Beyond improvement skills: what do clinicians, managers, patients and others need to do to make improvement happen?

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In this issue of the journal, Wright *et al* offer an in-depth examination of the implementation of six improvement projects in three English hospitals to elucidate the work that matters most to those directly involved. The framework they inductively derive from their analysis—a set of 'socio-organisational functional and facilitative tasks', or SOFFTs—gives substance to the activities undertaken by practitioners at the sharp end of improvement projects, beyond the technical skills involved in delivering quality improvement methods.[1] The notion that this class of activity may be important to the success of improvement work is not new: previous researchers, the authors of this study among them, have drawn attention to the range of organising activities that are central to success or failure of improvement efforts, for example, in engaging colleagues and ensuring fit with organisational processes, structures and culture.[2–5] Research in the field of implementation science, such as the Consolidated Framework for Implementation Research and Normalisation Process Theory,[6 7] also set out a similar range of influences on improvement efforts. This paper helpfully adds to this literature by specifying in some detail what this SOFFT work involves, with a particular focus on its implications for improvement practitioners.

To varying extents, the 20 subcomponents of the SOFFT framework that Wright *et al* set out represent bundles of activities that are closely entwined. 'Inculcating dedication to high-quality care', for example, combines work to integrate and communicate evidence-based standards, to embody and exemplify appropriate professional behaviours, and to influence, inspire and occasionally reproach others, in order to instil commitment to an improvement project and its aims. In presenting their SOFFTs as interdependent bundles in this way, and refusing the temptation to disaggregate into a list of atomised and abstracted skills, Wright *et al* take seriously the idea that the work of improvement is best understood in its enactment. Impactful improvement work is not reducible to a list of ingredients that will secure success: rather, the magic is to be found in the *phronesis* and *metis*[8]—the practical wisdom and intuitive understanding—of the practitioners who bring them together, and know from experience-informed instinct what to do with them in a particular situation. An equally important implication of Wright *et al*'s findings is the need to combine skills, dispositions and responsibilities that are likely to rest with a wide range of healthcare staff, and potentially patients and informal carers too. It is axiomatic that improvement work is a collective effort, but Wright *et al* point towards the importance of careful thought about the elements that are likely to be needed in building a productive improvement team. A productive team will need to incorporate not only the right skills for the task, project or programme in hand, but also the relational and influencing skills that help it to cohere and engage effectively with others.

This way of thinking has important implications for skills development and macro-level workforce planning. If process improvement is key to achieving daunting ambitions around quality and safety in resource-constrained environments,[9] then competence in tasks of this kind is likely to be just as important as technical acumen in improvement methods, and high-level management and

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leadership skills. Wright *et al* offer a skills audit tool based on their SOFFTs—the Fitness for Improvement Tool—and this might also have some use in plotting the content of training courses. Many of these tasks, though, are unlikely to be readily teachable. Wright *et al* draw attention to the importance of 'multidisciplinary, team-based approaches to learning,' and kinaesthetic, case-based or simulation-based group learning is undoubtedly likely to be valuable.[10] But the characteristics implied by some SOFFTs—for example, 'style' and 'tone,' key constituents of 'Adopting and promulgating the appropriate organisational environment'—may elude any formal training setting.

Accordingly, Wright *et al* argue for the potential of informal learning settings, such as communities of practice, in providing the basis for induction into effective individual and collective improvement practice. Communities of practice are groups of individuals with a shared interest who learn from one another, usually on an informal and elective basis, to develop their professional work.[11] The value of communities of practice is widely vaunted, and there is some evidence for their potential in helping participants to share and develop their professional practices, as well as in supporting specific improvement and implementation projects.[12] But communities of practice, particularly those that tend towards the original conceptualisation of self-forming communities that evolve around shared problems and practices,[11] can exhibit professional exclusivity.[13] While the participants in Wright *et al*'s study came primarily—though not exclusively—from clinical backgrounds, the combinations of skills, dispositions, responsibilities and relationships likely to be needed for most improvement projects will come from a wide range of actors, clinical and non-clinical, within and beyond an organisation. A key challenge, therefore, is diversity of participation in communities of practice, both to ensure access to the full range of contributions made by people in different parts of health and care systems, and to enable the exposure to contrasting experiences, mindsets and approaches that is likely itself to provide an important component in developing competence as an improvement practitioner. Efforts to cultivate communities that span the full range of positions and contributions offered by stakeholders in improvement—patients and carers as well as clinical and non-clinical staff—may offer a useful platform for such interactions: for example, the Q Community in the UK.[14]

Wright *et al*'s paper thus offers a welcome focus on the social and organisational work undertaken by a wide range of improvement actors, drawing attention to activities that cut across the technical and the social. The interaction of these activities with the wider organisation, however, remains crucial. Wright *et al* draw attention to the work of aligning improvement efforts with strategic priorities set at organisational level, and accessing resources and support from the top of an organisation. Thus, while the capabilities available within an extended improvement team may be important, attention to the politics of improvement remains critical: without managerial support, even projects involving the optimal range of personnel may flounder.[2 3] Work to secure high-level buy-in is indispensable. But this brings with it quandaries for those in senior roles in organisations as well, particularly as they look to provide opportunities for improvement practitioners to develop. Where resources are limited, and where capacity to enact SOFFTs is unevenly distributed, there is a risk that some improvement efforts accelerate while others are left standing. Teams that combine the right personnel, achieve improvement objectives and successfully compete for organisational attention may leave others behind. For those in senior positions, therefore, an important overarching socio-organisational functional and facilitative task may be to intervene actively to nurture the development of improvement practitioners throughout organisations, not just in high-performing silos. Facilitating the sharing of good practice and encouraging mutual learning across units may be crucial in seeding teams with the right capabilities for improvement organisation-wide.

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