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Understanding service improvement in healthcare

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Introduction

This free course, *Understanding service improvement in healthcare*, explores the idea of service improvement in healthcare. You will find it useful if you work in healthcare, or if you are involved in healthcare in some other way, for example as a volunteer, campaigner, relative or service user.

The concept of service improvement is important because it is usually at the centre of discussions around change, particularly when resources are limited and difficult decisions have to be made about healthcare priorities. In such circumstances there is likely to be considerable ambiguity about what constitutes ‘improvement’ and ‘quality’.

This OpenLearn course is an adapted extract from the Open University course K828 *Researching and evaluating practice*.

Learning Outcomes

After studying this course, you should be able to:

- define ‘service’ in the context of healthcare
- understand what is meant by ‘service improvement’ in healthcare settings
- monitor when progress is being made towards service improvement
- understand what sustains service improvement.

1 Speculating about knowledge

Before you can fully explore what is meant by the concepts of ‘service’, or ‘improvement’, it is important to examine what knowledge consists of and how it is obtained. A great deal of knowledge is tentative, partially developed, and perhaps conflicts with other knowledge. Arguments about what improvements should be made often draw upon a variety of knowledge, attitudes and values. Indeed, knowledge is rarely ‘objective’.

Understanding what you value, what motivates you, what you understand as ‘truth’ is a critical starting point for improving healthcare practice. Healthcare is ‘lived’ by clients, patients and practitioners. It would be surprising, therefore, if matters such as human values and attitudes did not play a part. Often, in healthcare practice, concepts such as ‘improvement’ and ‘quality’ can become battlegrounds for competing interests, where even the definition of a term might be influenced by the standpoint you adopt (or are given) as a practitioner, manager or service user.

Understanding the plural nature of the values that drive people can reduce the risk that you dismiss or downplay others’ agendas. As soon as issues are discussed relating to what ‘*should* happen’, or ‘what *could* be done’, different notions of improvement come to the fore. Even where consensus exists that a service improvement has been achieved, external forces (like research and policy), or unintended consequences of the change, are likely to lead to a new set of problems to be addressed. This recognition that the ‘final answer’ may remain stubbornly elusive is a key insight of reflective practice. Despite that, the effort of reflecting, discussing and debating is worthwhile as it can broaden your appreciation of the issues.

1.1 The value of doubt

It is sometimes suggested that academics and researchers are doubtful by nature, and that they rarely make a bold assertion, because they can always imagine circumstances that could undermine their claim. That may be true, but it is a relatively unhelpful stance to adopt in day-to-day healthcare service improvement. You need to proceed with an element of trust and consultation, but nor can you remain paralysed by speculation. That said, an element of doubt about what you know, what you think and what others argue, will stand you in good stead if you continue to study this topic.

Activity 1

Video content is not available in this format.
Socrates: Genius of the Ancient World

Watch this excerpt from a BBC programme on the ancient Greek philosopher Socrates and consider the following questions:

- How helpful do you think this method is when considering service improvements?
- What 'tips' would you take from Socrates in facilitating dialogue with others in your healthcare setting, as you debate service improvement?

Discussion

You may have realised that central to Socrates's thinking was empathetic and rigorous argument. This might well be helpful to you when planning a service improvement though it would need careful handling. What you glean from the literature, from theory, or from an expert speaker, is information. It is only as you use that information, and discuss and debate it with others, that learning, development and improvement take place. Learning how to argue and debate exercises your critical faculties, and (suggests Socrates) helps develop a sense of humility. In sharing a rhetorical argument with colleagues or other stakeholders in a healthcare service, you might discover a lot about yourself and the situation. It need not be a contest, a combat, a 'game of chess'.

The ease of communicating via email, social media and online forums now means that it is possible to conduct 'dialogues' in new ways that are not literally face-to-face, adopting Socrates' principles and using 'netiquette' in your discussions with others. The tips from Socrates are valid in any medium:

- Don't simply think it, discuss it. Only in this way will you deepen your command of ideas.
- Approach your discussions with a spirit of discovery, wondering what this might teach you. There may be no right or wrong, absolute best or worst perspective, only a diversity of rich perspectives that you can then deliberate upon.
- Be prepared to 'turn around', to question your comfortable and familiar assumptions. While you might fear that others will judge you as weak because of this, it means that others note your openness and thoughtfulness.

Having explored the difficulties of knowledge and speculated over the claims about what constitutes knowledge, you are ready to consider the concept 'service' in the next section. If you are engaged in service improvement, then you need to be prepared to consider what 'service' is.

2 Understanding ‘service’

A ‘service’ can be thought of in different ways, for example as:

- **Something contracted and exchanged for a reward:** Healthcare unions emphasise the contractual nature of a service. Practitioners exchange skills and knowledge in return for rewards in the form of pay, status and related privileges.
- **As a product:** Healthcare systems may be conceived of as a product, a whole package of skills, know-how, problem solving, needs meeting, priority-determining activity, one that people feel passionate about (hence recurring debates on any changes to the way in which the service is conceived or delivered). National health services in countries like Belgium, France, Germany, Sweden and the United Kingdom are examples of this.
- **As an activity:** This can be further differentiated as people-based or resource-based. Are people working closely with patients’ expectations and experiences or making the best use of finite resources? Is ‘service’ based on needs or on available resources? This poses some interesting challenges for reflecting on improvement, because the question arises: how do you evaluate such a diverse activity?
- **As a necessity:** Healthcare is not a service that people can necessarily choose to take or leave, so working towards improvement involves partnership with clients or consumers. If the service comprises essential activities, facilities that cannot realistically be obtained elsewhere, then changes to that service affect the vested interests of a great many people. Okpokoto (2013), for example, describes the necessity for primary healthcare in developing countries.
- **As a promise:** In some countries healthcare is seen as a right. For example, Swedish policy states ‘that every county council must provide residents with good-quality health and medical care, and work to promote good health for the entire population’ (Healthcare in Sweden, 2016). The NHS Constitution in the UK portrays the National Health Service as a place of rights and responsibilities. You might consider that such an interpretation enhances the transparency of expectations, creates opportunities for conflict, and highlights the need for teamwork/corporate definition of service.

Activity 2

It is time now to exercise some Socratic reasoning. Reflect on the following two questions and then note down your thoughts.

1. Is our description of ‘service’ a complete and adequate portrayal of the different ways healthcare as a service might be portrayed in your setting?
2. What are the possible implications for improvement if one or other definition of service is adopted?

Discussion

Some definitions of service might work better in some areas of healthcare than others. What is important is realising how different understandings of such a fundamental term can either assist or undermine work towards service improvement.

There are often far-reaching consequences of defining ‘service’ in particular ways. This may be made worse where individuals or agencies don’t specify how they are defining service. If you don’t discuss what you mean by key terms, then they may mean different things to different people, and later undermine collaborative work. This seems particularly true with regard to care service providers and service users. If service is a commodity, responsibilities will be of one sort or another, either vendor or purchaser. But if service is a partnership, one of negotiated activities and contributions, then responsibilities will seem rather different. It becomes easy to work towards shared goals and initiatives only as stakeholders start to unpick what is really meant by a service.

3 How do I determine improvement and identify progress?

Having explored the notion of 'service', you are ready to reflect on the terms *improvement* and *progress*. The two terms are not quite the same thing. Improvement implies a direction, working towards stated aims, and a new state of affairs. Progress is more about the monitoring of events, experiences, behaviour or outcomes to gauge whether a service is going in the right direction.

It is notable that key aspects of healthcare quality and quality improvement do not include cost (The Health Foundation, 2013). In other words, we should work towards an ideal. However, quality is a slippery concept and relates to that which is valued in any given context. In medicine, this focuses upon the best possible health outcome in the light of current medical knowledge. You are left to debate what constitutes an outcome. Quality improvement may focus on some or all of the following:

- patient experience
- effectiveness of the intervention
- efficiency
- timeliness
- safety
- equity.

It can be valuable to first clarify your own understanding of improvement associated with the service with which you are most familiar.

Activity 3

Consider the different ways in which improvement might be conceived using the examples in the list below:

- working faster enabling more clients to benefit from the service
- working in a more coordinated way with others
- working more sensitively with others
- negotiating the plan of action-enabling client choice
- demonstrating that the service is based upon robust evidence
- using your skills to strategic purpose and better effect
- managing financial resources to better effect
- using technology to better effect
- making the service transaction more transparent
- keeping better records
- working demonstrably with standards, protocols or policies
- feeling professionally fulfilled in the work delivered.

Is one or more of these important for notions of improvement in your healthcare setting? Make a note on why one or more of these might apply to your service

improvement and then add any relevant improvement criteria that have not been suggested here.

Then share your thoughts with someone else who knows your healthcare setting, perhaps a colleague or a fellow patient or service user.

Improvement criteria that I accept and why

Provide your answer...

Other improvement criteria that I have identified

Provide your answer...

Discussion

Inviting other people to look at your chosen criteria for improvement requires a little trust, even if you are careful about who you share your notes with. However, to support the Socratic principles that were outlined earlier, this is necessary in order to learn through discourse or discussion. Simply completing your reflections will not necessarily lead to new insights. You need to gather in and respect different perspectives.

3.1 Indicators of improvement

Taking stock with others of your understanding of the service in the round, what it comprises and what improvement consists of, can liberate your grasp of healthcare work. No one expects there to be full agreement over all facets of a service or what constitutes improvement. That said, improvement is arguably predicated upon a common, thoughtful and collegiate recognition of different ideas. Until you are ready to express such ideas and welcome those of others, then improvement cannot begin.

The last stage of reflective practice work is to determine the next steps – what you will do with the new information and insights gained. In service improvement, this is closely related to the business of identifying progress. If, as a result of your reflective exercise, you have a new, broader understanding of improvement, then you will look for signs of progress in a different way. You will not only reflect on the benefits of it, but will quite possibly accept new indicators of progress within the chosen service.

Logically, progress exists when incremental work can be seen towards what you (and others) accept as improvement. Perhaps the work is being done faster, there is a more efficient mechanism in place to gather and process information. Perhaps you, and others in your healthcare setting, can cite episodes where patients or other stakeholders in your service are able to negotiate agreements more easily. The key question here may be around who has authority. Who identifies progress towards a given goal, towards a higher quality of service delivery? There is a real chance that if you evaluate your own service, without recourse to inviting stakeholder opinion, that you might congratulate yourself prematurely.

There's a variety of ways to involve others' perspectives on progress towards service improvement, particularly if you are a healthcare practitioner. Some that may be suggested are:

- Using satisfaction surveys (note however, it is worth questioning whether these address the stated improvement or blandly refer to broad categories of client satisfaction). It may be tempting to survey only that which is required by statute or policy.
- During healthcare episodes, asking individuals to expand on why they are either content or unhappy with the stated service.
- Reviewing letters of satisfaction and complaint – what are the recurring themes relating to the stated service?
- Inviting stakeholders to join focus group discussions on the progress or otherwise of a service.
- Running an inter-agency/inter-team/interprofessional workshop where feedback is fostered. For example by reviewing case studies of the service in delivery and asking stakeholders to indicate what was best or problematic about them.

The interactive guide 'In Safe Hands', produced by Health Education England (HEE), offers guidance and examples of how healthcare workers can adopt safe clinical practice and improve the safety of patients in the care sector.

4 What sustains the practice improvement?

Having ascertained what the service is, and having reflected on improvement criteria, we turn to the business of what sustains a practice improvement. How you address this question will depend on whether you are examining an improvement that is largely complete, ongoing, or an improvement that is planned or aspired to.

The reflections and discussions that you have completed so far may already have enabled you to develop a series of views on what principles help to sustain improvement. Among these may be:

- clarity as regards the service
- coherence of views on the improvement
- personal and colleague commitment
- open to investment (not just in terms of money, but practitioner time as well). Failing to accurately estimate what can be achieved by a given team or budget may undermine success.

For an improvement to move forward, it is necessary for the stakeholders to have the relevant skills. Skills are not only used by service providers, they are used by service recipients as well. The four short case study examples (below) make the point.

Case study: Danielle

Daniel is a lecturer working in the healthcare faculty of a university and she teaches students a variety of practice-based skills. She is keen to make more use of practice simulations so that students can build their confidence in clinical matters, without competing for limited opportunities on placements in different healthcare settings.

Practice simulations, either computer, written case study, or role-play based are cost effective, minimise risk for others (such as patients) and will often enable students to conduct their studies at a time that suits them. But for Danielle's vision of more simulated practice to operate, not only will she need to have skills of simulation design (some involving computers), but students will need skills associated with simulation-based learning. Working through the simulation, venturing responses and correcting mistakes is a different matter than attending lectures or reading handouts.

So, for this improvement to proceed, Danielle will need to attend to both her and the students' current skills. All will need to evaluate their skills and improve some of them if the initiative is to succeed.

Case study: Emmanuel

Emmanuel is a physiotherapist who is eager to help manage the considerable workload that he and colleagues in the department face. He realises that part of the problem is associated with the record system and the lengthy notes that he and others

have to make and review in association with different patients. He therefore designs a different record system, one that involves checking off different questions about the patients' condition, and selecting treatments from a menu of options. Only variations on the above most common questions and treatment options are recorded manually.

For this improvement to work Emmanuel has already exercised skills of design and consultation (his colleagues like the ideas put forward), but he now relies on the skill of a computer programmer to translate this into an electronic system that can be quickly and securely accessed.

Case study: Adele

Adele works as a project officer in a healthcare charity and she is interested in the ways that storytelling might help patients suffering from chronic illness to manage their difficulties. She has read a lot about patient narratives and how these are used. But to make patient narratives a part of what she uses in group sessions with patients and their families, there is a need to develop a bank of illustrative narratives.

She will need skills associated with interviewing, helping the patients to tell their stories in a clear and coherent way. She may need to edit the audio tapes to enable the patient journey to be understood. But patients will have to develop their storytelling abilities, too. They have been used to sharing only brief observations on how they are getting on. Now, they must tell a story, putting events in an order to demonstrate their reasoning, insight and coping with a condition.

Case study: Joel

Joel works voluntarily running a self-help group for mental health service users. He is interested in how the group can work better with formal services to ensure the best healthcare for people with mental health problems. Joel needs to be skillful in understanding the structures of formal services and the roles of professionals, as well as being able to engage with a range of people at a range of levels.

Skill is a fundamental support within service and service improvement (Stowe et al., 2010). Skill training and personal development become central when demands on service change or increase, when roles are altered and resources are updated. Investment in skills by individual practitioners and their employers is necessary if the service is to remain responsive and able to seize new opportunities.

Activity 4

Make a note in the box below regarding how important skill is to service improvement in your own healthcare setting. Whose skill are you talking about? What sort of skills might be in action here?

Critical skills for service improvement

Provide your answer...

Discussion

As you think about service improvement in your own setting, you might realise that you have insufficient skills for this work. Alternatively, you may have the full array of skills that are relevant, but some are more developed than others. Other skills may seem well rehearsed, even polished and fully developed. Remember, skills may be clinical, managerial, educational, interpersonal, technical – what you need relates to the chosen service that you are working on.

Conclusion

In this course, *Understanding service improvement in healthcare*, you have explored a familiar term (service), and discovered that it is not as simple as it initially might seem. You have started to examine how that term relates to the concept of improvement, at least, in your own experience.

With regard to your own healthcare setting, you should have arrived at a number of judgements. You will have determined just how clearly defined the service is, what you and others think constitutes an improvement, and what it takes to sustain the improvement. The service might seem a good deal more complex than you thought, it may have progressed less than you hoped, but you will have begun a reflective appraisal that can help you, and hopefully others, in the future. You have taken a snapshot picture of the service today. Remember though, you wielded the camera and chose what to note in your reflections. If you use your insights to plan to advance the service in some way now, remember that consultation with others is important. Your reflections here are a starting point.

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Acknowledgements

This free course was written by Martin Robb.

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