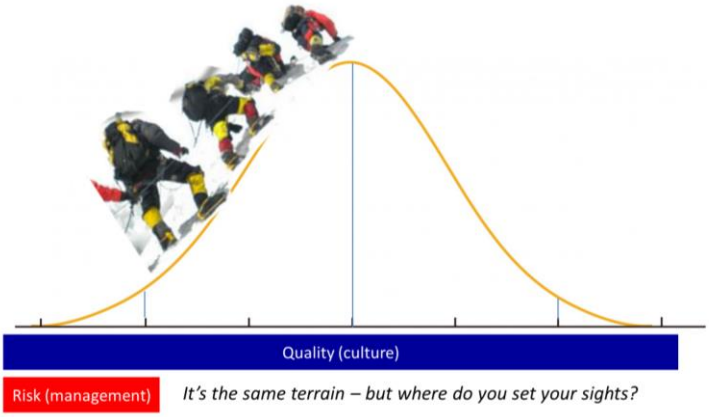
Moving from Punishment to Improvement

– a different lens on health inspection

Once you ensure 'safety' where do you go next?



There is a 'coming of age' of a quality lens on healthcare. While once the task of specific departments and used interchangeably with the terms 'audit' and 'inspection' – the language is now developing into one of 'culture' and 'leadership'.

In March 2017 Eurinspect in co-operation with EPSO (the European Partnership for Supervisory Organisations www.epsonet.eu) was invited by the Bulgarian Executive Agency "Medical Audit" (EAMA) to run a 2-day intensive workshop to help inform a new national risk and audit framework for their health system.

EPSO is a highly leveraged organisation that is a support network for the various health and social care monitoring agencies in many of the EU countries. It has a large and diverse membership spanning Scandinavian, UK and Balkan territories to name a few.

The role of our small team was to provide some context, advice and a working session to stimulate ideas around designing a risk assessment framework. The local team were a combination of clinical, legal and policy experts. Over two and a half days we traversed much ground. It was rewarding to see some very senior people there who stayed for the duration and were deeply engaged – including the secretary general of health. In total there were more than 20 people in the room – and one translator.

Not speaking the same language and being translated actually proved useful. It makes you focus on the key messages keeping them short and clear and triangulating with questions to make sure you understand what is being said or asked.

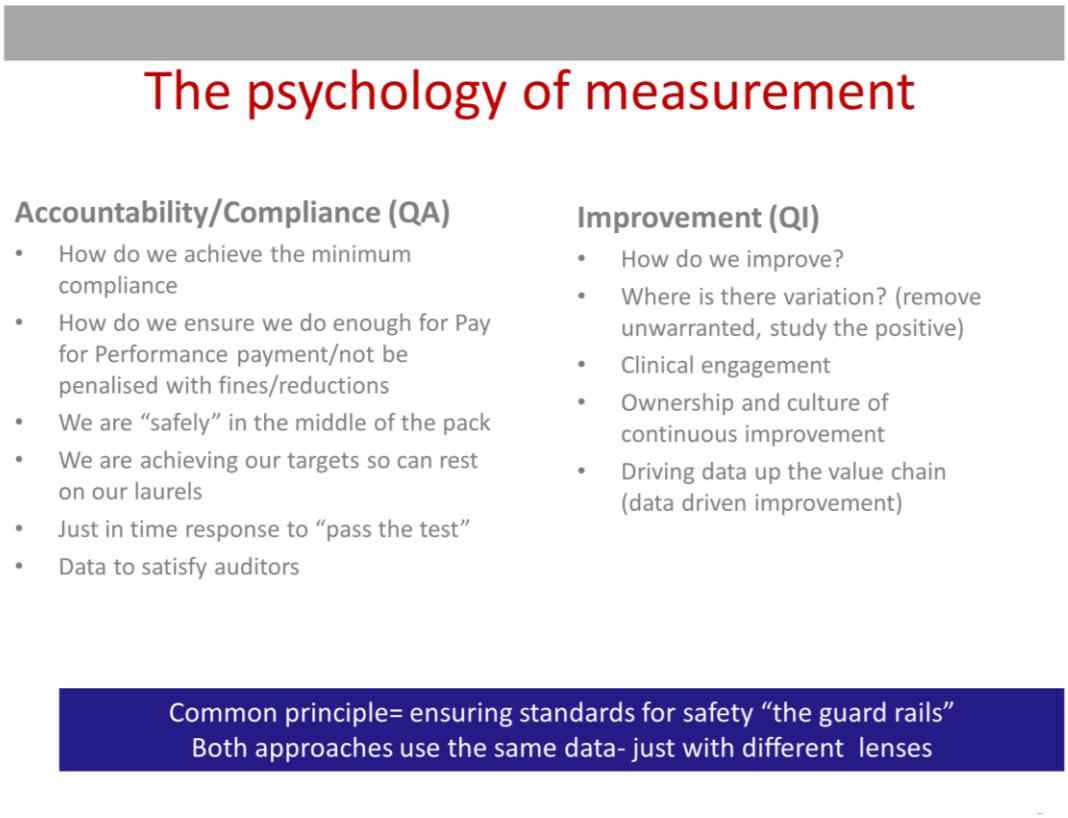
So, what were the key messages?

Moving the philosophy from one of finding errors (and being happy the more we find) to being a part of the solution.

First and foremost, ensure safe care delivery. Then, beyond that, how do you ensure there is (or help to foster) a learning organisation and an improvement culture?

Setting the tone – Quality Assurance or Quality Improvement?

How do they leaders keep their organisations and systems climbing up the mountain of quality? Culture changes based on the perception of consequences. A risk averse culture focuses on achieving minimum standards and compliance. A quality and learning culture ensures these safety nets are in place …and then keeps climbing up the quality ladder.



Some of this perception and behaviour is shaped by the regulators.

What is the behaviour of your regulatory inspection agencies? How do they adjust their focus and behaviour based on what they find? As an inspector or inspection agency, how do you re-program your focus to improvement and not (just) compliance?

Safe clinical practice is paramount. Once you've achieved that, where do you put your focus?

a) Do you review more procedures to pick up the outliers that are still not 'as per the rules', or:
b) do you decide to invest time, effort and money into engaging the organisation in a culture of learning and improvement?

Lessons from the Bulgarian workshop

The answer to the question "How to ensure the safety of care?" traditionally comes down to the application of coercive policies of an administrative nature - laws, guidelines, regulations, standards, inspections, penalties, etc.

Although the mechanism remains up to date, it's definitely not efficient enough, often - with contradictory effects of its application and, especially, very slow and prone to conjuncture, political and economic interests.

The workshop led to the exploring of another and equally important approach to the successful achievement of the ultimate goal. This method is about finding a "soft" way to bind the processes of both patients and health care providers, in an effort to find the intersection of their interests. Defining these fundamental hypotheses and their adoption by consensus at the national level is a first, but very necessary, step before the application of the other administrative actions mentioned above.

Obviously, the two processes must be developed in parallel and a major factor for their successful implementation is the existence of strong political will and a leadership program that can be applied in the short term.

The work of the interactive session focused on preparation of an action plan for EAMA to improve the quality of healthcare in Bulgaria by introducing a Risk based approach for inspections and supervision as a new working method for EAMA.

Various approaches where discussed before reaching more concrete essential components. Emphasis is placed on the answer to the following questions:

1. How to involve internal staff of EAMA and stakeholders in the process?

2. What is our interpretation of the principles and goal of EAMA and how do we achieve the goal?

3. Creating a Framework of indicators – which indicator first? The advice is "keep it simple"!

4. How to get data for these indicators?

5. Which data can we trust?

The first step is done! For EAMA, as a learning organization, the above questions are the foundation upon which all other aspects of the way of re-programming the focus of inspections to improvement, not compliance, are built.

Who is already on the Quality improvement journey as part of monitoring?

There are some strong examples of the latter playing out in some countries already.

The Swedish health inspectorate – IVO (http://www.ivo.se/om-ivo/other-languages/english/) have spent years refining their approach. Their key message – 'if we want improvement to be sustainable and part of the culture of an organisation, then we need to support a learning organisation.'

In a 2015 BMJ Outcomes paper (http://15762-presscdn-0-11.pagely.netdna-cdn.com/wp-content/uploads/2016/08/BMJ-Outcomes-Article-Collection.pdf), the Dutch Health Care inspectorate outlines their approach to developing Quality Indicators and a "*Collaborative governance as a strategy for developing effecting national quality indicators for hospital care".*

Like many of the quality journeys, they state that the direct impact of improvement is hard to prove-though trends are emerging on the reduction in the prevalence of pressure ulcers and some movement in reduction in hospital mortality following research and shifts in low-volume to high volume centres for some procedures.

New Zealand's Health Quality Safety Commission has developed a report that openly discusses failure and the positive learning that can be taken from it (http://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Learning-from-adverse-events-2015-16-Nov-2016.pdf)

As the science and evidence of risk profiling comes under the microscope, (http://qualitysafety.bmj.com/content/early/2016/04/15/bmjqs-2015-004687) more countries are looking at their measurement frameworks to see where the best measures and highest correlation to risk actually are.

What indicators to use for predictive risk assessment?

One of the lessons from EPSO Risk working group (including lessons from the UK, Netherlands, Sweden and France) is that we should focus less on 'Big Data' and complex risk profiling. Instead we should identify find a smaller group of indictors that have the best correlation with on-site audit findings and focus on these indicators, thus 'finding the signal through all of the noise'.

EPSO is already engaged in this simplification project of identifying the 'best indicators'. Perhaps unsurprisingly, some of the best data sources for the 'state of health' of an organisation are found within patient and staff surveys and cover patient engagement and leadership. This sets the tone for the culture of care and quality.

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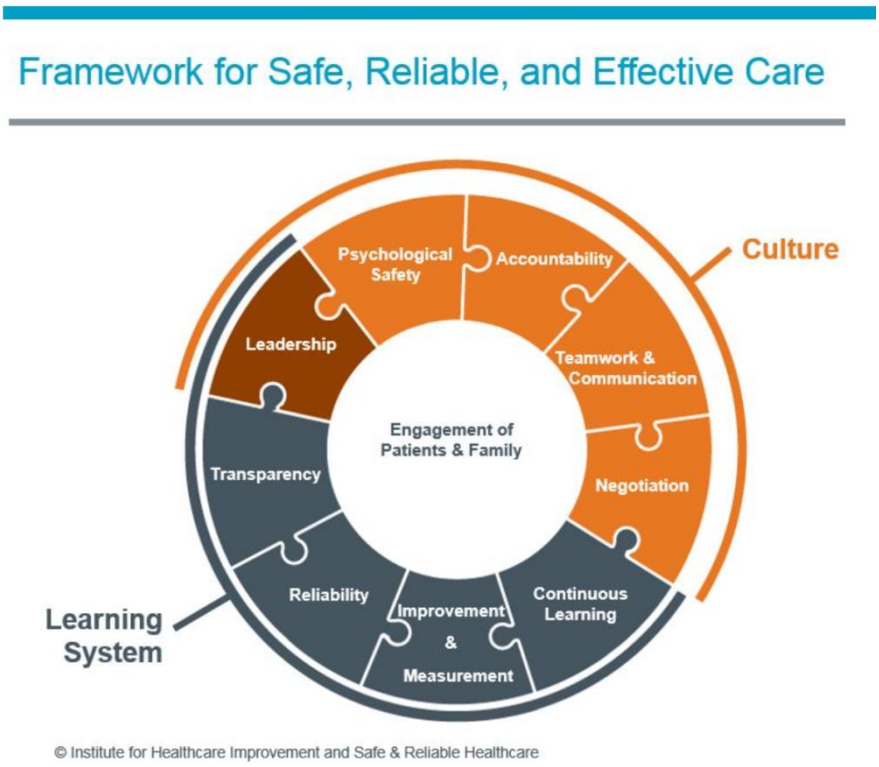
The Institute for Healthcare improvement (IHI) refer to this in their recent 2017 whitepaper (Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*.)) as "*a "system of safety," not just a collection of stand-alone safety improvement projects."* and provide a useful framework that outlines some key dimensions of a learning system.



http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

So- back to the mountain. Clip in and stay 'safe' – or put the safety in then keep climbing?

(May 2017)

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EPSO European Partnership for Supervisory Organisations in Health Services and Social Care (www.epsonet.eu)

With special thanks to the Bulgarian Executive Agency "Medical Audit" (EAMA), especially to Alexandrina Gigova (Head of Administrative and Legal department) and Dimitar Georgiev (MD), Head of Department for their insights and permission to share this article.