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research

Quality improvement in the voluntary sector: knowledge, capacity and education

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Quality improvement has been proposed as a means of enhancing health and social care on an international scale. Despite being a key stakeholder in health and social care delivery, there is a lack of evidence regarding the adoption of quality improvement in the voluntary sector. For this study, 21 semi-structured interviews and five focus groups were conducted with Scottish voluntary sector staff. A gap analysis was undertaken, and findings were used to co-create educational sessions that may aid capacity building. Our findings suggest that knowledge, adoption and practice of quality improvement are currently variable in the Scottish voluntary sector. Capacity building for improvement is most successful when supported with sector-specific examples and networking opportunities. We conclude that the current policy landscape provides an opportunity for national governments to involve the voluntary sector as an equal partner in the adoption of quality improvement. We make recommendations for researchers and policy makers on how this may be achieved.

Key words voluntary sector • quality improvement • quality management • capacity building

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Introduction

Improving the quality of services is a global priority for health and social care. In many developed countries, quality improvement has been adopted as a means of elevating quality of care. A review of quality improvement in Europe found that most European Union member states have established nationally accredited quality improvement systems and national societies for quality in health care (Knežević and Marinković, 2019). Quality improvement methods have also been proposed as a way of strengthening action on a range of international health priorities and achieving universal health coverage. It is argued that quality improvement can help developing nations to reorient care delivery systems from provider-centred to integrated people-centred services, and advance progress towards achieving the 2030 Sustainable Development Goals (Ovretveit, 2002; Abrampah et al, 2018).

Since the 1980s, there has been a global shift in social care roles, moving from the public sector to the voluntary sector (Baines et al, 2014). This movement has led to voluntary sector organisations playing a central role in the provision of public services (Jevanesan et al, 2019). With sustained advocacy of quality improvement methods and commitment as a means of raising service user outcomes across the globe, and the voluntary sector as a key provider of social care, there is a need to understand voluntary sector perspectives on quality improvement, and the enablers and barriers to building capacity for improvement within the sector. This study explores these issues in the context of the Scottish voluntary sector.

The Healthcare Quality Strategy for NHS Scotland (Scottish Government, 2010) set three quality ambitions: for care to be person-centred, safe and effective. This strategy set out to expand the adoption of quality improvement approaches across health and social care. The Scottish government is committed to investing in quality improvement capacity, capability building and education (Scottish Government, 2016), and national organisations have been mandated with promoting the adoption of quality improvement across public services, including social services, health, education, the police and the voluntary sector (Scottish Government, 2018). In the UK, these national organisations include the National Institute for Health and Care Excellence (NICE), the Care Inspectorate, Social Care Wales and the Regulation and Quality Improvement Authority (RQIA).

The Public Bodies (Joint Working) (Scotland) Act 2014 put in place the legislative framework to integrate health and social care services in Scotland. Thirty-one integrated joint boards (IJBs) were established, bringing together representatives from the National Health Service (NHS), local authorities, the voluntary and independent sectors and those who use health and social care services, to work in partnership and manage the planning of integrated arrangements and onward service delivery (Scottish Government, 2016). Thus, the voluntary sector is a key partner in delivering integrated health and social care services and providing registered care services in Scotland.

Organisations such as NHS Improvement (NHSI) and Healthcare Improvement Scotland (HIS) are both regulating and improvement bodies. With the integration of health and social care, their remit has broadened beyond health, and one of their key aims is to support health and social care organisations to redesign and continuously improve services (Audit Scotland, 2015). The Care Inspectorate, a scrutiny body for registered care services in Scotland, has a role in supporting

improvement through its inspectors and Improvement Hub ([Care Inspectorate, 2019](#)). And the Scottish government has made an explicit commitment to expand and embed quality improvement approaches across social care and the voluntary sector: 'There is always room for more improvement. The work needs to continue to expand and become embedded across health and social care' ([Scottish Government, 2018: 30](#)).

The voluntary sector in Scotland encompasses more than 40,000 organisations, with the regulated voluntary sector employing more than 108,000 staff (3.4% of the Scottish workforce) and 1.26 million volunteers (28% of the adult population in Scotland). In 2019, the sector had a combined turnover of £6.06 billion and an annual spend of £5.75 billion. Health and social care organisations employ over half of all paid staff in the Scottish voluntary sector, with the sector spending £423.5 million on innovation and activity related to health and social care in Scotland's communities ([Scottish Council for Voluntary Organisations, 2020](#)).

Some voluntary sector funders, such as the [National Lottery Community Fund \(2020\)](#), seek evidence of the utilisation of quality management, assurance and/or improvement approaches by voluntary organisations in funding applications. There are, however, distinct differences between quality concepts, and confusion can arise from the interchangeable use of terms.

Quality management is an overarching approach, incorporating other quality concepts: quality design/planning, quality control, quality assurance and quality improvement (see [Appendix 1](#)). [Flynn \(1994\)](#) defines quality management as 'an integrated approach to achieving and sustaining high-quality output, focusing on the maintenance and continuous improvement of processes and defect prevention at all levels of the organization, in order to meet or exceed customer expectation'. Quality management is sometimes implemented through a quality management framework – 'a formalised system that documents processes, procedures, and responsibilities for achieving quality policies and objectives' ([American Society for Quality, 2021](#)).

The quality management framework most often used in the Scottish voluntary sector was the Practical Quality Assurance System for Small Organisations (PQASSO) ([Morris and Ogden, 2011](#)). The European Framework for Quality Management (EFQM) then became more popular with the sector ([Al-Tabbaa et al, 2013](#)). Although relevant to the voluntary sector context ([Manville and Barnard, 2008](#)), several changes have been proposed to adapt the EFQM to a voluntary sector audience. Based on interviews with 12 senior managers across three poverty reduction charities, [Al-Tabbaa et al's \(2013\)](#) proposals included acknowledging the role of an organisation's board of trustees in leadership criteria, renaming 'customers' as beneficiaries and donors, and reweighting person-based outcomes as more important than health and safety. The authors concluded that further work was required to build the evidence base for the framework. The limited evidence regarding the use of quality management frameworks in the voluntary sector suggests that adoption is inconsistent, although the importance of reflecting the sector's values and the importance of personal outcomes are pertinent themes arising from the literature ([Morris and Ogden, 2011](#); [Al-Tabbaa et al, 2013](#); [Jevanesan et al, 2019](#)).

Quality improvement is an important element of quality management. In a health context, quality improvement refers to the systematic use of appropriate methods and tools to continuously improve the quality of care and outcomes for service users. Where quality control and assurance focus on maintaining a specific level of quality

and compliance to existing standards, quality improvement aims to incrementally improve quality through a range of methods ([East London NHS Foundation Trust, 2018](#)). The principles of quality improvement include:

- understanding the problem and what the data say;
- understanding the organisational processes, systems and pathways – and whether these can be simplified;
- analysing the demand, capacity and flow of the service;
- choosing the appropriate tools to bring about change, including leadership, skills development, and staff and service user participation;
- evaluating and measuring the impact of a change ([The Health Foundation, 2013](#)).

Some of the most established approaches to quality improvement include the Model for Improvement, including Plan, Do, Study, Act (PDSA), experience-based co-design, Lean ([Womack et al, 1990](#)) and Six Sigma ([Smith, 1993](#)). Additionally, some quality management philosophies place particular emphasis on improving quality. Total Quality Management (TQM), sometimes referred to as ‘continuous quality improvement’, is a management approach that ‘focuses on quality and the role of the people within an organisation to develop changes in culture, processes and practice’ ([The Health Foundation, 2013](#): 26). TQM focuses on organisation-wide factors that can bring about improved customer satisfaction ([Feigenbaum, 1961](#)).

Quality improvement education in Scotland is largely provided by NHS Education for Scotland (NES) via a blended learning approach ([NHS Education for Scotland, 2021b](#)). NES also delivers the Scottish Improvement Leader (ScIL) Programme. This is an educational programme to address increasing demands across public services by developing quality improvement capacity and capability. NES has a targeted recruitment and application process for the 10-month blended learning programme, which is designed for anyone working in the Scottish public service (including the voluntary sector) who occupies a role with a significant focus on quality improvement and who can create dedicated time to lead improvement projects ([NHS Education for Scotland, 2021b](#)).

A systematic review on the application of quality improvement approaches in the voluntary sector identified 20 papers, from the United States/Canada (11), Europe (4), Asia (2), Australia (1) and others (2) ([Jevanesan et al, 2019](#)). The authors conclude that, despite the wide acceptance of improvement methodologies in the manufacturing, services and health industries, there is a notable lack of evidence and adoption in the voluntary sector. They suggested that the potential benefits of implementing quality improvement in the voluntary sector are cost reduction, increased service user satisfaction and staff empowerment ([Jevanesan et al, 2019](#)). However, a lack of acceptance to change initiatives was a common challenge to undertaking improvement in the voluntary sector. The authors suggest that this was due to fear of, and resistance to, change ([Jevanesan et al, 2019](#)). An additional barrier to undertaking improvement was the diversity of the voluntary sector customer base. However, strong organisational culture and staff engagement could help facilitate the adoption of improvement approaches ([Jevanesan et al, 2019](#)).

As part of this study, we conducted a scoping review of quality improvement projects undertaken by, or in partnership with, UK-based voluntary organisations. The scope of the review was to find examples of quality improvement in the voluntary sector and identify factors that could determine the success or failure of capacity-building

initiatives. Capacity building was defined as the ‘planned development of knowledge, skills and other capabilities of a system or an organisation to improve quality’ (Mery et al, 2017: 2). The lead reviewer extracted the studies and tabulated the findings using a framework approach (Gale et al, 2013). All of the papers were quality assessed using the NICE appraisal tool (NICE, 2012).

In line with Jevanesan et al (2019), there were few examples of quality improvement within the voluntary sector in academic literature. We found only five papers on the subject. These consisted of small qualitative studies testing one-off educational programmes and capacity-building interventions; a Collaborative Learning Network for voluntary organisations (Steen and Mellor-Clark, 2020), a project to improve waiting times in a charitable hospice using the Model for Improvement (Sime et al, 2019), a Master’s degree course (Netto et al, 2012), a peer-review programme (Purcell and Hawtin, 2010) and an action research case study of organisational capacity building (Cairns et al, 2005). A summary of the findings of the review and quality ratings are presented in Appendix 2.

Despite the small pool of literature in this area, there was consistency in the factors reported to aid or hinder capacity-building activities. The analysis suggested two main factors that aided or hindered capacity building: whether sufficient time was dedicated to capacity building and whether there was organisational and management buy-in (Purcell and Hawtin, 2010; Netto et al, 2012; Sime et al, 2019; Steen and Mellor-Clark, 2020). Other factors affecting the success of capacity-building activities included the credibility and appropriateness of what was on offer and the skill of the person delivering the intervention (Purcell and Hawtin, 2010; Netto et al, 2012).

While there were limited examples of quality improvement in the academic literature, this does not mean that improvement activity is not being undertaken. It is likely that many activities are unpublished or not shared widely outside their immediate context. But based on current evidence, it is difficult to conclude the extent of quality improvement activity in the Scottish voluntary sector. Furthermore, the current evidence base remains too limited to state conclusively that the aforementioned factors are central in determining the success of capacity building for quality improvement.

Research questions

Despite the aspiration to support the implementation of quality improvement methods and expand quality improvement education beyond health (Scottish Government, 2018), there remains a lack of evidence regarding current experiences and knowledge of quality improvement in the voluntary sector (Jevanesan et al, 2019). There are particular knowledge gaps regarding the experience of quality improvement among voluntary sector staff and students and little is known about how to build capability and capacity among the voluntary sector workforce to undertake quality improvement (Connolly et al, 2020). This was the context for the collaborative project between the University of the West of Scotland and Health and Social Care Alliance Scotland (the ALLIANCE), which set out to answer the following questions:

- What quality improvement activity is currently undertaken in the Scottish voluntary sector?
- What are the enablers and barriers to building capacity for quality improvement in the voluntary sector?

- What educational provision is accessed by the voluntary sector workforce?
- What gaps exist in current educational provision?
- What is needed, in terms of educational provision, to facilitate capacity building for quality improvement in the voluntary sector?

This article reports the findings of the data collection, gap analysis and subsequent development of the educational competencies and sessions. The wider implications of these findings for the health and social care integration agenda are considered in the Discussion section.

Methods

A qualitative descriptive research design was utilised to provide a comprehensive summary of the events experienced by participants (Lambert and Lambert, 2012). Between April 2019 and March 2020, a literature review, interviews, focus groups and a gap analysis were completed; these activities informed the development of co-produced educational sessions. The study received ethical approval from the University of the West of Scotland's ethics committee in June 2019. Due to the COVID-19 pandemic, further testing of the educational sessions was deferred.

Recruitment: Participants were recruited through fliers distributed at ALLIANCE events and circulated through the ALLIANCE Member's Network. Individuals who expressed an interest were invited to participate in an interview or focus group. Health and social care students, who had the experience of working within the voluntary sector, were recruited through a flier circulated via email at the University of the West of Scotland.

Sampling: A convenience sampling approach was used to identify and approach individuals who worked in health and social care and who were likely to have pre-existing knowledge of and interest in quality improvement or had expressed an interest in the study. We also used a snowballing approach to reach participants initially unknown to us (Lavrakas, 2008). Participants received an information sheet about the study and informed consent was obtained.

Data collection: To establish what quality improvement activity was currently undertaken and identify enablers and barriers to building capacity for quality improvement in the voluntary sector, we conducted 21 qualitative semi-structured face-to-face interviews. Of the voluntary sector participants, six held strategic roles, five were in a managerial role and three had frontline service delivery roles. The remaining seven interviews were conducted with strategic figures in the public sector, including representatives from the NHS (n=3), the Scottish government (n=2), the Care Inspectorate (n=1) and the Scottish Social Services Council (n=1).

Five focus groups were conducted in Scotland: three across the central belt, one in the Highlands and one in the Scottish borders. Twenty participants were in frontline service delivery roles and came from across 18 voluntary organisations. Seven were health and social care students who had the experience of working within the voluntary sector. This mix provided a variety of experience across a diversity of workplace contexts. A full breakdown of participating organisations is provided in [Appendix 3](#).

The interview and focus group schedules were developed iteratively, with outcomes from previous data collection used to further refine the wording of the questions. The

broad areas that were explored were participants' experience of quality improvement, their perceptions about the enablers and barriers to building capacity for quality improvement within the voluntary sector, and the perceived gaps in current quality improvement training and resources for the voluntary sector.

Data analysis: Handwritten notes were collected in place of audio-recorded data. While handwritten notes allowed for quick transcription, we acknowledge that this approach was limited in the way that it relies on instantaneous interpretation of data by the researcher, who may prioritise some types of data over others, risking bias. To enhance trustworthiness, data collection was conducted with two members of the research team present taking notes. Notes were then compared to ensure consistency in the accounts. Handwritten notes from the data collection were transcribed into a framework analysis (Pacheco-Vega, 2014).

Framework analysis is a qualitative method whereby data are tabulated and sorted into key issues and themes using five steps: familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation (Ritchie and Spencer, 2002). This approach allowed the interview and focus group data to be structured and analysed, before being synthesised with the literature review in the gap analysis. The interpretation of the data was guided by the pre-identified research aims.

Educational gap analysis: A gap analysis compares what currently exists against what is desired by stakeholders (Brown and Dodd, 1998). To achieve this we synthesised the findings from the literature review and framework analysis to identify key gaps in existing quality improvement educational provision. We utilised a four-step framework that would allow us to identify specific educational competencies for the voluntary sector workforce, which could then be used to form the basis of the educational sessions (Touzery et al, 2015).

Findings

Findings from the interviews and focus groups are reported under the following headings: quality improvement activity undertaken in the voluntary sector; building capacity for improvement within the voluntary sector; and educational provision and current gaps.

Quality improvement activity undertaken in the voluntary sector

When asked about quality improvement in the voluntary sector, some participants from organisations with in-house quality departments and third sector interfaces (TSIs) cited the use of the European Framework for Quality Management (EFQM) or Practical Quality Assurance System for Small Organisations (PQASSO, now Trusted Charity) as evidence of undertaking quality improvement. This could indicate a blurring of the distinction between quality management and quality improvement.

‘We use the EFQM. It’s pretty straightforward when you know what you’re doing. I like it because you can use it as a framework to set standard indicators.’ (Frontline focus group participant #1)

‘You do want that wee quality assurance badge, to evidence that you are better than these false flag organisations that just take people’s money.’ (Frontline focus group participant #3)

Participants who used the EFQM were comfortable identifying the benefits of quality management frameworks. As found by Al-Tabbaa et al (2013), voluntary sector participants praised the accessible language of the EFQM and cited the funder-recognised accreditation as a reason for adoption. Echoing the findings of Cairns et al (2005), participants praised the PQASSO framework for its relevance to the voluntary sector, low financial cost, low administration time and ‘quality mark’ accreditation. However, while participants recognised that these tools could provide useful benchmarks and identify areas for improvement within the organisation, practical examples of quality improvement deriving from these frameworks were scarce.

Smaller voluntary sector organisations reported challenges sourcing appropriate quality improvement resources. TSIs provide a single point of access for support and advice for the organisations within their local areas. However, although they support the sector, they do not always have the capacity or knowledge to support the adoption of quality improvement.

‘I think having a body that can facilitate QI [quality improvement] training across the voluntary sector in a way that people want to engage with. TSIs use EFQM but we could play a role in disseminating QI methods. We currently do a lot of work teaching social enterprises how to make their organisation more efficient and building capability so they are able to compete for public sector tenders.’ (Strategic leader interview #5)

‘I approached my local third sector interface and asked for recommendations for a quality framework but received no guidance.’ (Frontline focus group participant #4)

The lack of help received from a local TSI led one focus group participant to search for a quality improvement framework, which she reported was time-consuming and challenging. This was not atypical for participants from smaller organisations, and their approach to quality improvement was generally more ad-hoc and unsystematic. Smaller organisations tended to use various quality toolkits flexibly as and when they needed them. Examples of resources identified included the Advancing Quality Alliance’s Introduction to Improvement (Advancing Quality Alliance, 2021), the Scottish Council for Voluntary Organisations’ ‘Big Picture’ quality improvement tool (Scottish Council for Voluntary Organisations, 2009) and the Lasting Difference toolkit (The Lasting Difference, 2020). Knowledge of tools came from internal organisational knowledge and personal research: “I dip in and out as I need to, I spend hours just googling things” (strategic leader interview #1).

Frontline staff and students were aware that the organisations they worked for used quality management frameworks, but had limited understanding and, often, very little direct experience of using them:

‘EFQM is the main framework we’re supposed to use. We picked three areas to improve using the EFQM process ... one was strategy. I just remember there were a lot of tables and sticky notes. We still use it but don’t refer to the actual guidance.’ (Frontline focus group participant #2)

It was primarily strategic and managerial participants who were able to provide illustrative examples of using quality improvement in their roles, as opposed to quality management. Examples of voluntary sector quality improvement identified by managers included: Winning Scotland Foundation's 'Growth Mindset' education programme (Winning Scotland, 2019), the 'Jigsaw Project' to co-design new pathways of intervention in mental health care in Glasgow (COPE Scotland, 2019), a Scottish mental health charity's use of improvement methodology when redesigning the role of community champions (See Me Scotland, 2021) and the National Association for Care and Resettlement of Offenders' use of process mapping to identify flaws in a six-month youth offender programme, improve efficiency and use underutilised capacity (NACRO, 2007).

The project team was also directed to posters available through the NHS Education for Scotland's (2021a) Quality Improvement Zone (2021) website, which details individual quality improvement projects undertaken by ScIL programme graduates. One example drawn from this was an employee from a national dementia charity, who conducted an improvement project to test whether Twitter was a useful platform to increase engagement with the public about dementia and the role of allied health professionals. We collated and analysed these examples and found there was little uniformity in the approaches taken to quality improvement, and the reporting of the exact improvement methodology was sometimes unclear. Participants tended to utilise one or two quality improvement tools (PDSA cycles, fishbone diagrams, process mapping) and often the project was driven by one or two key figures within the organisation.

Our findings showed that participants in strategic and management roles, who were often mandated to promote the practice of quality improvement within their organisation, tended to have more knowledge and examples of quality improvement application in the voluntary sector. Frontline participants' discussions centred on quality management frameworks rather than quality improvement.

Building capacity for quality improvement in the voluntary sector

As part of the data collection, participants were asked about factors that acted as barriers or enablers to the adoption of quality improvement. Participants tended to find it easier to identify barriers. The economic climate and funding were major themes in the interviews and focus groups:

'Funding in the voluntary sector is tough. Training is compromised first when budgets are squeezed. There's a mentality that the sector doesn't have time and capacity for reflective learning, which is required in order to do quality improvement – there's a focus on frontline delivery. The consequence of this is there [is] no respite, which drives quality down.' (Strategic leader interview #10)

'The political and economic climate means that we are in competition when we should be collaborating. Instead, we are against each other and every time a local council finds a cheaper service, they use that, which removes funding from another organisation.' (Student focus group participant #5)

Cutbacks and increased scrutiny have put voluntary organisations under tremendous pressure to remain operationally efficient and sustainable (Al-Tabbaa et al, 2013). This has led to criticism that short-term strategic goals are prioritised over long-term competitiveness (Tranholt-Hochstein, 2015).

Participants identified ‘short-termism’ as a barrier, in terms of both inconsistent funding and high turnover in the workforce. Tied to this was another pertinent theme, that of time. Participants from smaller organisations reported difficulty releasing staff to attend training or delegating time to quality improvement activity. This reinforces a key finding from the review of existing literature: that sufficient time needs to be dedicated to capacity building (Purcell and Hawtin, 2010; Netto et al, 2012; Steen and Mellor-Clark, 2020).

There were also some differences in findings between focus groups conducted in the central belt and those conducted in rural areas (the Highlands and the Scottish borders). Highland and Scottish border focus group participants stressed that remote and rural geography could be a barrier to accessing training: “Rurality is a big issue up here. There’s a Highland–central belt divide. All the training takes place in the central belt. It’s expensive to attend because training always starts at 9am so you’re taking hotel costs into account” (frontline focus group participant #3). The financial cost of and time to attend training often situated in the major cities, limited opportunities for stakeholders from rural areas to participate. Additionally, focus group participants noted that, while delivering training remotely might be a way to address this geographical divide, unreliable technology and a poor internet connection could prevent participation in digital training – an issue that is also reported in the literature (Reeve et al, 2016; Bach-Mortensen et al, 2018).

Educational provision and current gaps

Participants identified 38 different educational resources spanning quality improvement, quality management and quality assurance. These included EFQM (Quality Scotland, 2021), PQASSO (Evaluation Support Scotland, 2019), The Outcomes Star (Triangle Consulting Social Enterprise, 2021) and Education Scotland’s (2020) ‘How good is our third sector organisation?’ resource document. Participants tended to access educational provision that was freely available and congruent with their role. These included Care Inspectorate improvement workshops (Care Inspectorate, 2018), online learning modules on the NHS Education for Scotland’s (2021a) Quality Improvement Zone, the NHS England and NHS Improvement website (NHS England, 2021), Getting It Right For Every Child (Scottish Government, 2019) and Investing in Volunteers (Volunteer Scotland, 2021). The full list of quality frameworks and education resources is available on the ALLIANCE website (<https://www.alliancescotland.org.uk/>).

The multitude of resources available and the synonymous use of terminology made it difficult for inexperienced participants to discern whether the education was about quality improvement, quality assurance or quality management. It has also been argued in the academic literature that opaque language creates barriers to adoption and implementation (Walsh et al, 2016). This lack of clarity around terminology was coupled with limited knowledge of and ability to select, appraise and implement relevant resources to meet their learning needs.

‘Language is different across resources and organisations. You need very plain English – explain what quality is and what improvement is.’ (Frontline focus group participant #2)

‘It’s a minefield – nobody knows what’s for them!’ (Frontline focus group participant #1)

The educational programme often advocated by strategic leaders and public sector figures was the Scottish Improvement Leaders (ScIL) programme. Three voluntary sector participants had completed the ScIL programme. ScIL graduates reported that the programme gave them ‘credibility’ and the ‘currency’ of being able to talk about quality improvement. The programme was praised for its blended learning approach and the learning retreats. It was critiqued for its significant time demands, cost and the health-focused content. “The support with the report writing and mentorship was good. I took issue with some of the other aspects ... it was mostly NHS staff there and it was [a] very health-focused curriculum” (strategic leader interview #9). However, despite efforts to open up the ScIL programme to voluntary sector organisations, uptake has remained relatively low, with between one and two voluntary sector representatives per cohort of 20 learners. “It is difficult to get access to ScIL in the voluntary sector; it is very expensive and requires a clear commitment” (strategic leader interview #11). Participants representing NHS Education for Scotland agreed that further work was required to tailor the programme to a voluntary sector audience. “The three residentials were generally made up of people with a medical background; it was difficult to find any commonality with them. I found my own project to be different from the others and had to work hard to make it transferable” (strategic leader interview #12).

Some strategic public sector figures felt that ScIL, or a similar programme, could facilitate the adoption of quality improvement in the voluntary sector. However, there was a very strong view across voluntary sector participants, at all levels, that the voluntary sector is distinct from ‘health’ and that quality improvement cannot be something ‘imposed’ by the health sector. This conflict potentially has significant implications if the Scottish government intends for NHS Education for Scotland to have a key role in the expansion of quality improvement into the voluntary sector:

‘Recognise the difference between sectors. NHS and health is prescriptive, more black/white – you are ill or you are not. The third sector is more grey ... there’s more than one way to do something. Don’t take a regimented approach to building capacity for improvement in the voluntary sector ... the third sector values co-creation and co-production.’ (Strategic leader interview #9)

Frontline participants expressed concern that a focus on co-production and soft outcomes led to the negative perception that the voluntary sector was not evidence-based: “We perform things to a high quality but just don’t have the tools to evidence it” (frontline focus group participant #4).

‘There are differences and gaps between the sectors. There is a temptation in the NHS to say ‘we’re doing so well’ and ticking a box to say there has been third sector engagement, but not really doing community engagement or co-production. And then you’ve got some QI [quality improvement] gurus who are inclined to see subjective data as less valuable.’ (Strategic leader interview #7)

Participants emphasised the importance of ‘soft data’ to the voluntary sector; suggestions included explaining how stories of a person’s experiences and qualitative information are integral to the process of evidencing improvement. The importance of qualitative approaches to the voluntary sector is supported in [Moullin’s \(2017\)](#) review of the Public Sector Scorecard, which critiqued the scorecard’s focus on quantitative data over qualitative data and human-related outputs.

Participants felt that the voluntary sector should have an equal role in shaping any quality improvement education that was intended to support the voluntary sector to use quality improvement. They wanted the delivery to adopt a ‘coaching, not telling, approach’, one that embraced co-production. They criticised the idea of a visiting expert in the field delivering a lecture to voluntary sector staff. They also felt that the content needed to include contextualised examples of voluntary sector quality improvement. They found some of the language of quality improvement inaccessible and some terminology sector-specific, for example they associated the term ‘improvement science’ with health.

‘Don’t get me started; they always use these acronyms and expect you to know what they mean.’ (Frontline focus group participant #1)

‘There is a power issue raised by having “gurus” who speak quality improvement language coming in to educate staff; this is not co-creation or co-production and goes against voluntary sector sensibilities.’ (Strategic leader interview #7)

Networking as a means of sharing improvement experience and examples of best practice was also a prevalent theme. There was a perceived lack of opportunities to share quality improvement experiences with colleagues: “When improvement projects are carried out, it doesn’t mean you can implement it anywhere. Taking local context into account is important. Networking has a place ... to share experiences of improvement. There might be some lessons others might be able to take away and adapt” (voluntary sector manager interview #8). Although improvement networks do exist – for example, the Q community ([The Health Foundation, 2021](#)) and Quality Scotland’s network meetings ([Quality Scotland, 2019](#)) – most participants were unaware of them. There was an identified need to raise awareness of these and to develop voluntary sector opportunities to network and share quality improvement learning.

The findings of our data collection aligned with the findings of the review of quality management and quality improvement literature. Quality approaches receive a more positive response when they are seen to be sector-specific ([Cairns et al, 2005](#); [Manville and Barnard, 2008](#)). Furthermore, approaches that require a low time and financial investment are valued ([Purcell and Hawtin, 2010](#); [Netto et al, 2012](#); [Steen and](#)

Mellor-Clark, 2020). Our findings also suggest that accessible language, appreciating the value of qualitative data and creating networking opportunities are key to facilitating the implementation of quality improvement within the voluntary sector.

Co-design of educational sessions

The first iteration of the educational provision was developed by the project team based on the findings of the educational gap analysis. These were then presented to a panel of cross-sector stakeholders, drawn from previous interviewees and focus group attendees. A consensus approach (Fink et al, 1984) was used to create a structured environment in which to review and refine the educational provision. Voluntary sector stakeholders identified a strong preference for blended learning (a mixture of taught online and in-person). They wanted an opportunity to be involved in the development of education and for the education to draw on contextualised examples of voluntary sector quality improvement. Stakeholders wanted the learning to be applied, through having an opportunity to progress an individual or organisational quality improvement project. They wanted reflective and peer-to-peer learning and sharing good practice to be integral to the design.

The findings of the gap analysis, the educational competencies (see Figure 1) and the three pilot educational sessions informed the design of the educational sessions. The three sessions developed are: 1. Introduction to Quality Improvement; 2. Quality Improvement in Practice; and 3. Sharing and Measuring Improvements.

The educational sessions were presented at a cross-sector Quality Improvement Educational Development Day, hosted by the ALLIANCE in February 2020. Participants at the event expressed a commitment to continued joint working to refine and test the sessions and to improve signposting to existing quality improvement provision. However, plans to pilot and refine the education were impacted by the COVID-19 pandemic (Nicola et al, 2020). This time was instead dedicated to the online dissemination of the project outputs.

Figure 1: Competencies for quality improvement education in the voluntary sector

On completion of the educational sessions, participants will be able to:

- Understand how quality improvement models can support the experience of service users.
- Understand that developing quality improvement experience in an organisation can improve efficiency and productivity.
- Understand the key concepts of systems thinking.
- Reflect on their organisation and system with a view to proposing a change idea
- Recognise key improvement models relevant to a voluntary sector context
- Apply an improvement model to their practice in the voluntary sector
- Understand key methods for measuring improvement
- Demonstrate how they might measure improvement in their organisation.
- Identify suitable networks for learning and sharing quality improvement knowledge and experiences.
- Demonstrate knowledge of how to manage and communicate change in a voluntary sector setting.

Discussion

With the outbreak of the COVID-19 pandemic, and the health and social care sectors facing unprecedented pressure, there are renewed calls to hasten the adoption of quality improvement to improve care and ensure cost-effectiveness (Fitzsimons, 2020; Staines et al, 2020). The findings of our study question whether the current drive towards the adoption of quality improvement will benefit the voluntary sector and equip it to meet the challenges in the health and social care systems (Toma et al, 2018).

Our findings chimed with the current evidence which suggests that understanding and the application of quality improvement are variable. Quality improvement was associated with an investment of time and money. While strategic leaders tended to be well versed in quality improvement, frontline staff conflated quality improvement with aspects of quality management. While this may not seem surprising, many participants had a mandate for promoting quality improvement among colleagues. To this end, some sought advice from TSI organisations but received little support or guidance as quality improvement is not a mainstream methodology for TSIs. Many sought out low-cost education that was congruent to their role but found it difficult to ascertain the quality and content of educational offers available. Those who participated in existing education offers found them to be health focused, lacking in contextualised examples from the voluntary sector and difficult to transfer to the values and ethos of their organisational culture.

Frontline and strategic voluntary sector participants criticised the notion of having quality improvement forced on the sector and strongly emphasised the need to be equal partners in any drive to adopt quality improvement within the voluntary sector. This is an important consideration for those health and social care improvement bodies charged with implementing the current strategy of the Scottish government. Our findings suggest that if there is the perception that quality improvement is being imposed on the voluntary sector, this will be damaging to capacity-building efforts. Our findings indicate that future capacity building would do well to embrace voluntary sector sensibilities, take a co-production approach and create spaces for intra- and inter-sector learning and sharing. We argue that this will require going further than simply reframing existing offers from the health sector.

The recent Independent Review of Adult Social Care, undertaken by Derek Feeley (Scottish Government, 2021: 59), notes that the adoption of 'quality improvement methods will require a significant building of improvement capability at the point of social care support ... we will have to create some kind of quality improvement infrastructure for this work'. The recommendations of the Feeley report have not yet progressed to implementation. Currently, there is no dominant improvement body within the Scottish voluntary sector, equivalent to NHS Education for Scotland for the health sector. It is therefore prudent to ask what the most effective means of building capacity for quality improvement in the voluntary sector are.

Based on the findings of this study, we suggest that existing infrastructure organisations for the voluntary sector, such as TSIs, may be well placed to support capacity building for quality improvement. We would also like to highlight the role that the higher education sector can play in educating and developing staff across all sectors. We offer a list of educational competencies (Figure 1) as principles that may inform the development of future quality improvement education.

The adoption of quality improvement in the voluntary sector in Scotland is less advanced than in the health and education sectors. This can be viewed as either a deficit or an opportunity. The Scottish government continues its commitment to investment in quality improvement education and this has recently been endorsed through the recommendations of the Independent Review of Adult Social Care in Scotland (Scottish Government, 2021). To promote this further, there are serious considerations and opportunities for politicians and policy makers regarding capacity building for improvement within the Scottish voluntary sector as an equal partner in developing quality improvement capacity and capability through equal access to national quality improvement and leadership programmes, thus supporting intra- and inter-sector collaborative learning to support the remobilisation and transformation of the public sector.

Implications for research, policy and practice

- Based on our findings, we call for further research to address the knowledge gaps found in the literature – specifically, a mapping exercise or survey to gain a more detailed picture of what quality approaches are used by which voluntary sector organisations.
- A key aspect of the proposed educational sessions was the value of networking; there was a gap in the literature concerning this. Further research regarding the role of networking in facilitating the adoption of quality improvement would be beneficial.
- Based on the findings of the two rural focus groups, there is potential value in investigating the specific challenges faced by organisations in rural and remote areas doing quality improvement.
- Academic testing and refinement of the developed educational sessions/competencies would prove beneficial for capacity building and the development of future education.
- With the incremental adoption of quality improvement in the voluntary sector, we question the current approach that the Scottish government and national bodies have taken to the recruitment and participation of the voluntary sector. We recommend that this is explored through a co-production and user-led approach.
- Despite having a potential platform to support the adoption of quality improvement, some infrastructure organisations may not yet have the capacity to do so. Further support is needed from the Scottish government to strengthen the capacity of infrastructure organisations, such as TSIs, to support quality improvement.
- For those with a role in quality improvement education, the use of contextualised examples, accessible language, qualitative data and opportunities to share good practice are key to effective quality improvement education.

Strengths and limitations

In the wake of the Scottish government's commitment to invest in quality improvement education, this study has contributed new knowledge in this emergent area by providing an account of the current practice of quality improvement in the Scottish voluntary sector and identifying barriers to future capacity building for

improvement. While representatives from more than 30 organisations participated in the study, we recognise that this is not an exhaustive sample. Nevertheless, a diverse range of perspectives is represented from across the public and voluntary sectors, including frontline and strategic figures. A full breakdown of the study sample is presented in [Appendix 3](#).

Due to time and resourcing constraints, three of our five focus groups were conducted across the central belt of Scotland. We were restricted to conducting a single focus group in the Highlands, and one in the Scottish Borders, limiting representation from more rural areas of Scotland. A key finding arising from the focus groups conducted in rural areas was that unreliable technology and the tendency for improvement organisations to be based in large cities made it difficult for organisations in more remote areas to engage with training. This highlights a need to consider the specific barriers faced by voluntary organisations based in rural or remote geographic areas – a possible area for future research.

We were also unable to proceed with the planned testing of the educational sessions developed from the findings due to the outbreak of COVID-19 and the difficulties many organisations faced managing the ongoing impact of the pandemic. The future testing of the educational competencies and sessions forms part of our recommendations.

Conclusion

The health and social care integration agenda envisions the adoption of quality improvement across health and social care. Although quality improvement is promoted in health care education, practice and systems, there is limited understanding regarding experiences and knowledge of quality improvement in the voluntary sector. The findings of this qualitative descriptive study reveal a limited understanding and implementation of quality improvement approaches in the Scottish voluntary sector. For quality improvement to develop, we recommend that quality improvement resources and capacity-building activities are co-produced, including user-led experiences and grounded in contextualised sector-specific examples. There is an opportunity to embrace the recommendations of the Feeley report ([Scottish Government, 2021](#)) and create an infrastructure for quality improvement within the voluntary sector.

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Conflict of interest

The authors declare that there is no conflict of interest.

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Appendix 1: Differences between key concepts in quality

Approach	Definition
Quality planning/ redesign	Understanding the needs of service users. Horizon scanning for best service models to address unmet needs. Structural reorganisation.
Quality control	Efforts of an organisation to ensure that a product or service fulfils the minimum quality requirements. Reactive.
Quality assurance	Ongoing efforts to instil confidence in customers that a product or service fulfils the expected requirements. Sometimes used interchangeably with quality control, but has a broader proactive focus, verifying that the organisation's operations, quality policies and procedures are consistent with the prescribed requirements.
Quality improvement	Quality improvement comprises an organisation's systematic efforts to improve the reliability of generating quality products and services and raise the level of quality. Quality improvement tries to avoid attributing blame and aims to foster a culture of continuous improvement.

Source: [German Health Alliance, 2015](#); [East London NHS Foundation Trust, 2018](#)

Appendix 2: Summary of the literature review findings and NICE (2012) quality ratings

Authors (year)	Sample	Methods	Quality improvement	Findings	NICE rating (2012)
Cairns et al (2005)	8 HIV/AIDS charities and an interfaith forum	Action research	Action learning and action research capacity-building training delivered by Aston Business School	Action research can provide an instrument for building organisational capacity	-
Netto et al (2012)	19 individuals from black and minority ethnic charities undertaking a Master's in Business Administration (MBA)	Interviews and documentary analysis	Capacity-building training as part of the MBA qualification	Timing was a significant factor in the success of capacity-building processes	+
Purcell and Hawtin (2010)	3 charities from across Yorkshire	Interviews	Piloting peer-review workshops as a means of improving performance	Peer review can help improve performance with sufficient staff buy-in	+
Sime et al (2019)	40 patients in a hospice breathlessness service	Case study	Systems thinking to analyse service flow, PDSA cycles	Waiting times in the charitable hospice were reduced	++
Steen and Mellor-Clark (2020)	12 mental health organisations	Case study	Formed a collaborative learning network (CLN) to share improvement knowledge	CLN membership reduced due to resourcing challenges	+

Appendix 3: Table of 32 participating organisations, how they were involved and their size, as defined by the [National Council for Voluntary Organisations' \(2020\) Almanac](#)

Name/description of organisation	Professional grouping	Interviewed	Represented at focus group	Size
ALLIANCE individual member	Frontline	✓		Micro
Alzheimer Scotland	Manager	✓	✓	Major
Care Inspectorate	Strategic (public sector)	✓		Large
Citizens Advice Scotland	Frontline		✓	Major
Cope Scotland	Strategic	✓	✓	Medium
Deaf Scotland	Manager	✓		Medium
Engage Renfrewshire	Manager	✓	✓	Large
Evaluation Support Scotland	Strategic	✓		Medium
Hansel	Frontline		✓	Large
Healthcare Improvement Scotland	Strategic (public sector)	✓		Large
Highland Children & Young People's Forum	Frontline		✓	Micro
Highland Third Sector Interface	Frontline		✓	Large
Home Start UK	Frontline		✓	Major
Independent Living Support	Frontline		✓	Large
Inverness Women's Aid	Frontline		✓	Medium
Iriss	Strategic	✓		Medium
Lead Scotland	Frontline		✓	Medium
Macmillan Cancer Support	Manager	✓		Super-major
NHS Education for Scotland	Strategic (public sector)	✓		Major
Quality Scotland	Strategic	✓		Medium
Quarriers	Manager	✓	✓	Large
Queens Nursing Institute Scotland	Strategic	✓		Large
SAMH	Frontline	✓		Medium
Scottish Autism	Frontline		✓	Major
Scottish Government	Strategic (public sector)	✓		N/A
Scottish Government – Children and Young People Improvement Collaborative	Strategic (public sector)	✓		N/A
Scottish Social Services Council	Strategic (public sector)	✓		Major
Sense Scotland	Frontline		✓	Major
Shelter	Frontline		✓	Major
Voluntary Action East Renfrewshire	Frontline	✓		Medium

(Continued)

Appendix 3: (Continued)

Name/description of organisation	Professional grouping	Interviewed	Represented at focus group	Size
Voluntary Action North Lanarkshire	Frontline		✓	Medium
Voluntary Action South Lanarkshire	Strategic	✓	✓	Medium
Volunteer Glasgow	Frontline		✓	Large

Note: [NCVO \(2020\)](#) defines the size of organisations under the following annual income brackets: Micro (Under £10,000), Small (£10,000-£100,000), Medium (£100,000-£1 million), Large (£1 million-£10 million), Major (£10 million-£100 million), Super-Major (£100 million+).