Quality improvement from the perspective of the health care work floor

INTERVIEW WITH TWO QUALITY MANAGERS FROM THE NETHERLANDS AND THE UK

We spoke with Catharina Walma, quality manager Groenekruis Domicura Maastricht, Lead Auditor and nursing scientist; and with Yolanda Fernandes, independent management consultant from the UK.

By: B. van der Linden

Firstly, could you introduce yourself to our readers, what is your current position, what is your role within your organization in quality improvement and how many years experience do you have in quality improvement?
Catharina: These last ten years, I have been working as a quality manager in home care. Originally I was trained as a nurse and I worked as a nurse for twenty five years in various sectors, during which I also studied health sciences. My nursing background keeps me close to the work floor. I think it's an added value, because you don't only work through quality theories but from personal experience: you know what's important in health care. Quality management is an amazing field, but it has to suit you. You're the driving force and more or less the conscience in the organization, always looking for improvement, in the sense of a better professional quality of care for our clients. Recently, we took the first steps to integrate a patient safety system. This also affects the accident committee and the internal audit team that I manage. In addition I work on certification processes, inspection reports and patient experience surveys.

Yolanda: Six months ago I gave up a 37-year career of corporate employment in the National Health Service, to pursue a career as an independent management consultant with a special interest in quality improvement in the health & social care sector. I have been involved in quality improvement and patient safety initiatives for the past six years in both acute hospital and community settings. I have a clinical background as a paediatric nurse with over fifteen years of clinical experience and a further ten years of operational management experience. My particular professional interest in quality improvement (besides the technical aspects of improving service delivery and enhancing patient safety) is the engagement of staff and patients to achieve sustainable change in services delivered by staff and experienced by both patients and commissioners of care.

The articles in this special edition outline a number of quality improvement strategies that have been developed and carried out in the last 10-15 years in western countries:

- *Indicator development*
- *Target setting*
- *Quality measurement and reporting/transparancy (including for the public)*
- *Accreditation*
- *Focus on safety improvement*
- *Focus on integrated care*
- *Large-scale improvement programmes*
- *Quality-improvement skill development and skill improvement*
- *Quality research*
- *Buying quality/financial incentives*

Do you have any comments on this list? Are any important developments missing, which have been most successful in improving quality of care, especially from the perspective of daily health care practice?
Yolanda: I recognize many of the strategies listed here. Quality measurement and report-

Catharina Walma

Yolanda Fernandes

ing supports giving information about return on investment and also the spread and sustainability of the improvement actions. Indicator development, target setting and financial incentives for quality are all familiar, but more in the context of business performance measures and external accountability than as measures for people involved in daily practice. Examples of these systems in the UK are: Commissioning for Quality & Innovations (CQUIN), Quality Accounts, quality assurance by external inspectors i.e. Care Quality Commission & Monitor and national policy drivers i.e. Quality, Innovation, Productivity, Prevention (QIPP), and Waiting Time targets.

Catharina: Many developments in quality in recent years have emerged from introducing market driven health care. Generally I think we've gone too far on that road. We have introduced too many principles that focus on control and accountability. The idea that measurement gives insight, may work well in manufacturing. The development of indicators and norms are part of that philosophy. This leads to far-reaching standardization, and to selectivity and simplification, and also to distrust and penalties. This can result in negative non-open behaviour, avoidance, and frustration. That is not why caregivers chose to work in health care! Einstein's statement: 'not everything that is measurable matters and not everything that matters is measurable,' certainly applies here.

If I must choose which of the above list so far has been the most 'successful', I think it would be the focus on safety improvement. Safety has become a normal part of good quality care. The safe conduct by the professional literally saves lives. Improvement in medication delivery, alertness to abuse and individual risk identification are achievements to be proud of. Professionals thrive in a culture focussed on safety. In my organization we are currently seeking suitable tools to support and simplify this.

Yolanda: I agree that patient safety initiatives have had the most success, especially when you look at involving clinical staff. Success includes national (Institute of Innovation & Improvement, The Health Foundation, The Kings Fund), regional (Strategic Health Authorities) and locally (Commissioners & Hospital Charities) sponsored initiatives to reduce infections, medication errors, redesign in care pathways to improve efficiency in the flow of patients and their experience, improvement in communications between teams particularly at handover, at change of shifts and discharge. In the UK, we have also seen meaningful improvements made to enhance leadership at board level to become involved in monitoring the quality and safety of patient care through initiatives like 'Weekly Executive WalkRounds' to clinical and

non-clinical areas e.g. medical records, and culture surveys including board development programmes.

Catharina: In the area of quality skill improvement I am working on getting our own audit team to use the principles of appreciative inquiry. By this we want to stimulate the improvement capacity of caregivers, which will have positive effects for themselves as well as for patients.

Yolanda: I also see improvements as a result of the focus on integrated care. By that I mean when care crosses organisational and sector boundaries. In addition there is an increased awareness of the use of quality improvement knowledge and skills, especially in building local capability and capacity amongst front line staff and developing quality champions. Also there has been national and regional financial and educational support, through a variety of awards to health organisations. For instance NHS Kidney Care, that aims to significantly improve the care of patients with chronic kidney disease. And programmes to develop clinical leaders.

Catharina: Yolanda mentions some important successes. In Holland, influenced by the financial crisis, we are seeing a growing discussion about responsibilities between specialists and generalists, in elderly care and in youth care. Also the question arises whether integrated care pathways are perhaps too medical, where they should be holistic and focussed on patients' actual needs.

Could you comment on what in your view has been achieved in quality improvement up to 2012? Or on the flip side: which developments have decreased quality of care?
Catharina: It is clear that in recent years we have learned a lot, and gained insights and awareness about the necessity of quality improvement. But not all developments are positive. I spent a lot of time incorporating new legislation and external requirements, sometimes it seems to be a goal in itself. If you compare the current health care legislation manual with that of 10 years ago, you can measure the increase in legislatory burden by the increased weight of the book!

Yolanda: I would say that we have achieved much in local communities adopting an activist movement to improve. They have participated in changes in policy decisions, service re-design, advocacy and changes in funding to support chronic care in the community. In addition, national patient support organisations like the Alzheimer's Society, Age UK and Macmillan Support, are beginning to take a proactive role in both challenging and influencing national policy and care standards, through a variety of initiatives and strategic alliances.
On the downside, there have been changes like moving some acute care into the community, without much attention to other infrastructure changes like data/information sharing, flow of funding and informing/educating the public on the pro's/cons of such changes. This has had some negative impact on patient experience and outcomes. In the UK, we have seen that the frequent top down changes, which were implemented, have negatively influenced quality improvement efforts on the frontline. There have also been mergers of organisations, staff redundancies or moving on to other jobs which disrupt quality improvement activities.

Which initiatives have made the most difference for patients?
Catharina: There have been many initiatives focussed on bringing back small scale neighborhood-oriented home care organisations with the professional in the lead. In addition we see a development towards shared decision making and self-management. Examples are the national quality collaboratives for home care nurses, prevention in home care and for long term care. I'd like to specifically mention Buurtzorg: the first example of small scale self managing home care teams in Holland. They really showed that improvement can be achieved, and they had great influence on the shift to small scale that is now going on everywhere.
The question now is how to sustain projects that have shown large gains for both clients and professionals, and also saved costs. Perhaps government intervention is necessary. The Ministry of Health Care will in any case need to facilitate financing of regional and/or integrated care packages.

Yolanda: In the UK we have seen many examples of genuine involvement and engagement of patients in their care. However, there are still many challenges. For example we are fast learning about the impact of poor health literacy amongst patients. That is, understanding health statistics to help them make informed decisions about the choices on offer for their respective treatments and care – for example women with breast cancer having to

make a decision on options for surgery, chemo and radiotherapy or options for men around prostate cancer. But also we need to improve health care professionals' understanding of health statistics, to ensure they are confident in interpreting the results in order to give their patients accurate information. There is also the issue of the education level of patients who are unable to read or whose first language is not English. Health care professionals need support in being able to assess the patients capacity to work with them as equal partners, or need for advocacy in making decisions about their care.

What would be your view on where we are heading from here? Which developments would you view to be promising in improving health care quality in the next few years?
Yolanda: In the UK there is a strong national policy drive around Shared Decision Making and Integrated Care, with a focus on delivery of care nearer to home; given the demographic changes and the impact of chronic disease management.
I think a *whole system* approach is needed instead of fragmented initiatives. If we are to achieve improving health care quality to reflect the local health economy context and patient outcomes, i.e. what adds value to the patient rather than to the health professional or service, we are going to have to move from small incremental improvements on the frontline to whole system changes, across primary, secondary, tertiary and community boundaries. Education of medical, nursing and allied health professionals will need to prepare staff to recognise the need and have the courage to take both responsibility and accountability for working in different ways. And in equal partnership with patients and their carers, including a variety of other services in the voluntary sector, social enterprises and the private sector. All the above is becoming more relevant as we see a national move on the implementation of the 'Personalisation' agenda, where financial support for social & personal care support, normally provided and managed by Social Care organisations, is now being given directly to the patient and their agents to manage and procure the appropriate services.
The challenge to these significant changes is going to be the process of assuring the quality of the services provided by a variety of organisations and/or individuals, including the Safeguarding of Adults and Children.

Catharina: I would say that we need to change, from a culture of distrust to trusting professionals to take the lead. My big wish is that an 'all-round nurse', perhaps even including childrens health care again (0-100yrs!), will make her re-entry into homecare. She is the most approachable professional for the entire family system. She can coordinate the entire spectrum of bio-psychosocial needs of the client. There are a huge potential preventive aspect and savings to be gained by this.
I think that we are on the verge of a breakthrough in the Netherlands. Slowly the road to a less regulated health care is being taken, where professionals are responsible and the relationship between client and care-giver is again the starting point. Care revolves around people: people needing care *and* those who wish to provide it.
We do need to have a suitable classification method for diagnosis and care interventions. This can provide a basis for health care professionals, but should only monitor the effects of care. It can be used for (multi) disciplinary collaboration and accountability to the client; but not for external accountability. Well-organized preconditions make letting-go and confidence possible, then quality can develop from an intrinsic motivation.

Yolanda: I strongly agree with Catharina's thinking around building a culture of trust and a sense of 'joy at work' if we are to deliver sustainable, high quality, person centred services. Staff need to commit to new ways of working, because it is the right thing to do for the patient. In return, staff need to be valued by their employers through a variety of incentives i.e. shared ownership in the organisation, similar to the retail 'John Lewis Partnership' or the private health provider 'Circle Health' model in the UK Leadership programmes, including Fellowships in a variety of health care settings.
If we want to genuinely achieve the above we will also need to continue to create an environment that actively encourages and supports initiatives that increase the number of activated patients. That is, patients that have the motivation, information, skills and confidence to effectively make decisions about their health care and relate to professionals they meet as confident partners.
In the UK, it is important that we find a balance between managing what adds value to the provider (usual focus on outputs and efficiency) and what adds value to the patient (usual focus on outcomes and effectiveness on their respective quality of life). Common to both, is a quality of access to equitable service at point of delivery. Once again the challenge that we will face

Catharina: We need to develop tools that help define suitable core values. Recently I have seen the first steps to create certified (ISO HSC) organizations, to support the redesign of their quality system, based on culture and trust. Care professionals have recently re-written their professional profiles, and I hear they are positive about the levels of autonomy, competence, prevention, outcome responsibility and the positioning of the client in all this. We also face the next phase: *Health 2.0,* in which a new relationship between care-giver and client (consumer) arises. Information is essential and will be subject to quality requirements. I think that also the quality manager 2.0 will make her entrance.
Managers will also play a different role. They must lead by example and inspire their workers. It is ultimately the people in your organization that need to feel connected and become really motivated to improve. That brings positive and creative energy. We need to create a genuine culture of openness, where self-reflection and the learning ability of teams is stimulated. A culture where workers are connected to each other and to themselves, through a profound vision.

Samenvatting
Om de invloed te peilen van alle ontwikkelingen in kwaliteitsverbetering op de dagelijkse werkvloer heeft KiZ twee ervaren kwaliteitsmanagers geïnterviewd, uit Nederland en Engeland. We legden de verschillende strategieën die in dit nummer aan de orde zijn geweest aan hen voor en vroegen naar het succes ervan. Naast successen in patiëntveiligheid en geïntegreerde zorg vinden de geïnterviewden dat er te veel tijd en energie zit in externe verantwoording. Er moet meer terug in handen komen van de professionals die op lokale schaal samenwerken met patiënten. Het vertrouwen in de zorgverlener moet terug en de focus moet komen te liggen op wat patiënten zelf kunnen en willen.

The ethics of quality would in my opinion be the focus in the next ten years. I have committed myself to exchanging 'doing the thing good' for 'doing the good thing' and if I know I can succeed in bringing those two together, my mission will be accomplished!.
Daniel Ofman puts it nicely: 'Quality is essentially an expression of love.' We must regain the balance between the human-world and the system-world. I look to the future with confidence!!