



## CRITICAL COMMENTARY

### Quality improvement – rival or ally of practice development?

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The majority of nurses, doctors, allied health professionals and other healthcare staff possess a strong desire to provide the best possible care and experience for their patients. Unfortunately, this sometimes falls short of what was planned or intended (Institute of Medicine, 2001, p 23). The gap between care intended and care delivered can be explained by problems with systems and processes and/or people and culture. The narrowing of this gap is the focus of many strategies, methodologies and approaches.

Practice development is described as ‘an activity focused on developing people and practice for the ultimate purpose of achieving high-quality person-centred care’ and a ‘methodology that aims to achieve effective workplace cultures that are person-centred’ (Shaw, 2012; Manley et al., 2014). Practice development undoubtedly has a strong focus on people and culture and the potential to change processes and systems.

Another approach, widely referred to as quality improvement, aims to improve safety, effectiveness and person-centredness in healthcare using principles proven effective in other industries such as manufacturing – notably car manufacturing (Toyota), oil production, nuclear power and aviation. The fundamental principles of quality improvement for healthcare include making care reliable (every patient receiving care as intended every time, using well-designed processes) and reducing variation (agreeing a consistent way to provide care). At first glance this may appear to be an approach suited only to systems and processes. However, better processes, designed by those who use them, resulting in fewer errors and less re-working or working around problems, can reduce stress on staff, offer greater job satisfaction with improved morale and free up time to provide person-centred care. In his report, *A Promise to Learn – a Commitment to Act* (2013, p 24), Professor Don Berwick says:

*‘Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals including managers and executives. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.’*

I have spent more than a decade learning, developing and practising my skills in quality improvement. More recently, having been invited to give an overview of the subject to delegates at a practice development course, I decided to immerse myself by signing up as a practice development course

participant. During this introduction, I noticed the methodology shares aims and ideas with quality improvement and came to feel the two could have a shared agenda. While appearing to take different paths towards quality, they are synergistic – potentially two sides of the same coin.

The central focus of practice development is developing person-centred care in an evidenced-based workplace supported by an enabling culture. For more than 20 years, the term has been used to cover a spectrum of approaches and methodologies intended to develop practice. This has led to uncertainty about what should be viewed as practice development and, in 2008, Manley, McCormack and Wilson proposed nine key principles (Table 1).

<b>Table 1: Principles of practice development (Manley, McCormack and Wilson, 2008)</b>	
<b>Principle 1</b>	Practice development aims to achieve person-centred and evidence-based care that is manifested through human flourishing and a workplace culture of effectiveness in all healthcare settings and situations
<b>Principle 2</b>	Practice development directs its attention at the micro-systems level – the level at which most healthcare is experienced and provided, but requires coherent support from interrelated mezzo- and macro-systems levels
<b>Principle 3</b>	Practice development integrates workbased learning with its focus on active learning and formal systems for enabling learning in the workplace to transform care
<b>Principle 4</b>	Practice development integrates and enables both the development of evidence from practice and the use of evidence in practice
<b>Principle 5</b>	Practice development integrates creativity with cognition in order to blend mind, heart and soul energies, enabling practitioners to free their thinking and allow opportunities for human flourishing to emerge
<b>Principle 6</b>	Practice development is a complex methodology that can be used across healthcare teams and interfaces to involve all internal and external stakeholders
<b>Principle 7</b>	Practice development uses key methods that are utilised according to the methodological principles being operationalised and the contextual characteristics of the programme of work
<b>Principle 8</b>	Practice development is associated with a set of processes including skilled facilitation that can be translated into a specific skillset required as near to the interface of care as possible
<b>Principle 9</b>	Practice development integrates evaluation approaches that are always inclusive, participative and collaborative

Quality improvement has also struggled to develop a clear narrative. What is quality improvement, and what is not? Since the intention of all healthcare strategies is to bring about change leading to an increase in 'quality', doesn't the term apply to all activity focused on change? This has led to many groups and organisations mistakenly believing they are 'doing quality improvement'. The accepted definition of quality in healthcare is helpful – that it has person-centred, safe and effective care as its foundation (Institute of Medicine, 2001, p 41). A recent definition of quality improvement builds on this definition, stating that improvement requires:

- Profound knowledge of the system and those who work in it
- Use of a methodology to promote and facilitate change
- A disciplined use of (real-time) measures to show progress (or the lack of it) and prove the effectiveness of change

(Academy of Medical Royal Colleges, 2016, p 12).

Quality improvement does not necessarily require an increase in resources, although it may indicate that resources are needed to reach an arbitrary level, standard or target. In reality, it often gains more traction in times of austerity when we can no longer 'solve' a problem by adding more resources to a flawed system.

The confusion around its definition may be compounded by terminology – particularly the term 'service improvement'. This term is frequently used in healthcare and, theoretically, could be viewed as synonymous with quality improvement, since the latter is focused on improving one or more elements of the care or services patients receive. However, in many healthcare contexts, these two terms and approaches have come to mean very different things. Service improvement often includes the use of additional resources (either permanent or temporary) and an intention to produce system change but often with no identifiable improvement methodology. Service improvement often results in little or no change to the processes and culture underpinning care. Yet, many healthcare managers and clinicians within healthcare see little or no distinction between this approach and quality improvement.

The two key quality improvement principles are making care reliable and reducing variation, which ease the burden on staff so they have the mindset and capacity to provide person-centred care including, when required, to themselves and colleagues. Thus quality improvement could be viewed as having person-centred care as a specific aim and as providing a means to make it easier to achieve.

Does the above suggest that practice development and quality improvement could be synergistic or that their respective exponents/practitioners could combine their efforts to achieve more? Both methodologies have enthusiastic proponents struggling to engage the majority of frontline staff. Practice development activity is predominantly a nursing phenomenon and, while quality improvement would claim to have a broader, multiprofessional base including senior doctors and managers, it is also probably strongest in nursing. It would be fair to say, though, that both have failed to engage the majority of healthcare practitioners.

Thus, I would suggest that the two are linked by the following:

- Difficulties around defining or differentiating their approach
- A common aim – to build an environment in which staff work better together in a changed culture with redesigned, improved processes underpinning better care
- Enthusiastic and expert practitioners who face an uphill battle in engaging large numbers of their colleagues

Both methodologies have a focus at the micro-system level (where patient and clinician interact) and the macro-system level (which underpins the delivery of care). While practice development has cultural change at its heart, quality improvement also recognises the importance of culture: 'Culture will trump rules, standards, and control strategies every single time. A safer NHS will depend far more on major cultural change than on a new regulatory regime' (Berwick, 2013, p 11). Both recognise the need to link with outcomes for patients while having different emphasis – quality improvement tends to look at quantitative data, while practice development often uses a more qualitative approach focused on person-centredness. Both aim to combat the obstacles that prevent or retard evidence-based practice from becoming everyday practice.

Considering Manley, McCormack and Wilson's nine principles (2008) in the context of quality improvement is illuminating. Terms such as 'person-centred, evidence-based care in an effective culture' would resonate just as strongly with 'quality improvers'. Is 'human flourishing' articulated in quality improvement as 'joy in work'? Practice development values evidence from practice while quality improvement, through its use of PDSA (plan-do-study-act) cycles, allows local context to shape how new practices become part of 'normal' work. Both emphasise a facilitative, collaborative approach in which thinking creatively is encouraged – what might today be described as crowd-sourcing ideas to inform change.

Often the exponents of both approaches find themselves trying to engage systems that are not ready, or able, to listen and respond. Given the synergy, could there be advantage in a more explicit link between the two? For those attempting to produce any change, the feeling of being isolated or overwhelmed – a ‘David and Goliath’ situation – is a significant barrier. Those promoting change using either methodology are vastly outnumbered by those who see such activity as threatening, pointless, unnecessary or just inferior (to research). Joining forces and acknowledging what unites practice development and quality improvement might strengthen both in the same way that forming the North Atlantic Treaty Organisation (NATO) gave strength to individual nations sharing common concerns.

Bringing the strengths of practice development and quality improvement together could fashion a blended approach stronger than either alone. If cynics feel practice development is ethereal in its approach, grafting the focus on process redesign and measurement from quality improvement may be a good thing. If those using quality improvement sometimes appear to over-emphasise technical elements such as measurement and PDSA, this may be balanced by the emphasis on cultural change that is central to practice development. Alternatively, even if they remain separate and unchanged in their approach, their influence could be amplified by collaboration. Exponents of both methods collaborating, signposting and sharing a strategic agenda will ‘increase the signal’ indicating the need to move to new ways of thinking and working. Blending or collaboration will boost our numbers of ‘change agents’ and may help increase our ability to build workplaces that are focused on person-centredness, joy in work, high-quality, reliable processes and learning from error.

Is it time for a merger or strategic alliance? It is usually easier to build support for the latter rather than the former. Quality improvement methodology might suggest that we ‘start small’. This might take the form of testing the blending of practice development content into quality improvement events and conferences or vice-versa. Platform sharing, in any form, is a powerful way to demonstrate ‘like-mindedness’. There could be benefit in aligning the vocabulary and terms we use to underline, rather than disguise, similarities between the two. Since neither has formal hierarchical structures, the onus would be on opinion leaders to build the conditions to allow the above to occur. A strategic alliance would change both disciplines and could lead to a new way of portraying the importance of individual behaviour and motivation, group culture and the technical skills needed for improvement. With more advocates, such a collaborative approach might have a greater chance of reaching a tipping point at which, across the system, it becomes ‘the way we do things around here’.

## References

- Academy of Medical Royal Colleges (2016) *Quality Improvement: Training for Better Outcomes*. Retrieved from: [tinyurl.com/AMRC-QI](http://tinyurl.com/AMRC-QI). (Last accessed 12<sup>th</sup> May 2016).
- Berwick, D. (2013) *A Promise to Learn – a Commitment to Act: Improving the Safety of Patients in England*. London: Department of Health.
- Institute of Medicine (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.
- Manley, K., O’Keefe, H., Jackson, C., Pearce, J. and Smith, S. (2014) A shared purpose framework to deliver person-centred, safe and effective care: organisational transformation using practice development methodology. *International Practice Development Journal*. Vol. 4. No. 1. Article 2. pp 1-31. Retrieved from: [fons.org/library/journal/volume4-issue1/article2](http://fons.org/library/journal/volume4-issue1/article2). (Last accessed 12<sup>th</sup> May 2016).
- Manley, K., McCormack, B. and Wilson, V. (2008) Introduction in Manley, K., McCormack, B. and Wilson, V. (Eds.) (2008) *International Practice Development in Nursing and Healthcare*. Oxford: Blackwell. pp 1-16.
- Shaw, T. (2012) Unravelling the consequence of practice development: an exploration of the experiences of healthcare practitioners. *International Practice Development Journal*. Vol. 2. No. 2. Article 2. pp 1-29. Retrieved from: [fons.org/library/journal/volume2-issue2/article2](http://fons.org/library/journal/volume2-issue2/article2). (Last accessed 12<sup>th</sup> May 2016).

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