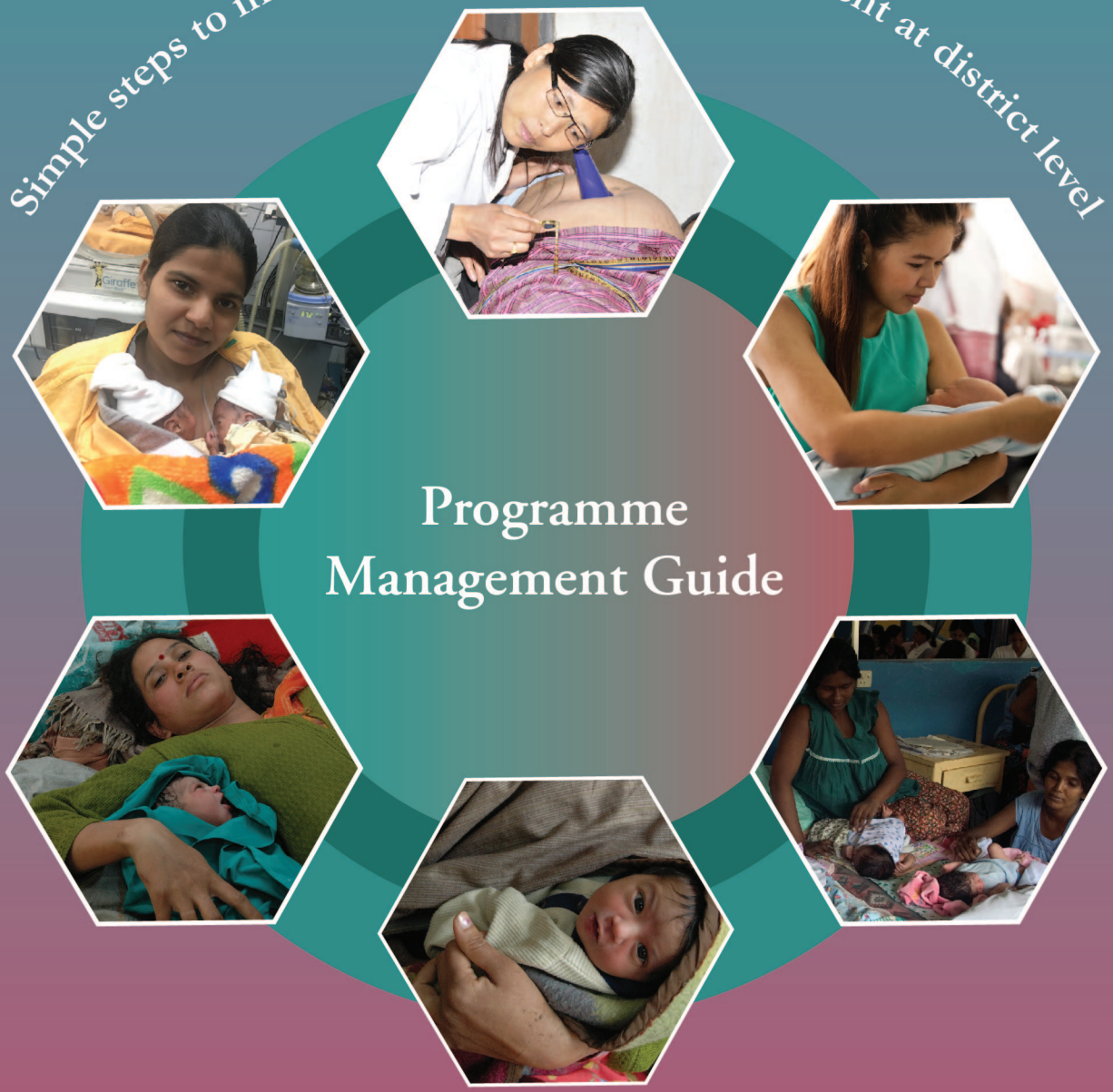
Setting Up and Managing a Quality Improvement Programme at District Level

POCQI: Point of Care Quality Improvement

Simple steps to institutionalize quality improvement at district level



Programme Management Guide

World Health Organization
REGIONAL OFFICE FOR South-East Asia

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World Health Organization
WHO Collaborating Centre for Training & Research in Newborn Care
All India Institute of Medical Sciences, New Delhi

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This guidance document for "Setting up and managing a quality improvement programme at district level" is a component of the regional package for improving the quality of care for mothers and newborns in health facilities. The package now consists of:

1. The training manuals "Point of Care Quality Improvement" (POCQI Version 02). This includes a Facilitators Manual and a Learners Manual.
2. The guidance document "Coaching for quality improvement"
3. This document on "Setting up and managing a quality improvement programme at district level"

All these documents can be accessed on the POCQI website – www.pocqi.org.

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Table of contents

Introduction

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WHO-SEARO has embarked on an ambitious programme to improve the quality of care for pregnant women and newborns. To support countries in this work, WHO-SEARO has launched the following:

1. Regional Framework for Improving Quality of Care for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)
2. A package to build capacity in improving quality for mothers and newborns. The Point of Care Quality Improvement (POCQI) model for training front-line workers to use quality improvement (QI) methods
4. A guide on "Coaching Support for Quality improvement" for supporting on-the-job mentoring through a QI coaching network for the SEAR countries.

Several SEAR Countries have established mechanisms to govern quality of care at national and sub-national levels. A number of countries have also adopted global standards and guidelines for managing maternal, newborn and child health conditions. Several countries have used WHO tools for assessment of quality of care for maternal, newborn and child health care and identified common gaps in quality of care.

WHO SEARO is working with ministries of health, partners and stakeholders to strengthen all components of a quality management system at national, district and health facility levels. Particular emphasis has been to build the capacity of healthcare workers in the health facilities to use QI approaches to solve problems that are within their influence and can be solved without too many additional resources. The POCQI training manuals presently include care of mothers and newborns at the time of birth and care of sick and small newborns in newborn units. Pediatric care will be included subsequently.

Quality Improvement (QI) is a management approach that health workers can use to re-organize patient care at their level to ensure that patients receive good quality healthcare. It starts by identifying specific problems to address and forming teams of frontline workers. These teams then analyze their current work situation and make changes in their way of working so that patients get better care.

While QI primarily focuses on re-organizing care within the existing resources, it also contributes to addressing other health system issues. For example, QI leads to more efficient use of resources that can solve some issues of scarcity. It can also help to identify the most relevant gaps in knowledge and skills among healthcare workers and helps to prioritize training and skills building. In its vision for quality of care for mothers at newborns at healthcare facilities, WHO-SEARO states that QI should address both provision and experience of care.

Since improvements in patient outcomes or experiences of care only occur if change happens at the level of the individual patient, the development of QI skills among frontline health workers is critical. Providing QI training to front line workers is a good start and can lead to significant improvement in trained facilities. But if the goal is to scale-up the QI programme across several health facilities in the district. QI training at health facilities on its own is not good enough. The district health system must support frontline staff to continuously use QI skills and help fix problems that cannot be fixed at the level of frontline staff. It is, therefore, important for management and leadership at sub-national and national levels to develop structures and systems in the districts to provide support to facilities doing improvement work and to develop a culture that encourages continuous QI.

This document provides **practical guidance to set up and manage a large-scale QI programme at district level.** It describes the key components of scalable and sustainable QI programmes along with illustrative examples.

The approach followed in South-East Asia Region is consistent with the global Quality, Equity and Dignity (QED) initiative that has been supported by WHO and partner agencies. The QED network for Improving Quality of Care for Maternal, Newborn and Child Health was initiated with nine participating countries, including Bangladesh and India from the WHO South-East Asia Region, with plans to include more countries in the future. The vision of the QED Network is that every pregnant woman, newborn and child receives good quality care in health services. The countries in the QED Network are using a four-pronged approach to meet this agenda with four strategic objectives of leadership, action, learning and accountability:

1. Strengthening **leadership** for quality of care, through governance structures, national plans and strategies.
2. Acceleration **action** for quality of care by supporting the development and strengthening of clinical and managerial capability to support improvements in quality of care.
3. Foster **learning** and sharing of knowledge and experiences in improving quality of care across and within network countries.
4. Support countries in developing mechanisms for **accountability** for quality of care.

This POCQI Programme Management Guide is consistent with this QED approach and covers the four strategic objectives to support actions for institutionalizing the roll-out of POCQI model in local health systems.

Guiding principles for a quality improvement programme

Guiding principles for a quality improvement programme

Managing a large QI programme requires the right guiding principles, attitudes and leadership involvement. Below we outline some of the key principles for operationalizing and managing an effective large-scale QI programme.

1. **Start quickly:** We encourage starting QI activities in the health facilities quickly after the healthcare teams have learnt the basics through POCQI training. Avoid spending excessive time in planning and developing extensive guidance materials. Once QI projects begin at the frontline, on the job learning and coaching helps to further build capacity and improve their performance. Early successes from QI teams help provide motivation for the rest of the programme in the district.
2. **Support change at the point of care:** The only way to reduce mortality and improve the experience of care is to change what is happening between patients and healthcare workers at health facilities. So the focus of all efforts should be directed towards supporting healthcare teams to improve clinical outcomes and better patient experience of care.
3. **Build on existing structures and activities:** To whatever extent possible, the QI programme should be housed in the existing management structures and departments / administrative units instead of creating parallel systems.
4. **Recognize everyone's ability to contribute:** Healthcare is delivered by range of people of diverse cadres including doctors, nurses, support staff, cleaners and auxiliary staff as well as patients themselves or people accompanying them. Good ideas to improve services and support can come from any of the stakeholders.
5. **Learn and adapt:** All levels of the health system should keep an eye on how things are progressing. Are the activities happening as planned? Are facilities making improvements in care or not? All levels of the health system should be able to iterate and make changes in their plans or modify their strategy, as needed.
6. **Continuously strive to improve:** There is always room for doing things better. Identifying problems is not a bad thing but a good thing because it is only when we identify and acknowledge problems that they become opportunities for improvement. Focus on what needs to be done in the future to make care better.
7. **Develop an empathic approach:** Health workers around the world are often working in conditions that are difficult, stressful and under-resourced. In QI work we should act with empathy towards health workers and provide them support to ensure that they in turn provide compassionate care for patients and the community.
8. **Celebrate success:** Praise is the most cost-effective motivator, it costs nothing and it encourages people to work. All implementers and leaders in the QI work should be quick to recognize the good work done by healthcare teams and convey their appreciation immediately.
9. **Change systems instead of punishing individuals:** Most healthcare workers are committed to doing their best and are working hard. When things do not go as planned it is not because of bad people, it is because the system is set up to fail. We have to be careful that these QI activities do not become yet another monitoring, supervision framework.

10. **Facilitate sharing and learning**: Promote meetings of participating health facilities and districts. This would foster a climate of openness, sharing and collaborative learning. This atmosphere will materialize only when successes are celebrated, praise is generous, specific and timely and the focus is on changing systems and not punishing individuals.

Table 1: Guiding principles for a quality improvement programme
1. Start quick after training
2. Support teams at the point of care
3. Build on existing structures and activities
4. Recognize everyone's ability to contribute
5. Learn and adapt
6. Continuously strive to improve
7. Develop an empathic approach for providers and patients
8. Celebrate success often
9. Change systems instead of punishing individuals
10. Facilitate sharing and learning

Designing and implementing a QI programme

Designing and implementing a QI programme

Key components of a large-scale quality improvement programme at the district level.

To carry out QI on a large scale within a district it is useful to consider seven key components 1) an overall improvement plan 2) facility teams improving care at the frontline 3) ongoing QI coaching support for facility teams 4) peer to peer sharing forums 5) programme management structure to operationalize and sustain the QI work 6) human resources, financial and data systems aligned to enable QI and 7) leadership support and participation (Table 1).

Table 1: Seven key components for a large-scale quality improvement programme

1	**Quality improvement plan**	This is the overall programme plan aligned with the national or sub-national levels.
2	**Facility teams improving care at the frontline**	Facility staff need to know how to use QI approaches to improve care.
3	**Ongoing quality improvement coaching support**	Coaches have prior experience in using QI methods and guide frontline workers applying these methods to deliver better care.
4	**Peer-to-peer sharing and learning**	Opportunities for staff from the same or different facilities to learn from each other's experiences and to motivate each other.
5	**QI programme management structure**	Departments / administrative bodies who have specific roles and responsibilities for QI programme management in the districts and sub-national levels.
6	**System functions (finance, human resources, data) aligned to support the QI programme**	Successful functioning of a large-scale QI programme will require some modification in existing systems including: 1. Financial systems (e.g. budgeting to support coaching visits); 2. Human resource system (e.g. permitting staff to undertake QI activities); 3. data systems (e.g. including process indicators used by health facility teams and QI management at district level).
7	**Leadership support**	Leadership support and active participation at health facility, district and state levels is critical to success. Leadership has to provide material support for QI, enable all of the above components and must foster a culture of trust, transparency and improvement.

With adequate coaching guidance, peer to peer support, leadership support, structures and systems in place; we can enable frontline teams in health facilities to improve service quality leading to large gains in maternal and newborn health. It is also expected that this way of working will lead to strengthening of the health system that will make it easier to improve quality in other areas of healthcare (like pediatric care) in the future.

The executive leadership of the sub-national and district levels should be involved in the development of the QI plan. Specific responsibilities and timelines should be assigned for the development of this plan. A sample planning template for the development of such a programme is given in Annex 2.

Below, we provide brief guidance for what to consider in each of these components for a large-scale QI programme and how to operationalize the strategy.

1. Quality improvement plan

It is almost impossible for a district that is beginning their QI journey to immediately start a QI programme in all facilities and for all technical healthcare areas in the facilities. Trying to do too much at once has a risk of failure. Therefore it is usually good to start the programme in a limited number of facilities with a defined clinical area and use this experience to learn how to scale it up. The QI programme plan describes the initial facilities where the programme will start and the initial clinical focus for the programme. It will also give a timeline for when to move beyond the initial learning sites so that the work does not stay a pilot project and is scaled-up.

a) Identify initial facilities and timeline for scale-up

Unless you already have QI teams, a functional coaching system and strong QI structures, it is usually best to start the QI programme in a few facilities in the district and use this experience to figure out the best way to make all the seven key components work. You want to help staff in these facilities improve care but almost as importantly, you want to learn about how the other six components can support QI work in your setting. Because the focus is on learning, it is best to choose facilities that can contribute to it.

Facilities will contribute more learning if they:

- Are not the best performers (if they are the best performers then they don't have much room to improve) and not the worst performers (they may have deeper problems which will take time to address). Choose facilities that perform in the middle.
- Have a reasonable work load. If they are too small, it will take too long to show improvements. It is recommended that initial selected facilities have least 30 deliveries a month.
- Are interested in joining in. You can work with skeptics later but initially, the enthusiastic facilities will generate more learning. Choose facilities that are willing to use QI methods.
- Are easy to visit. If you cannot visit a site regularly you cannot provide good support or quickly learn how to make the support better. You will eventually want to work with all the facilities but to start with, choose facilities that are easy to visit.

Case scenario: Select initial facilities and districts and describe initial scale up timeline:

Current situation	Proposed plan
State X has 12 districts of around 300 000 people each. The number of facilities in each district is more than 100 including hospitals, community health centers, primary health centers and sub-centers. The leadership wants to develop a QI programme for the entire state.	This is a large area. The government decides to start the QI programme in a limited area to begin with. They select two districts and about 10 facilities in each of those districts. This will be easier to manage for initial learning. They plan to spread to four additional districts in 18 months.

b) Decide areas of focus and roll-out plan

It is best to focus on only one or two clinical areas of healthcare to begin with and then expand to other clinical areas. It is important to pick areas that align with government priorities and policies.

Case scenario: Select initial areas for improvement and scale up plans:

Current situation	Proposed plan
The government's current priority is to reduce maternal and neonatal mortality.	The QI programme's initial focus will be on care around childbirth. For the next year, they plan to broaden their focus to apply QI methods in other components of maternal health (e.g. antenatal care), newborn health (e.g. newborn units) and later on expand to child health (e.g. pediatric care).

A sample QI programme plan could look like this:

	Year 1	Years 2–3	Years 4–5
Number of districts	Two Districts	Four Districts	All Districts
Facility coverage within selected districts	High-volume facilities	High-volume facilities in the new districts All facilities in previous 2 districts	All facilities
Clinical focus	Care around the time of delivery	Care around the time of delivery. Care of small and sick newborns in newborn units. Antenatal care.	Additional components of care (e.g., In-patient care of maternal complications. Pediatric care)

2. Facility teams improving care at the frontline

"Supporting change at the point of care" is one of the foundational principles of any QI programme. The focus of the QI programme should be on improving care at the frontline. Enabling teams to improve care at the frontline requires that: a) facility staff know how to use QI approaches and b) they have permission and support to apply these skills to deliver better care.

a) Building QI skills of frontline healthcare teams

People can learn QI skills from classroom training, online resources, coaching support, peers and, most importantly, from practice. Some classroom training is almost always useful. The focus of initial training should be to give practical skills that people can use immediately. There is no need to go deeply into theory or complicated QI methods as this can put off people new to the field. The Point of Care Quality Improvement (POCQI) training approach has been successfully used to train hundreds of QI teams in the countries of the South-East Asia Region.

There are different approaches that you can use to build the skills of front line workers in the initial QI sites. One common approach is to first train trainers at national / sub-national level. Such a resource pool of trainers is usually composed of clinicians, preferably from higher level facilities, who can initially practice QI skills themselves. This ensures that the QI trainers gain both theoretical and practical expertise

before training others in QI. These national / state level trainers train district level trainers who can in turn the front-line workers in health facilities. Using such trainers to train front line workers also helps build relationships between QI practitioners at different levels of the health system that can be important in building a critical mass of QI practitioners along a referral chain.

Training should be carried out for teams of healthcare professionals – for example – a group of doctors and nurses from the same facility who provide care to mothers and newborns around the time of delivery.

Case scenario: Plan for building QI skills of frontline teams

Current situation	Proposed plan
Healthcare workers in the selected two districts have not had exposure to QI. Six faculty members in a medical college close to these districts have experience in QI and can train others.	The government forms a QI resource group within the district composed of staff responsible for improving maternal and newborn health. The QI trainers from medical college will train the members of this district level resource pool in POCQI. These district trainers also visit the medical colleges to see QI work in action. District trainers then train the staff at health facilities (on site) with the support of the medical college faculty.

b) Providing permission and support to frontline workers to use QI approaches

The facility leadership (director / superintendent / manager/ chief medical officer) should provide healthcare professionals the permission, encouragement and opportunity to use QI skills to improve care. This is most likely to happen if facility leaders are engaged from the start and are informed about the importance of the work by district and higher leadership. The facility leader should clearly express to staff his or her support for QI and state that it is priority area to focus for the facility.

3. Ongoing quality improvement coaching support

Initial POCQI training in classrooms is important to teach people foundational QI skills. But many people will require hands-on support to apply those skills to real world problems in their facilities and to learn more advanced QI skills. Most QI programmes solve these issues by forming a resource pool of QI coaches. Coaches are not inspectors or supervisors, instead, their role is to help facility level staff learn how to apply QI methods themselves to independently fix problems at their level. Many POCQI trainers can become coaches with additional practice and inter-personal skills. They need to take time out of their routine and also need support to undertake field visits to other health facilities. For more information on QI coaching please see the POCQI document "Coaching Support for Quality improvement."

There are two ways of setting up coaching systems depending on the plan for scaling up QI.

a) If you are planning a small QI programme in a limited number of facilities then it is best to identify people who are already experienced in using QI methods in their own facilities and assigning them to coach other teams in their own facility as well as in other facilities. You can also use this approach if your goal is to demonstrate that a QI programme can work in a specific region before planning how to scale it up.

b) If you are planning a large-scale QI programme, however, you will need to create coaching capacity within the existing district health system. This can be done either by creating dedicated positions

if you have sufficient funds or assigning existing staff to provide coaching support to facilities. In general, a coach should visit each facility at least once a month and one coach can usually support 5-20 facilities depending on their other responsibilities and the ease of transportation to facilities.

Case scenario: Providing coaching support to frontline teams

Current situation	Proposed plan
Six faculty members from the medical colleges in the selected two districts have experience in doing QI. There is currently no coaching system in the districts.	The QI programme plan is to start with 20 facilities. Eventually, staff in every facility in the state should be using QI methods in the next four years. They discuss two options: a) Assigning the experienced medical college staff to coach the 20 initial facilities, or b) Building the skills of district medical officers and nursing supervisors to act as coaches. The advantage of using the medical college staff is that they are experienced and can quickly begin to support the facilities. The disadvantage is that this approach is difficult to scale up. When all the health facilities in the district will be included, it will be difficult to coach all facilities using this limited number of coaches. Because they are developing a large-scale QI programme they decide to include coaching in the job descriptions of existing staff members in the district management. The district medical officer will coach the district hospital; the sub-district medical officers will coach the large clinics in their sub-district; the nursing supervisors will each coach the 4-6 small clinics that they are already supporting. Both the districts also create a QI coordinator position to support all the coaches and coordinate their activities.
The coaches have experience in QI in their own settings but don't have experience in coaching external teams.	The government develops a plan to help the coaches learn the important coaching skills (based on the POCQI "Coaching quality improvement"). They have monthly group phone calls to discuss progress and address specific topics to improve their coaching skills. These calls are also attended by the POCQI trainers. In addition, the more experienced medical college facility conduct joint visits to facilities with any new coaches to help them improve their skills.

4. Peer-to-peer learning and sharing systems

In addition to initial training and coaching, people can improve their QI skills by learning how peers in different facilities use these skills. Peer-to-peer learning can help teams to solve logistical challenges (e.g. by learning how other teams organize QI team meetings) and improve their QI skills (e.g. by learning how other teams have used flowcharts to identify steps in processes that need to be improved). Peer to peer learning can also be highly motivating. Teams that are struggling get a chance to see that the people in similar facilities are fixing problems and everyone gets a chance to share their good work and be recognized by their peers.

Various formats can be used to support peer-to-peer learning.

- In-person learning sessions:
  - During in-person learning sessions, QI teams from different facilities meet periodically to share their work. These are not training or lecture sessions, instead most of the time is spent in small-group, interactive discussions so that team members from different facilities get a chance to meet and talk to each other about what they are doing and what they have learned – what has worked and what did not.
  - Such learning sessions can be organized at the time of existing district or sub-district meetings or can be stand-alone meetings as required. In general, learning sessions should happen every 2-3 months.
- Virtual learning sessions:
  - In areas with good internet connectivity, virtual learning sessions over a web-based platform can allow teams to interact with each other.
- Exchange visits:
  - Exchange visits between different facilities can also support learning. Such visits are particularly useful when staff from less experienced QI teams get a chance to visit more experienced QI teams and see them in action.

Case scenario: Providing avenues for peer to peer sharing and learning in the district.

Current situation	Proposed plan
Currently monthly review meetings are held at the district headquarters. All facilities from the district come and share their updates at these meetings. These meetings currently only have a 'report-out' format and there is limited discussion between teams.	The government decides to extend these meetings in the selected districts by 1 hour each month. During this time QI teams are invited to share their work and the QI coordinator and coaches facilitate discussions. Discussions on QI topics suggested by the QI teams are also included in these meetings. In addition, the government allocates funds for a one day meeting every six months for the QI teams to display and share their improvement work and to discuss progress. Senior officials from the government, politicians and community leaders are invited to these meetings. These discussions are designed to be interactive and aimed at problem solving and not fault finding and for recognizing good performance.

5. Quality improvement programme management structures

Improving quality of care on a large scale requires strong management structures in the states and districts to support the QI programme under the national QI leadership.

The function of these structures is to:

1. Ensure healthcare teams in health facilities and district management receive training in basic QI skills
2. Prepare a pool of QI coaches in the districts and ensure that post-training on-the-job coaching happens in an ongoing manner
3. Ensure that peer to peer support and learning happens among QI practitioners
4. Ensure that quality gaps that are not fixable at the facility level are addressed by the management at the higher level.

To ensure that the QI programme does not become a series of standalone activities that are unconnected to the overall health system, it is important that the above functions are built into existing state and district management structures. The QI management structure typically requires both operational and executive groups.

- The operational groups will ensure that staff are trained, coaching visits occur, peer-to-peer learning opportunities are supported and that QI data moves to where it is needed.
- The executive groups include existing senior management and leadership bodies responsible for the overall function of the health system in a district. They will ensure that the programme has the material and non-material support required and will step in to solve problems not solvable at the operational level.

Case scenario:

Current situation	Proposed plan
State X has a Maternal Health Committee which consists of 10 officials and one administrative assistant. Each district in the state also has a functional District Maternal Health Committee with one district official and one administrative assistant. These committees are responsible for an active ongoing programme on clinical skills training in maternal, newborn and child health among healthcare workers in the state. They also carry out the incentive programmes like awarding high performing facilities.	The government decides that these existing committees can carry out the operational functions in managing the QI programme. The government and organizes a QI training for the Maternal Health Committee members. A pediatrician and an obstetrician with QI experience from the medical college are added to this committee. A new section is added in the terms of reference for the Committee directing them to ensure that staff are trained in QI, coaching visits happen, peer to peer support happens and data on the QI programme is reviewed by the committee on a regular basis. The existing senior management structures in the state and district level are also directed to provide executive support and leadership to the QI programme. An agenda item on the QI programme is added to all meetings.

Sometimes the same people might be common to both the operational and executive management.

It is important that the QI structures not run parallel to existing management structures. While districts may have QI committees that support the running of the programme, these committees need to fall under and report to the overall district health management units.

6. System functions aligned to support the quality improvement programme

So far, we have discussed the importance of teams of front-line workers using QI methods; regular, onsite QI coaching; peer-to-peer learning and management structures to support and oversee these activities. To be fully effective, these components will require other parts of the health system to make some changes. For example, if the people appointed as coaches are not given time to carry out coaching support or are not given transportation then the system will not work. If the goal is to build a sustainable and scalable QI programme, some key functions of the overall health system need to be aligned to support the QI programme.

The usual systems that require some alignment to support the QI programme are financing, human resources and information systems.

a) Financing system alignment

QI programmes are not necessarily expensive but some funds need to be allocated for the initial QI trainings, coaching, peer-to-peer learning and management meetings. If you want to have additional dedicated QI staff to support the programme, this is another cost to consider.

Case scenario: Aligning the financial systems to support the QI programme

Current situation	Proposed plan
In this state, there is currently no budget for a QI programme. There are however, budget line items for training, supervision visits and district and sub-district meetings.	For the first year of the QI programme, the state government earmarks some funding for QI trainings, coaching, peer-to-peer learning sessions and management meetings from the existing line items. For the following year, they develop a dedicated budget request for the QI programme with specific funding.

b) Human resource system alignment

Human resource systems will often require some changes to:

i) Allow staff to participate in QI activities

- Working on QI teams, participating in QI training, attending coaching sessions, undertaking coaching visits, participating in peer-to-peer learning meetings all take time. If staff are not allowed to take that time out from other activities, then the QI programme will not work. Simple solutions are: changing job descriptions to include QI activities and official letters from health authorities clarifying that individuals are expected to carry out QI coaching or training activities including field visits. Facility leadership can be engaged by explaining that giving time to staff for coaching will strengthen their skills for doing QI in one's own facility.

ii) Not punish people for participating in QI activities

- Some health systems have performance management systems that focus on specified activities. Spending time on QI activities can lead to doing less of the activities rewarded by the existing performance management system and can become a big barrier to people participating in the QI system. Ensuring that people are not punished for spending time on QI activities is an important and low-cost way of aligning the human resource system to support the QI programme.
- Another way that health systems sometimes discourage people from participating in QI programmes is how supervisors react when problems are identified. The purpose of QI programmes is to identify and then fix problems but many health systems implicitly encourage people to hide problems by taking punitive approaches. A human resource culture that punishes people for identifying problems will struggle to make progress in a QI programme. Leaders should focus on changing the culture of the system to encourage people to identify and solve problems.

iii) Recognize people for participating in QI activities: In addition to giving permission to participate in QI activities and removing disincentives, it is also important to publicly recognize people for their QI work. Updating the existing performance management systems to include QI activities will also encourage more people to do QI.

Case scenario: Aligning human resource activities to support the QI programme

Current situation	Proposed plan
Job descriptions do not include any mention of QI activities for any staff. No facility other than referral hospitals report neonatal deaths suggesting that people may be hiding problems.	Coaches are given an official letter by the department of health relieving them from their clinical work by half a day every week to carry out coaching activities. Leaders in the health system start talking about the importance of transparency and identifying and solving problems. They do not object or shout when problems are identified and brought to their knowledge.

c) Information system alignment

Data is an important tool for QI practitioners to identify problems and learn if possible solutions are effective. QI practitioners typically use data on processes of care and review it daily or weekly. Most health information systems do not contain this type of data or collect it this frequently. QI teams at facilities will need to set up some temporary system to collect frequent process data on whatever aim they are working on (reference POCQI manual). The coaches and QI programme managers will also need to see some of this data, including during peer-to-peer learning sessions, so that they can identify where things are going well (so that the system can learn from these facilities) and where things are not going so well (so that more support can be provided to these facilities).

Case scenario: Aligning the data and information systems to support the QI programme

Current situation	Proposed plan
Currently the data system includes only input and some outcome indicators – such as number of patients admitted and discharged or expired. There is no information on indicators such as how many patients received the correct treatment interventions as per the standards of care, and on processes of care.	A few selected indicators related to key processes of care that are in the current priority areas of the QI programme are included in the data / information system.
Staff is currently used to collecting data for reporting.	Staff is reassured during the improvement trainings and by their coach that the data from their improvement work will not be merely for reporting to higher levels but that they will find this data useful to solve their problems. Selected indicators will in due course be included in the current HMIS.

7. Leadership support for improvement

Setting up a new QI programme and adapting existing systems to support it requires leadership support. Leaders have a vital role to play in supporting QI programmes.

1. **Setting up effective management structures** and processes at the state / district level to support improvement work.
2. **Helping solve problems:** Leadership should help to solve problems that front line teams are not able to solve on their own (e.g. problems that require new resources or a change in existing policies). This requires that the QI management structures can accurately convey information so that leaders know what needs to be fixed and that leaders feel responsible for helping fix problems.
3. **Supporting a work culture that encourages people improve care:**
    a. ***Allow* improvement work to be carried out.** Leaders should encourage people to work on improvement, allowing time for undertaking QI projects in hospitals, undertaking coaching visits.
    b. **Believe that *finding and identifying* problems is a good thing!** Once a problem is identified it becomes an opportunity for improvement.
    c. **Focusing on the *root-causes of problems*** rather than blaming individual providers when things go wrong.
    d. **Believe that *change and improvement is possible.***
    e. ***Allow sharing*** of problems, data and experiences with coaches and other teams
    f. ***Appreciate and motivate* people who are improving services.**
    g. ***Taken keen interest* in the improvement work.** Know and be responsive to what is happening in the improvement programme.
    h. **Facilitate learning and adaptation.**

Conclusion

A QI programme provides the health care system with an effective approach to solve problems and deliver better care. Supporting health workers to learn QI skills is an important first step. Building a sustainable QI programme that can be scaled up to hundreds of facilities in a state / district requires more than just one time QI training. It also requires management structures within the state / district health system to support people to use QI skills and to align existing procedures and resources or include new procedures and resources to support the QI programme.

Leaders in the state and district health systems have a key role in ensuring that the key components described above are in place. Such a QI programme could bring a change in organizational culture to one that moves away from blaming individuals and supports people to identify and fix problems, thus continuously improving quality of care across the health facilities in the state / district.

Annexes

Annex 1 – Summary for developing a QI programme at the district level

Key component of the district QI programme	Description	Actions	Tips
Quality improvement plan	This is the overall programme plan for QI as defined by the national/sub-national strategy.	Select learning districts/ facilities, clinical care area of focus for improvement and a roll-out plan.	If possible, select sites with some prior improvement experience. Be specific – don't just say to reduce mortality. Don't try to do everything at once.
Facility teams improving care at the frontline	Facility staff need to know how to use QI approaches to improve care.	Prepare a plan for building **QI skills in the frontline healthcare teams and** plan for enlisting the support of facility leadership (managers) so that frontline staff can apply QI skills to improve care.	A pool of resource persons (POCQI trainers) will be needed to support these trainings.
Ongoing quality improvement coaching support	Coaches have prior experience in using QI methods and guide frontline workers applying these methods to deliver better care.	Plan for building and upgrading **coaching capacity** in the district.	Build capacity for ongoing QI coaching of the trained healthcare teams. Use the existing POCQI trainers to build them as coaches and recruit additional ones if required.
Peer-to-peer sharing and learning	Opportunities for staff from different facilities to learn from each other's experiences and to motivate each other.	District health department and QI leaders create and sustain system for **peer-to-peer learning and sharing**	Use existing opportunities like monthly meetings in the district for experience-sharing among QI teams doing improvement. Creating new opportunities for sharing learning if current ones are inadequate.

Key component of the district QI programme	Description	Actions	Tips
QI programme management structure	Departments / administrative bodies who have specific roles and responsibilities for QI programme management in the districts.	Determine **management structures** for the QI programme in the district.	Identify structures where the QI programme will be housed. It is better if the QI programme is housed within existing district management (health department). Roles and responsibilities of management should be modified to include QI programme in their functions.
System functions (finance, human resources, data) aligned to the QI programme	Successful functioning of a large-scale QI programme will require some modification in existing systems including: 1. Financial systems (e.g. to support coaching visits); 2. Human resource system (e.g. to encourage staff to undertake QI activities); 3. data systems (e.g. process indicators used by health facility teams and QI management at district level)	Review and prepare **systems** (Finance, HR, Data and information) to accommodate the needs of the QI programme.	Decide how these can be aligned to support QI work at the frontline.
Leadership support	Leadership support and active engagement at health facility, district and state levels is critical to success. Leadership has to provide material support for QI, enable all of the above components and must foster a culture of trust, transparency and improvement.	Review **leadership** commitment and participation.	Strengthen the leadership in their roles to support the improvement work. Decide who at district and sub-district level will be involved. Describe the operational and executive roles.

Annex 2 – Planning template for developing the sub-national/district-level QI programme

1. Developing the QI programme plan for the district

Activity	Person responsible	Timelines
Leadership support		
Clarify programme planning team and relationships		
Programme plan		
Identify initial learning health facilities where QI will be introduced		
Identify focus clinical care areas for QI		
Programme management structure		
Form management structures at the district/state level		
Develop action plans for each management structure and unit for the next 12 months		
Building frontline skills for QI		
Plan for POCQI training for districts		
Plan POCQI training for health facilities		
Initiate QI projects		
Ongoing QI coaching support		
Ongoing QI coaching support plan		
Integrate QI approaches and coaching support into district management system		
Enable peer-peer learning and support		
Meeting reports, documentation support for preparing case studies		
Plan to use existing or creating new opportunities for teams to share learning		
System alignment (finances, HR, data)		
Prepare additional budgetary requirements for the QI programme		
Prepare plan for how will the HR system support QI		
Identifying the indicators needed for the programme and easiest ways of collecting data and ensuring data reliability		

2. Developing the QI programme tools and processes

Activity	Person responsible	Timelines
Workshop to finalize tools and processes for the programme.		

3. Evaluate the QI programme on an ongoing basis and use the results to improve the roll-out.

Activity	Person responsible	Timelines
Evaluate QI trainings: Are they happening as planned? Any bottlenecks to be addressed?		
Evaluate ongoing coaching support: Is it happening as planned and any challenges to be resolved?		
Evaluate functioning of the management structures: Is the data system working? Are problems at the frontline being solved?		
Evaluate peer-to-peer learning: Are monthly meetings happening? Is there an environment of learning and improving instead of punishing and reprimanding?		
Evaluate impact of the programme: How much improvement has happened and what are the learnings?		

Share learnings from district QI programme

Activity	Person responsible	Timelines
Success in district QI programme used to guide spread to new districts		

Annex 3 – Challenges in a large-scale QI programme

Challenge	What are the possible causes?	What to do?
The QI programme turns into yet another data reporting system without any improvements taking place. **Data is not being used at the frontline for improvement.**	Frontline staff do not have the skills for quality improvement. But they are already used to reporting data so they do that much only. Frontline staff knows quality improvement but is not getting adequate coaching support and is pressured by supervisors to just report data. Management focuses more on data collection and reporting and not on problem-solving.	Leadership at all levels should be aware of this major risk to any QI programme. More emphasis should be made by the leadership and coaches on other elements of improvement such as analyzing and understanding processes of care and problem solving.
Data shows some improvements but there is no information on how these improvements happened.	This is not an unusual situation. Possible causes include: New teams may not know that they have improved Often new teams can't articulate well how they have improved. A coach has to be skillful and thorough in asking questions about what the team did to improve care. Often teams will consider their new ideas too simple or straightforward and don't mention these ideas till they are asked specifically. Teams often don't document what they have done.	The coach should congratulate the team for the improvement and show the team how the data is showing that they have improvement. The coach should ask the teams in detail about what all they did to improve care. Coach and district management should provide extra support to teams who are showing improvements to document their work.
Care is not improving despite good training, adequate coaching support, having good skills in quality improvement and good leadership support.	Some problems can be challenging and the frontline teams may not be able to solve them even with a coach's support. Or these problems may be outside of a team's control and need problem solving at the higher levels.	The programme leadership should identify other teams which have been able to improve in this area of care and organize a site visit for the struggling site to learn from the successful site. A larger learning session can also be organized for all sites to learn from each other. If the problem needs to be solved at higher levels then the leadership should be solving these issues.

Annex 4 - Data collection, use and reporting

In a district-wide QI programme there are four basic information needs. We need to know:

1. Is care improving?
2. What did facilities do to improve care?
3. Is the district management system responsible for improvement, the overall QI programme itself, working?
4. What was done by the district, state or partners to support improvement?

1. Is care improving? (Data for improvement)

Facilities should measure specific indicators related to the aims on which they are working. This data should be used by the facility staff to assess their progress towards their aim and to learn whether their solutions to improve care are working or do they need to try something else.

This data can be aggregated at higher levels to understand which facilities and districts are doing well so that their success stories can be identified and to determine who needs more support.

Health facilities in a district-wide QI programme will need a systematic way to track and review their progress. One way to do this is to include the quality improvement indicators in the health routine information systems. However, often this is not feasible and separate excel databases might be needed. Data on the QI aims from the facilities should be shared at, district and sub-national level on a monthly basis. Depending on computer access and use the database can be given in paper format or in soft copy.

2. What did the facilities do to improve care? (Learning)

Along with the quantitative data showing improvement we should also capture details of what the facility staff did to achieve these improvements. Success and failure both should be shared, and coaches and facility staff should identify key lessons and guidance to offer others.

3. Is the system to support improvement working? (Data for programme management)

This information comes by monitoring the programme activities. For example the district might need to measure:

- how many facilities have been trained
- how many facilities have started improvement work
- number and frequency of coaching visits
- problems being addressed
- number of peer-to-peer learning sessions

4. What was done by the district, state levels, or partners to support improvement? (Learning)

At higher levels we need to know what worked and did not work in supporting improvement at a large scale. What resources, structure and processes were needed to enable this work? Which elements of this support were effective and which were ineffective.

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