Embedding quality improvement into routine clinical practice

Our patients rightly expect quality healthcare, our politicians expect the £100bn funding of the NHS to deliver quality healthcare and we, as clinicians, strive to deliver quality healthcare; so why is quality improvement (QI) so difficult to routinely deliver, and why does it remain a Cinderella function in healthcare?

This edition of *Future Hospital Journal* (*FHJ*) presents a series of articles that offer readers the opportunity to view QI from multiple perspectives covering different aspects of the theory, educational requirement, delivery and intended outcomes of QI within the UK healthcare sector. A number of major challenges are identified that all require addressing if we are to embed a routine quality driven culture within our clinical workspace.

Highlighting systemic issues, Leatherman *et al*[1] give a strategic view from the Health Foundation, highlighting the lack of ownership of the quality agenda within NHS England, the disparate accountability landscape for quality and the lack of national leadership development for QI (as opposed to initiatives for personal development). Along with other contributors, the challenges and tensions that arise from both top-down, policy driven and bottom-up, local approaches to QI are acknowledged and explored. As is so often the way, while setting of standards from the top down appears to be appropriate, the mandated imposition of one-size-fits-all initiatives remain highly questionable although prevalent. Successfully developing a quality culture and productive initiatives from the bottom up requires time to locally contextualise initiatives and deliver them properly.

Mary Dixon-Woods and Graham Martin[2] build on this strategic viewpoint and argue that for QI endeavours to be truly successful across the healthcare sector, we must develop and enable a systemic approach, with appropriately trained and skilled individuals given the necessary time and infrastructure to develop scientifically rigorous (with proper study of effects), larger scale QI projects that take into account the specific contexts of healthcare (as opposed to the industries where much of the scientific validation of QI tools evolved).

The educational need is further explored in a passionate article by Dr Emma Vaux[3] who focuses on the training requirement for the whole workforce if we are to inculcate QI into routine clinical practice, delivered by an appropriately informed and educated workforce. Julie Reed[4] and colleagues introduce the foundations of QI science with a simple and practical guide to the use of plan-do-study-act (PDSA) cycles. They richly illustrate this with an excellent hypothetical worked example that highlights the value of a well-structured process where appropriate time is dedicated to studying the effects of initiatives and adequate space is given for thinking and working through the unexpected challenges raised in small scale 'pilots' before wider implementation across organisations.

However, as they all point out, we have to be realistic about the current atmosphere that QI initiatives are being conducted against and acknowledge that many of us have been victim to well-intentioned 'pilot' studies that have made negligible impact; once embarked upon, they become the new normal, despite little or no rigorous study or evidence of the effect or benefit on the process, personnel or the patients. Add to this the need to tackle the challenge of engaging a wider clinical workforce, largely disengaged by a process of top-down, quick-fix, centrally mandated quality initiatives that lack explanation and feel imposed, a generation (mostly of doctors) who suffered the lamentable practice of small scale local annual 'audit for the sake of audit' within an ill-informed regulatory process for trainees, and a deep seated cynicism of the perennial 'tick-box culture of quality assurance' and one can see why this 'obvious' cultural deficit within healthcare is not so easily addressed.

However, despite this challenging backdrop, great strides are being made by passionate advocates of QI and solutions to tackle these obstacles are writ large through this edition of *FHJ*. A few key 'take home' messages stand out for me; firstly, far wider sharing of practice (successful or otherwise) in QI is required, whether this be via initiatives such as the Royal College of Physicians QI Hub, as described by Choudry *et al*,[5] or through a more concerted effort in supporting the publication of both QI methodology and data in academic journals. *FHJ* is just one vehicle that I wish to see support this call-to-arms and the request by several authors to share experiences (good or

bad) in peer-reviewed journals echoes the request I made in my last editorial.[6]

Secondly, methodology from successful QI initiatives should not result in individuals or organisations slavishly applying the same processes without ensuring that it is contextualised locally and all facets of the local organisation considered. What works in one complex organisation may well not deliver the same benefit in another and while the problem and desired outcome may be very similar, a lack of rigorous testing of small pilot initiatives locally may well deliver entirely different (and less successful) outcomes if attempted on a larger scale.

Thirdly, we need to focus on providing space to perform the study phase of processes at local level, such as used in the PDSA cycle, and we must fight for organisational support for QI education and infrastructure. We must work together, as clinicians and managers, to overcome the weak organisational commitment to real QI. This work must focus on building the skills required for robust and sustainable QI, use evidence to re-engage the wider healthcare workforce (such as with the simple but effective changes to blood transfusion processes outlined by Warburton and colleagues[7]) and once again show the value of QI initiatives that combine the clinical and managerial community, ideally across primary and secondary care boundaries, such as with the more recent national stroke and hip replacement audits.[8]

Finally, we must, at all times, remain patient centred in our endeavours; while maximising the quality of our processes, we must continually acknowledge that quality in healthcare to an individual receiving care is a human domain; the rest should be invisible to the patient, merely oiling the wheels of a process that allows all healthcare providers to focus on compassion and quality in their individual clinical interactions. ■

References

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