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Office of the Nursing & Midwifery Services Director

National Leadership and Innovation Centre

AN EXPLORATION OF HEALTH CARE PROFESSIONALS' EXPERIENCES OF PARTICIPATING IN AND LEADING A QUALITY IMPROVEMENT COLLABORATIVE IN THE UNIVERSITY OF LIMERICK HOSPITALS

Professor Fiona Murphy
Professor, Department of Nursing and Midwifery, University of Limerick

Dr Brid O' Brien
Lecturer, Department of Nursing and Midwifery, University of Limerick

Maebh Barry
Lecturer, Department of Nursing and Midwifery, University of Limerick

DEPARTMENT OF NURSING AND MIDWIFERY

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The contact address for further information is:

Professor Fiona Murphy
Department of Nursing and Midwifery
University of Limerick
Castletroy
Limerick
Ireland

fiona.murphy@ul.ie

FOREWORD

On behalf of National Leadership and Innovation Centre (NLIC), Office of the Nursing and Midwifery Services Director, the University of Limerick Hospitals (ULH's) and the National Quality Improvement Programme/Health Service Executive/Royal College of Physicians Ireland, I am pleased to present this review of health care professional's experiences of leading and participating in a quality improvement collaborative within their Directorate.

A primary function of the NLIC is to work with nurses, midwives, and all sectors of the health services, to build leadership capability and capacity and to contribute to innovative and creative solutions to enable the provision of safe, quality healthcare. This report illustrates the work of the Centre, and demonstrates how front line staff can achieve real improvements in care delivery through a triad of leadership development, education in quality improvement practices and teamwork. The Report also demonstrates the benefits of using an integrated "bottom-up" approach to bring about tangible changes to practice.

I wish to thank the many individuals, teams and agencies who participated in and supported the initiative. Particular thanks is extended to the staff and management of UL Hospitals, especially those who participated in the quality improvement initiatives and those who gave of their time and expertise so willingly to ensure the success of the programmes. A very special thanks to Teresa Moore, NLIC Project Lead, for all her hard work, unwavering support and guidance throughout the process.

Signed

Mary Mac Mahon,

Acting Director, National Leadership and Innovation Centre for Nursing and Midwifery,

Office of the Nursing and Midwifery Services Director HSE,

Clinical Strategy and Programmes Division,

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EXECUTIVE SUMMARY

This report provides the findings of a qualitative descriptive study exploring the experiences of nurses, midwives and other health care professionals involved in three Quality Improvement Collaboratives (QICs). These were linked to a bespoke Nurse and Midwife leadership programme in the University of Limerick Hospitals (ULH) between March 2013 and April 2015. Each Collaborative was comprised of a four day Future Nurse and Midwife Leadership (FNML) programme interspersed with a four day Quality Collaborative Programme (total=8 days). The learning derived from the FNML programme and outcomes from the quality improvement initiatives were presented by participants at a forum day at the end of programme. The overall aim of these initiatives was to build leadership capacity while enabling clinical managers to develop the skills to implement quality improvements. Three sets of collaboratives, each linked to an area of practice requiring improvement were initiated. These were (a) falls and falls prevention (b) communication in maternal and child health and (c) safe surgery and patient flow through theatres. The clinical nurse or midwife manager (from the FNML programme) led or co-led a team with a medical or surgical colleague.

This study **aimed t**o explore nurse/midwife managers and other health care professionals' experiences of leading and being part of a quality improvement collaborative in three HSE practice areas in the Mid–West Region. A qualitative descriptive research design using focus group interviews was considered appropriate to achieve this aim. All participants involved in the three collaboratives (n=138) were invited to participate. Five focus groups were conducted with 18 participants with the data transcribed and analysed using thematic analysis.

In the **findings**, five main themes emerged:

- Enablers and Barriers in the QIC process
- Learning about leadership
- Managing and sustaining change
- Benefits of being in a collaborative
- Planning future collaboratives

Significant **enablers** centred on how the QIC programme was structured, organised and facilitated. Participants enjoyed the programme and appreciated the opportunity to take a 'bottom up' approach, supported by senior management, to bring about change. The multi-disciplinary approach of the QICs functioned both as an enabler for some groups but as a **barrier** for others. There was a perception by some that not all professions and occupational groups were fully engaged in the process.

In **learning about leadership**, the connections between the learning opportunities provided on the leadership programme (FNML) and leading a QIC was not overtly identified by all participants. However, there was some evidence of the clinical nurse and midwife managers demonstrating leadership in their different collaboratives.

Managing and sustaining change in practice was seen as an important but challenging issue for participants. Examples were provided where change had been sustained and others where the momentum had faltered. Participants suggested that each group and organisation develop a plan with an identified lead at the beginning of the process to ensure sustainability once the collaboratives had completed.

The benefits of being part of a QIC included developing relationships with colleagues across the hospital group. The participants' worldview broadened as they became aware of the hospital as a whole inter-connected system. They also appreciated seeing how the change that had been introduced impacted on practice in a positive way. Participants recognised the 'ripple effect' where one change made in one area in the organisation impacts on other areas. Finally, as part of the QIC process, staff disseminated their findings and gained acknowledgement for their work.

The final theme relates to participants ideas for **planning future collaboratives** and how they may be organised. Participants identified the need for more attention in preparing individuals to understand the function and purpose of collaboratives. The multi-disciplinary aspect, although beneficial, did generate some tension for some groups where there was a perception that some occupational groups were not fully engaged with the process. The need for planning for the end of the collaborative particularly in terms of sustainability was again identified.

The **recommendations** discussed include:

1. Continue with the existing structure, facilitation and organisational processes with minor amendments.
2. In the preparatory phase include more input on what collaboratives are and what being in a collaborative entails.
3. Prepare participants to effectively identify and manage the micro-culture and group processes within their QIC groups.
4. Implement a strategy for managing non-attendance and non-engagement by individuals and occupational groups.
5. Require each group and organisation to develop a sustainability plan for their collaborative from the beginning of the QIC process and before the groups disband.
6. Implement a longer term (one year) follow up evaluation of being in a collaborative including a focus on leadership.

The report acknowledges that the study has **limitations**:

1. This study did not aim to produce generalisable findings in common with other qualitative studies.
2. The study focused on the processes involved in attending these collaboratives and did not seek to quantify outcomes.
3. Although the sample size was sufficient to generate meaningful data, the participants tended to be nurses and midwives with some representation from clinical therapists and managers. This meant that other groups such as medical and administrative staff were not represented in the focus groups.
4. The collaboratives were completed in 2014 and 2015 and this time lapse may have influenced participants' recall of their experiences.

SECTION 1: INTRODUCTION

1.1 BACKGROUND

Quality Improvement Collaboratives (QICs) are an increasingly common strategy within wider quality improvement initiatives for implementing evidence-based practices in health care (Nembhard 2009). At a global level, they aim to accomplish rapid healthcare improvements in different clinical areas and organisational contexts (Øvretveit, et al. 2002, Schouten et al. 2008). Although there are many variations, Quality Improvement Collaboratives are mostly modelled on the 'Breakthrough Series' (IHI 2003) developed in the United States (Ovretveit, et al. 2002, Nembhard 2009). Quality Improvement Collaboratives are considered to be innovative, challenging and provide effective and efficient use of experts and peers to implement best practice.

In a QIC, small teams of experts and practitioners work together to focus on real life practice issues. An issue within practice is identified, the difference between actual and evidence based standards of care established and a 'change' strategy developed to 'improve' the practice. Multi-disciplinary teams together with change experts work to learn techniques, including planning, implementation, evaluation and dissemination. Within organisations, collaboratives generally range from 12 to 160 organisational teams, with representation from each team. In a QIC programme, all the QIC members come together with facilitators to help them through the process to bring about the desired change. These programmes usually involve three to four days attendance spread over six to 15 months with a series of tasks to achieve and outcomes in-between (Flynn 2014).

Despite the widespread interest and adoption of Quality Improvement Collaboratives to improve quality, such initiatives require a substantial involvement of time and effort from all involved. In particular, funding and adequate resources including senior management support is essential (Health Foundation 2014). For a successful interdisciplinary collaborative, attention needs also to be paid to organisational structuralism, power relationships between the different professions and how different members are socialised into their role. Leadership (both formal and informal) at all levels is also fundamental to make and achieve sustainable change in practice and culture. In recognition of this, the Irish Health Service Executive (HSE) in 2007 emphasised the need for clinical leadership and team based service delivery (HSE 2007). A further needs analysis relating to nursing and midwifery leadership (HSE 2009) clearly

identified the importance of a more structured approach to clinical leadership development. Consequently, programmes were developed to provide leadership skills in key groups including nurses and midwives (Murphy et al. 2009). A Clinical Leadership Pilot project conducted in the HSE West involving 21 nurse managers clearly identified positive outcomes for participants in attending a clinical leadership programme. Attendance by nurse managers on leadership programmes was also thought to impact positively on other aspects such as patient care and the clinical environment (Lunn et al. 2008).

At a more micro level, the culture within the QIC group will also be influential in whether the group succeeds in working effectively to achieve their goals (Nembhard 2009). Carter et al. (2014) consider both the costs and benefits to individuals and the group in being part of a collaborative. Ideally within a QIC group there should be collaboration, shared learning and achievement of goals however their study revealed a mixed picture of collaboration, free-riding and competition.

The research evidence of the effectiveness of QICs is mixed. Some studies demonstrated marked improvements in practice and others were less equivocal (Mittman 2004, Schouten et al. 2008, Nembhard 2009, The Health Foundation 2014). Schouten et al. (2008) in a systematic review of the literature found reported evidence that Quality Improvement Collaboratives had positive outcomes on patient care. However, they also noted that some were seen to be of limited value, unknown cost and unpredictable dependent on the context. They did point however, to the methodological difficulties in conducting such studies. Trying to establish outcomes in complex interventions such as QICs where other factors might also impact is challenging. The Health Foundation (2014) also identified a substantial body of literature looking at the effect of collaboratives including systematic reviews and a small number of randomised controlled trials. They concluded that there was *'some evidence that collaboratives may have potential……they may not always be associated with immediate or large-scale change and it is uncertain whether they are more or less effective than other approaches'* (The Health Foundation 2014 p.13). More research is required therefore on the impact of quality improvement collaboratives including effectiveness and success factors.

In Ireland, the need for research to evaluate quality improvement collaboratives is particularly important as little research has been conducted in an Irish context. In particular the culture within QIC groups and the connection between developing leadership in nurses

and midwives and participation in the quality collaboratives has not been explored. How a QIC is led, what leadership strategies work and how the group might be motivated are of interest. This kind of micro-analysis of the processes is less evident however in the research in this area (Orchard et al. 2005).

The focus of this study therefore was to explore from the perspectives of the participants their experiences of leading and being part of a QIC. A particular emphasis was placed on leadership within the collaboratives, in exploring how they were led, built and how the change was sustained.

1.2 THE QUALITY IMPROVEMENT COLLABORATIVES INITIATIVE IN THE UL HOSPITAL GROUP

The Chief Director of Nursing and Midwifery in the University of Limerick Hospitals (ULH) commissioned the National Leadership and Innovation Centre for Nursing and Midwifery (NLIC) to design and deliver quality focused leadership programmes for clinical nurse and midwife managers. In response to this, the NLIC facilitated the design and delivery of the Future Nurse/Midwife Leadership (FNML) programme.

To promote a style of leadership that reinforced the values and standards associated with quality and safety, this programme was interspersed with a four-day Quality Collaborative facilitated by the Royal College of Physicians of Ireland (RCPI) and the National Quality Improvement Programme/HSE/RCPI in collaboration with the NLIC. This was then supported by HSE West/Mid West Centre of Nurse and Midwifery Education (CNME). The overall aim was to build leadership capacity and at the same time enable clinical mangers to develop the skills to implement quality improvements (Appendix 1).

The target population for the first FNML programme were Clinical Nurse and Midwife Managers (CNM/CMMs) from Medicine (March 2013, to March 2014), Maternal and Child Health (January 2014 to October 2014), with the final programme delivered to staff from the Peri-Operative Directorate (September 2014 to April 2015). 18 to 20 participants in each directorate registered for the programme.

In tandem with the FNML programme was a Quality Improvement Collaborative which included formal sessions on quality improvement methodologies, and support and guidance to teams in the clinical areas. The format for the collaboratives was a small team approach with each team consisting of five to eight members of the relevant multi-disciplinary team. The CNM/CMM (from the FNML programme) led or co-led the team with a medical or surgical colleague. The composition of the teams depended on the focus of the quality improvement initiative in that generally it was a cross section of staff, including administrative staff, porters, quality, and risk management, members of the directorate management teams, finance, business managers and nurse managers. Each collaborative had five to seven teams.

For the CNM/CMM and their teams, a critical element of the collaborative work was identifying and agreeing an area of practice that needed to be improved and agreeing the changes necessary to bring about that improvement. Equally important was mapping improvement activity to the strategic vision for the Directorate or the organisation, or to other quality initiatives such as Productive Ward or Nursing Metrics. Following, often quite a lengthy consultation process, the teams agreed aims, SMART objectives and work processes. Teams used the Plan, Do, Study Act (PDSA) Cycle to test out and implement improvements and changes. Review and evaluation was an integral part of each collaborative meeting and following this the topics identified were:

- Falls and fall prevention (Medicine Directorate)
- Test out and implement the ISBAR (identification, situation, background, assessment and recommendations) communication tool (Maternal and Child Health Directorate)
- Safe surgery and patient- flow through theatres (Peri-operative Directorate)

This was a venture between the NLIC, National Quality Improvement Programme/HSE/RCPI and UHL both as co-funders and as collaborative partners. The first two collaboratives were funded through the National Quality Improvement programme by the National Health Service Executive. The third and final collaborative was funded by University of Limerick Hospitals.

The nursing and midwifery leadership programme and the quality collaboratives were

therefore offered in tandem to allow cross-over and intermixing of quality improvement with leadership. Days one to three of the leadership programme were delivered approximately one day a month over four months followed by four Collaborative days. The Collaborative days were delivered away from the hospital sites at intervals of four to six weeks which was to allow CNM/CNMs and their teams the time to work on the quality improvement initiatives. Day four of the FNML programme was delivered when the teams had completed their collaborative work.

On completion of the programmes (eight days), the Directorate teams presented their outcomes, findings or learning to their colleagues and to the wider healthcare community. They were also responsible for demonstrating how they intended to sustain or build on the work done. Sustainability was a key consideration and it was the responsibility of the Oversight Group and the Quality Nurse Manager for the hospital group to support the teams to plan and develop strategies to solidify the outputs from the Collaboratives.

SECTION 2: METHODS

2.1 STUDY AIM

To explore nurse/midwife managers and other health care professionals' experiences of leading and being part of a quality improvement collaborative in three HSE practice areas in the Mid –West Region.

2.2 STUDY OBJECTIVES

1. Identify the enablers and barriers to creating an effective quality improvement collaborative.
2. Identify the learning that occurred from a leadership perspective.
3. Explore participants' views on managing and sustaining the change in their area of practice.
4. Explore participants' views on the benefits of being part of a quality improvement collaborative.

2.3 STUDY DESIGN

A descriptive qualitative approach using focus group interviews was utilised in order to achieve the study aim. This approach is described as a combination of sampling, data collection and data analysis techniques which produce valuable descriptive findings (Sandelowski 2000, Sandelowski 2010). This facilitates the representation of findings which generate knowledge while remaining true to the data (Sandelowski 2000, Lambert & Lambert 2012).

2.4 SAMPLE

All participants who were involved in the three collaboratives (n=138) were invited to participate in the study along with key stakeholders. The minimum sample size proposed was 18 and the maximum 24, which was provided as an indication rather than a target in line with best practice in qualitative research. 18 members of the collaboratives participated in the study.

Inclusion criteria: All participants involved in the quality collaborative programmes in three HSE practice areas in the Mid-West Region.

Exclusion criteria: Healthcare professionals who were not involved in the collaborative programme.

2.5 RECRUITMENT

Three phases were employed to recruit participants. There was a pre-recruitment phase to raise awareness within the Region that the study was about to begin and that all individuals would be invited. Key stakeholders such as the Quality Nurse/Midwife Manager, the Directors and Assistant Directors of Nursing and The Director for Nursing Integration were informed. Posters advertising the study were put up on key sites and publicity given at two main nursing and inter-professional conferences taking place in the Region prior to data collection.

In a second more formal recruitment phase, every member of the collaboratives were emailed individually, invited to participate and given a choice of venues and dates throughout April 2016. In addition, on the date of the focus group, the researchers went around the sites to further invite participants and to ensure that they knew that the event was taking place. Finally, a third and final recruitment phase was instigated where again Directors and Assistant Directors of Nursing were approached to further encourage staff to participate.

2.6 DATA COLLECTION

The method of data collection was focus groups, which are group discussions in which the researcher is actively encouraging of and attentive to the group interaction (Barbour 2007, Burns & Grove 2011, Creswell 2013). Focus groups allow spontaneous conversational interaction which enables sharing, identification and convergence of common aspects of the participant's experiences and highlights differences that require further clarifications in meaning (Clark 2009). Focus groups therefore are considered an effective way of uncovering a range of ideas and feelings from different perspectives (Krueger & Casey 2000, Joyce 2008).

In total six focus groups were offered and five were conducted with a total of 18 participants. Two in the University Hospital Limerick (UHL), one in the Maternity Hospital (ULMH) and two in Ennis Hospital all held between between April and June 2016 (Table 1). Participants from the

three different quality collaborative programmes were combined in each focus group in order to capture a broad perspective of their experiences. The aim of the focus groups was to explore with participants their experience of participating in and leading a quality improvement collaborative in practice**.** The focus groups ranged from 27 to 56 minutes in length, were digitally recorded and later transcribed for data analysis. Apart from one, all focus groups were conducted by two researchers with one to facilitate the discussion and one to note the group interaction recorded as field notes.

Table 1: Focus group participants and venues

Venue	Number of Focus Groups	Total number of participants	Participants
UHL	2	7	Nursing and Midwifery Clinical therapies Programme stakeholders
ULMH	1	5	Nursing and Midwifery
Ennis Hospital	2	6	Nursing and Midwifery Clinical therapies Programme stakeholders

A topic guide based on the literature review on quality improvement collaboratives was used to stimulate the discussion within the focus group (Appendix 2).

2.7 DATA ANALYSIS

The data were analysed using Braun and Clark's (2006) Phases of Thematic Analysis. Initial sorting and coding were developed to employ a deeper analysis and interpretation to identify emerging concepts and themes. To enhance quality and rigour, the three researchers analysed the transcripts independently and then in a data analysis clinic two

researchers further refined the emerging themes (Rapport 2010). The third researcher peer reviewed the final themes and all three agreed on the final thematic analysis.

2.8 ETHICAL CONSIDERATIONS

Due consideration was given to issues of informed consent, anonymity and confidentiality and ensuring participant physical and psychological comfort throughout the research process. Ethical approval was granted by the Research Ethics Committee, University Hospital Limerick Mid-West Region.

2.9 STUDY LIMITATIONS

This study did not aim to produce generalisable findings in common with other qualitative studies. Similarly, the study focused on the processes involved in attending these collaboratives and did not seek to quantify outcomes. Although the sample size was sufficient to generate meaningful data, the participants tended to be nurses and midwives with some representation from clinical therapists and managers. This meant that other groups such as medics and administrative staff were not represented in the focus groups. Finally, the collaboratives were completed in 2014 and 2015 and this time lapse may have influenced participants' recall of their experiences.

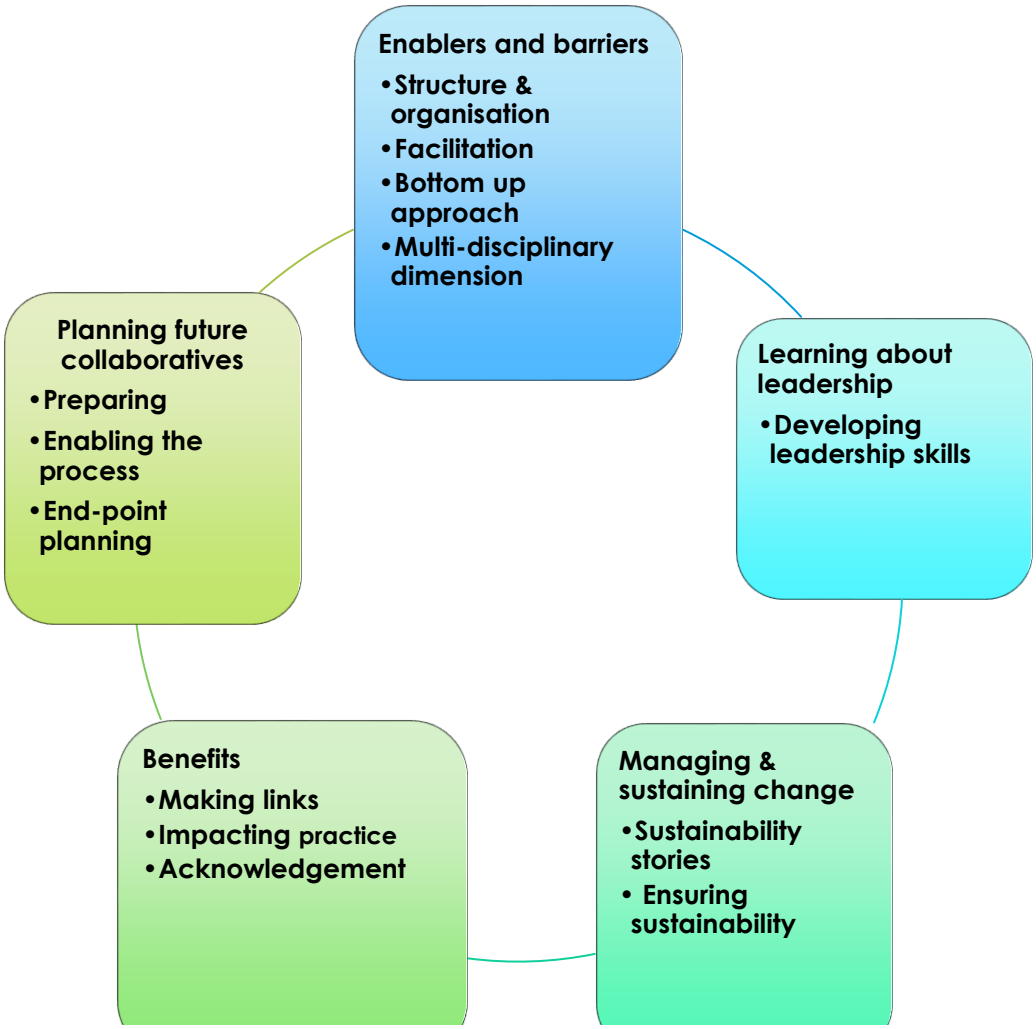
SECTION 3: FINDINGS

This section is structured around the objectives of the study. To recap these were:

1. Identify the enablers and barriers to creating an effective quality improvement collaborative.
2. Identify the learning that occurred from a leadership perspective.
3. Explore participants' views on managing and sustaining the change in their area of practice.
4. Explore participants' views of the benefits on being part of a quality improvement collaborative.

Five themes were generated and are summarised in Figure 1. These themes will be described and illustrated by participant extracts from the focus groups. To preserve anonymity, the focus groups (FG) and participants (P) are identified by numerals.

Figure 1: Schematic overview of main findings



3.1. ENABLERS AND BARRIERS IN CREATING AN EFFECTIVE QUALITY IMPROVEMENT COLLABORATIVE

In reflecting on their experiences, participants could clearly identify the enablers and barriers in the collaborative process and this formed a major part of the discussions within all focus groups. This theme is sub-divided into four; structure and organisation, facilitation, a 'bottom-up' approach and the multi-disciplinary dimension.

3.1.1 Structure and organisation

Part of the organisation of the collaborative was attendance at a series of study days that were away from the participants' main workplace. Overall, participants appreciated this opportunity to have time out from their normal roles which allowed space to think around the issues and challenges presented in the collaborative process:

> *It added to the atmosphere definitely. When you're coming here for an hour from practice it's a different story altogether. You're mind-set is different. So having the whole day was positive. FG2 P4*

Some however had reservations particularly in terms of leaving the workplace for an extended period:

> *I think the off-site was for me personally was difficult and I know that came from a few of the CNMs. FG4 P1*

> *That can have swing and roundabouts. Because if it's off site you're away from everything. But I often find if you come into the placement it's very difficult to get out even if it's on site. What was an advantage for me is they laid out the meeting dates in advance. FG4 P2*

Some concerns over attendance and engagement by some individuals and occupational groups were expressed. Initial attendance was good and then as the collaborative continued, attendance become poorer with some professional groups absent with less engagement. It was recognised though, that it can be difficult to get diverse groups together and that release was a significant challenge:

> *I think as well with peoples' time, it was very hard to get people to come to meetings. So it's very time consuming. I definitely found that was one of the down sides to it in a sense that people found it hard to commit the time to coming. And even doing the work back at base as well was difficult. FG3 P1*

Participants also appreciated the venues that the meetings were held in, as these were comfortable and again being off-site provided much needed opportunities to be able to engage with the task in hand:

> *Facilities provided were excellent. A lot of it was done through the hotel and lunches were provided, very well catered for and facilitated for on the days. The facilities on the days it was running were very good. FG5 P1*

Some appreciated that there was a clear structure and time frame in terms of what was expected:

> *We had achievement to meet and we got there. So it wasn't just a project that was on the never never. We had a time frame and there were a lot of goals and targets built in to that. That made you work together as a team as well and share ideas and move it across all the hospitals again. FG4 P2*

Although some would have appreciated more direction as to how to achieve the expected goals:

> *We were left to our own devices a lot at the start. This was the first collaborative of its kind (falls) so you had very little direction. There was always direction there and to be sought from, but still it was 'well whatever you think, you develop your idea'. FG5 P1*

Participants felt this process had been tried and tested in many other settings internationally and that the lessons learnt meant they were the beneficiaries of that. They could see that this was a well organised, well executed initiative which was trying to move the participants to bring about:

> *..a small test of change. FG3 P2*

> *We were moved on without realising it let's say we were guided and whilst we were, an energy grew up within the group we were working with and we were moving with that goal. Also I would imagine the goals were set for us to meet as well and it were very rewarding. FG4 P3*

This process while requiring commitment was also fun and this was a significant enabler:

> *There was fun in it as well as everything else yeah. Cos the girls over in the medicine and in perioperative would absolutely say they had fun. You know, it was great to actually get that time invested and to learn while they were doing it. Time out was really important. FG2 P2*

They also appreciated the mentoring and coaching supports that were offered in the leadership programme and this helped them in the process:

> *There were several issues from the ward that I would have brought to my mentor and sometimes it's listening to yourself saying it and you're nearly coming up with the solution. FG2 P5*

However, in some collaboratives, internal group dynamics affected their experience and the functioning of the group. For example, clearly defining tasks did not always occur:

> *I suppose clearly defining between one meeting and the next. Because sometimes people were coming back the next day and there was mixed messages about what we were meant to have done. I think more clarity sometimes around this is exactly what you need to do for the next day. Because when you've a lot of people together people can go away with different perceptions of what ... not the homework but it is homework in a sense I suppose in that it needs to be very clear. FG2 P5*

> *And maybe whose doing what with the homework….. You've those that will always be doers and those that will sit on the fence. FG2 P1*

As 13 of the 18 participants were nurses and midwives, it is unsurprising that there was a clear sense that the collaboratives were driven from a nursing and midwifery perspective. They did appreciate though the need to have buy-in from medical colleagues and other health care professionals:

> *It's seeing it in operation and realising the value of it. That's beneficial.* ***…….****We had to sell it and bring them on board and when they came in we had to make sure that we kept them within the group as well. FG2 P1*

Buy in from medical consultants was seen as particularly important in terms of driving forward with the individual initiatives:

> *So a consultant lead was identified and he took it on board. And I tell you, he really made all the difference. When there was challenges he just picked up the phone, identified who was having the issue, got on straight away and knocked it on the head. FG4 P2*

3.1.2 Facilitation

This second sub-theme focused on how the collaboratives were facilitated on the off-site days. As part of the process, each collaborative was assigned experienced facilitators to help the groups achieve their goals. Participants were overwhelmingly positive regarding the facilitation process noting for example how the facilitators could energise the group:

> *(Facilitator 1) who ran it, (they) was fantastic. (They) just pulled our (group) together completely and (Facilitator 2) who came down from the (organisation). They were insightful and would motivate the dead to get up! FG4 P5*

It was also noted that the facilitators could and would challenge groups if necessary:

> *You see (they) called a spade a spade. When people didn't turn up (they) quite easily challenged and said 'well ye weren't here the last time'. So there was a lot of honesty and (they) didn't in any way kowtow to their own profession. And laid it quite clearly on the line if you guys want quality, then you have to be part of the quality side. Don't be expecting the nurses to do it. FG3 P2*

This participant went on to comment on the personal and professional attributes of the facilitators as being a powerful motivator in the success of the group's endeavours:

> *I think the credibility as well, when it came to the collaborative and the quality methodology, the credibility of (facilitator) was absolutely crucial in a lot of that. Because (they) has walked the walk and talked ... (they) not just ... (they) has done this over and over again across the world. And I think you couldn't underestimate that when it came to the quality piece of it. FG3 P2*

In addition to these more personal attributes, the participants recognised and enjoyed some of the teaching and learning strategies that the facilitators employed:

> *What it created a fantastic buzz! Like there was a healthy competition at the end of it because yes we were all together but we were broken down into groups all with one common goal to come up with a falls programme that worked within the sites. So obviously there was a healthy relationship between us all because we all wanted to win! FG4 P4*

The innovative learning strategies employed helped to build confidence, empowerment and for one participant was effective in tackling 'learned helplessness':

> *You mean we have to go and do this now so we're happy to go and sit there and listen, but now you're expecting me to implement it. I work every day and I do really good patient care, now you want me to have an output from an initiative as well. So that learned bit of helplessness had to be dealt with and managed. FG3 P2*

> *I think it was a shared learning experience. I think the learning was organic. As I said, because it was so well structured it prompted us along the way cleverly. FG4 P3*

3.1.3 'Bottom- up' approach

This third sub-theme reflects the importance of adopting a 'bottom-up' approach to change management. Because the initiatives came from the ground, staff were empowered to make the changes and this was seen as very important to the success of the initiative. Staff had ownership and were not 'being told' to implement change. Participants acknowledged and appreciated the investment that had been provided to enable the collaborative and that institutional and management support for the collaborative was very evident:

> *The steering group was led by the Chief DON. The key members were the business and finance managers – so it wasn't tokenism, there was no point in doing a change if the finance manager wasn't going to support it. FG3 P2*

> *You had the Executive Team backing you. So when you did run into difficulties or challenges you could go back and things that might have taken a really long time to access were moved along very quickly. FG4 P2*

Support from management was very much appreciated, and while it was seen as core to the success of the initiatives; driving change from the ground up was very motivating, rewarding and generated momentum:

> *So while you had top management support and no interference you had bottom led change. FG3 P2*

> *The midwives were involved in it and I think that was a good part of the success of it as well. That it wasn't being imposed from the top down. People were being given an opportunity to be involved. FG2 P1*

3.1.4 The Multi-disciplinary dimension

This final sub-theme relates to the multi-disciplinary nature of the collaborative groups. Each collaborative was intended to be a mixture of different disciplines and occupational groups within the entire hospital structure with a focus on a specific area of practice to change. For some groups this was an essential factor in success:

> *Having a multi-disciplinary sold it as well. It was shown to be important. We were taking it seriously. We needed to do something in relation to our communication and to do so safely. FG2 P1*

> *By having the multi-disciplinary team embracing it and having a clear focus on what they're trying to achieve, they really can get a huge amount more out of it leading to real change on the ground for quality improvements for patients. FG2 P2*

How successful this multi-disciplinary engagement seemed to vary, with some groups reporting good engagement and others feeling that it was left to one professional group, primarily nurses. In the groups where there was good engagement there were perceived benefits. The most frequent comment was that the multi-disciplinary nature of the collaborative helped to build relationships and this was beneficial:

> *I think that was really helpful. It's quite intense when you're working within the site. So it's nice to get out and have that bit of time to get to know people and to try and you know, work together on the main issues that you have within the sites. …….So there was big integration, big networking within the directorate. I suppose for them to network within the wider health care community … that multi- disciplinary piece – that was really huge. FG2 P3*

The multi-disciplinary nature of the collaborative helped to develop links across disciplines and professions:

> *And it was great for us as a directorate because we wouldn't have had that link with our paediatric colleagues before and we really secured a relationship there. FG2 P5*

They also respected and were made aware of the contribution, knowledge and attributes that other professional and occupational groups bring:

> *It broke down barriers you said about multidisciplinary for us and really strengthened physio, nursing relationships within the hospital for ourselves. And allowed people to bring their own expertise and there was a great awareness of the skill set people had and what they could bring to the table. FG4 P5*

> *I think the whole multi-disciplinary aspect of the collaborative comes through in the DVD because we had everybody involved in it. All the different ... physios, consultants, student midwives. FG2 P5*

These benefits were not reported in all groups however. If there was a perceived lack of engagement by other professional and occupational groupings then this was problematic:

> *The consultant's involvement sometimes as well was difficult. Trying to get them to actually attend the learning sessions and we had ... like we have a few incidents where they just didn't turn up. FG3 P1*

Some participants within some focus groups felt that there was an over–reliance on small numbers of one professional group (nurses) to drive the change. There was a perception that some of the other professional and occupational groups sometimes lacked full engagement in the process:

> *We didn't have medical buy in shall we say in our group. We tried to get a consultant on board as was deemed appropriate. FG4 P5*

> *I think some of that problem too came from the lack of multidisciplinary input at the start. No one took it back to the medics or allied health professionals. FG5 P1*

3. 2 LEARNING ABOUT LEADERSHIP

The second objective of the study related to identifying any learning from a leadership perspective that may have occurred as the collaborative was linked with the Future Nurse/ Midwife Leadership programme. Unlike the previous theme, there was less discussion around leadership although all recognised the importance of it. In sharing their experiences, being part of a collaborative helped some participants learn how to be a leader and develop their leadership skills.

3.2.1 Developing leadership

Some, but not all participants made the connection between the leadership programme and the QIC and found the connection between the two helpful:

> *Participant: See the collaborative was done as part of a leadership and quality programme so I suppose when you combine the two programmes there was a lot of learning in them. But from the collaborative itself …. As far as learning from leadership …. I suppose you start to get more assertive in your role (laughter). I suppose a lot of us were invested in it and then there was a lot of people that didn't buy in. So you had to kind of get … very vocal and arrange and organise things. A lot of it came down to a few people. FG5 P2*

> *Interviewer: Did participating in the quality improvement collaborative influence understanding of leadership and change management – did it help you? Are you better because of it?*
>
> *Participant: Oh yeah absolutely. Because you work with other people besides your own. So you get a better insight into working with other people. Absolutely yeah. And because I think it's very important to have a good overview of other peoples' .... because I think you can get very insular in your own world sometimes. FG1 P1*

For those nurses in more junior managerial roles, being part of the collaborative helped them to become a leader and they recognised this:

> *I went from a staff nurse to a CNM2 role at the beginning of the collaborative. So my leadership skills..it really influenced those because I was going into an area that was unknown to me……. I gained loads from it. .....I gained confidence in myself, in my skills as a CNM2 in my area… I suppose being a leader you have to gain skills of being approachable and not being too authoritative with people as well. You're trying to bring in change as well. FG4 P1*

For others in more senior managerial roles, although they recognised that potentially the two programmes were designed to connect, in their experience there was a disconnect:

> *The collaborative was part of a wider programme of quality in management and leadership and I think the two didn't really marry up. The collaborative kind of took over from the quality and leadership programme in that it took a different direction as opposed to the leadership. So I don't know that the two of them married quite well. FG5 P1*

In trying to further explore in the focus groups what leadership skills may have been developed, characteristics such as confidence was identified:

> *There was a confidence, how things was brought back to the wards... the tool was self-explanatory, it worked. To have the confidence to bring it into practice and to change management. To be able to bring all staff involved...to get behind it. But it gave the CMM2s I think that attended a confidence in leadership. FG2 P4*

> *I* gained confidence in myself, in my skills as a CNM2 in my area. And I suppose it opened doors, knowing who people were was a big thing for me. Like you said, picking up the phone and knowing someone at the other end. And what you say actually counts for something. And I suppose being a leader you have to gain skills of being approachable and not being too authoritative with people as well. FG4 P1

Some participants acknowledged that those at CNM2 level and above already had leadership attributes and skills and that these were developed and exploited further by being part of the collaboratives:

The CNM2s actually turned out to be geniuses at getting teams together - as we do. So that was a really good model. Because what they did, they got their team

relevant to their area. So we had multiple teams. But the CNM2s were really good at cajoling, inviting ... FG3P2

Differing opinions were offered though on how the collaboratives impacted on leadership skills. One participant commented that as the leadership role was inherent with one's personality, being part of the collaborative might help to develop that further:

> *I suppose we all have leadership qualities in yourself, intrinsic in our personalities but it's defining I suppose what qualities you have as a leader can be more influential and gaining skills to further develop that. FG4 P1*

Having had the opportunity to have 'time out' themselves in attending the collaboratives, helped one participant to recognise the need to facilitate creativity in their staff members. This they saw as a leadership attribute:

> *I think too from the leadership perspective, about allowing, you know the way sometimes we're very focused on rosters and absenteeism and everything that all that brings, it's also really to think that we need to allow the staff – of all disciplines, time out to come together with good ideas. It is there we have to facilitate that. it's about ... they can't do it and I can't do it, may other people can but it's very difficult to do it in your working day when you know you have a very very set agenda and you've meetings and diaries and you know, it's when you're out and about and you're talking to other people or you're doing a walk about somewhere that you know, you're struck by something and that's where you get that idea from. FG3 P3*

It was worth noting that some participants commented that for them being part of a collaborative had no impact on their leadership skills:

> *To answer your question specifically, I don't think it did for me. I'm agreeing with what everybody is saying. But I don't think it had an impact on my leadership skills. I don't think it improved them necessarily or dis-improved them. It allowed me to use the skills that I have. But I don't think it enhanced them. FG4 P5*

3.3 MANAGING AND SUSTAINING CHANGE IN PRACTICE

This third objective related to an important aspect of change management which is sustaining the change once it has been introduced and was regarded as an important but challenging issue by the participants. Within this theme there are two sub-themes; sustainability stories and ensuring sustainability.

3.3.1 Sustainability stories

Some participants identified that the change had been sustained in practice:

> *Our community based programme in falls prevention came out of it and also our linking with the LIU (local injuries unit) within the hospital. We had a really successful collaborative. We reduced falls by 40%. So that they now refer fallers to us who don't have a fracture. FG4 P5*

> *Yes it's a quality improvement initiative and it has improved the standards of care especially here. I'm only here a couple of weeks but you can see on a site where it does work well and the momentum has been kept up. FG5 P3*

> *We're sustaining it. It really perks everybody up for six months you know. You can see it has lasted all you have to do is walk into our wards and see. I've no problems in doing that with you right now. That's how confident I am that it's in use. FG3 P3*

If the collaborative centred on choosing a project that was central to daily work for example safety pauses in the peri-operative environment, this enabled sustainability:

> *And so like, it has become the norm now and doctors that come from other hospitals expect this. Expect time out to be called. Expect to have to sign in. it's expected. So it's a normalised practice. But the funny thing now is, it's never initiated now the medical team, by the doctors. It's usually the nurse "now we'll have time out now". So before you'd have a surgeon saying "ok we'll have time out" and now it's left to the nurses to call it. So I don't mind as long as it's called and the questions are answered. FG4 P2*

Some participants mentioned that introducing the change started well but then lost momentum as time went on:

> *We had good momentum for quite a while. Then things dipped off a little bit but we've always been conscious of it and highlighting it. So next Monday we're starting again to reinvigorate…we're meeting to discuss how we can drive it on again. FG4 P5*

However, these success stories were not evident across all collaboratives and in all hospital group sites:

> *I can't say it's been visible. I would have to be honest and say that. FG5P2*

3.3.2 Ensuring sustainability: change agents and leadership

The importance of continued, effective leadership to ensure sustainability was recognised in all focus groups as summarised by one participant:

> *I suppose the importance of leading with it was the message that even though we'd done all the work with it, we needed to maintain it. And sustain it as leaders in the clinical areas. FG2 P1*

This was supported by another who commented on the importance of an individual motivated to ensure sustaining the change:

> *Unless there is somebody interested to drive it in it, it's not going to work. You can see how well it's working here… FG5 P3*

This reliance on a single individual can be problematic in that if they take up a different role or leave then the physical resources such as leaflets and stickers specially obtained for the intervention may be lost as well:

> *It wound up being very person dependent. Like all the falls identifiers, the stickers, the magnets, leaflets – I've stored them all where I was working. I haven't worked there in two years. I couldn't honestly tell you where they're stored now. FG5 P2*

In summary, all participants discussed that sustainability was a challenge:

> *Quality improvement is challenging to sustain I think a lot of it then comes back to people who are burnt out and new things are difficult to implement. It often is the same people who are leading quality improvements... barriers can often be the same barriers and it can be difficult and challenging to come around that. It's always the same people who want to change things ... FG1 P1*

> *Trying to sustain it is very difficult. I suppose in order for something like this to work champions are needed. People who have a genuine interest or a love of trying to get this done and maybe if this collaborative was done again people who have that buy in should be targeted. FG5 P2*

3.4 BENEFITS OF BEING PART OF A QUALITY IMPROVEMENT COLLABORATIVE.

The final study objective explored participants' views of the benefits of being part of a quality improvement collaborative. For the participants, the experience of participating in these collaborative was primarily a positive one. The benefit of the collaboratives in breaking down inter-professional relationship barriers within sites and between sites was highlighted by all participants. Within this theme were three sub-themes; making links and opening up communication, impacting practice and acknowledgement of work done.

3.4.1 Making links and opening up communication

Once again in reflecting on the benefits of being part of the collaboratives, participants talked of the benefits of the multi-disciplinary approach that was adopted in the collaboratives. The opportunity for staff to link with colleagues within their own site and across sites was greatly valued and resulted in a sharing of knowledge, information and the opportunity to learn from each other:

> *We've all said probably that was the most positive thing that ever came out of it – you link up* with your colleagues on other sites. FG5 P1

> *There was lot of barriers broken down and then people were able to work collectively in a group for the better outcome of whatever collaborative they were working on. FG4 P3*

The opportunity for collaboration provided different perspectives which stimulated thinking and problem solving:

> *... you've somebody to, discuss it with that has the similar problem and maybe work out the solution. FG3P3*

Those links developed and impacted not only within the collaborative but on the day to day working environment where participants spoke of the difference it made to them in being able to put a' face to a name' when communicating across the sites:

> *Now I'm talking to real people rather than the CNM2 from (hospital name). So there was a lot of that. That was very powerful to see that happening. FG3 P2*

> *So it brought cohesiveness and a collaboration to the table and people got to know each other very well. So now since the collaborative, people are able to communicate much better with each other. Because the barriers have been broken down. They know each other, they've worked with each other and they can build up an allegiance with each other. FG2 P2*

3.4.2 Impacting practice

The purpose of the collaborative was to bring about a small change in practice and it was evident that this was achieved across all three collaboratives. In the first collaborative which was falls prevention, some tangible changes were evident:

> *There's a small discharge huddle regarding falls and discharge planning and forward thinking you know with physio, discharge nursing. So out of that grew this. So it's great. FG4 P4*

In the second collaborative which was maternal and child health, an internationally recognised tool for communication the ISBAR was introduced:

> *A lot of new changes happened across all of the sites and the collaboratives as a result in ISBAR communication, ISBAR stickers, the way handover is given. FG2P2*

> *And the ownership you could see it in staff. Because they were learning simple improvement, quality improvement techniques like the PDSA cycles, like the RUN charts and they were proud of them. FG2P3*

Thirdly the final collaborative which was in the peri-operative directorate:

> *…the new checklists for surgery you know there's certainly real tangible outcomes as a result of the work in the three divisions. FG1P2*

Being part of the collaborative also brought a sense of accountability and responsibility in each initiative. Two of the collaboratives (falls and maternal and child health) decided to produce an in-house DVD as part of their outputs from their collaboratives. For one site initially struggling with 'buy-in' from their colleagues to implement the change, the production of a DVD helped the implementation of the change in practice:

> *I think if the DVD wasn't there, it could have fallen apart completely. Because I felt under pressure, I signed up to do this, I said I would get this done … I was going to get this done. So in that way it was a focus and in order to produce the DVD we had to have x, y and z done about falls. FG5 P2*

Overall, participants also became aware as well of the hospital as a whole inter-connected system in recognising the *'ripple effect'* where one change made in one place impacts on others:

> *It's a hospital. It's different than any other type of business. So you quickly find out that what you change there has a ripple effect, with documents, with patients, with porters and cleaners. So you have to bring the whole world into the room. And suddenly it becomes very difficult to change the whole world. But that's what you have to do, bit by bit ... to facilitate the change because there is a ripple effect somewhere along the way. FG3 P3*

3.4.3 Acknowledgement of work done

Participants valued the acknowledgement for the work they had done within the collaboratives. 'Celebrating' the work of the groups was part of the process and was much appreciated as was disseminating their work to their peers and colleagues:

> *The celebration days that the videos were shown was fun. It was also acknowledgement of good work done and that's so important because that doesn't happen. FG3 P3*

> *We were invited to speak at the Research and Innovation Conference in The Strand as well which promoted our falls programme. So that was all positive. FG4 P4*

Internally, within their clinical directorates there was also acknowledgement of the work done and their contribution to practice. For nurses, this meant their medical colleagues approaching them to collaborate and this was seen as very beneficial:

> *And funnily enough it was the anaesthetic registrars approached us after our collaborative to work with them. FG2 P5*

Acknowledgement from outside agencies such as the local Nursing and Midwifery Practice Development Unit was appreciated:

> *The girls were very successful when they made an application for the DVD. That was very appreciative and supportive. FG2 P3*

3.5 PLANNING FUTURE COLLABORATIVES

This final theme relates to the overall aim of the study which was to explore experiences in leading and being part of a quality improvement collaborative. Attendance at the focus groups and the subsequent discussions allowed participants an opportunity to further reflect on their experiences. In doing so there emerged a clear theme around ideas for future collaboratives. Throughout the course of the interviews and in reflecting on their experience, participants made a number of recommendations relating to the process. These were; preparing for the collaborative, enabling the process and end point planning.

3.5.1 Preparing for the collaborative

Participants valued the lead in time to the project and thought it was beneficial. Some felt though that this time could be extended to include more information on what collaboratives are and what their function might be:

> *The engagement sessions are key. People know what they're getting into and you have a bit more time for this pre-work. There are so many different*

> *things involved in running a collaborative…. I think the lead in time is very important. FG3P1*

> *More planning and organisation earlier would help. I think more information sessions within the organisation of what a collaborative is and what we'd expect people to come out with towards the end. More briefing. FG1P2*

One participant felt that bringing in key personnel earlier in the process to provide an overview of their directorate would be helpful:

> *To give an overview of the directorate vision half ways through the collaborative and then suddenly they all went "oh now I get why we're all in the room" they all knew were suddenly one hospital. But they saw suddenly where they sat in the chain and how it worked. So even if that overview is very early on, it's very important. For people to realise why they're there or why people around them are there. FG2P2*

The importance of selecting an appropriate topic was echoed through all the interviews. The topic had to be of clinical significance and be informed by policy with sufficient interest to engage all members of the collaborative. The participants identified the importance of adequate ground work in terms of reviewing available evidence and actively seeking out policies and practice guidelines that might underpin the change:

> *Start small with a steering committee, get your focus right, get a policy together that you can work from…so that everybody is doing the same thing on every site in every ward in every department…. taking it small and taking baby steps into big steps. FG5 P1*

Reviewing and appraising the available evidence is a skilled and time consuming process and it may be that this vital step might have not been fully addressed in some groups.

Although it was acknowledged it might be difficult to anticipate this at the beginning, a clear identification of structured and achievable targets and goals would also have helped:

> *I suppose clear targets. Clear goals. …Identify roles within the group so that people aren't left isolated within the group and their voices are heard. I suppose having it measurable then as well, I suppose that's the only way you're going to know how efficient it is, to measure it. That's another topic is*

> *how to measure it! That would be important. I suppose the feasibility then as well needs to be something, feasibility of whatever it is you're doing. FG1 P2*

3.5.2 Enabling the process

As the collaboratives began, the need for leadership in particular the perceived need for a project lead who would oversee the individual project was suggested:

> *Maybe if somebody had been assigned….like a mentor maybe ….to work with the group that could have gone between the different sites. FG5 P3*

Part of the need for this kind of more visible leadership was trying to address the issue of perceived non-engagement by some other members of the multi-disciplinary team:

> *Stick it through to the end. I would nearly make people sign a contract to it! Not make it so easy for people to fall out. There was no follow up on people that didn't attend. FG5 P1*

Participants pointed to some practical concerns, which functioned as barriers throughout the process which could be anticipated and planned for in future collaboratives:

> *I do think an awful lot of time got caught up in procuring and securing the identifiers, for want of a better description that we used. So we went with the Falling Star initiative …….But trying to get the wrist bands we decided to use from Posey in the States and trying to get different identifiers to identify the patient without singling them out proved very time costly. And it was hard to progress until we had them and the collaborative was over by the time the merchandise arrived. FG5 P1*

3.5.3 End-point planning

In terms of sustainability, some participants expressed a wish for a longer term more formal follow up and evaluation process:

> *Probably would have been nice if there was some follow up. Even twelve months later, if everyone could have come back together. And just see … because that's the thing about a lot of new initiatives, they're not sustained. So just to see like where was it still working and how had they achieved that and what were the problems that caused it to fizzle out in other sites. It all went cold very quickly. FG5 P3*

Some participants suggested that the ground work and effort in the initial project could be used to move forward to implement a second phase of action and evaluation cycles:

> *D'you know what might have been an idea. Like we were the first collaborative for falls, maybe a second collaborative for falls should have been started where you begin again with the information you have now. And now you start and I think that way, cos we would have had all our information maybe it would have been launched at a higher scale or wider scale. Like, we had discussed that by the end of this our plan would be the Falling Star initiative would be viral. So that it would just go everywhere. But unfortunately it didn't go that way. But maybe if we had a second collaborative where you've learned this much now, we start again…. FG5 P2*

> *One thing, if you're talking about a phase two collaborative it's very important you don't go off on a tangent without closing off the first one. Because I know like, there's phases out of that first collaborative that need to be tied up, that documentation needs to be sorted, that we need to get across the board, we need to be streamlining our documentation. So different in (hospital name) than it is here. And it's from all different printers. It's a logistical nightmare. FG4 P2*

The recognition of the importance of sustaining the change led to a recommendation that a sustainability plan be identified before the group disbands:

I suppose at the end, before everybody kind of disbands as a collaborative, it's about ensuring there's a sustainability plan worked on. People go back to the workforce with an idea of how they come back together on the ground, to try and keep it going to develop it further because it's not just going to stagnate it's going to get better. FG2 P2

SECTION 4: DISCUSSION

4.1 ENABLERS AND BARRIERS IN CREATING AN EFFECTIVE QUALITY IMPROVEMENT COLLABORATIVE

From the findings, participants were extremely positive regarding their experience of the collaboratives as they recognised the knowledge and skills that went into organising and facilitating them. The expert guidance by outside facilitators was regarded as a powerful enabler to drive the collaboratives towards their goals. In this sense, the whole ethos of a bottom-up change, well facilitated, using off-site venues and supported by senior management was an effective strategy. This should be repeated in any future collaboratives.

A key component of collaboratives to improve quality of care and implement evidence-based practice is to use a multi-disciplinary approach (Nadeem et al. 2013). This was adhered to in these groups with all members of the team not just healthcare professionals being invited to participate. The rationale for this is well articulated in the literature aiming for peers to meet and learn from each other in developing and implementing data-driven quality improvement plans (Agency for Healthcare Research and Quality 2014, Compas et al. 2008). Bevan (2010) also highlights the importance of having the right number and level of people with the confidence and knowledge for meaningful engagement. However, the actual experience of such a multi-disciplinary approach was mixed in these collaboratives. In some groups where there was a committed multi-disciplinary engagement the benefits were clear in terms of identifying shared goals and strategies to achieve those goals. Working together resulted in identification and understanding of the others' contributions and the importance of building networks. In other groups, such engagement was less apparent and resulted in stress and tension where some members felt obliged to take on the responsibility to ensure the group met their goals. Paying attention to this aspect of the micro-culture of collaboratives is important (Orchard et al. 2005, Nembhard et al. 2009). Furthermore acknowledgement of power relationships between individual occupational groups and how these are managed internally within the collaboratives is also essential (Carter et al. 2014). This is an area that could be explored further both in the pre-collaborative and on-going phases of the process. The collaboratives were evaluated by the participants at the end of the programme but the opportunity for an evaluation in the longer term is needed to further

reflect on the process. Interestingly, attending the focus groups gave participants the opportunity to reflect on their experiences. In doing so, they identified aspects of the process that they wanted to retain and aspects that could be improved in future collaboratives.

4.2 FACILITATING LEADERSHIP

These collaboratives were connected to a national programme to develop nurse leadership (HSE 2009) where it was hoped that CNM/CMMs would become familiar with both the fundamentals of effective leadership, and quality improvement methodologies. It also aimed to offer clinical managers the opportunity to adopt a team approach to quality improvement, and provide nursing and midwifery participants with a multidisciplinary forum to embed learning derived from the leadership programme. Therefore, leadership, particularly in relation to nurses and midwives, was specifically addressed in the focus groups. In response to focus group interview questions on leadership, the findings from the data were mixed. Some participants were aware of how the QIC had impacted on their leadership skills, while others were not. This may be dependent on the experience and skills that participants already had and the role they played in the collaborative. They appeared to recognise the lack of contribution by some members of some collaboratives (other collaborative groups had good engagement by all participants) and dealt with this by taking the lead in order to ensure the group was successful. There were numerous examples therefore, of where the nurse/midwife participants presented themselves as having to take a leadership role in order to ensure that the goals of the collaborative were achieved. Often, true leadership is independent of prescribed roles and responsibilities (Browning et al. 2011), thus nurses and midwives took on these leadership roles within the collaboratives as they were naturally active leaders. However, participants did not always make a clear connection between the leadership programme they had undergone and their attendance at the collaboratives. Active, focused reflection on evaluation of their leadership roles, and strategies they used within the collaboratives, may facilitate participants to make these connections.

In designing the collaboratives, key elements included building and sustaining collaborative relationships and the use of critical questioning techniques to challenge inappropriate practices and behaviours. Despite this, there appeared to be a limited amount of strategies utilised or at least reported by participants in trying to ensure those who would not engage with the process would make a contribution. Participants mentioned some strategies such as ensuring everyone sign a contract to ensure their commitment but in the end they resorted to taking on the roles and responsibilities themselves to ensure the group would succeed.

Orchard et al. (2005) recommend that in transforming barriers such as non-engagement in the group process into enablers; role clarification, role valuing and power sharing are central to the change process. It is therefore necessary to challenge power imbalances and value conflicts within the groups and within practice thus enhancing satisfaction with patient care provision and delivery. Developing effective strategies to manage group processes, the so called 'black box' (Nembhard 2009) is an area that could usefully be reinforced in the planning of future collaboratives.

4.3 MANAGING AND SUSTAINING CHANGE IN PRACTICE

Ensuring sustainability of clinical change is recognised as being extremely important once the initial change has been introduced (Bray et al. 2009). Theoretically, this equates to Lewin's 'freezing' stage (Robbins and Judge 2016) in which the change is embedded and sustained within the organisation. Participants made great efforts to bring about important changes in practice resulting in a sense of pride in their achievements. The challenge was to sustain the change and again a varied picture emerged. Some participants reported that the change was visible and embedded such as in the peri-operative and maternal and child health collaboratives. A more mixed picture emerged from the falls collaborative reporting that changes were visible in some areas but not in others. Factors such as site size and staff changes were cited as possible barriers to enabling sustainability. It appeared to be easier to sustain the change in some of the smaller hospitals for example.

When asked how change may be sustained the participants recognised that a key component was maintaining continuity of clinical leadership within the clinical area. They suggested that an identified person is appointed to drive the change once the collaboratives were completed. This is consistently cited as a crucial factor in sustainability within the literature (Bray et al. 2009). Additionally, while QICs have the potential for increasing sustained change by building local capacity (Nadeem et al. 2013) without continuing evident sponsorship and support from senior leaders, improvement will not occur (Øvretveit 2002).

Recent evidence proposes managed networks as a means to ensure sustainability and continuous quality improvement in healthcare (Cunningham et al. 2012, Malbay and Mervyn, 2012a, 2012b, Randall 2013). The potential of these 'managed networks' had been recognised within the organisation with some initial planning for their implementation

identified before the collaboratives began. The participants though made little mention of this strategy being visible in ensuring sustainability and suggested that prior to any future collaboratives a 'sustainability plan' should be devised.

4.4 PARTICIPANTS' VIEWS OF THE BENEFITS OF BEING PART OF A QUALITY IMPROVEMENT COLLABORATIVE

Participants described three key benefits. The first related to a perception of improved relationships and communication within the multi-disciplinary team and with colleagues across sites within the ULH Mid-West Region. Despite some tensions and issues raised regarding the multi-disciplinary input into the groups, participants could see benefits in practice by effectively communicating and linking with their colleagues. Participants acquired an increased understanding of the roles and functions of individuals within the broader organisation. This is similar to the findings of research by Nembhard, (2009) where collaboratives work best if they capitalise on their inter-organisational features such as actively engaging with each other within the organisation to learn from each other.

The second benefit relates to seeing a tangible change introduced into practice which was perceived as extremely positive. Clinical governance and patient safety is a major concern in today's resource limited health care environments (HSE 2014). Organisations where nurses are empowered to practise their profession to the best of their ability are organisations that optimise conditions for providing safe patient care (Armstrong and Laschinger 2006). It was evident that all of the QICs were underpinned by participants' strong commitment to patient safety. There was a pride in bringing about such a change accompanied by a sense of empowerment.

The third benefit related to feeling valued through acknowledgement of the work that participants had done and the importance of celebrating successes (Willeumier 2004). Tangible outputs such as the production of DVDs by two of the collaboratives with valued multi-disciplinary input provided a platform to help implement change amongst their wider peers and colleagues at a local level. There was huge work and commitment made to the development of the DVDs with some participants suggesting that the focus needed to be more on providing structures and process to facilitate the change in practice. The

dissemination events of the collaboratives within the local region were quite effective though in presenting and demonstrating measurable outcomes of how the different changes had impacted on practice. Duckers et al. (2014) suggest that perceived success at group level based on the opinions of individual project leaders has been shown to be very important in dissemination potential within the organisation.

SECTION 5: CONCLUSION

Being part of these collaboratives in the University of Limerick Hospitals was to be involved in a well organised and well facilitated process in which participants enjoyed and gained from immensely. The benefits related to working with and developing relationships, outside of their professional and occupational group across ULH to bring about a tangible change in practice. Their focus was on patient safety and the commitment to that was very evident throughout the process and beyond. The participants worked hard and appreciated the celebration of their achievements that the process offered them.

In reflecting on their experience, participants identified areas of the process which might be improved such as more attention to preparing individuals to join the collaborative in terms of understanding what their aims are. The multi-disciplinary aspect although beneficial did generate some tension for some groups particularly where there was a perception that some occupational groups were not fully engaging with the process all of the time. The nurses and midwives in particular, compensated for this by making extra efforts to ensure that the groups achieved their outcomes. Paying attention to the micro-culture and group processes within individual collaboratives, in particular, strategies to manage challenging issues within the groups would be useful. Although, for some participants being part of a QIC helped them to attain and develop leadership skills and attributes, the connection between attending or leading a collaborative and developing and utilising leadership skills in nurses and midwives was not overtly made by participants. In future collaboratives, an opportunity to formally reflect in a structured way on the experience of being part of a collaborative with an emphasis on identifying the learning about leadership would be beneficial.

The challenges in ensuring sustainability of the interventions were significant. All recognised these challenges and sustainability should be built into all stages of the collaborative process. Building sustainability plans should be on-going and certainly should be in place before the collaboratives conclude with an identified person appointed to continue to drive the change once the collaboratives are completed.

SECTION 6: RECOMMENDATIONS

1. Continue with the existing structure, facilitation and organisational processes with minor amendments.
2. In the preparatory phase include more input on what collaboratives are and what being in a collaborative entails.
3. Prepare participants to effectively identify and manage the micro-culture and group processes within their QIC groups.
4. Implement a strategy for managing non-attendance and non-engagement by individuals and occupational groups.
5. Require each group and organisation to develop a sustainability plan for their collaborative from the beginning of the QIC process and before the groups disband.
6. Implement a longer term (one year) follow up evaluation of being in a collaborative including a focus on leadership.

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SECTION 8: APPENDICES

APPENDIX 1: FNML AND QIC PROGRAMME STRUCTURE

University of Limerick Hospitals: Future Nurse/Midwife Leaders (FNML) Programmes and Quality Collaboratives

Overview: Teresa Moore Leadership and Innovation Advisor/Project Lead

Phone: +353 87 983 0592 email: Teresam.moore@hse.ie

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Context

Between 2011- 2012 six hospitals in the Mid-West region were reconfigured, into one hospital group-ULH's, the existing governance structures were streamlined and four clinical directorates established to manage the clinical specialities across all the hospitals. The new Directorates were Medicine, Peri-Operative, Maternal & Child Health and Diagnostics. While the Directorate management structure had many advantages, some of the challenges identified were geographic dispersion, variance in work practices and protocols, and organizational cultures and team communication issues. To support nurses and midwives to manage these challenges the Chief Director of Nursing and Midwifery commissioned the NLIC to design and deliver a quality focused leadership programmes for clinical nurse and

midwife managers (CNM2/CMM2). Each bespoke programme designed to meet the needs a cohort of CNM/CMM's from a specific Directorate.

Overall aim of the initiative

The overall aim of the initiative was to build leadership capacity and at the same time enable clinical managers to gain an understanding of quality improvement methodology and develop the skills to implement quality initiatives. Other potential outcomes include integration, improved team working (nursing and midwifery and MDT) communications, and standardisation of practices across the Directorate.

Governance

Governance for the programme was by way of an Oversight Group, consisting of key stakeholders who had the decision-making power to champion the work, and to manage the barriers. As far as possible Group meetings were via teleconference, and chaired by the Commissioner or by a Directorate Nurse/Midwife Manager.

Funding

The initiative was funded by NLIC, National Quality Improvement Programme/HSE/RCPI and ULHs

Why CNM /CMM's 2?

The Commissioner identified the CNM/CMM 2 as the target group because they play a critical role in the coordination of care activity, and in ensuring the delivery of safe quality, care.

Leadership & Quality

The aim of the FNML programme was to promote a style of leadership that reinforced the values and standards associated with quality and safety, for this reason the four days programme was interspersed with a four-day Quality Collaborative. The aim was to enable the CNM/CMM's to become familiar with both the fundamentals of effective leadership, and quality improvement methodologies. This approach also offered the clinical managers the

opportunity to adopt a team attitude to quality improvement, and it provided participants with a multidisciplinary forum to bed-in learning derived from the leadership programme. On completion of both components, participants and their MDT teams celebrated their achievements by sharing the learning and outcomes at an end of programme forum day and later with the wider healthcare community.

Facilitators

The NLIC facilitated the design and delivery of the *Future Nurse/Midwife Leadership programme*. The National Quality Improvement Programme/HSE/RCPI in collaboration with NLIC facilitated the *Quality Collaborative* element.

Other Supports

The Nursing and Midwifery Planning and Development Unit /Centre of Nursing and Midwifery Education (CNME) HSE West/Mid-West supported the educational element. The Nursing and Midwifery Board of Ireland has awarded the FNML programme Category 1 status and 34 Continuing Education Units (CEU's).

Design Format: Future Nurse/Midwife Leadership Programme.

The NLIC used a co-design arrangement to determine the leadership needs of the Clinical Nurse/midwife managers. The process included consultation with Commissioners, line managers, and participants. The target population for the first FNML programme were CNM/CMM's from Medicine, second was Maternal and Child Health, and final programme was delivered to staff from Peri-Operative Directorate.

Dates

- Medicine - from March 2013, to March 2014,
- Maternal & Child - from January 2014 to October 2014
- Peri-Operative – from September 2014 to April 2015

Participant numbers on FNML Programme:

Exploration of health care professionals' experiences

While 18 - 20 participants registered for each of the programmes, staffing levels did dictate attendance on a given day; nonetheless attendance remained stable throughout the programmes.

Format for Delivery

The programme applied an experiential approach that included interventions such as leadership competence-specific workshops, critical thinking processes, quality observations, reflection and mentoring. Each day was semi-structured, which meant it had the flexibility to adapt to the changing needs of the Group. Days one to three were delivered a day a month (approx.) over a period of four to five months, with the Collaborative days, delivered over a similar time periods. This format enabled the CNM/CNM's and their team's time to work on their quality improvement initiatives. Day four of the FNML programme was only delivered when the teams completed their collaborative work. While the two components may appear linear or separate in practice there was a dynamic flow to the days, which allowed cross- over and intermixing of quality improvement with leadership.

Design and Format: Quality Collaborative

The National Quality Improvement Programme /HSE/RCPI and NLIC facilitated the Quality Collaborative component. It included formal information sessions on quality improvement methodologies, and support and guidance to the teams to enable them to determine baselines, and to complete their plan, do, study, act cycles.

Makeup of Collaborative teams

The format for the Collaborative meetings was the small team approach; each team consisted of 5-8 members of the MDT Team. The CNM/CMM (from the FNML programme) led or co-led a team with a medical or surgical colleague. The make –up of the teams depended on the focus of the quality improvement initiative, generally team had a cross sections of staff, which included administrative staff, porters, quality, risk management, members of the Directorate Management team, Finance, business management team and nursing-midwifery managers. Each collaborative had 5-7 teams (total 40- 50 staff).

Quality Initiative

For the CNM/CMM and their teams, a critical element of the collaborative was identifying and agreeing an area of practice that needed to be improved, and agreeing the changes

necessary to bring about that improvement. Equally important was mapping improvement activity to the strategic vision for the Directorate or the organisation, or to other quality initiatives happening with the Directorate, such as Productive Ward or Nursing Metrics. Following, a lengthy consultation process, the teams agreed the aims, SMART objectives and work processed and used Plan, Do, Study Act (PDSA) Cycle to test out and implement improvements and changes. Review and evaluation was integral part of each Collaborative cycle.

Some of the quality improvement initiatives include:

- Medicine Directorate Teams – built their quality improvement initiatives on work which was already in progress on falls and falls prevention
- Maternal and Child Health Teams - identified communication as an area ripe for improvement (both inter-disciplinary and MDT), and agreed to test out and implement the ISBAR communication tool
- Peri-operative team- worked on areas pertinent to safe surgery and issues relating to patient- flow through theatres

End of Programme Celebration

On completion of the 8 days each Directorate team presented their findings and learning to their colleagues and the wider healthcare community at an end of programme forum day. Presentations demonstrated impact or potential impact on care, costs and quality, and included recommendations on how to sustain or build on the work.

Sustainability:

It was the responsibility of the Oversight Groups and the Quality Nurse Manager to support the teams to plan and develop strategies to solidify the outputs from the Collaboratives. At the end of the initiative in May 2015 a sustainability mechanism under examination was the development of quality networks.

APPENDIX 2: INTERVIEW TOPIC GUIDE

1. What has been your experience of being in the collaborative?
2. From your experience, what factors do you think helped the group to work well and what factors did not?
3. Did participating in the quality improvement collaborative influence your understanding of leadership and change management?
4. If you were advising a team that was joining a collaborative for the first time, what advice would you give them?
5. What has it been like in trying to keep the change going?

Are there any issues that we haven't mentioned that you feel are important for you and would like to discuss further today?

END OF REPORT