SERVICE IMPLEMENTATION AND QUALITY IMPROVEMENT

A THEORETICALLY INFORMED APPROACH

CONTENTS

PURPOSE OF THIS DOCUMENT

This document is intended to orientate staff working at Orygen to the Service Implementation and Quality Improvement (SIQI) team, including its aims, principles, activities, and theoretical framework. We use one of our key activities, the Implementation Lab, to demonstrate how the framework is applied in practice.

ORYGEN'S SERVICE IMPLEMENTATION AND QUALITY IMPROVEMENT TEAM

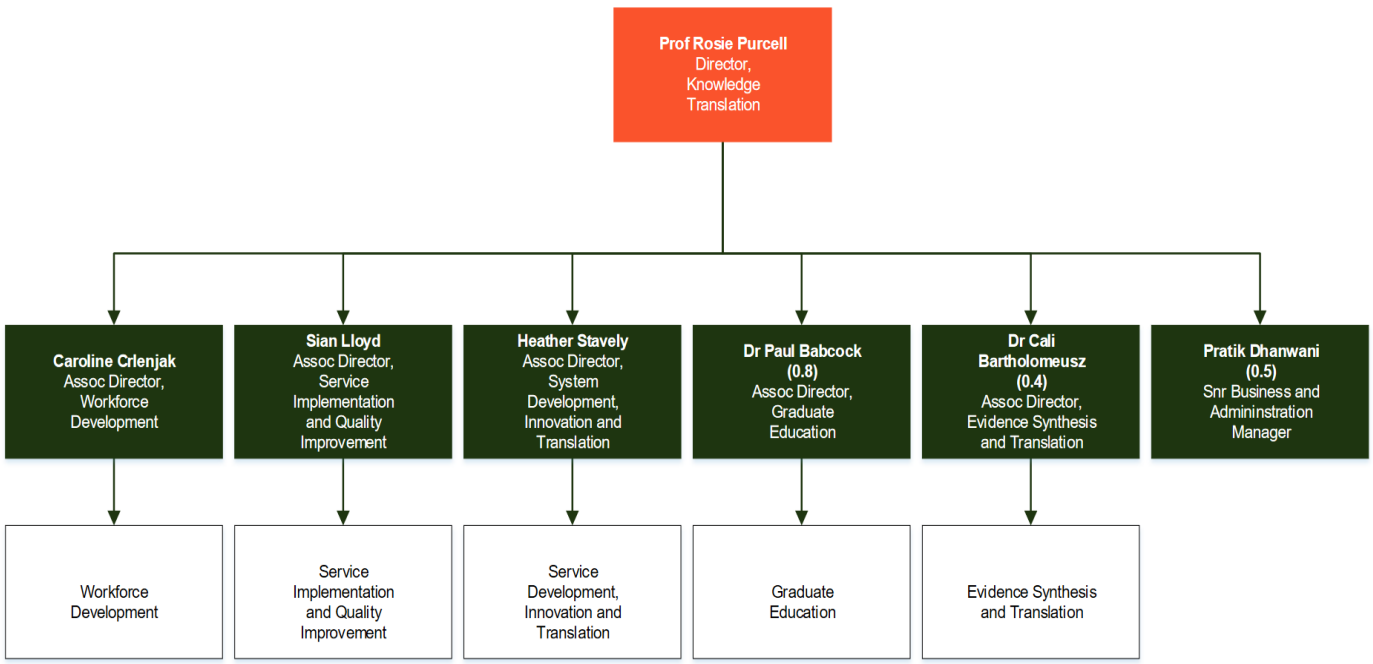
BACKGROUND AND HISTORY

The SIQI team (formerly known as the Youth Enhanced Services team) sits in Orygen's Knowledge Translation division (see Figure 1). Funded by the Australian Department of Health, the SIQI team has worked with Primary Health Networks (PHNs) to support the commissioning of new services for young people experiencing, or at risk of experiencing, complex and severe mental ill-health (aka Youth Enhanced) since 2017.

This support includes activities such as sitting on tender panels, facilitating service provider and community workshops, developing resources and tools, bringing the PHNs together to learn from each other, and providing ad hoc consultation and advice. Additionally, three PHNs were designated as 'lead sites', and in these regions, the team had an extended remit to work directly with the service providers to support the implementation of Youth Enhanced Services.

By 2019, most commissioning of Youth Enhanced Services had been completed and Orygen received an increasing number of requests from PHNs to support services with implementation and quality improvement. Responding to this need, the team developed a new quality improvement program known as the Implementation Lab ('the Lab'). The Lab was piloted with six services between November 2019 and June 2021, and learnings from this informed version 2 of the Lab which will run between July 2021 and June 2022.

FIGURE 1. ORGANISATIONAL CHART OF ORYGEN'S KNOWLEDGE TRANSLATION DIVISION



SIQI AIMS

PRIMARY AIM:

- To build the capacity of service providers and commissioners to design, deliver, and evaluate youth mental health services

SECONDARY AIM:

- To contribute to the evidence-base for approaches to implementation and quality improvement in youth mental health

SIQI ACTIVITIES

In pursuit of these of aims, the team takes a multi-faceted approach that targets healthcare commissioners within PHNs and professionals working in youth mental health services. The logic model in Table 1 illustrates the relationship between SIQI activities and expected outcomes at the practitioner, service and commissioner levels.

TEAM PRINCIPLES

Recognising that *how* we do things is as important as *what* we do, the team's approach is guided by four core principles:

- **Curiosity** – We acknowledge that there is much that we do not yet know. We seek out new knowledge and information from the people working in the youth mental health field, as well as the research literature.
- **Collaboration** – We appreciate the value of working with people with diverse skills and experiences. We help each other and jointly own the outcomes of our work.
- **Openness** – We recognise that there are often different ways to approach a challenge and welcome alternative ideas and perspectives.
- **Adaptability** – We act scientifically and pragmatically. We combine knowledge of existing evidence with knowledge of the local contexts we work in and adapt our approach as learning emerges.

TEAM MEMBERS

Sian Lloyd, Associate Director, SIQI
Angus Crump, Administration Support
Craig Hamilton, Lead, SIQI
Yamiko Marama, Clinical Consultant
Sophie Prober, SIQI Advisor
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TABLE 1. SIQI PROGRAM LOGIC MODEL

SIQI ACTIVITIES	TARGET AUDIENCES	DELIVERY OUTCOMES	PRACTITIONER, SERVICE, AND COMMISSIONER OUTCOMES		YOUNG PEOPLE OUTCOMES
			Short-term	Medium-term	Longer-term
Delivery of Implementation Lab Delivery of telehealth (secondary consultation and reflective practice) Delivery of YES hub (webinars, LMS) Documentation of service models (case studies) Refinement and articulation of YES model Delivery of quarterly newsletter Delivery of 2 national PHN forums per year Consultation with PHNs and service providers Development of resources	Youth mental health staff (frontline workforce, leaders) Youth mental health service commissioners at PHNs	SIQI activities reach target audiences and are perceived as acceptable, feasible, and appropriate Target audiences perceive SIQI team to have demonstrated the team principles (curiosity, collaboration, openness, adaptability)	**Practitioner level:** Improved knowledge of relevant evidence, Orygen resources and supports Improved capability and confidence to work with YPs with complex MH needs in system contexts **Service level:** Improved capacity for organisational learning Improved service model design and implementation Achievement of service development goals Improved engagement in system integration processes **Commissioner level:** Improved knowledge of relevant evidence, Orygen resources and supports	Improved service quality (e.g. acceptability, appropriateness, reach, timeliness and accessibility, engagement of YP, coordinated care, system integration, family inclusiveness, YP connection to peers)	Improved mental health and functional outcomes for young people

EXAMPLES OF MODERATING FACTORS	
Youth mental health staff and service characteristics	**System characteristics**
Motivation Values and beliefs Skills and knowledge Time and resources Learning environment Collaboration and teamwork Formal and informal leadership Culture and climate Evaluation and feedback processes Organisational strategy and priorities	Policy drivers and priorities Incentives and mandates Regulatory frameworks Environmental (in)stability Inter-organisational networks and relationships

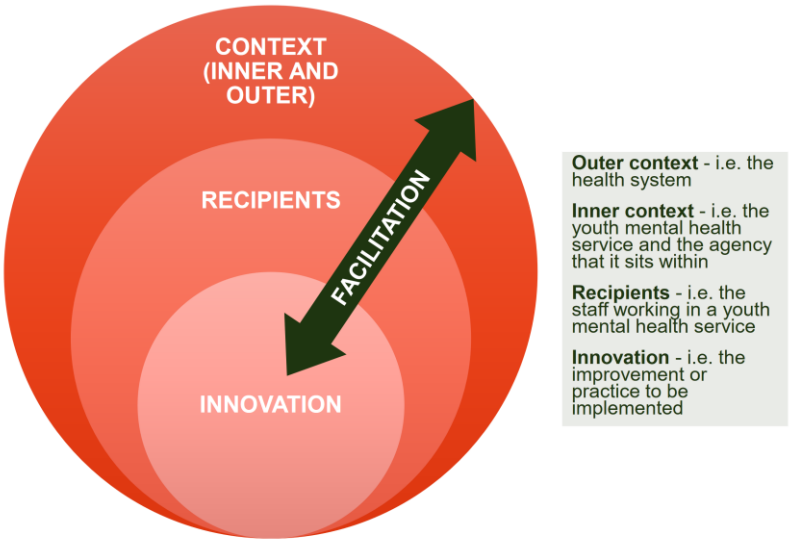
I-PARIHS: AN ORGANISING FRAMEWORK FOR IMPLEMENTATION AND QUALITY IMPROVEMENT

For intermediary organisations,[1] like Orygen, there is great value in using frameworks, models, and theories in knowledge translation (KT) projects.[2,3] They can provide shared language among Orygen staff and external stakeholders, and function as practical tools for designing, delivering, and evaluating projects.[4] Numerous frameworks, models, and theories can be found in the literature so when planning a project it is useful to refer to the available guidance.[4,5]

Given the considerable challenge of embedding innovation and improvement in healthcare, combining theoretical perspectives from the fields of implementation science, complexity science, and social science is recommended.[2] The SIQI team's approach is underpinned primarily by the Promoting Action on Research Implementation in Health Services integrated (i-PARIHS) framework,[6–8] which integrates theories from the aforementioned fields. We suggest that i-PARIHS may also be a useful organising or conceptual framework for other service and workforce development activities delivered by Orygen, which if adopted, would promote theoretical coherence among projects.

i-PARIHS conceptualises how evidence, including published research, case studies, expert or consensus opinion, and accrued experience can be successfully implemented in healthcare settings using the process of facilitation. It has four core constructs: facilitation, innovation, recipients, and context (illustrated by Figure 2). The implementation process is viewed as inherently complex, involving a dynamic interplay between the proposed innovation (i.e. the improvement or practice to be implemented), the recipients (i.e. individual practitioners or team), and the organisational and wider system context.[8] Facilitation is regarded as the active ingredient that enables successful implementation by assessing and aligning the other three constructs.[6]

FIGURE 2. THE CORE CONTRUCTS OF I-PARIHS. ADAPTED FROM HARVEY AND KITSON.[8]



i-PARIHS was selected as an organising framework for the SIQI approach because it was regarded as 1) credible, 2) relevant, 3) comprehensive, and 4) practical.

CREDIBILITY

i-PARIHS, formerly known as just PARIHS, was initially developed in 1998. Over the last two decades it has been widely used in healthcare improvement programs.[5] The authors have remained active in the development of the framework and there have been several iterations based on experiential and empirical findings.[5] The most notable change came in 2015 when the framework was revised to i-PARIHS, which integrated developments from other theories (shown in Table 2).[6]

TABLE 2. THEORIES THAT INFORMED I-PARIHS' CORE CONSTRUCTS. ADAPTED FROM HARVEY AND KITSON.[8]

INNOVATION	RECIPIENTS	CONTEXT	FACILITATION
Evidence-based decision making Experiential, problem-based and situated learning Diffusion of innovations Engaged scholarship	Diffusion of innovations Organisational readiness to change Theoretical Domains Framework (and COM-B) Communities of practice Sticky knowledge and boundary theory	Complexity/complex adaptive systems Distributed leadership Organisational culture and climate Learning organisation Absorptive capacity Sustainability	Humanist/student-centred learning Cooperative inquiry Quality improvement

RELEVANCE

i-PARIHS aligns with the SIQI team's approach to service implementation and quality improvement in several ways:

- It encourages systemic thinking and recognises the importance of understanding and attending to the context in which stakeholders work;
- It recommends systematically assessing needs and identifying opportunities for improvement before developing potential solutions;
- It regards implementation to be more of a relational process than a technical one;
- It highlights the value of empowering staff and building the capacity of teams and organisations; and
- It integrates theories already used by the SIQI team (and other Orygen KT teams), such as Theoretical Domain Framework,[9] COM-B (capability, opportunity, motivation, and behaviour),[10] complexity theory,[11,12] organisational readiness to change,[13] organisational culture and climate,[14] and organisational learning.[15,16]

COMPREHENSIVENESS

i-PARIHS has a strong emphasis on understanding and addressing the complexities of implementation. It illuminates the many characteristics of innovations, individual staff and teams, organisations, and wider systems, which can influence implementation success (shown in Table 3). This aids the identification of barriers and enablers prospectively (to inform implementation strategies) and retrospectively (to aid in reflection and to assess their potential impact on implementation success).

i-PARIHS' integration of other theories, and the authors' encouragement to utilise these theories, enables the SIQI team to use a broad range of theoretical perspectives while maintaining coherence with i-PARIHS' organising structure. Examples include using theories of:

- organisational readiness for change, such as R=MC^2,[17] to assess the motivation and capacity of services to participate in implementation and quality improvement projects;
- individual behaviour change, such as COM-B,[10] to identify barriers and enablers of specific practice change perceived by youth mental health staff, and to inform the design of appropriate behaviour change strategies; and
- organisational learning[15] to assess services' capacity for continuous improvement and to inform the design of appropriate capacity building strategies.

TABLE 3. EXAMPLE CHARACTERISTICS OF INNOVATIONS, RECIPIENTS, AND CONTEXT (INNER AND OUTER) THAT CAN INFLUENCE IMPLEMENTATION. ADAPTED FROM HARVEY AND KITSON.[8]

INNOVATION	RECIPIENTS	INNER CONTEXT	OUTER CONTEXT
Underlying knowledge sources	Motivation	Formal and informal leadership support	Policy drivers and priorities
Clarity	Values and beliefs	Culture and climate	Incentives and mandates
Degree of fit (compatibility or contestability)	Clinical consensus	Past experiences of change	Regulatory frameworks
Degree of novelty	Local opinion leaders	Mechanisms for embedding change	Environmental (in)stability
Likely boundaries	Existing data sources	Evaluation and feedback processes	Inter-organisational networks and relationships
Trialability	Skills and knowledge	Organisational priorities	
Relative advantage	Time and resources	Structure	
	Learning environment	Systems and processes	
	Collaboration and teamwork	Absorptive capacity	
	Power and authority		
	Professional boundaries and networks		

PRACTICALITY

Unlike many frameworks which identify implementation determinants, i-PARIHS provides practical guidance on how to approach the process of implementation. A facilitators toolkit[8] documents a phased approach to implementation and guides readers on how to assess and align the different i-PARIHS constructs, and evaluate projects. More information about the role of facilitation is detailed below.

FACILITATION: THE ACTIVE INGREDIENT IN HEALTHCARE IMPROVEMENT

Facilitation has been defined as ‘a technique where an individual makes things easier for others, by providing support to help them change their ways of thinking and working’.[18] It is frequently cited as being a key implementation and quality improvement strategy.[18,19] In i-PARIHS, it is the active ingredient that enables successful implementation by aligning the proposed innovation with the individuals and teams involved and the context in which they work.[8] In recent years there has been growing interest in unpacking 1) what ‘providing support’ entails and 2) the characteristics and competencies required of those providing it.[7,8,18,20–22] Box 1 references two resources that provide practitioners with useful guidance on both topics.

THE FACILITATION PROCESS

Given the complexities involved in implementation, it is helpful for practitioners supporting the process to know what activities they may need to deliver and when.

BOX 1. PRACTICAL FACILITATION RESOURCES

- **Implementing Evidence-Based Practice in Healthcare: a Facilitation Guide.**[8]
- **A Practice Guide to Supporting Implementation - What Competencies Do We Need?**[23]

Table 4 shows examples of activities performed during an implementation project, which are grouped into four phases/areas of focus highlighted by the i-PARIHS authors (i.e. clarifying and engaging, assessing and measuring, action and implementation, reviewing and sharing). Some activities are task orientated, while others have more of a developmental focus (i.e. are concerned with building the capacities of individuals and teams).[8]

Implementing in the ‘real-world’ is rarely a linear or sequential process, and the four phases should be thought of as a general guide rather than a manual to be followed step by step. Practitioners need to

tailor their approach in response to changing needs, circumstances, and feedback. Activities from different phases may occur concurrently and activities from prior phases may need to be revisited.

TABLE 4. EXAMPLE FACILITATION ACTIVITIES. ADAPTED FROM HARVEY AND LYNCH,[7] HARVEY AND KITSON,[8] BERTA ET AL.,[20] AND METZ ET AL.[24]

PHASE/AREA OF FOCUS	ACTIVITIES
1. Clarifying and engaging	Using data-driven inquiry methods to support 'discovery' processes that holistically consider needs and assets Helping stakeholders understand each other's perspectives and expectations regarding the area of need or opportunity Introducing new ideas (i.e. research and associated knowledge that may address performance gaps) Clarifying the improvement issue to be addressed and assisting in establishing goals Establishing the level of interest and commitment to the improvement topic Identifying the local champions and wider stakeholders Getting the right people together to form an improvement team Developing a preliminary project plan Securing stakeholder support (e.g. from formal and informal leaders)
2. Assessing and measuring	Developing and understanding of the state of 'readiness' (motivation and capability to be involved in the proposed improvement Assessing barriers and enablers at level of individual, team, organisation, and broader system Undertaking baseline audit
3. Action and implementation	Reviewing and interpreting baseline data Collaborating with stakeholders on development of an implementation and action plan Tailoring facilitation activities to local needs, circumstance, and feedback Providing ongoing support and resources to achieve goals Creating a supportive local climate Empowering staff Supporting the development of new competencies/skills among staff Promoting learning through critical reflection Running small tests of change (Plan-Do-Study-Act cycles) Tracking progress over time and adapting as required Maintaining change momentum Brokering intra- and inter-organisational relationships Helping to create feedback loops that connect leadership with frontline service delivery
4. Reviewing and sharing	Undertaking repeat audit Reflecting on the process: what worked well and less well Feeding back to wider stakeholder group Organising a 'celebratory event' Planning for sustainability and spread

CHARACTERISTICS AND COMPETENCIES OF PRACTITIONERS AND TEAMS

Personal characteristics of practitioners include being empathetic, authentic, curious, sensitive, flexible, pragmatic, patient, resilient, a critical thinker, and willing to challenge the status quo.[7,24]

Practitioners require technical knowledge that enables them to appraise evidence; to manage projects; to train and educate stakeholders on an innovation (i.e. a specific practice or improvement) and the implementation process; to assess needs and context; to plan, monitor, and evaluate implementation; and to adapt implementation strategies.[8,21]

Strong relational skills are needed to build and sustain relationships with stakeholders, and to broker relationships between stakeholders.[22] Examples of relevant skills include stakeholder engagement; interpersonal communication; negotiation; participatory decision-making; and managing vulnerability, discomfort, and conflict.

The diverse range of skills and knowledge needed may be beyond the capacity of a single individual, so taking a team-approach to projects may be advisable, particularly for more complex projects.[7]

THE IMPLEMENTATION LAB: A KEY SIQI ACTIVITY

One of the SIQI team's key activities is the Implementation Lab, a systemic approach to the quality improvement of youth mental health services that has been delivered by the team since 2019. The Lab's design has been informed by the i-PARIHS framework (including its theoretical antecedents such as organisational learning) and the team's prior experience of working with youth mental health services and PHNs.

OVERVIEW OF THE APPROACH

Recognising that sustainable quality improvement requires a systemic approach,[2] the team works in partnership with a youth mental health service and the PHN that commissions the service (collectively known as a 'Lab site'). The team work simultaneously with a small cohort of Lab sites (up to six) over the course of 12 months,

The team works with the Lab sites to achieve collaboratively agreed service developments goals. Additionally, services are supported to build their internal capacity for organisational learning,[15] so that they are able to continuously improve in the longer-term, independently of Orygen's support.

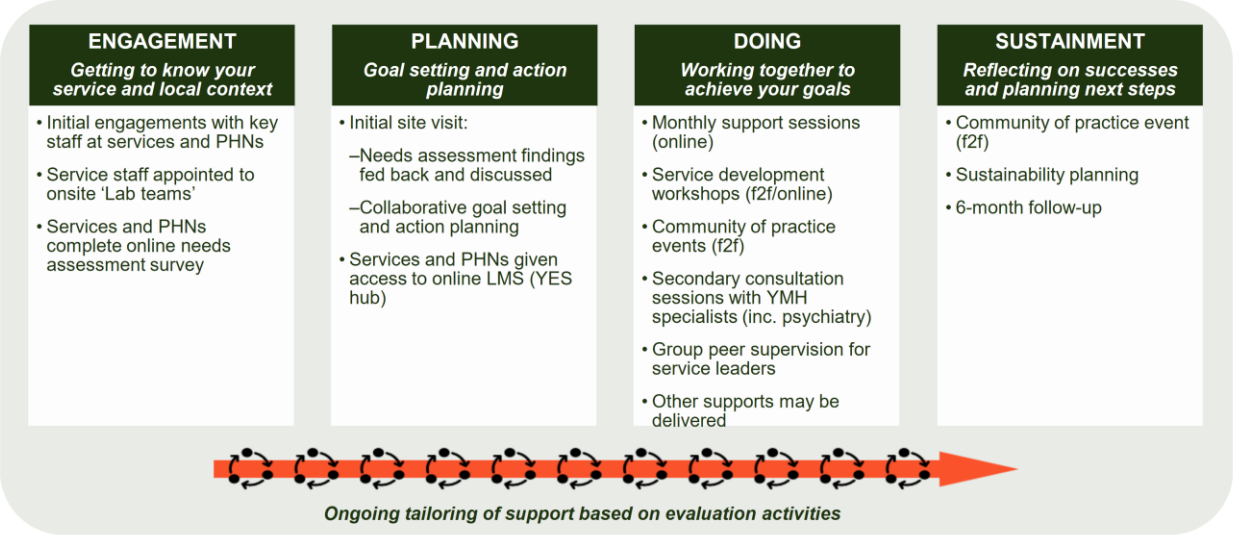
RECRUITMENT

The recruitment process allows the SIQI team to provisionally assess applicant's needs and level of readiness (i.e. motivation and capacity) to participate in the Lab, and to begin engagement with key stakeholders. PHNs and youth mental health services interested in the Lab are asked to jointly complete an application form and then attend an interview with the SIQI team. Successful applicants then complete a memorandum of understanding which clarifies the responsibilities and expectations of Orygen, PHNs, and service providers.

FOUR PHASES OF THE LAB

Once accepted, there are four phases of the Lab (illustrated by Figure 3). Major activities include stakeholder engagement, needs analysis, collaborative goal setting and action planning, service development and capacity building workshops, reflective practice sessions, facilitation of a community of practice, and evaluation.

FIGURE 3. THE FOUR PHASES OF THE IMPLEMENTATION LAB



PHASE 1: ENGAGEMENT

In this phase, there is an initial set-up meeting with each Lab site, in which the SIQI team talk through the Lab process and get to know some of the wider staff group. Sites appoint a 'Lab team' of three people (including someone in a leadership role) who are responsible for championing and coordinating Lab activities onsite and act as the main point of contact for the SIQI team. An online survey designed to assess needs, assets, and context is sent to staff at each site as well as the relevant PHN commissioner. The survey covers four main domains: staff capabilities, general organisational capacity, organisational learning capacity and system integration. To encourage candour, staff are informed no individual responses will be reported and that data is aggregated at a site level.

PHASE 2: PLANNING

The SIQI team analyse the survey data and in the following weeks, travel to each Lab site to deliver a 1.5-day workshop which is attended by all service staff and the PHN commissioner. On the first day, survey findings are presented and reflected upon by the group, participatory decision-making techniques are used to prioritise priority areas for service development and relevant goals, and idea generation methods are used to elicit ideas from the group about what could be done to progress toward the service development goals. On the second day, the SIQI team meet with the site's Lab team to discuss potential barriers to action (and how these may be mitigated), recommendations for embedding organisational learning processes and practices, and begin developing an action plan. The action plan is continued and refined after the workshop and remains as a working document throughout the entire Lab process.

Sites are also given access to an online learning management system, known as the YES hub, which includes numerous service development and clinical resources, including monthly webinars, and a forum to engage with other sites.

PHASE 3: DOING

Throughout this phase, the SIQI team deliver service development workshops (onsite or online) with sites, which are tailored to their particular needs and goals (e.g. working with a site to review their eligibility criteria and intake processes). There is a significant onus on sites to take ownership of progressing their service development goals, and the SIQI team videoconference with sites every month to check-in on progress, problem-solve, and provide practical guidance on next steps.

Each Lab site is entitled to receive 10 optional secondary consultations with youth mental health specialists (including psychiatrists) delivered via videoconferencing. In general, the sessions follow a case-based learning format. One or two staff from a site complete an anonymised case review

template which they submit to the SIQI team prior to a secondary consultation session. The format of these sessions can be amended to the needs of each site.

To facilitate the development of a community of practice among the cohort of Lab sites and PHNs, the SIQI team facilitate two Lab events during this phase. The first event is held virtually just after the 'engagement' phase has finished. Sites present an overview or their service, context, and service development goals. The second event is held face-to-face at Orygen (if feasible) and includes presentations from sites on their progress, challenges, and learnings; presentations from Orygen's youth mental health specialists; and opportunities for networking.

Recognising the vital role that leadership plays in the continuous improvement of youth mental health services, the SIQI team facilitate bi-monthly peer group supervision sessions for leaders (i.e. management, clinical leads) working at Lab sites. These sessions focus on service development (rather than clinical case discussion) and participants are encouraged to share issues and learnings.

PHASE 4: SUSTAINMENT

While the sustainment of improvements is considered throughout the entire Lab process (most notably by supporting sites to embed organisational learning processes), it is a particular focus in the last phase of the Lab. The SIQI team make recommendations for each site and help to plan how sites can continue to engage in service development without the structure of the Lab. A final face-to-face Lab event focuses on sites sharing their successes and learnings, and working together to plan for future service developments.

There is an open-door policy for sites once the Lab process ends, in which the SIQI team offer ad hoc consultation. Six months after the Lab ends, sites are asked to participate in an interview to discuss how service developments have progressed, and the barriers and enablers to making progress.

ONGOING TAILORING OF SUPPORT

An integral component of the Lab is tailoring the support provided to each site in response to changing needs, circumstances, and feedback. Throughout the Lab's four phases, the SIQI team collect qualitative and quantitative data from sites (see Implementation Lab Evaluation Plan), and meet monthly to have data-informed discussion about sites' progress and feedback on the Lab process, and decide on any relevant adaptations.

WHAT DOES SUCCESS LOOK LIKE?

The relationship between all SIQI activities and expected outcomes at the practitioner, service and commissioner levels are illustrated in the logic model in Table 1. Drawing on this model, the intended outcomes for the Lab include:

- Lab activities reach target audiences and are perceived as acceptable, feasible, and appropriate;
- Participating youth mental health services and PHNs perceive the SIQI team to have demonstrated the team values (curiosity, collaboration, openness, adaptability);
- Services achieve their specific service development goals; and
- Services have an improved capacity for organisational learning.

It is likely that there will also be other unanticipated outcomes, which will be explored in the evaluation (see Implementation Lab Evaluation Plan) and will inform future iterations of the Lab approach.

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