

International Forum on Quality and Safety in Health and Care Berlin, 17-20 March 2009

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INTRODUCTION

The annual Forum on Quality and Safety in Health and Care, presented by the Institute for Healthcare Improvement (IHI) and the BMJ Group, was held this year in Berlin. It was attended by over 1,800 delegates and focussed on healthcare improvement.

Each day began with a plenary session followed by a series of parallel sessions offering a very wide range of workshops and presentations. In my choice of sessions (which had to be specified at the time of registering for the conference) I tried to strike a balance between technical workshops on improvement methodology and more conventional presentations (lectures) describing examples of work from different parts of the world.

I made a conscious decision not to attend workshops or presentations by UK-based delegates as I have an opportunity to engage with most of them through the NHS Institute for Innovation and Improvement (NHSII) fellowship programme.

As well as the formal sessions there were opportunities to “network” informally with other delegates during the breaks and there was an exhibition at which several useful organisations were represented. There were also poster displays although these were located away from the main conference area and this, together with the fact that there were so very many posters, made it difficult to do justice to them.

KEY LEARNING POINTS

Improvement methodology and the IHI

- Improvement methodology is not rocket science! It just brings together other (often familiar) techniques in a new way.
- Examples of what can be termed “improvement” can be found almost everywhere but not necessarily with that label.
- The IHI has developed some useful tools for improvement (as has the NHSII). However, they all need to be adapted to local circumstances. Unfortunately this view is at odds with that of some of the IHI fellows who are rather rigid in their approaches, arguing that there is only one way of doing things.
- The IHI tends to concentrate on small step changes, tackling one component of healthcare at a time. In doing this they advocate the use of techniques originally developed in commercial, usually industrial, settings (e.g. Toyota) and have had some notable successes. However, I do not accept their argument that these techniques are appropriate in all healthcare settings as they do not

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allow for a whole systems approach.

Primary care

- Primary care redesign does not readily lend itself to current improvement methodologies (although some components of primary care clearly do).
- It differs significantly from acute care in that it is not a production line industry where the service providers are in control and protocols are used to manage work on a day to day basis. It is mainly a service industry in which the patients / clients are in control and exercising choice (e.g. whether to consult primary care professionals or to admit them into their homes; whether to take their medication).
- A whole systems approach is needed for primary care redesign. This was exemplified by the “Bellagio model”, which seeks to facilitate vertical integration (to promote effective, diagnosis, treatment and follow up through a more effective and efficient flow of information) and horizontal integration (to promote holistic models of care and management of conditions).
- Shared leadership and shared governance at all levels is crucial to both system redesign and small scale improvement projects.
- The value of communication and networking cannot be overstated.

Quality and cost

- All improvement initiatives cost money to put into place but only some save money in the longer term.
- There is a “credibility crisis” for quality improvement work at the moment, with questions being asked about the extent to which activities take staff away from patient care. This is an important issue to address in the current economic climate. I believe that the answer lies in another question - what is the cost of not seeking to improve the quality of the services we provide?

Some suggested approaches:

- Choose an intervention known to work in other settings.
- Use research to identify high cost problems or low cost interventions.

- Assess the cost of poor quality care (taking into account not only financial measures but also less easily quantified costs such as suffering (of patients) and morale (of staff)).
- (For commissioners) Introduce a no payment policy for “never” events, e.g. objects left in after surgery; air embolism; blood incompatibility; other preventable conditions such as DVT, pulmonary embolism, staphylococcus, aureus septicaemia, ventilator associated pneumonia.
- (For commissioners) Introduce cost sharing agreements, e.g. for MRSA testing for patients admitted to hospital from nursing homes (I am not sure that this is a good example but it is one idea currently being tested).
- When demonstrating the value of new ways of working, choose a small number of process or output measures as indicators of improvement. These should demonstrate an association with the improvement process but it is generally recognised that an explicit causal association is not always possible (there are direct parallels here with much public health work although, in cash strapped times, public health is usually subjected to a much higher burden of proof).

FURTHER INFORMATION

The plenary videos can be viewed on:

<http://www.axisto.com/webcasting/bmj/berlin-2009/>

The posters can be viewed on:

<http://internationalforum.bmj.com/2009-forum/international-forum-posters>

For further information on the IHI, go to <http://ihi.org>