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Editorial

Engaging clinicians in quality improvement initiatives: art or science?

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Engaging clinicians, from whichever health setting or discipline, whether they are doctors, nurses or allied health professionals, is increasingly acknowledged to be an essential precondition for the success of quality improvement initiatives. This is because clinicians (and increasingly clinician assistants such as healthcare support workers) are at the front line of health care where service users' health needs are addressed and healthcare is delivered.[1] Clinical engagement, which might range from passive support to active participation to effective leadership, is often essential for quality improvement initiatives to work. Although quality improvement is viewed as self-evident in current UK health policy,[2] clinicians may be more sceptical towards it, particularly if it is seen as being imposed externally, particularly by 'management', in the form of controls, targets or (dis)incentives.[3,4]

Although clinical engagement is a necessary precondition for improvement, it is not sufficient in itself. This is because, although the clinician and the consultation is central to the clinical interaction, clinicians are not working in isolation but are part of a wider clinical microsystem.[5] A clinical microsystem has been defined as a 'small, organized patient care unit with a specific clinical purpose, set of patients, technologies and practitioners who work directly with these patients'.[6] This may be why engagement in itself has not been found to be a strong predictor of successful outcomes from quality improvement collaboratives.[7]

However, given that engagement is likely to be a critical success factor for quality improvement, and given the credibility gap among some clinicians, what do we know about engagement, what factors make engagement more or less likely and what can we do to try and encourage and secure engagement of clinicians? Engagement means not only an initial interest in quality improvement in one or more areas but also requires maintenance of this initial enthusiasm and activity. A number of studies have identified barriers to quality improvement and factors that increase the likelihood of clinical engagement.

Barriers to engagement commonly include lack of time, inadequate resources and the pressure of competing demands; but other barriers include lack of information systems (information management and/or technology) and training, insufficient skills, inadequate rewards (both financial and non-financial), staff turnover, disinterest and resistance.[8] It is important to understand why resistance is occurring – whether this is due to imperfect evidence being presented, impractical solutions offered or negative attitudes or beliefs towards the initiatives under consideration.[9] It is essential to address these barriers and a number of strategies for doing this have been found to be useful.

Clinicians are less likely to be attracted to abstract concepts which are not recognisable as being relevant to their day-to-day practice, whereas they are much more likely to be interested in clinical issues. The specific area for improvement may therefore be an important motivator. The area for improvement is commonly recognised through the significance of the health need, and identified through gaps in performance shown through benchmarking or trends and expressed as complaints, significant events, expert opinion (including publications or guidance), wasted resources or, more rarely, litigation.[8] However, more general issues of patient or staff dissatisfaction, public reporting of results, pressure from commissioners and financial incentives, as well as the availability of education, training, tools and solutions, may also spur engagement. Availability of each of these, for example training in quality improvement methods, although beneficial is unlikely to succeed without clinical engagement.[10] Ownership of the problem and the generation of solutions by clinicians is vital.

Other factors that might attract clinicians are benefits to patients and the delivery of health care, but they may also be interested in the potential benefits for the organisation, practice or team. Benefits for patients include more effective, timely and safer care leading to improved outcomes, experience and satisfaction. Organisational changes are the means of achieving improved patient care and these are implemented through more efficient and consistent processes as well as better team communication and co-ordination. The organisational changes and perceived or actual benefits for patients

lead to increased staff satisfaction, enhanced reputation, a greater ability to achieve external assurance or accreditation and even cost savings or increased profits.[8]

By adopting a communication strategy that addresses the barriers and emphasises the benefits of engagement it is sometimes possible to create an 'attractor pattern' that will draw clinicians towards an improvement initiative rather than attempting to overcome clinicians' resistance to involvement.[11]

Opinion leaders or practice champions within the organisation as well as supportive clinicians and staff are important facilitators of engagement.[12] External support provided by an expert resource, collaborative or educational resource can support improvement activity but is unlikely to sustain continuing improvement efforts unless the internal drivers are already in place or can be activated. The evidence on the importance of team culture is equivocal, with some studies suggesting team factors are important[13] and others that they are not.[14] This may be because the instruments for measuring culture are not sufficiently developed or because certain components of culture are more important than others for engagement.

There are also a number of practical issues which can either stimulate or smother enthusiasm for and continuing engagement in improvement. Clinicians are busy people; factoring in too many meetings over too long a timeline and being overly focused on processes is often counterproductive.[15] Improvement needs a project team which is carefully selected to have the appropriate skills. It is also important to understand the clinical setting, to encourage learning from colleagues, to use data cautiously and to align any incentives or disincentives appropriately.[16]

Despite the wealth of knowledge on how to engage clinicians with or turn them off from quality improvement, there is no silver bullet for success. There are currently several large-scale projects seeking to engage clinicians in quality improvement and the evaluation of these initiatives could reveal insights into how we should approach this issue in the future.[17] Whatever the answers, it is likely that the art of engagement will be in applying this knowledge judiciously with the benefit and experience of working with and supporting clinical teams.

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CONFLICTS OF INTEREST

None.

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