



The National Centre  
for Post-Qualifying  
Social Work

Endorsed by  
THE COLLEGE OF  
**SOCIALWORK**  
The voice of social work in England

# Service Improvement in Social Work and Health

An E-Guide for Practitioners and Managers

Steven Keen and Lynne Rutter

ISBN: 978-0-9926457-1-7

The National Centre for Post-Qualifying Social Work

Keen, S. & Rutter, L. (2013) Service Improvement in Social Work and Health; an E-Guide for Practitioners and Managers

Copyright © Steve Keen and Lynne Rutter

Permission granted to and redistribute and reproduce for personal and educational use only. Commercial copying, hiring, lending is prohibited.

# Contents

Contents	3
Introduction	4
Context	5
BU's Service Improvement Model (SIM)	6
{ THINKING }	8
Aims	8
Intervention	8
Evaluation	10
Interviews	10
Focus groups	11
Questionnaires	11
{ DOING }	12
PDSA cycle	12
{ THINKING and DOING }	14
References	16

# Introduction

This short e-book aims to provide practitioners and managers working within social care and health environments with the knowledge to be able to ask precise questions of a potential service improvement project.

We propose three key questions, summarised in [Box 1](#) adapted and developed from Langley et al.'s (2009) Model for Improvement, to guide your potential roles of either 'doing' or 'overseeing' service improvement.

After explaining the context and boundaries of what we mean by the term service improvement, the remainder of this e-guide centres on the [Bournemouth University \(BU\) Service Improvement Model \(SIM\)](#) and how these three main questions and related areas – aims, intervention and evaluation – interact with both research tools and the ['PlanDoStudyAct' \(PDSA\) cycle](#). This is why there are two main parts to this publication; THINKING and DOING.

Toward the end of the guide we refer to a fictitious case study, Ruth's story, which is related to adult social work and health. In using this example, we wish to make the point that the content of this guide can equally be applied to potential improvement projects in children and families services. This area of work is especially important given the new [Children and Families Bill](#) currently going through parliament.

# Context

In designing the [SIM](#) we have responded to the central call of the [Health and Social Care Act 2012](#), that is, to put the user at the heart of service provision.

Within this call, the importance of crosscutting themes such as 'improvement', 'research' and 'education and training' are brought to the fore. These themes interact with the findings from the more recent [Mid Staffordshire Public Inquiry \(2013\)](#) otherwise known as the Francis report, in the desire for whole-scale commitment to not only valuing the users of services but also those that lead and manage them.

One of the ways of fostering a right culture of care is to shape the way organisations work, beginning with front line services. [Our model of service improvement](#) aims to do just that – empower individual practitioners and managers working in social work and health contexts to improve services for the people they serve. It is, in essence, a tool to encourage positive change – one that is likely to play an increasingly role in the future development of professional expertise ([Munro 2011](#); [Rutter 2013](#)) – particularly in social work with its current emphasis on critical reflection and professional judgement ([Social Work Reform Board 2012](#)).

The number of organisations involved in the improvement of health and social work services is both breathtaking and confusing. Martin (2005) suggests that this rise of 'top-down' inspection agencies and improvement agendas comes from policy makers' dissatisfaction with the ability of research to deliver change. The danger with this dissatisfaction though is that it could lead to future service improvement initiatives that are largely devoid of research knowledge. What we propose in this e-guide is an integration or joining of these two worlds – the world of service improvement and the world of research – in the form of the [SIM](#).

Service improvement is defined as bringing about a measurable benefit to a service or services against a stated aim. Implicit in this definition is the notion of the 'bottom-up' design of a locally-based project, one where professional wisdom is valued as much as research knowledge ([Pawson et al. 2003](#)). Therefore, this e-guide is not about systems or strategic-level service improvement, or even a detailed exposition of performance or change management initiatives per se; these are available elsewhere (for instance, [here](#), [here](#) and [here](#)).

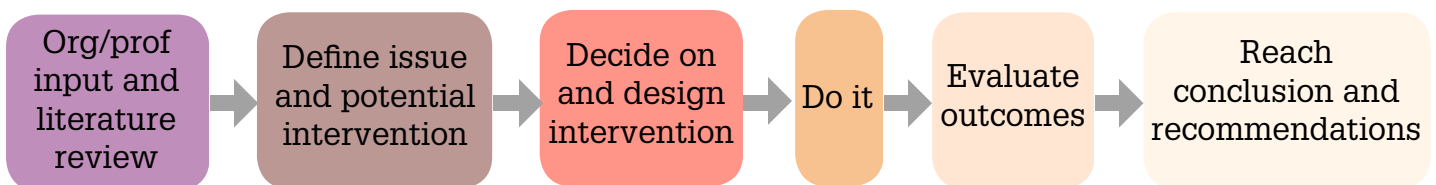
This e-guide is, however, about **THINKING** and **DOING** – the two main parts of this publication.

**It is about providing practitioners and managers of health and social work services with the knowledge and understanding to be able to ask precise questions of potential improvement initiatives (THINKING) in order to benefit local users of services (DOING).**

This aim is underpinned by BU's SIM.

# BU's Service Improvement Model (SIM)

The SIM is a straight-forward process of designing, conducting and evaluating a service improvement project to reach a series of conclusions and recommendations. Although this process is best displayed using a number of connected boxes, it is recognised that any conclusions or recommendations may lead to the development of further projects.



This process is supported by 'THINKING'. 'THINKING' is required to answer three key questions aligning to the three areas of the SIM - aims, intervention and evaluation. These questions can be answered in any order and are shown below in Box 1 (Langley et al. 2009).

Box 1 – Key questions to ask of service improvement projects		
Aims	Intervention	Evaluation
What are you trying to accomplish?	What changes can you make that will result in improvement?	How will you know that a change is an improvement?

The 'THINKING' component is completed before any 'DOING' or PDSA cycle starts.

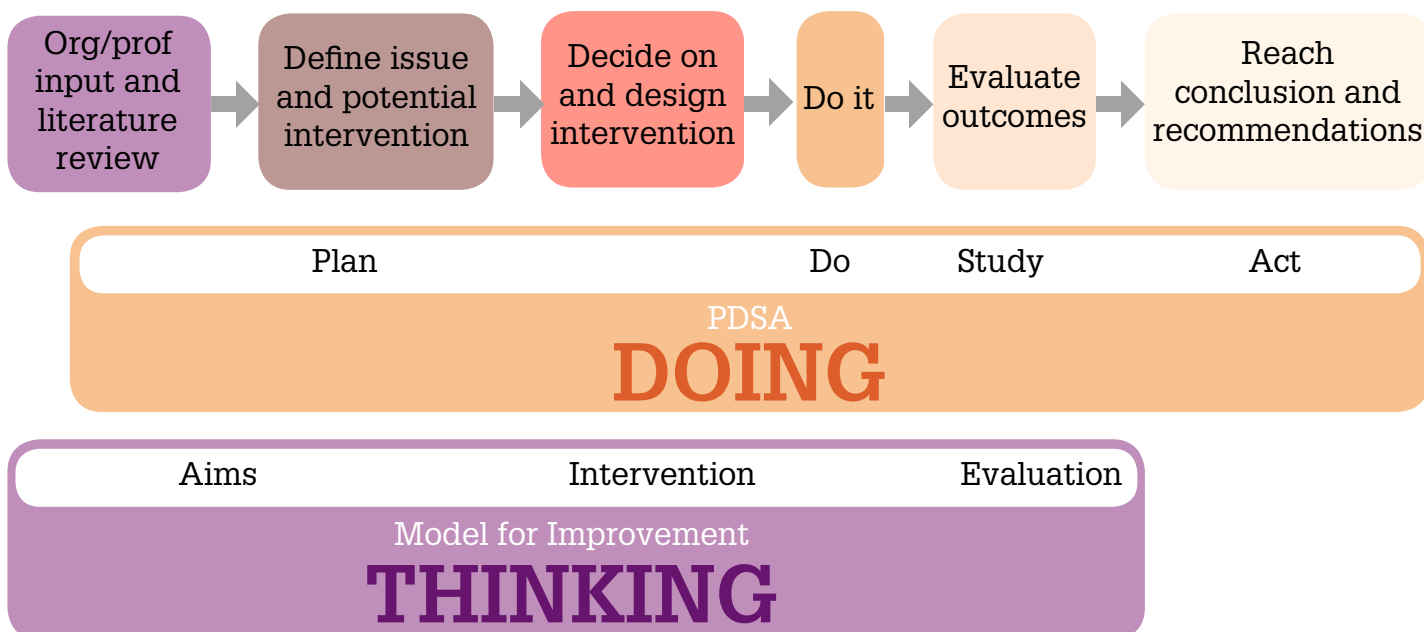
PDSA cycles are widely used in the [National Health Service](#) and private organisations (e.g. Toyota) to provide a framework for developing, implementing and evaluating ideas leading to improvement. The cycle is based on scientific method i.e. the sequence of hypothesising, testing and evaluation (Shewhart 1939) and moderates the desire to take immediate action with careful study.

The four stages of the PDSA cycle are:

- **Plan** – define and design/plan the change or intervention
- **Do** – carry out the change or intervention and document it
- **Study** – collect and analyse information on the change or intervention process and outcomes
- **Act** – use this knowledge to recommend and amend plans.

So, the process of the SIM is underpinned by 'THINKING' and DOING'.

The model now looks like this...



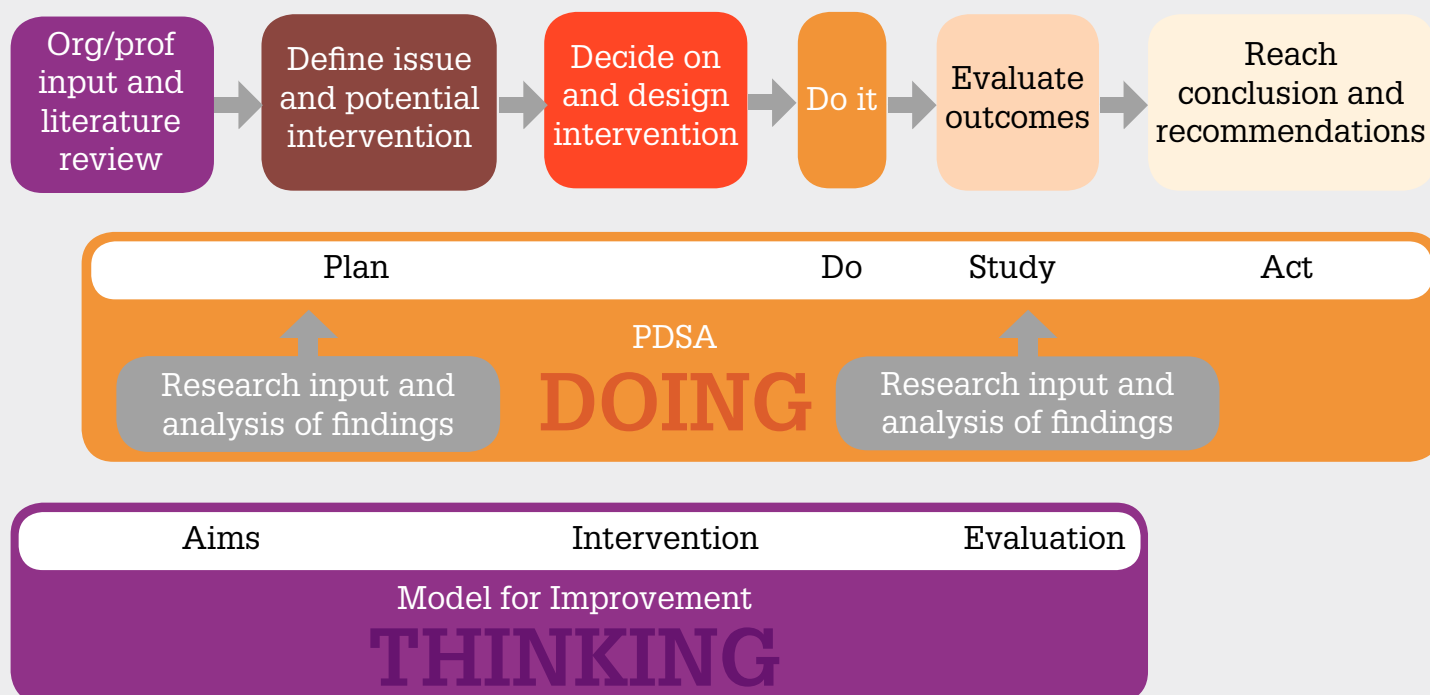
The 'THINKING' questions in Box 1 ensure a primary focus on service improvement thinking and methodology as opposed to a focus on research. This is an important point to grasp.

The driving force behind the SIM is not a focus on a research approach but on the thinking required to answer these three service improvement questions, of which

a secondary focus on research, research questions and methods may be a part. But, how does research fit in? A focus on research to either define service issues and ideas for change and/or to help evaluate the outcomes of any intervention will add robustness to the process.

By adding this research input into the model, the completed SIM now looks like this...

Diagram 1 - BU's Service Improvement Model (SIM)



This e-guide now looks into the 'THINKING' and 'DOING' components in more depth.

# { THINKING }

## Aims

The question, 'What are you trying to accomplish?' prompts thinking about a clear and focussed aim that states what you want the outcome of the project to be. The emphasis here is on being totally clear about what you want to achieve, so the answer has to relate to what needs to be improved. This aim may be easy to identify, for example, to reduce the average amount of waiting time, or it may be less tangible, for instance, a positive change in attitude or confidence. Without a well-formed and specific aim it will be impossible to know whether the outcome is an improvement, or decide what action to take to achieve it. The aim should be stated precisely and positively rather than becoming distracted by trying to solve a problem.

Ideas around what you would like to improve often come from your own practice or the practice of others. There may be an issue that your team struggle with on a daily basis. Practice knowledge is not the only source of ideas though ([Pawson et al. 2003](#)). Improvement initiatives can also come from the wider policy agenda and from within your organisation, for example, with a senior management imposed improvement project. Equally, ideas for positive change can come from people who use services and their carers as well as from the research community in the most likely form of academic publications. Knowing how to search for and appraise these sources of knowledge is covered in more detail in the following 'Intervention' section.

## Intervention

'All improvement requires change, but not every change is improvement' (Langley et al. 2009, p.109). The intervention question, 'What changes can you make that will result in improvement?' prompts thinking about how you might intervene to improve services. To answer this question, clarity around the underlying problems or issues in relation to what needs to be improved is required, as is hard thinking about which changes are most likely to work best to bring about that improvement. Put another way, there are two parts to this intervention question: 'what is wrong?' and 'what might work?' ([1000 Lives Plus 2011](#)). A number of other tools may also be helpful to you at this stage - these include [process mapping](#) and [Pareto analysis](#).

To answer 'what is wrong?', there may already be existing evidence gathered from in-house studies or audit, an appraisal of the research literature, the experience of staff or feedback from carers or people who use services. Thinking about what you can learn from this information alongside reflecting on how current systems work can also help to answer 'what is wrong?'

To answer 'what might work?' concerns decisions about what to put in place – the change or intervention that can address 'what is wrong?'. Again, there may be evidence available from other appropriate sources, for example, systematic reviews of relevant publications, professional guidelines, national service frameworks or good practice guidance. Your organisation may also have an idea of what to put in place, for instance, from strategic meetings, policy directives, previous pilot studies or research/consultancy already undertaken. Importantly, the creative opinions of staff or users of services can also help here. Developing changes that result in improvements for end users is not always easy. It is imperative,



however, that the answer to ‘what is wrong?’ is established first.

Two key tools that can be used to help answer and develop thinking around ‘what is wrong?’ and ‘what might work?’ are:

- Critical appraisals of existing literature/knowledge sources
- Research methods such as questionnaires, interviews, and focus groups.

It is vital to know where and how to search for appropriate sources of knowledge before appraising or assessing any results.

Information can come from wide-ranging sources including people, websites, organisational or policy documents, audit information and electronic databases such as [Social Care Online](#) or [Medline](#).

If you choose to start using electronic databases it is important to find out how they work before you begin searching them. Most will use Boolean operators (AND, OR and NOT) to help focus your searches.

For example:

- A search of ‘health OR social care’ will broaden a search to include all publications examining ‘health’ in addition to all those looking at ‘social care’
- A search of ‘health AND social care’ will narrow a search to only include those publications that include the topics of ‘health’ alongside ‘social care’
- A search of ‘health NOT social care’ will narrow a search to only include those publications that are exclusively about ‘health’.

Before you start searching databases, it is a good idea to identify key concepts. These can then be broken down into keywords, alternative terms and abbreviations. Applying Boolean operators to these keywords, alternative terms and abbreviations will help hone the results of a search strategy. Often databases will have an ‘advanced’ facility to ‘include’ or ‘exclude’ certain publications using filters such as language, location and time period.

The development of a robust aim and intervention requires the critical appraisal and therefore assessment of these and other sources of knowledge, as appropriate to the topic area. One way you can attempt this appraisal is to ask questions of or test these sources of knowledge against a review framework such as TAPUPAS ([Pawson et al. 2003](#)) (Box 2).

## Box 2 – TAPUPAS

**TAPUPAS is an acronym based on a knowledge review from the Social Care Institute for Excellence.** Each of the letters stands for a different word and a series of questions:

**T**ransparency – are the aims/objectives, reasons, method, etc clear?

**A**ccuracy – is it honestly based on relevant and appropriate evidence/information?

**P**urposivity – is the approach/method used suitable for the aims of the work?

**U**tility – what are the results or key messages – do they provide answers to the questions

**S**et – do they help your intended improvement project?

**P**ropriety – is it legal and ethical?

**A**ccessibility – can you understand it?

**S**pecificity – does it meet the quality standards already used for this type of knowledge?

Adapted from ([Pawson et al. 2003](#))

Searching for and appraising existing sources of knowledge in these ways should enable a robust presentation of the inherent strengths and limitations of the sources of knowledge you have found and how they apply to the development of your proposed aim and intervention.

Going back to the [SIM](#), to define the service issue/intervention and answer 'what is wrong?' and 'what might work?' might also necessitate the use of research tools such as interviews, focus groups, questionnaires, documentary analysis and/or practice observation. Generating appropriate information at this stage should ensure not only a robust definition of the service issue but also what can be done about it. The following Evaluation section will expand on the use of research tools in more detail.

## Evaluation

The question, 'How will you know that a change is an improvement?' prompts thinking about how to measure the impact or outcomes of the intervention. 'An effective answer to this question lays the foundation for learning that is fundamental to effective improvement' (Langley et al. 2009, p.93). It may seem strange, at this thinking stage, to ponder how you will be able to tell if an improvement has occurred. Yet, it is crucial, because if you can't show a difference, then what is the point of service improvement? So, although this question looks at how you might measure or evaluate the outcome of any change, it may help you to consider a more appropriate or feasible aim and also a more relevant change. Any standard of improvement or measurement chosen should be simple, well-defined, easy to use and relate to the aim of the project. Some measures may already be in use. For example, if the aim of a project is to reduce the number of patient complaints on a particular ward, over a period of time, one outcome measure could be the number of patient complaints. But it can be difficult to find a measure that is perfect; using

this example, are only written complaints included and not verbal ones – who records the complaints and how? Langley et al. (2009; see p.94-5) offer four guidelines for developing measures; if possible:

- Include the interests of the end user
- Look at data collected both before and after the intervention
- Consider using multiple measures
- Develop 'progress' outcomes if the information needed to assess an intervention is likely to take a long time.

Sometimes service improvement is about adopting and adapting practice. So, especially if a project is part of a longer-term strategy, measures of 'progress' may need to be developed rather than outcomes, for instance, whether certain procedures have been followed as a result of an intervention. The less tangible an aim is, the harder it will be to measure it using statistical methods, so other methods may need to be applied here. Measures have to be meaningful and appropriate to the type of change and this may include the use of more qualitative research tools such as interviews and focus groups to help gauge the effect of the intervention.

So, as the [SIM](#) highlights, research tools and analysis can be used to clarify 'what is wrong?' and 'what might work?' as well to evaluate the impact of an intervention. The use of research tools helps to add robustness to the process. Answering 'what is it exactly you need to know?' will help choose your measure/s and the way in which you find out this information. In some cases you are likely to be using interviews, focus groups, questionnaires or a combination of these research tools.

## Interviews

In essence, interviews are a type of data collection where one individual asks questions and the other answers. They are particularly good for exploring participants' biography, experience, knowledge, values, beliefs, feeling and attitudes. The one-to-one interview technique covers a wide number of opportunities, ranging from

structured through semi-structured to unstructured styles. Different options are contained within each of these opportunities.

### Focus groups

A focus group is usually a group of 6 to 12 people recruited to discuss a specific 'focus' or topic for up to two hours, co-ordinated by a facilitator or moderator. The facilitator will enable participants to discuss each other's views. Yet, there are a number of focus group styles ranging from directive to non-directive approaches and much in-between. A moderator taking a non-directive approach would set the topic area and the ground rules and then have minimal input into the group discussion. A more directive approach would see the facilitator controlling and guiding the discussion by probing answers and asking specific questions of the participants, more akin to a group interview. Focus groups can be used in stand-alone designs, or alongside, prior or after other tools.

Although focus groups provide an opportunity to interact with others and allow a range of opinion in a relatively short space of time (Whittaker 2012), the factors that contribute to the strength of the technique can also be potential sources of weakness. The composition of a group may encourage or inhibit individuals to speak. One individual may dominate the discussion and less dominant members say

nothing. Yet, the dynamics of a group may also allow individuals to develop and refine their views as a result of lively interaction.

### Questionnaires

The questionnaire is classed as a quick and inexpensive tool, most suited to collecting self-report data on well-known topics relating to attitudes, perceptions, beliefs and knowledge (Whittaker 2012). As part of a more numbers based approach to research, the questionnaire, usually made up of a series of fixed questions, is used to collect data often within large-scale surveys.

There are a number of good textbooks (e.g. Robson 2011) and websites (e.g. [www.statisticshell.com](http://www.statisticshell.com)) that can help in choices around research tools. They highlight that within each choice of method, it is critical to know how any resultant data will be analysed before the process of data collection starts. Answering 'What is the intent of your analysis?' – for instance, is it about description, comparison, or associations? – will help thinking about how any collected data might be analysed and aligned with your aims and intervention.

This **thinking** should lead on to **doing**; covered in the next section of this e-guide.



# { DOING }

## PDSA cycle

As [Diagram 1](#) demonstrates the SIM is underpinned by providing answers to the three questions in Box 1 that, in turn, relate to the previous – aims, intervention and evaluation – sections.

This 'THINKING' component of the SIM must happen before any 'DOING' starts. The PDSA or PlanDoStudyAct cycle is utilised as the 'DOING' component of the SIM. 'The cycle can be used to turn ideas into action and connect action to learning' (Langley et al. 2009, p.97) in the following way:

- **Plan** – define and design/plan the change or intervention
- **Do** – carry out the intervention and document it
- **Study** – collect and analyse information on the change or intervention processes and outcomes
- **Act** – use this knowledge to recommend and amend plans.

Here's a basic example of how the PDSA cycle could be used in a project to develop and provide in-house training in the correct use of referral forms to reduce transfer delays:

- **Plan** – assess current training provision, gather ideas from others; design new training provision and its evaluation
- **Do** – carry out the new training
- **Study** – evaluate whether the new training was effective and had an impact on delayed transfers of care
- **Act** – use new understanding to make conclusions and recommendations for forward planning and action.

In implementing any proposed service improvement initiative like this, a project management approach maybe useful. Thinking through the proposed service improvement journey is important here. What do you need to accomplish? What are your key milestones? At an essential level, the milestones for the above project could look something like this:

- Complete appraisal of research literature around delayed transfers
- Conduct 5 semi-structured interviews with key staff
- Analyse findings
- Apply findings to design intervention
- Conduct intervention
- Evaluate intervention using pretest-posttest questionnaires
- Revisit knowledge review and make recommendations.

You will be able to be more specific as you break down each milestone into more manageable tasks. For instance, the above 'Conduct 5 semi-structured interviews with key staff' milestone could break down into 'Preparation' and 'Resource Requirements':

### Preparation

- Design Participant Information Sheet and Consent Form
- Design interview guide
- Plan how to analyse interviews using Brown & Clarke (2006)
- Inform/notify research governance
- Pilot interview guide – develop research interview skills

- Email key staff with project information
- Gain staff consent to take part
- Book interview dates
- Book suitable room
- Organise and practise using audio-recording equipment
- Buy notebook for reflective diary
- Inform admin/colleagues of lone interviewing dates.

### Resource requirements

- Your time
- Other staff time
- Notebook
- Audio-recording equipment
- Interview room
- Refreshments

Once you have broken down each milestone into smaller tasks you can then decide how you are going to complete them and by when. It is a good idea to identify potential problems (and solutions too) and build any necessary additional timing, resources and activity into the project plan.

If you are overseeing a service improvement project it makes good sense to look at the skill base of your staff before allocating tasks, in other words, what are their strengths? Think about when is the best time for those involved in the project to feedback on their task. It could be that some tasks maybe better completed at certain times of the year e.g. avoiding known busy periods.

One of the most well-known and easiest project management tools to use is the [Gantt chart](#) - a type of bar chart that illustrates a project schedule or timeline of activity. The most helpful thing a project management tool like this will do, will be to ask questions of your project that you have not yet considered the answers to. The [NHS Institute for Innovation and Improvement website](#) lists a series of helpful project management tools.

‘The PDSA cycle is a vehicle for learning and action’ (Langley et al. 2009, p. 99).

Learning can happen as you build knowledge to help answer one of the three main ([Box 1](#)) questions, for instance, in the above interviews with key staff. Learning can also happen as you evaluate an intervention. Here are some suggestions for collecting and analysing data; consider:

- The questions to be answered by the data
- Completing a pilot study
- Using sampling strategies to reduce the burden of data analysis
- Keeping a diary of what went well/not so well during data collection
- The best way of displaying your data (Langley et al. 2009).

The process of collecting and analysing data contains many ethical issues, even though the process of completing a service improvement project is most likely to be defined as service evaluation, development

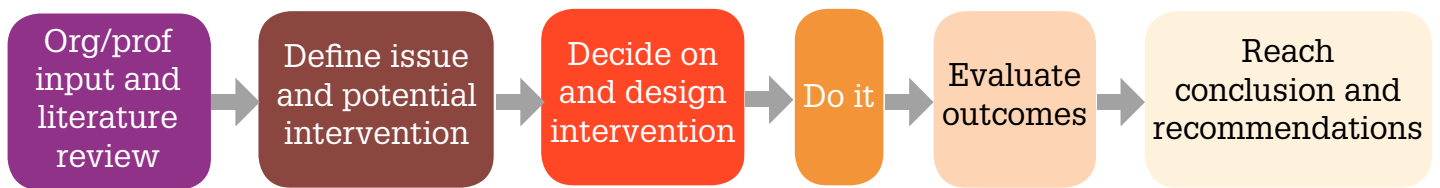
or quality improvement ([Health Research Authority 2013](#)) and, therefore, not require formal ethical review. Nevertheless, it is good practice to think through well-known ethical principles that encourage:

- Respecting the decisions of others (e.g. to take part in a project)
- Doing good
- Doing no harm
- Being fair.

It is also good practice to inform your local research governance department or appropriate individual of any intended service improvement activity. Before this task is completed, ensure the completion of any project documentation such as [risk assessments, participant information sheets and/or consent forms](#).

# { THINKING and DOING }

The following fictitious case study provides an example of how the straight forward process of designing, conducting and evaluating a service improvement project can work out in practice. Ruth's story also shows how the THINKING and DOING components of the SIM interact (see [Diagram 1](#)).



## Ruth's story – Deprivation of Liberty Safeguards (DoLS)

My manager raised a perception that Wessex Trust (based across 5 sites) has comparatively very low rates of DoLS applications when compared to national averages. This perception resonated with my own practice as an Approved Mental Health Practitioner, as I have seen a number of patients where I felt safeguards should have been put in place but weren't. I completed a review of the literature and found that although DoLS application rates have been lower than predicted across the country, there is a wide variation between areas and hospitals.

These papers offered a number of explanations for the low application rates yet I found no specific research that attempted to consider in more detail the reasons for these low application rates, in particular with staff involved in the process. Nor did the literature highlight a particular intervention that would improve application rates. Yet, improving this area is critical for vulnerable patients, who may struggle to have a voice in society anyway, and could be having their human rights breached. To answer, what I want to accomplish, I have now realised I am seeking to reduce the risk of patients in Wessex hospital being cared for in a manner which may be depriving them of their liberty.

To design an effective intervention to increase the application rate I needed to critically review the literature as well as gain a better understanding of the reasons for the current low rate of applications from the staff responsible for making such decisions. I also needed to identify, at a local level, the specific issues to help define the problem before an appropriate intervention could be created.

I thought that by using an interview-based approach I could allow staff the space to express their views and reasoning around DoLS. But I was concerned about the time-consuming nature of this approach and so chose to use a focus group instead that included each of the DoLS leads from the five Wessex hospital sites.

I notified my Trust's Research Governance department and provided them with all project documentation, including a participant information sheet that was given to staff before they signed a consent form.

Part of the focus group was focussed on views and reasoning around DoLS but the second half centred on the future and how the situation might be improved. What I soon realised during my analysis of the session was that two issues stood out as key to increasing application rates – the knowledge and confidence of general nursing staff around DoLS.

A number of the DoLS leads had successfully used a method of group-work with their staff in other areas and suggested this as a way forward.

On the basis of this research evidence, I designed an intervention that comprised an easy to understand information pack, including a number of vignettes to encourage discussion within these groups. In order to evaluate this intervention I used four simple questions around staff knowledge about DoLS and their confidence in using the application process, with the intention of asking these before and after the session. Positively, nursing staff believed that as a result of the reflective practice groups, their knowledge about DoLS had increased, as had their perceived levels of confidence in using the application process. Application rates are always monitored, so over the period of a number of months I could see that these were rising. Using a combination of research methods i.e. the focus group to help define the exact focus of the intervention and a simple questionnaire to help evaluate the intervention alongside routine data, I believe, increased the robustness of my work.

Yet, although application rates had increased (quantity), this said nothing of how (quality) the forms were being completed. I may have succeeded in my original aim of reducing risk and indeed in raising awareness, but now we are receiving feedback around some 'inappropriate referrals'. I have recently recommended that an audit be carried out with a sample of recent applications. Based on these findings I intend to extend the current intervention to cover how complete the form in a more detailed fashion and this, I hope, will raise the quality of form completions.

This example draws together the **THINKING and DOING** components of our model for service improvement (**SIM**). Our hope is that the contents of this e-guide will cause you to reflect on any projects you are currently involved with as a practitioner and/or manager. We welcome any feedback on its contents.

Please contact either of us at the National Centre for Post-Qualifying Social Work by email (Steve at [skeen@bournemouth.ac.uk](mailto:skeen@bournemouth.ac.uk) or Lynne at [lutter@bournemouth.ac.uk](mailto:lutter@bournemouth.ac.uk)) or phone 00 (44) 1202 964765. We would like to thank **Lucy Morrison** for her help in the excellent design of this publication.

# References

1000 Lives Plus., 2011. The 1000 Lives Plus Quality Improvement Guide. Cardiff: 1000 Lives Plus.

Braun, V., and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3, 77-101.

Health Research Authority., 2013. Defining research. London: Health Research Authority.

Langley, G., Moen, R., Nolan, K., Nolan, T., Norman, C., Provost, L., 2009. The improvement guide: a practical approach to enhancing organizational performance (2nd edition). San Francisco: Jossey-Bass Publishers.

Munro, E., 2011. Munro Review of Child Protection: final report – a child centred system. London: Department for Education.

Pawson, R., Boaz, A., Grayson, L., Long, A., Barnes, C., 2003. Types and quality of knowledge. Bristol: SCIE/The Policy Press.

Robson, C., 2011. Real world research (3rd edition). London: Sage.

Rutter, L., 2013. Continuing professional development in social work. London: Sage.

Rutter, R., and Keen, S., 2013. Unit guide: Preparing for your service improvement project. Bournemouth: Bournemouth University.

Shewhart, W., 1939. Statistical Method from the Viewpoint of Quality Control. New York: Dover.

Social Work Reform Board., 2012. Building a safe and confident future. Maintaining momentum. Progress Report from the Social Work Reform Board. London: Department for Education.

Whittaker, A., 2012. Research skills for social work (2nd edition). London: Sage.





