**Zoom chat response from Dr Tom Rose – 19th March 2024 Q Community webinar**

**During the webinar**

**Comment**

Very interested in trying to understand QMSs generally, and how much the NHS could be learning from other sectors that use QMSs. Plus the role of process mapping in all this.

**Response**

The first point is that it’s just a ‘management system’. In the case of a QMS, the management system is designed to ensure that your deliverables comply with the organisations ‘Policy’ and the pre-set ‘Standards’ for those deliverables. (It may be worth having a look at ‘management systems’ more generally. I’ll do that. Second point, the reason for process mapping is that it’s the Service realisation system (processes) that implement policy and deliver the Service to the required standard, so it’s a prerequisite that these processes are understood, standardised, represent best practice, and, importantly, are managed.

**Comment**

Hi all, I'm QI Lead at CLCH and interested in process documentation in relation to QMS and learning management.

**Response**

If processes are to be understood and improved it’s necessary to start from a stable baseline that represents work-as-done (WAD). The only way to achieve this is to design representative process documentation. In my experience the most effective way of doing is by using a process flow charting technique. A simple process flowchart, with links to more detailed task descriptions/procedures where necessary, will suffice. To manage the ‘quality’ of how these processes are implemented will require further documentation/record dependent on the design of your management system. All these documents are specified if you implement the management system described in BS ISO 7101:2023 or ISO 9001.

**Comment**

 Would just really like an overview and to learn from your experience. I work in Digital Health.

**Response**

I have a great deal of experience of management systems and digital applications. One thing that I do Know from my experience is that ill-defined processes and much variation make for very difficult digitisation and poor application design. It would be great to hear from you in response to the webinar and comments here. Please email: t.rose.1@bham.ac.uk

**Comment**

Interested in how we overcome the work as imagined / work as done divide in process documentation.

**Response**

Certainly initial process flow charts MUST represent WAD and be produces by front line staff (FLS). This representation of WAD must be agreed by all the people delivering that particular process, again FLS. The many examples of internal WAI (work-as imagined) can be gathered together, relevant SOPs for example. The WAD process flow chart can then be reviewed against selected WAI documentation to assess compliance. Any areas of non-compliance can then result in changes to the WAD and/or changes to the WAI documentation. Approvals for the changes must follow an authorisation process. Over time the result will be WAD=WAI and this will represent best practice. Then and only then can true CI (continual improvement) be effective.

**Comment**

I'm interested in hearing about how mapping can help with improvement work.

**Response**

I will be posting some detail in the Q SIGs regarding ‘management systems’. It’s all about understanding and improving your organisation’s processes. That is a prerequisite for improvement. My experience in this area has been that the best way to understand your processes is to do some simple process mapping. As your skills in this area improve and you identify and map more processes you can then build on your system and create a ‘management system’ to address a range of things like Quality and Patient Safety but also things like Staff Wellbeing.

**Comment**

I am a GP in Dorset and aspiring to master the concept of Learning Health Systems and within this the importance of process mapping!

**Response**

The question is ‘what do you want to learn?’ Two elements may be – the theory and the practice of your chosen subjects. It will boil down to, though, data! Data is collected via your processes and if that data is to be valid then your processes need to be understood. This may sound a bit simplistic but that’s good!

**Comment**

I'm a PhD student with an interest in safety management and how a QMS can be used to support safety as part of quality.

**Response**

The same management system can manage both Safety and Quality. But – you do first need a management system. My view is that you should not try to design one – you will make a mess of it or kid yourselves that you already have one – you haven’t! BS ISO 7101:2023 has been designed with the help of WHO Internationally and is a management system that will do the job. If you need any help understanding management systems then get in touch with me.

**Questions/comments and answers**

I hope that you were able to learn something from the webinar. Please feel free to ask me any questions.

**Comment 1**

A good book on that Cynefin model (complicated, complex etc) came out in 2021 - includes some healthcare-focused chapters. It's called 'Cynefin - weaving sense-making into the fabric of our world'. Q has run a couple of Zooms about projects that used the SenseMaker narrative-mapping software, linked to Cynefin/Dave Snowden....

Here's a snippet about how Cynefin model says we must work in the 'complex' domain: "Complex contexts are often unpredictable, and the best approach here is to "Probe – Sense – Respond." Rather than trying to control the situation or insisting on a plan of action, it's often best to be patient, look for patterns, and encourage a solution to emerge."

This seems unrelated to best practices, process mapping, QMS to me...

'What good looks like' is the approach used in the 'complicated' domain, but is not relevant in the 'complex' domain, as far as I know. I think Tom's kind of using complex to mean 'very complicated', but that misses the issue of emergence and unpredictability of the 'complex' domain...

**Response**

I think it is important. There is some confusion as to what these terms are being used to describe in healthcare. It should be clear – is it process, procedure, or situation that is being referred to as being one or other of these domains? And if so then why? And what our options?

**Comment 2**

Ought the conversation be extended across NHS and ASC (Local Authorities), not just the clinical sense but the overall flow across the patient journey as a whole rather than just the NHS boundary? Thoughts anyone?

**Response**

The simple answer is YES! Why is it so difficult? The right processes and the right process management is the answer but I think we are some way off that. With the right processes and process management, IT application could then play the part that they are so good at – communication! How do we get to that point?

**Response**

Yes and I think we all agree!

**Comment 3**

Maybe it's just me, but does the complex/emergent domain require a different approach than a conventional Quality Management System...?

**Response**

Not necessarily. Understanding systems, process design and proper management systems will remove a lot of the perceived/self-generated ‘complexity’ and any remaining can be address by the good design/application of technology. We have some way to go to get to that scenario.

Additional comment: Interesting question perhaps partly answered by approach taken.

**Response**

I agree but only true if the approach is taken!

Additional comment: I'm not sure that this does. I do think that in healthcare there are a lot of elements of care delivery that can't be simply documented in great detail, typically due to the significant amount of variation that can occur. Complex clinical decision making is a typical situation where the 'correct' next step is determined by a multitude of different factors and it isn't practicable to attempt to document every nuance. There are however, many elements of healthcare which can and should be standardised. A QMS is trying to ensure that we have defined what 'good looks like' and that we have a system in place to check that we are following that practice reliably. If you take this as the principle, the level of detail required in the process documentation should reflect this. I.e. where it is possible to, document it. Where it isn't possible to document everything, ensure the principles that underpin 'good practice' should be documented.

**Response**

I agree. People that work in healthcare have had many years of training and assessments. They are monitored for CPD annually. Over their years of practice that have developed a vast array of skills to be used in their work situations. There are many organisations and publications that address improvements to medical procedures and communication channels that get this detail to the people that need to know. This level of detail need not be replicated in internal process/procedure documentation. Processes are required to ensure that this detail is not only available but is being used in practice.

This is not the case for other elements of the process, things like data collection, record keeping, form filling, handover, etc., need to be included in process documentation and monitored for compliance. I’m not suggesting that this is simple to achieve. Like most things a degree of learning is required and skills developed. Practice makes perfect!

**Comment 4**

Toyotas 'LEAN' approach is a great example but once a car leaves the factory there is little to no interest for the vehicle... whereas the NHS is merely a component of the overall patient journey and that patient is likely to return.

**Response**

That’s true up to a point. There have been some big vehicle re-calls over the last few years, often as a result of errors in design and a cover-up by the manufactures. There certainly is a similar situation in the NHS.

On another point I don’t think that a LEAN approach is the right approach for healthcare although VMI favour it. We can reduce waste via our QI tools and good process management. It’s the LEAN emphasis on takt time that I think is unsuitable for healthcare and good patient care.

**Comment 5**

Why should we be taking out the detail?

This is where the variation can be found...and then reduced.

**Response**

The detail need not be included in the process flow chart illustration. Only that that is necessary to make the process clear in required in the final document. Things like Task headings and simple descriptions. Certainly during the early design process more detail may be required. As the flow chart design matures a lot of the task/procedure detail can be removed from the flow chart and ‘links’ included to more detailed task/procedure detail. It’s certainly not taken away, just re-located. Task/procedure detail can the be improved without changing the flow chart detail and visa-versa.

**Comment 6**

I have found that process mapping is really useful for straightforward processes in 2 main ways. Firstly facilitating a group to visualise and agree a process that is not clear, and is followed with way too much variation. Secondly just getting folk to follow a process reliably. Even something simple like action tracking around a meeting can carry way too much variation.

**Response**

Yes. But it’s important that all the process mapping effort is not treated as a ‘one off’ exercise. Retention of the documentation produced must be formalised and used for process review and CI activity in the future. The documentation can be used for ‘desktop reviews’ for things like Patient Safety and HF meaning the subject experts do not necessarily need a site visit mitigating all the time and effort that requires. I should add that this scenario takes some maturity to be established in the process. Getting people to follow the process is certainly a big issue in the NHS. It’s down to the managements system to address this – and your Leadership of course!

**Comment 7**

That really helps, it’s the future state map that we talk about.

**Response**

Initial process mapping must represent WAD. Certainly a ‘future state map’ is a great improvement ambition and should always be in mind. In fact Toyota publish ‘future state’ process maps in the workplace in order to generate ideas from the employees on how to get there.

**Comment 8**

The physicality of mapping is key. It is as much about the facilitation - all key players in the room, safe space, and collaborative compilation of what the process is and why it does not work reliably. Typically (*we undertake)* mapping existing process, with a 'rock throwing' session to identify a) poor process and b) poor adherence. The skill comes in capturing the conversation and documenting it, then presenting it back for subsequent sessions around focus for improvement and ownership of testing change. For me I often end up with swim-lane diagrams illustrating process hand-offs over a timeline. Non-co-design approaches don't work in my experience

**Response**

I’m not sure what a rock throwing session is. The process of generating a WAD process map (flow chart) has many routes. My view is to keep it simple (KISS) and take your time. I find it best to use simple templates as demonstrated in the webinar. It may take a few iterations to get there. Meeting are not the best method as most of the right people will not be in the room. I have found that initial steps are best kept a bit informal and don’t start any final documentation until the design has settled down a bit. This is an important process to get right and does require some training/skill.

**Comment 9**

Believe too many try to put everything at a single level which inherently makes it complex. Developing process on multi-level, multi-tier with drill down capability helps separate this complexity into what Tom describes as simple process.

**Response**

Yes. See my comments above.

Additional comment: Absolutely - this is helpful when things change. For an example, when a nursing team receives a referral, the process might be very simple: Receive referral, triage referral, allocate referral. The detail of how to do this isn't needed in the process document. The detail for how to do each step, should be documented in separate procedure documents. This is helpful for teams who are accessing the documents, they might only need to refer to a single procedure, rather than a massive process *(system/pathway)* document. It is also easier to manage change. If the way we allocate a referral to a nurse might change if we start to use a different clinical system. However, the process isn't changing, we still undertake the same tasks in the same order, it is the procedure level that is changing in that example. Therefore it is only the procedure step that needs updating.

Additional comment: For me process mapping has to have a purpose - for example examining the process or reducing variation. The product is more about the collaborative conversation and less about the final visualisation.

**Response**

Yes. See my comments above.

**Comment 10**

Might be worth a separate event to walk through a process, what a bad one looks like and how it might be improved/simplified/split?

**Response**

Yes. I think that needs to be a Trust specific exercise and really needs to be undertaken ‘live’. I’d be happy to facilitate that if any Trust is interested.

Additional comment: Sounds like Tom would run more of a clinic-style session...? Might be fun.

**Response**

Yes. See my comment above. We need some good examples if anyone is interested and able to participate, if so Email and we can make a plan.

 **Comment 11**

How does quality management balance with a recognition that there are multiple uncontrollable contextual factors that mean many processes can't be completed the same way each time?

**Response**

That’s down to understanding the process and how the flow chart is designed. As I said above, some discretion must be placed in the hands of the clinician; decisions may need to be justified at a later date though.

**Comment 12**

It might be good to provide an outline of the different types of documentation that we might require and what kind of information should be held in each. In my experience, there are a lot of documents that have similar titles but contain vastly different levels of detail.

**Response**

I’m just doing some work on what a ‘management system’ looks like. This will define types of documentation and, importantly, records. Design of these documents is down to individual organisations but to save time and understanding I think that it’s preferable to follow an internationally recognised management system standard like ISO 9001 or the new healthcare management standard BS ISO 7101:2023.

Thanks.

Please email me with any comments or questions.

Tom Rose, March 2023. Email: t.rose.1@bham.ac.uk