

The Bevan Commission
in partnership with
1000 Lives Plus



Improving Healthcare White Paper Series - No. 1

Accelerating best practice: Minimising waste, harm and variation

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About 1000 Lives Plus

1000 Lives Plus aims to improve outcomes and drive quality improvement in Wales through reducing harm, waste and variation in the system and improving the overall experience of care.

It was launched in May 2010 and is one of several national programmes which form a five year strategic framework for NHS Wales.

As a national programme, it is committed to enabling rapid acceleration in the scale and pace of sustainable improvements to give every person in Wales reliable, high-quality care every time.

Meeting this challenge is central to improving services and cultural transformation in Wales. It requires exceptional leadership and commitment to ensure continuous improvement is integrated into everyday working.

Through a series of work streams 1000 Lives Plus takes forward the standardised improvement methodology, use of evidence-based interventions and measurement for improvement introduced by the 1000 Lives Campaign and Intelligent Targets work.

It supports all health boards and trusts to set and achieve appropriate targets for the reduction of harm and hospital mortality through the reliable implementation and spread of evidence-based interventions and the tracking of outcomes.

1000 Lives Plus currently delivers several evidence-based areas of work to ensure better health outcomes, a better experience of care and better use of resources. New areas driven by population-need will continue to be introduced to enable innovations and local developments, whilst also embedding improvements across Wales.

Further information is available at www.1000livesplus.wales.nhs.uk

The Bevan Commission

The Bevan Commission is an independent, expert advisory panel which provides the Welsh Assembly Government with advice on the reform of the NHS in Wales and related matters. It was established in July 2008 to coincide with the 60th Anniversary of the National Health Service and takes its name from Aneurin Bevan, a Welsh MP and the Minister for Health who founded the NHS in 1946.

The Bevan Commission supports the aim of establishing a “world class” healthcare service in Wales, through an integrated system of healthcare delivery. To this end, it advises on how to successfully create a health service that is publicly owned and publicly provided; rooted in an ethic of care, rather than competition; for the pursuit of health as well as treatment of illness. As part of its work, the Commission scrutinises the relevance of emerging health issues and ideas, assesses opportunities for speedier improvements in health and social care provision, and advises on rebalancing and streamlining the health and social care system within Wales, ensuring the patient is the focus of healthcare.

Accelerating best practice: Minimising waste, harm and variation

Introduction

This white paper was written to capture key learning points at seminars hosted by Public Health Wales, which addressed the questions 'If quality and patient safety are the priorities in an organisation, what does this look like?' and 'How do we embed improvement in healthcare services?'

The seminars took place in Swansea on 29 September 2009 and in Cardiff on 22 March 2010. Both seminars were attended by Chief Executives and Chairs of the NHS Wales Health Boards, members of the Faculty for Healthcare Improvement, the Bevan Commission, clinical leaders, and other invited guests from within the NHS in Wales.

The speakers at both seminars were:

- Professor Donald M Berwick KBE, Bevan Commission member and President and Chief Executive Officer of the Institute for Healthcare Improvement;
- Gerry Marr, Chief Operating Officer for the integrated Acute and Primary Care Services, NHS Tayside; and
- Sir Ian Carruthers OBE, Bevan Commission member and Chief Executive of the South West Strategic Health Authority.

There was an opportunity for attending guests to raise questions for the panel of speakers during a short question time after the keynote addresses.

The speakers were introduced by Professor Sir Mansel Aylward CB, Chair of the Bevan Commission and Public Health Wales, who also facilitated the question and answer session. Recurrent themes in the presentations and discussions were waste, harm and variation - and how focussing on these can improve patient care, clinical statistics, and address the tough financial challenges facing the NHS.

In this white paper, the various points made by the three speakers have been ordered within the structured sections. Some points are attributed to certain speakers, where this is necessary. References to particular contributors are generally made using first names. This is done not as a mark of disrespect, but to highlight the positive and collaborative atmosphere of the evenings, and the overwhelming sense that healthcare improvement is a team effort that will be achieved through breaking down institutional barriers of formality and tradition.

Key conclusions

- Quality can only be achieved if clear leadership is given from the very top in a healthcare organisation, and built into its structures, values, practices and business processes.
- Quality improvement can be successfully achieved by addressing three key areas of activity: reducing waste, harm and variation.
- There is no 'cookie cutter' template to follow in pursuing quality - each quality improvement is as individual as the healthcare organisation implementing it.
- Quality is achievable right across a healthcare organisation and has a significant impact in terms of lowering costs and increasing social equity (as well as staff morale and public confidence in the service).
- Quality should not be a victim of changing times (e.g. the current recession) - in fact difficult times are an opportunity to accelerate the pace of change and a justification for trying new strategies to improve quality.
- A new mindset is needed that does not consider quality and cost as exclusive alternatives.
- 'Patient safety' is a good place to start and an easy concept to 'sell' to stakeholders. But it is not the sole arena for quality improvement.
- Short cycles of change work best, and change must be linked to critical review.
- There is a moral imperative to achieve quality through eliminating waste, harm and variation before discussing healthcare 'rationing' or cutting services.
- Clinicians often rate the patient experience as better than patients, and patients' families, do. Primacy must be given to patients, to make them the number one priority.
- Getting practice 'right' will reduce the number of unintended outcomes.
- Getting 'value for money' is a legitimate 'quality' measure for healthcare organisations, but it should be achieved through best practice
- Higher expenditure does not necessarily mean higher quality - in fact low quality services drive up costs through wastage, repetition, systemic defects and harming patients.
- Improving access, e.g. by reducing waiting lists is not a political point - reducing pain and anxiety are real life concerns.
- Transformation will come to Wales when all staff are engaged in improving their own work and the system they work in.

Video highlights from the 'The Pursuit of Quality' seminar which was held in March 2010 are now available online at <http://tinyurl.com/2uxvxab>

The current challenges facing healthcare

The seminar in Swansea began with a short introduction from Paul Williams, the Chief Executive of NHS Wales and Director General, Health and Social Services Directorate, the Welsh Assembly Government. He took the opportunity to welcome members of the Bevan Commission to the evening, and outlined the challenge facing them - how to remain faithful to the founder's vision for the NHS as an open, accessible service in the 21st Century.

As Gerry Marr would later point out, the fiscal challenge in particular is affecting the potential reach and impact of NHS services. There is a need to find new ways of working in order to maximise the benefits of a 1948 model of care, without abandoning the principles that set the NHS apart from other healthcare systems, but still enable it to function in a sustainable way. But a key challenge is meeting that need to change "without setting the tone of just talking about money".

Sir Ian Carruthers widened the scope of the debate by indicating that medical advance is global. "The spread of knowledge is the limiting factor as advances will go forward regardless of funding because someone somewhere will make an improvement and someone else - here in Wales - will want to copy it. Advances in healthcare will still happen regardless."

So, assuming that the current recession will pass, as previous recessions have, a major management challenge is to keep improving healthcare despite fiscal belt-tightening in the short to medium-term. This will be achieved through proactive management. The recession may possibly contribute to the good of the NHS, in that it will accelerate the pace of change and speed up implementation of best practice, as long as the business case can be made for quality improvement in healthcare.

In terms of specific challenges to the NHS, Ian asked: "Why have we got a care system that does not always give a positive experience?" It is important to have a mindset that sees prevention, safety, clinical effectiveness, the patient experience, timely access, innovation, productivity, cost reduction and tax payer value as the same continuum, rather than individual competing entities."

Attempting to rectify this through organisational change is a key to both increasing efficiency and quality. However, improving quality won't solve all organisational problems. Specifically there is a danger that there will be many 'paper savings' but real 'hard' cash savings won't be forthcoming.

The short-term challenge for many NHS organisations will be the 'first year' in a climate of public spending cuts and a need to save money. Gerry highlighted the unarguable need for short-term efficiency, but added a caveat that leaders need to set the foundations for long-term improvement, otherwise every year will be a 'tough year' and eventually "you will run out of road".

There are advantages of the new structure being implemented in Wales, which brings primary and secondary care services together into combined organisations. Genuine change is needed in the way primary and acute care interfaces, in order to find efficient means of working and improve patient care. Quality cannot just be driven from acute centres. The difficulties surrounding integration of acute care, primary care, social care and mental health are challenges the Bevan Commission, alongside the whole health community, will need to address if quality is to be a hallmark of the entire system.

However, Ian warned that: “Integrated organisations must deliver integrated care. The patient wants to move through care and then return home. We all want a pathway which enables us to receive high quality care as we move through the local health and social care systems. Within the new Welsh structures, the focus has to be on the ‘patient pathway’ if quality is going to be embedded into healthcare.

Yet, the development of new structures within Wales, and the way that improvement has been embraced through the 1000 Lives Campaign and other initiatives shows that transformation is possible.

Is “Quality” a meaningful concept within healthcare?

An issue identified by Paul Williams was “the problem with quality is that people use it as a slogan” and it can become meaningless. However “quality has a hard edge” - it can be defined as an aim, enshrined as a value and assessed as an achievement. Quality can be the difference between life and death in the experience of a patient, and brings a host of benefits including improved morale; leaner, more flexible organisations that are better able to cope with the changing world; and budgets with financial surpluses.

Quality could become a means of rediscovering the essential qualities of the NHS; “it should be the driver to take the NHS through difficult financial times”. While views on what a healthcare organisation committed to quality would look like might differ, leaders in the NHS can begin to ask the question “What does it mean to be world class?” and believe both that the question is answerable, and the answers are achievable.

Drivers to quality: Focusing on harm, waste and variation

Gerry led the way in the discussion of this area of quality improvement. During his tenure as Chief Operating Officer at NHS Tayside, he has continually sought to adopt and implement improvement methodology throughout the organisation.

In Tayside this involved tackling three particular problem areas:

- Waste
- Harm
- Variation

In terms of reducing wastage in the system, Tayside mapped where money was spent. They discovered that out of a budget of £650 million, £350 million went on expenditure not directly linked to referrals or treatment. Within the hospitals, outpatient ‘redundancy’ (e.g. no shows or unnecessary referrals) ran at 40%.

Gerry made the point that inconvenience, to both doctors and staff, is a reliable indicator that wastage is occurring. Variation also ties in with wastage. It soon became clear that in primary care ‘high prescribers’ were also high users of referrals. Spotting the variations between clinicians, practices, wards and hospitals is a useful way of spotting wastage.

Variation is also an indicator of social need. “You may wonder why the residents of the leafy suburbs of Dundee all seem to have heart problems and are on statins. All that really indicates is that the people who live there read the broadsheets and request treatments. But the people we need to talk to are the ‘unworried unwell’, many of whom do not take a proactive interest in their own health.”

It is important to identify ways to prevent harm to patients and eliminate wastage from the system, although making those changes requires will and effort. In NHS Tayside, length of hospital stay has been reduced, including in ITU. “Simply put, we’ve stopped harming patients.”

Reducing harm is a strategic challenge. Resources and talents need to be released and leaders must encourage innovation (not the same as invention) and the spread of best practice. There is also a need to balance the cost of treatment, the quality of healthcare, and the experience of the patient.

The financial side of healthcare can also be ‘recruited’ as a driver towards quality. As Don pointed out: “Reducing costs is a sign of maturity. It’s okay to say that reducing cost is a quality requirement to work on.”

Ian agreed. “If we get the practice right, we reduce the number of unintended outcomes. We need to recognise that higher expenditure does not mean higher quality. Often the highest spenders are the poorest performers. Cost reduction is a legitimate quality aim, and we have to do it through best practice.”

Drivers to quality: ethical commitment

Gerry stated his belief that there is a moral imperative underlining the drive to quality, which links in to the founding principles of the NHS, particularly the notion of universal free healthcare. “We need to crack all three areas - waste, harm, variation - before we start talking about rationing healthcare. The commitment to reducing waste, harm and variation is actually an ethical commitment.”

Another ethical commitment is the drive to offer taxpayers value for money. This was emphasised by Ian, who said: “We should focus on quality with taxpayer value. ‘Money’ is part of quality.”

“We need quality across the whole system - it should be a core value of what we do, and people and organisations need to be held to account.” Recognising that financial pressure is a key issue for most healthcare organisations, Ian proposed that a focus on quality would solve the finance issue. “The money will take care of itself because it is tied up in poor clinical procedure, repetition and other wastage. A successful system will focus on prevention and deliver taxpayer value and good social value.”

Adopting best practice is also ethically imperative. Ian drew out an inconsistency in the way that senior managers emphasise safety, but do not insist on best practice. “I go round the boards. Everyone says they believe in safety. But there is no excuse for not adopting best practice. We have known what the best practice is for 30 years - if we haven’t adopted it then we can’t say we value safety.”

Ian acknowledged: “No country has cracked adoption and spread of best practice.” However, he also reiterated the point that: “Best practice must trump local autonomy. No other business would tolerate such inconsistency.” The ethical element is summed up by his comment that “We are short-changing the population.”

Drivers to quality: Leadership

“An organisation committed to quality is most clearly found in servant leaders who put the quality agenda first.” - Don Berwick

As he outlined the particular and vital role that leaders play in taking forward the quality agenda, Don discussed the Safer Patient Initiative (instituted in Wales in Glan Clwyd initially, and then Cardiff and Vale, Gwent and Wrexham in the later stages), which “raised the bar because leaders had to focus on patient safety.”

Don identified three important aspects of leadership:

1. Will
2. Ideas (generation and harvest)
3. Execution

The will to achieve quality means there must be an absolute clarity of aim, which is spelled out to everyone. This does not necessarily translate to a dictated ‘command and control’ model of leadership, rather it is explaining the developments, and engaging with staff. The ‘will’ needs to be underpinned by values - these are *how* things get done and are foundational to the aim.

The importance of ideas in improving quality is seen in the results of existing healthcare systems. ‘Every system is designed to achieve the result it gets.’ Leaders must be willing to change the system if they want to change the result of that system. All aspects of healthcare are results of a system, and therefore all aspects of healthcare can be changed, because every *system* can be changed. There will be a need to re-design systems because performance is a function of design. The secret to ‘better’ (i.e. quality improvement) is the improved design of the system.

Not all changes are improvements, but all improvements are changes. Organisations need to be curious about how they function and “leaders must be okay with curiosity”. “Leaders have to be willing to ‘go get’ knowledge” to enable them to enact changes that will improve the quality of healthcare through improving the system.

One example of ‘going to get knowledge’ is the adoption of Noriaki Kano’s three rules for improvement:

- Eliminate defects
- Reduce costs
- Add features

In healthcare terms, these would be expressed as:

- Decreasing defects - in terms of harm
- Decreasing costs - “waste reduction is not an afterthought”
- Improving the patient experience

‘Execution’ is the hardest part of the process. However, quality improvements in any area of the system can learn from the finance function. Improving the system will be very similar to how a budget is managed. The process of financial management - control, process, reports - can be replicated across other areas of healthcare, through strategic planning, careful monitoring of the process, and constant assessment.

There is a link to human resources, in terms of training and equipping staff. As Don explained, people do not automatically know how to improve, and even if they do, like children trying to jump higher, they can only improve individually. But improvement in healthcare is not independent, it is *interdependent* and it needs to be done everywhere, by everyone, at the same time.

So, a key step for any leader is to encourage the workforce to think of new ways of doing work, break old habits and begin constantly seeking to improve. It is important to engage frontline staff to drive towards quality improvement. Gerry explained that there is no one methodology for this, but there are some general characteristics that are necessary:

- Organisations with stable management
- Organisations that develop to tackle waste, harm and variation
- Organisations with a commitment to quality

These are all leader-led aspects of life in a healthcare institution. Stability, the willingness to tackle the three big drains on resources - waste, harm and variation - and the commitment to quality have to be prioritised from the very top.

Gerry also challenged the leaders present to visualise big changes. “You can make small changes, but how do you scale it up to achieve systematic improvement in everything? We need to focus on the 97% that is going *right* and look to make improvements there too.”

Like their staff, leaders also need to improve and investment is needed in leaders to enable them to develop the skills they need to lead organisations through a constantly changing process. Leadership mindsets may need to shift from ‘constrained’ to ‘can do’ - with a belief that change can happen and a desire to put quality central.

In addition, management and clinical work must be coherent. Both management and clinical leaders need to work together to reverse the culture where a hospital board reacts more to a £1 million deficit than to 50 avoidable deaths. To do this, leaders need to establish a culture that is patient-centred and behaviourally coherent.

“The recession will come and go. The management challenge is to keep improving health and healthcare within the new financial parameters. It’s the ‘mindset’ that will see this achieved, along with leadership where managers enable clinicians, patients and carers to deliver the changes they require.” - Sir Ian Carruthers

Drivers to quality: Expressing aims clearly

This links in closely with the need for leaders to take charge of the improvement agenda, because, as Don explains, “The aim needs to be articulated by leaders and show the shift from safety to a wider dimension.”

Successful aims cover six dimensions They are:

- Safe
- Effective
- Patient-centred
- Timely (because delay is waste)
- Efficient
- Equitable (including fair to staff)

“The aim must be communicated relentlessly. Being relentless is not a negative thing, and staff need to know that they cannot just ‘wait it out’ as another management fad imposed from above.” - Don Berwick

Drivers to quality: Putting the patient central

“The patient pathway is important. We need to manage pathways, as well as organisations. We need to manage the care journey to maximise the benefits for people, rather than focus on organisational survival for its own sake. It is important to develop a transparent values system which includes these components.”

- Sir Ian Carruthers

According to Ian, healthcare services need to improve the quality of care in four ways that impact on patient experience:

- Safety
- Patient experience
- Clinical excellence
- Access to services

Ian raised the particular point about access. Is the system made easy for people to get the care they need? He cited an example of an elderly man trying to get help for his partner. He made several phone calls, and kept getting passed onto another number. Eventually, he gave up. His partner did not get the care she needed, because of the difficulty of accessing it.

This example shows how ‘good healthcare’ is dependent on placing patient needs first and accessing services is frequently more difficult than professionals imagine. We need to look at how to improve the co-ordination of care from the perspective of each individual and their carer.

Access is an important issue, because “we need to reduce waiting time, to the quickest point where we can reduce pain and anxiety. This is not a political point - these are real life concerns.” Being able to access services successfully is crucial to improving the patient experience. Timely treatment in the right location can ease suffering and reduce the occurrence of adverse events. Drives to improve quality do need to consider how and when patients get on the pathway that will lead to successful treatment.

During the question and answer session in Swansea, the speakers were asked whether it was better to keep open a facility that was valued by the public, even if safety was compromised. This trade-off between ‘safety’ and ‘access’ highlights one of the difficulties in putting patients centre-stage.

However, Gerry pointed out that the ‘safety argument’ rarely convinces the public that it’s right to close hospitals or services on the periphery. Ian said the problem is that “The movement only ever seems to go one way - towards centralisation.

“Generally people want local services. We may need to centralise some services, but we could equally decentralise others. We could choose to do more in the high street where this is safe and economically effective. Everything doesn’t need to take place in a hospital setting and restructuring care so it’s close to home is a major challenge for us all.”

Don agreed with Ian, noting that some procedures (e.g. cardiac surgery) are far better off in a high volume centre, but perhaps only a select few procedures. The real driver in any decision has to be efficiency and there does need to be openness and honesty if that is the reason. But 'efficiency' does not automatically mean 'centralisation' and the two should not be considered synonymous.

Another aspect of patient-centred improvement is the imposition of best practice, from the top, with no excuse for non-compliance. Ian described the effects of failing to concentrate on instituting best practice, in terms of the negative impact on patient care:

“This often has adverse effects on patients and substantial improvements can be made if proven interventions are adopted quickly and the time lag is substantially reduced. It can take 15 years for proven techniques to become standard practice across the service. Our culture needs to ensure best practice trumps local autonomy.”

A question was raised during the Cardiff seminar about wastage caused by unnecessary tests - some of which may be carried out for fear of litigation. 'How could patients be recruited to help move the quality agenda forward?'

Don advised that "Protocolisation decreases the threat of litigation. It's disciplined and it's wise." Gerry agreed that protocol-based guidelines would reduce litigation, but also that it's important to "Invite clinicians to formulate and customise them. Guidelines aren't popular, but they do seem to work."

Don added: "The threat of litigation shows defects in the relationship, not defects in the care given. Also, if fear of litigation over-rides care, then that's not good for the patient." He advised healthcare organisations to "Invest in openness and respect. You need to get patients involved every way you can."

"Involvement is a virtuous cycle." Patients are ultimately an under-used resource in diagnosis and care management, as families and friends can offer advice to clinicians, based on the intimate knowledge families have of the patient. They can also provide pastoral care and comfort, relieving some of the care burden from clinical staff.

Involving patients has a great potential for quality improvement. As Ian pointed out: "NHS care is wonderful - if you're in the right place!" The solution is: "to plan with patients and dialogue with them to get them to the right place quickly." Gerry also highlighted that "long-term conditions are the starting point for patients as resources. We need to enable self-management."

Patients - and the general public - may have much to offer in terms of identifying areas of possible improvement. Don posed a question: "How can you elevate discussion with the public in Wales? Can the public help you make difficult decisions that have no easy answers?" Mansel also picked up this theme, asking: "Why can't we engage with our public? There's no reason not to. We just haven't."

Drivers to quality: Equipping staff as 'change agents'

At the Cardiff seminar Don stated: "I have a feeling that Wales is at the juncture of capability."

He explained that in the early stages of a drive towards improvement, organisations usually select a goal or project to focus on. “You can tick things off. Pick your favourite topic to do - safety is wonderful to do as it’s easy to explain. Then you need to pick your mechanism.”

Don identified selecting a goal as “the first level of work”, before continuing. “Wales is now into the second level. You need to be looking for continual improvement ‘in’ care and continual improvement ‘of’ care.”

As the NHS in Wales seeks to embed improvement in its processes, “improvement needs to be seen everywhere.” Results need to be visible. There should be expansion and widespread adoption of best practice that has been learned in the first level.

Don believes: “Transformation will come to Wales when everyone is engaged in improving their own work and the system they work in.” He illustrated this with a story: “I remember having a conversation with a nurse who said: ‘I get it. I have two jobs, *doing* my job and *improving* my job.’ In a transformation situation, everyone thinks like this.”

Don identified several preconditions for transformation. “It is based on the relationship between people and managers. (a) People need to be treated with respect. (b) They must be given the tools, resources and support to do it. And (c) someone needs to notice their achievements.”

Change agents are equipped to transform the workplace around them by leaders, said Ian: “We need strong leaders who will change the culture. People need to be given the chance to fly and address the issues.”

According to Don, the system will deliver improvement, if it is structured to equip people to improve. “We need to understand ‘system science’. Excellence is not a result of effort or heroism. It’s a question of design to utilise the effort and heroism of staff and direct it towards excellence in care.”

Achieving quality: practical considerations

All three speakers offered pithy insights into instituting quality in practical ways. This is a selection of key statements made by the speakers

Instituting quality improvements

“You can make small changes, but how do you scale it up to achieve systematic improvement in everything? We need to focus on the 97% that is going *right* and look to make improvements there too.” - Gerry Marr

“Investments in patient quality have personality. There is no ‘cookie cutter’ or universal template to follow.” - Don Berwick

“Make ‘improvement’ a strategy - this characterises the best companies.”
- Don Berwick

“Values must be embedded. They are not standards - they are values. Can we live up to them?” - Ian Carruthers

“The commitment to reducing waste, harm and variation is actually an ethical commitment.” - Gerry Marr

“Safety is easy to sell to people and a great place to start. Go for the ‘quick wins’.” - Don Berwick

“We need to create a new mindset. It’s not a choice between quality and cost. It’s all the same thing.” - Ian Carruthers

Getting the message across

“The aim must be communicated relentlessly. Being relentless is not a negative thing...” - Don Berwick

“Short cycles of change work best as they have pace and tempo. They need to be linked to reviews - not annually, but much shorter review periods.” - Don Berwick

Seeking inspiration

“The better idea may not be in healthcare. You need to ask ‘who does the kind of thing we do?’ Organisations committed to improvement won’t just benchmark locally. They will search for the best, and replicate it.” - Don Berwick

“We must encourage innovation and the spread of best practice so that patients benefit and effectiveness and efficiency are achieved.” - Ian Carruthers.

The role of the patient

“Successful organisations bring patients to the centre and don’t exclude them. They need to be involved in the process.” - Don Berwick

The role of healthcare staff

“Resource allocations by health boards must promote and facilitate best practice.” - Ian Carruthers

“The capacity of the local workforce is a challenge - you need to build both skills and confidence.” - Don Berwick

“We need healthy systems where relationships are good and people want to learn and adapt. We must put employees second and citizens first.” - Ian Carruthers

Ways to reduce harm

“You need to designate the forms of suffering that you want to decrease.” - Don Berwick

“There is no shortage of knowledge but there is a shortage of adoption and adaptation. Substantial improvement of best practice is implemented in every local area.” - Ian Carruthers

Measurement is essential

“You *must* review. You cannot improve if you don’t learn. You need to make the change, then reflect upon it.” - Don Berwick

“Good clinical teams benchmark themselves rigorously. What you need to change to reach the optimum practice are their drivers. The NHS performance culture will increasingly need to focus on being the best you can be in your local health system or organisation, rather than a favourable comparison with others.” - Ian Carruthers.

“Measurements require complete transparency. You need to know what you’re doing and be open. World-wide, we are plagued by fear of what will happen if we become transparent. But learning and life go together.”
- Don Berwick

“Metrics mean there is no hiding place. We must address the unspoken problems that are shown by the metrics. That will take courage. We must create a learning environment.” - Ian Carruthers.

“The measure of progress needs to be linked to the aims [that have been communicated by leaders]. Leaders must commit to visibly show success *and* failure.” - Don Berwick

The rewards of quality

“Best practice frequently reduces costs.” - Ian Carruthers

Healthcare organisations may need to restructure their ‘business’ to ensure that people are treated ‘in the right place, at the right time’. The drive to quality is about ambition and creating the right environment for optimal healthcare.

There is therefore a need for healthcare organisations to:

- Get the quality right
- Get the culture right
- Get the attitude right

If these three aspects of quality improvement are achieved, Ian reassured those present that “because meaning will have been created in a professional workforce, the focus on improving the quality of care, effectiveness and securing efficiency and cost reduction will produce the desired results.”

The question was asked ‘How can you measure the savings made through achieving quality?’ It was recognised that organisations needed to ‘be smart’ about what they chose to improve, but that by ‘thinking across the system’ it would be possible to pick the most important things, that will both prevent harm and save money.

There is always a tendency for savings in one area to be spent somewhere else. Without robust financial systems, savings will not be ‘drawn out’ of the system and converted into real ‘surplus’.

However it may also be useful to empower clinical teams and incentivise them to make savings with the promise that they can decide how some of those savings are then spent. If budget savings are simply diverted to other expenditure areas, there is little incentive for clinicians to cut costs, as they receive no benefit for doing so. There is a link between quality improvement and organisational design, as better design will offer significant cost-savings. This is a long-term strategy and may require radical changes in the ways primary and secondary care interface.

Conclusion

In summing up the points made by the speakers, Paul noted that there is always “a danger that people will take refuge in a particular system.” He appealed for leadership in the area of quality improvement and asked: “If we were the inspector looking for evidence of quality improvement, what would we be looking for?”

The answers are out there to be discovered by organisations that are committed to quality. Such organisations will be driven towards quality by focussed leaders, and will incarnate quality as a foundational value that permeates everything they do. They will be organisations committed to empowering staff at all levels to think in new ways and implement changes that put the patient central and the patient’s safety paramount. They will exhibit a righteous intolerance for wastage, harm and variation founded on a passionate belief in the principle of universal healthcare and a duty to maximise the taxpayer’s investment. They will be unafraid of change, curious about improvement, committed to analysis and review, and honest about their shortcomings. They will take every setback as an opportunity to learn, and every success as an opportunity to celebrate. Quality will be a watchword, a benchmark, a value and evident in every aspect of their professional lives.

Video highlights from the ‘The Pursuit of Quality’ seminar which was held in March 2010 are now available online at <http://tinyurl.com/2uxvxab>

About the author



Professor Jonathon Gray has more than twenty years experience in the field of health and his special interest is in healthcare improvement and innovative service development.

As Director of the 1000 Lives Campaign in Wales, he helped steer a national drive towards quality that resulted in 1,199 additional lives being saved in NHS Wales between 2008 and 2010.

In October 2010, Jonathon took up a new role as Director for Health Improvement and Innovation in Counties Manakau District Health Board, New Zealand. He was also appointed The Stevenson Professor of Health Improvement and Innovation at Auckland University.

Jonathon graduated in Medicine from Dundee University in 1988, where he also gained a PhD in molecular genetics. Over the following years Jonathon specialised in clinical genetics, and more recently achieved a defined specialist training in Public Health. As a Consultant in Clinical Genetics, he developed a specialist national service for people concerned about a family history of cancer.

After four years as Clinical Director for the all-Wales Genetics Service, Jonathon spent a year as a Health Foundation Fellow in the Institute of Healthcare Improvement and at the same time, took the Harvard Masters of Public Health. In 2006, he was appointed as Director of Healthcare Improvement at the Wales Centre for Health and in 2008 as Professor of Healthcare improvement at Cardiff University. He has also gained an Advanced Medical Leader Award from the British Association of Medical Managers.

Accelerating best practice: Minimising waste, harm and variation

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