is better to assume that 'solutions' travel poorly and cannot simply be copied or co-opted from elsewhere. Furthermore, most or all of the case studies describe key interactions and pressures with parties or influences external to their organization, hence the need to factor in the effect of the wider institutional and social environment. Without this 'contextualist'^{2,4,5} and 'institutionalist'⁶⁻⁹ framework, any attempt at making sense of the stories would risk overlooking or misattributing critical sources of organizational behavior and change.

It is not always a case of there being a difficult or hostile environment to manage.

External conditions can be enabling too, echoing the related notions of ‘structural conduciveness’¹⁰ and ‘opportunity structures’¹¹ in social movement theory, and ‘receptive context’ in organizational theory.¹² For example, the US Institute of Medicine reports *To Err is Human*¹³ and *Crossing the Quality Chasm*¹⁴ both gave a terrific boost to Cedar-Sinai’s internal improvement efforts (Chapter 4), as did the IHI Pursuing Perfection initiative in RD&E and Reinier de Graaf (Chapters 3 and 5). The explicit inclusion of external contextual factors in our framework stems from the importance these were given in the cases as sources of knowledge, as well as influences and impetus in reinforcing (or detracting from) the development of an organization’s quality agenda and journey. In many of the cases the internal–external divide was also an important locus of boundary-spanning activities (as described, for example, in the Luther Midelfort case study in Chapter 6). One of the particular strengths of the case study approach is its ability to show *how* these internal–external dynamics play out around QI in healthcare.

A ‘color-codebook’ for quality and service improvement

The six challenges described above are depicted by the large circles in Figure 9.1 (see color plate section), along with the major categories of contextual influences (from within and outside the organization), as shown at the top of the figure.

For ease of use as a diagnostic tool and heuristic (aid to thinking), we have translated the six common challenges into a color-coded schema, allocating a different color to each of the core challenges. We have found the color code to be a simple and readily accessible way for people to think and talk about complex issues in the change/improvement domain. There is nothing particularly new or original in this idea, since our use of colors as a visual metaphor is merely an adaptation and extension of Vermaak and de Caluwé’s ‘color-code for change’.¹⁵

In our view, the color code they developed for organizational development efforts can apply equally to quality and improvement efforts (themselves a form of organizational development). In our own color code, the blue, yellow and green remain broadly the same in concept as in Vermaak and de Caluwé’s scheme (namely, concerned with structure, politics and learning respectively). Based on our data, however, red has been changed from a human resources to a cultural perspective, defined as the need to create strong collective ideas and values around QI such that the meaning and identification with quality efforts are system-wide and part of the working ethos of the organization. We have also amended white, based on two of the current authors’ related social movements work,¹⁶ to indicate the ‘white heat’ and energy of a truly mobilized organization (everyone behind the quality ‘cause’), and have introduced the new color, pink, to represent the ‘flesh’ of organizational systems and infrastructures for improvement. Finally, we have also added in codes for the wider ‘inner’ (organizational) and ‘outer’ (external) context using the (admittedly less suggestive) colors of grey and black, respectively, to draw attention to the influence of environmental conditions on successful QI efforts (as discussed above).

Each of the six main ‘process’ colors was chosen to evoke the essence or fundamental nature of the challenge with which it is associated, as follows.

Blue

Blue (*structural* challenges) represents the cold, hard steel of structural and strategic support for the QI effort, acting like the metal hoops around the barrel to pull the various quality activities together. This first challenge encompasses – among many

other issues, as listed in the codebook at the end of this chapter – the establishment of quality systems, structures and roles, data and monitoring systems, and QI training programs, as well as the issue of strategic leadership for QI. This is illustrated by the following quotation from one of our case study organizations:

... going into next year, we have five strategic goals in this organization and one of them is about quality and safety. That's going to be on everybody's plate next year and that's a long way from a decade ago when we were looking at finances as number one. So, it's sort of setting the institutional priorities for quality and safety, and then asking what's going to happen in any particular neighbourhood in the institution.

Examples of 'blue' solutions from our case study organizations would include the development and organization-wide implementation of integrated care pathways at San Diego Children's (Chapter 2), the work of the central transformation team at Peterborough (Chapter 7) and the elaborate QI structure (or 'wiring diagram') that has evolved at Cedars-Sinai (Chapter 4).

Yellow

Yellow (challenges relating to the *power and politics* of organization) represents the frictional 'heat' of politics and the search for common ground between stakeholders, and sufficient appeal to their 'what's in it for me', to get them lining up behind the quality endeavour. In this regard, Kelman suggests that:

... rather than saying that 'people resist change' ... it is more appropriate to see initiation of a change process as setting in motion a political struggle inside the organization.¹⁷

Or as Stensaker and Langley put it, 'power and politics ... are simply an integral part of organizational reality necessarily affecting all associated with organizational change'.¹⁸ We would extend this to QI efforts, which are after all one type of change. Or, as one of our interviewees at RD&E (Chapter 3) suggested:

We've got to open the doors and we've actually got to listen – we may not agree but if somebody wants something, think of what you want to do and then see if you can hang it on their hook and then you can move forward. But let's start learning how to play politics – because if we don't all we do is damage our service.

This second challenge includes issues of clinical engagement, staff and patient empowerment, and partnership working with external stakeholders, with Bill's parties with key primary care stakeholders, as described in the Peterborough case study (Chapter 7), being a good example of a solution to the latter.

Red

Red (*cultural* challenges relating to creating a shared mindset or ethos around quality) stands for the blood or viscera of the organization: 'the way we do things around here', 'the pattern of basic assumptions', the organization as a social construction; in short, the culture of the organization.¹⁹ Culture is important to all aspects of the QI process, but particularly to the sustainability ('making it stick') aspect, 'anchoring' and 'fixing' the change – as it needs to do – in new 'habits of thinking'²⁰ and new patterns of behavior:

In large-scale change efforts, we use the power of culture to help make a transformation stick ... For our purposes here it means the norms of behavior and the shared values in a group of people. It's a set of common feelings about what is of value and how we should

act. A good test of whether something is embedded in a culture is if our peers, without really thinking, find ways to nudge us back to group norms when we go astray. The keys are *peers* – that is, a group activity – and *not really thinking*, which means behavior with roots deeper than rational thought.²¹

We have seen red at work in so many of our case study organizations, making quality more than just another project or goal, but a deeply embedded ideal, even mission, that is collectively valued and supported; not something that is enforced top down, but reinforced in peer-to-peer interactions and everyday, taken-for-granted behavior. Examples include the way quality was embedded in both the professional and corporate cultures of RD&E (Chapter 3), and the philosophies underlying the physician compacts at Luther Midelfort (Chapter 6) and Cedars-Sinai (Chapter 4).

Similarly, Weick introduced the idea that sustainability in an organization is essentially a social accomplishment, incorporated in the binding commitments that people make to each other in relation to a particular enacted change or innovation.²⁴ As the following quotation from one of our interviewees at Cedars-Sinai (Chapter 4) suggests, healthcare organizations that have successfully embedded QI in their culture may ‘feel’ very different from those that have not:

When I look back at some of the other hospitals I worked at . . . [they] were hospitals that were to some degree really proactive in their quality programs, or were interested . . . but their priorities were different. They say they have their structures, they have the corporate quality person and then they also have to ensure that everything is in place, but they weren’t building the culture, they were building the structure for it but it wasn’t really embodiment or belief in that philosophy.

Green

Green represents *growth and learning*. This fourth universal challenge is all about how one begins to accumulate and pass on the knowledge and lessons about quality from generation to generation: in the jargon, how does one build a learning organization around one’s QI and service improvement endeavours? Perhaps the clearest example of this from our case studies was the formal knowledge management system that had been established at Cedars-Sinai (Chapter 4). This overlaps to some extent with the blue structural challenge described above (around co-ordinating the QI effort) and we shall come to the interactions between the six challenges in Chapter 10. For the moment, this specific challenge asks: what will test people, what will develop them and what will stretch them to higher things (the notion of continuous improvement)? Importantly, like red, overcoming this challenge can be seen as a key stage towards sustainability (something of the holy grail of healthcare improvement). As Oliver Wendell Holmes the younger said, ‘Man’s mind, once stretched by a new idea, never regains its original dimensions.’

Learning about new approaches to QI, albeit one small part of the learning and development process, featured strongly in all of our case study sites:

All of us have come back from different meetings, have seen things, have reviewed things, or we see things in the literature, and we think, ‘Boy, this will be a great idea,’ and we put together a team and say, ‘Here’s something we’ve seen, let’s explore it, let’s examine it, and let’s figure out how to make it fit our organization.’

Other green issues – beyond learning about formal QI approaches – include knowledge harvesting (witness the specific boundary-spanning role created for this purpose at Luther Midelfort, in Chapter 6), experimentation and piloting, and leaders who take

on a mentorship role to encourage reflective practice and personal development (as we saw in the micro-systems in our San Diego Children's and Peterborough case studies, see Chapters 2 and 7 respectively).

White

White stands for the white heat of *emotion and mobilization*, the energy that is needed behind a quality and service improvement effort to get it going and then to keep it going. This is Kelman's notion of unleashing the passion and energy for change and improvement.¹⁷ Similarly, the stories we were told were not about improvement programs or targets, but simply about exciting people and making quality something that had to be done:

We started rolling these concepts out . . . engaging people in the decision-making process . . . We found a huge number of people at the frontline who said, 'Yes, that's what we should do.' It resonated with them, they were prepared to adopt it, they were very excited about it, they saw the connection with what we had explicitly said was our mission and they felt it was very important.

White is what changes an improvement 'effort' into a 'burning wish', or even a 'cause', and a quality program into a 'movement for improvement', terms that were actually used by some of our case study sites (in particular, Albany in Chapter 8) to describe that special something in change and improvement processes where they acquire a life of their own, and an unstoppable forward momentum.²²

Pink

Finally, pink is symbolic of the *flesh* of the organization, the physical and technical infrastructure that is needed to regularize quality and deliver it on a routine, everyday basis: 'tangible improvements to the estate and environment which just means that it is a different hospital to visit now than it was 10 years ago'.

This was not something we had anticipated would end up with its own color, nor is there any mention of it in Vermaak and Caluwé's original color-code for change. However, it became clear very early on how important a role physical environment (both functionally and aesthetically) and technical infrastructure (including IT systems) play in an organization's improvement journey, and how necessary it therefore is to have this challenge represented in the codebook.

Different failures of QI efforts

Before detailing these six challenges we invite readers to speculate on the flipside to all this: the implications of *not* responding to any one of these listed challenges. The main point here is to recognize that different kinds of failure are associated with each of the six challenges. Which is to say, improvement efforts do not just fail or succeed; they can fail or underachieve in many different ways. Hence, we wish to propose that if there is no effective:

- structural process (blue), the result will be *fragmentation* and a general lack of synergy and joined-upness between the different parts of the organization doing QI (reminiscent of the 'Six West problem' described in Chapter 1)
- political process (yellow), the result will be *disillusionment*, because QI is just not happening on the ground and because individuals and groups are blocking and resisting change; the failure scenario here is that the change process has become stymied or gridlocked as the result of the 'impossible politics' being played out in the organization, and people simply give up trying

- ❑ cultural process (red), the result will be *evaporation*, because the change has not properly anchored or become rooted in habitual everyday thinking and behavioral routines; this is highly reminiscent of program- or project-based approaches to QI, where the drive for quality lasts only as long as the flavour of the current program or project
- ❑ educational process (green), the result will be *amnesia or frustration*, as lessons and knowledge are forgotten or fail to accumulate (as in the notion of sedimentary learning), and improvement capabilities and skills fail to keep abreast of growing aspirations
- ❑ emotional process (white), the result will be *disinterest or fade-out*, as the change effort runs out of energy and forward movement; improvement theorists and practitioners like to talk about the accumulation of small steps or increments leading to final 'lift off' and transformation (think of a long-jumper running down the track to the board), but without the white, the effort is more likely to end up running into the sand than taking off
- ❑ physical, technological and systems design process (pink), the result will be *exhaustion*, as people run around trying to do it all by hand or word of mouth, not having the luxury of a system or standardized set of routines to take the weight of necessary everyday activities.

As noted above, participants in our case study organizations talked about the many and various solutions they had applied to these challenges at various points and stages on their quality journeys, and it is our contention that these solutions either helped them in a positive sense to meet the six core challenges, or in a negative sense to avoid the pitfalls associated with them that we have just described.

The codebook

Based on systematic review and coding of the cases, multiple illustrations of the different types of challenges and solutions were extracted from the individual case study narratives and assigned to the different colors. This is how the color codebook was born (*see* pages 177-85 below). In total, the codebook includes 56 such solutions spread across the six challenges, all derived ground-up from the cases themselves.

The codebook defines each of these solutions in turn, and Annex 1 illustrates how each may contribute to sustained quality and service improvement in the healthcare setting by drawing on quotations from the study participants (a sort of thesaurus or lexicon for the codebook). This 'quality thesaurus' needed to be included, first to support the codebook with real, empirical illustrations from the cases and to help readers with the definitions; but second because we considered it important to retain the words used by the participants themselves to define the various challenges and solutions, not to impose our own. Of course no single organization can be expected – or needs – to implement each and every one of the 56 'solutions'. Rather, the list of solutions is presented here to illustrate the whole range of responses made by high-performing healthcare organizations in our sample to the six common challenges we have identified.

Using the color codebook

We believe the codebook on pages 177-85 can serve a number of useful purposes, but let us begin by saying what it cannot do. It can tell organization members what the various challenges are and can illustrate the range of solutions, but, as we have insisted

all along, it cannot give them the 'correct' solution or answer – people still have to find these for themselves. Local context, whether it be cultural, structural or economic, is so unique and different as to require a properly tailored QI solution or set of solutions, and this can only mean that the QI system or process has to be home-grown, inside-out and bottom up, not appropriated or imported from elsewhere.

Wilkins made exactly the same point in relation to organizational culture when he observed, 'You cannot buy a distinctive organizational culture and you cannot copy it from someone else. You must grow it.'²³ The fact that our quality organizations did exactly this – that their process of selecting and constructing the solution was intelligent and effective – is the main point we want our readers to take away, even though there may be some initial disappointment that (unlike many of the best-selling business book authors) we cannot offer any universal plug-in or off-the-shelf solutions.

So, the codebook cannot be used prescriptively to come up with the right solution. Nor, for that matter, can it be used predictively to model the ideal theoretical solution. These limitations apart, we believe that it can help organizations to carry out an intelligent search for a solution by:

- providing a checklist of the areas and topics any QI effort will need to cover (a map of the terrain, including its main barriers and obstacles)
- giving improvement activists a way of charting where they and their organization are on their improvement journey, and a method for identifying any 'gaps' in their own QI activities that will need to be addressed (a self-administered diagnostic tool)
- allowing implicit assumptions about the theory and practice of QI to surface, and to be thought about, perhaps for the first time (a reflective model)
- providing people with a framework and language for talking about and debating the issues (a dialogical tool).

The codebook is mainly for practitioners, but QI theorists might also be able to use the tool to develop and then go out and test some of the sub-topics in the form of hypotheses – something we were not in a position to do at the start of our journey.

Leadership

At this point a few words about leadership and where it fits in to the overall scheme of things may be in order. We have so many wonderful examples of different kinds of leadership in our case studies, ranging from the distributed collective leadership system at Reinier de Graaf (Chapter 5), to the charismatic leadership of single individuals described at San Diego Children's Hospital (Chapter 2); the knowledge leadership at Cedars-Sinai (Chapter 4) and San Diego; as well as various forms of leadership at the micro-level, such as the mentoring leadership within the Asthma Clinic at San Diego and the Radiology Department at Peterborough (Chapter 7), the leadership-by-example and mobilization leadership of the medical director and administrator at Albany (Chapter 8), and the division of leadership between technical and political tasks in the Emergency Department at Cedars-Sinai.

Readers will notice that these different forms of leadership are provided as solutions throughout the six challenges contained in the codebook rather than leadership being represented as a challenge in its own right. While initially tempted to give leadership its own category – not least to underline its crucial importance in QI efforts – we finally decided against this on the grounds that leadership is not a challenge that can be separated from the other challenges but is integral to them. Blue (structuring) and pink (infrastructure), for example, call for leadership skills in design,²⁴ whether

this be organizational, software or facilities design; whereas yellow (politics) requires a conciliative, brokering form of leadership that is capable of ‘uniting the various parties in thought’.¹⁹ Different again, green (learning) requires leaders like the head of the Asthma Clinic at San Diego who, according to his staff, was mentor and teacher rolled into one. Red and white leaders also bring special and very different skills in engaging and mobilizing staff, and turning individual improvement enthusiasts into a community for improvement. In short, leadership, whether defined as a person or a process, is the means for delivering success on these challenges, not an abstract or independent challenge in its own right.

How to apply the codebook

A general word of warning about the use of the color codebook: the idea of a color code is attractive, but the ‘doing’ of effective QI is not the same as painting by numbers. In order to understand the interactions, timing and unfolding of these solutions in actual organizational settings and in real time, we strongly recommend that readers read this codebook in conjunction with both the companion case studies from which it was produced (Chapters 2 to 8), and with Chapter 10 in this book, which explores how the dynamic *interactions* between these solutions actively shaped the quality journeys in our case study organizations. Its proper place – and strength – therefore, is as a guide book to accompany fellow travelers on their quality journeys rather than a detailed do-it-yourself guide to home improvement. Its limitation is that, as with any book, it contains only the still photographs of the journey and no moving pictures at all. However, it is to these, the dynamics of QI processes, that we turn our attention in Chapter 10.

Achieving and Sustaining Healthcare Quality

A COLOR CODEBOOK FOR QUALITY AND SERVICE IMPROVEMENT PRACTICE

Organizational challenges and solutions

A checklist

- The structural challenge
- The political challenge
- The cultural challenge
- The educational challenge
- The emotional challenge
- The physical and technological challenge

Assess your own organization against the six universal challenges by checking (individually or as a team) how close you think it is to achieving each of the specific solutions within each challenge (in terms of either 'a long way to go', 'some way there' or 'already there').

Reviewing your overall responses across the six challenges can help identify current gaps and opportunities and help facilitate discussions on the necessary direction of travel of the organization's future QI efforts. (For example, does your organization have 'a long way to go' on most or all of the structural solutions? Is it 'already there' in terms of the majority of the political solutions?)

Annex 1 at the back of this book provides quotations from the case studies to further define and illustrate the various elements and solutions.

The structural challenge

Structuring, planning and co-ordinating the quality and service improvement effort, and embedding it within the organizational fabric.

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Quality strategy and plan	A formal strategy for quality and service improvement (Q & SI), and a plan for implementation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strategic leadership	Strong and decisive executive leadership, providing a clear, strategic direction and a disciplined and detailed focus around Q & SI matters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole-systems organizational design	A coordinated Q & SI effort that involves joined up whole-systems design and cross-functional improvement initiatives (as opposed to discreet local projects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Devolved authority system	A 'flat' organizational structure that minimizes hierarchy and provides opportunity and encouragement for bottom-up improvement and change initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality leadership positions	Formal roles and responsibilities in relation to Q & SI are shown on the organizational chart, which also shows a senior person at the top who is leading on quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multi-level leadership structure for quality	A dispersed, multi-level leadership structure that sees leadership in Q & SI being exercised simultaneously at the micro-system, intermediate/middle-management, directorate, medical board and corporate levels of the organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality facilitation team or group	A dedicated 'core' improvement/change team comprising improvement specialists and a wide range of Q & SI skills in areas such as process mapping, continuous quality improvement (CQI), organizational development (OD), team building and facilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
QI training programs	Formal education and training opportunities for staff development in the Q & SI area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enabling administrative role	Central HQ departments, managers and staff that function more as a performance and quality service to frontline units in Q & SI matters than a central, directing authority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Boundary-spanner roles	Hybrid dual, bridging, liaison, interlocutor or boundary-spanning roles, such as clinical leader/manager, which allow for lateral contact and communication between different groups, and the linking of resources, people and ideas around the Q & SI effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communities of practice	Cross-organizational and occupational networks, groups, and fora that come together to debate, share knowledge and take forward the Q & SI agenda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Results-oriented planning	Formally constituted procedures for planning and monitoring improvement projects with clear timelines and robust project management mechanisms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality governance system	An organization-wide infrastructure of Q & SI meetings and groups for co-ordinating and spreading improvement throughout the system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational slack for quality	Deliberate provision of slack resources or headroom in the organization (be it money, time, airline tickets or space) that enables staff periodically to stand back from everyday operations and think and work on service development issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Data and monitoring systems	Formal data collection and information processing systems for constant monitoring, measuring, benchmarking of organizational and clinical performance (e.g. dashboards, clinical information, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The political challenge

Negotiating the politics of change associated with implanting and sustaining the improvement process, including securing stakeholder buy-in and engagement, dealing with conflict and opposition, building change relationships, and agreeing and committing to a common agenda for improvement.

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Politically credible leadership	Senior leaders with the authority and skill to broker and manage the 'politics of engagement' associated with improvement work, including dealing with resistance, and selling the case for engaging in Q & SI activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical engagement	Strong and active clinician engagement in, and ownership of, the Q & SI process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer-to-peer relationships	Strong peer-to-peer lines of communication and influence, from clinician to clinician, manager to manager, that enable QI innovations to spread rapidly and effectively down through the organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical–managerial partnering	An agreed clinician and management compact (formal or informal) binding them to work together on the Q & SI agenda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff empowerment	Empowering staff to be able to influence and exercise real control over their local service environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient empowerment	Empowering patients to be able to influence and participate in improvement work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External partnering	Strong and close partnership and mutual interaction between internal staff and relevant external stakeholders in the improvement process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The cultural challenge

Building shared understanding, commitment and community around the improvement process.

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Culture of excellence	A culture that places a premium on excellence in delivering quality care to patients (reflected in the mission, values, language, systems and symbols)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Values / symbolic leadership	Leaders who are committed to developing a culture in which quality is the key and overriding concern, and who actively role model this commitment in their own everyday language and behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient-centered ethic	A strong patient/customer care ethic that infuses every part of the service, large or small	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culture of mindfulness	A culture of mindfulness that keeps staff constantly vigilant and alert as to their personal and group standards and practices – being awake to quality and safety concerns, and avoiding automatic or standard cookbook practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group/ collaborative culture	A strong 'we group' culture that promotes teamwork and co-operation between staff, placing a premium on human values like respect, integrity, trust, pride, honesty, inclusion and openness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scientific culture	A scientific culture that values data, measurement and evidence in both medical and managerial practice, while being strongly task- and results-driven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culture of learning	A culture of innovation and learning that values risk-taking and experimentation, and constantly encourages people to do more and differently, and to develop and share new knowledge, skills and expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Formal culture	A culture that emphasizes the need for formalized disciplines and enabling structures to ensure efficiency, effectiveness, and personal accountability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Culture of empowerment	A culture that genuinely nurtures and supports empowerment and 'self-leadership' at all levels of the organization, and that demonstrates this commitment in its reward systems and everyday practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Cosmopolitan culture	An outward-facing organizational culture that is sensitive to the dangers of isolation, arrogance and ethnocentric mentalities and behaviors, and is prepared to learn from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term culture	A culture that supports the longer-term perspective on Q & SI (the long haul rather than the quick sprint), and is alert to the dangers of fads and short-term quick fixes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational identity	A strong sense of organization pride and history, identity, legacy and tradition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruitment and retainment	Recruiting and rewarding people whose personal values closely align to the quality values of the organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acculturation	Socialization, induction and training processes that help people tune-in and acculturate to the core Q & SI values of the organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The educational challenge

Embedding and nurturing a continuous learning process in relation to quality and service improvement issues, including both formal and informal mentoring, instruction, education and training, and the acquisition of relevant knowledge, skills and expertise.

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Pedagogic leadership	Influential organizational leaders who champion reflective practice, and encourage staff and colleagues to engage in continuous learning and development in relation to quality and service improvement (Q & SI) issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational change knowledge	The acquisition and application of existing knowledge and an evidence base relating to Q & SI, and organizational development and change management knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality improvement knowledge	The acquisition and application of knowledge relating to specific Q & SI methods and techniques (e.g. PDSA, process mapping), and clinical care/improvement models (clinical pathways, chronic care model, etc.) in their work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge harvesting	Formal or informal activities to search for and bring back (i.e. harvest) new Q & SI methods, concepts and ideas from conferences and other sources outside of one's own organization or group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experimentation and piloting	Developing, piloting and systematically testing (and learning from) the application of new Q & SI methods and approaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence-based learning	Learning and developing new understanding from review and analysis of routine evidence and data (e.g. clinical auditing, benchmarking, and other activities to evaluate and measure the impact/benefits of Q & SI applications)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experience-based learning	Learning and developing new understanding from the involvement of patients and caregivers in the design of their own care, including the ability to listen and learn directly from the 'voice of experience'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The emotional challenge

Energizing, mobilizing and inspiring staff and other stakeholders to want to join in the improvement effort by their own volition and sustain its momentum through individual and collective motivation, enthusiasm and movement.

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Mobilizing leadership	Inspirational leaders who see Q & SI as much a mission or movement as a project, and who have sufficient skill in scripting/framing ideas for various audiences and sufficient standing within the organization to be able to mobilize large numbers and a wide cross-section of staff to join their 'improvement movement'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical and other change champions	Clinical champions and similarly influential others in the organization who are able to energize, mobilize, and engage fellow professionals and co-workers in the Q & SI effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collective momentum	Building powerful momentum around the Q & SI effort such that it ultimately takes on a life of its own, spreading and feeding off its own energies, and no longer needing to be driven from above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional and social affiliations	Local quality activists mobilizing and driving the improvement effort through their informal networks of professional and social affiliations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality as a mission/calling	Staff are energized and self-motivated around Q & SI, knowing they are helping people and contributing to the humanitarian goals of the organization – more than a job, it's a mission and a calling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional involvement	Staff are emotionally involved and invested in the improvement effort – it has become a matter of the heart as well as the head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement campaigns	Mounting improvement campaigns to speed up and carry the improvement work forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The physical and technological challenge

The design and use of a physical, informational and technological infrastructure that improves service quality and the experience of care.

SOLUTION	DEFINITION	'WHERE ARE WE?'		
		A long way to go	Some way there	Already there
Functional design	Functional design of architecture and the built environment to support and encourage Q & SI (i.e. does the job it is supposed to do, safely and effectively, and improves the usability of the service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aesthetic design	Aesthetic design of architecture and the built environment supporting and encouraging Q & SI (i.e. improves the patient's and carers' experience of care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technology/design leadership	A leadership that is aware of the positive effects of the built environment (both functionality and aesthetics) and/or of clinical and information technology on the patient experience, and incorporates these design elements into service improvement efforts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location of infrastructure and technology	Location of physical infrastructure and technological systems (e.g. free-standing vs. integrated facilities, proximity to other organizational units, separate vs. integrated IT systems, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supportive information technology	Design and implementation of IT and communications systems that support and encourage Q & SI efforts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supportive medical technology	Design and implementation of medical equipment and clinical technologies to support and encourage Q & SI efforts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>