Staying awake for lesson on quality
Kate Baddock

Quality is such a dry subject. We all understand what we mean by it and we all understand the importance of it, but it can be hard to stay awake when there is an entire symposium devoted to it. Except that it didn't turn out that way.

I attended the recent RNZCGP Quality Symposium, where concept of quality was applied to child health, turning the discussion from one of esoteric academia to something we could all relate to.

But one speaker really caught my imagination. Martin Marshall is professor of health care improvement at the University College, London, and the director of the improvement science development group at the UK's Health Foundation.

He worked as a GP for more than 20 years and, as one of the world's experts in the field, now plays a leading role in the advancement of improvement science.

The science of improvement is a practical science that addresses the gap between what the evidence suggests should happen and what actually happens in both clinical and managerial practice. It essentially uses an evidence-based approach to improve the quality of healthcare.

Structural solutions to quality problems rarely work and there are many approaches to improving care, including clinical teams, organisations and health systems (usually governments). Most of these exhibit only moderate efficacy.

Professor Marshall reinforced that all interventions have unintended consequences. This includes the UK Government's publishing performance data that led to gaming the system. Those of you who have not read about the mid-Staffordshire affair should do so.

He suggests therefore - and this is not rocket science - there is a need to adopt different approaches to implementing change in healthcare.

In some situations, you know what you want to change will have a high certainty of success, and there is a high level of agreement that this is the right thing to do.

It is much harder to generate change where the agreement is not as widespread and there is less certainty about success. Does this sound like the current drive for change in our health system in New Zealand?

Where there is a low level of agreement and a low level of certainty, then you get chaos. Simple to do the first, complex to do the second and chaotic to attempt the third...

If health service provision research is available, why do we not use it? Professor Marshall suggests the reasons are fourfold:

- the time it takes to change
- the norms and practices of the managerial decision makers
- the nature of the decision-making process, and
- the way evidence is created.
The first three are reasonably self-explanatory, but the fourth is where the gold is (figuratively speaking).

The way evidence is created is the very essence of the science of improvement.

You need the patients or the public, academia, other sectors and the health system...and then you create the evidence, using one of three models.

The first is the push model, where the Government or management tries to push for change; there is the pull model, where the patients or the public demand change; and then there is the co-creation model that uses the concept of a researcher-in-residence.

The researcher-in-residence allows for pragmatic rapid response evaluations, for large-scale evaluated improvement projects and also in-depth explanatory studies. This pretty much covers the range of possible ways to create evidence that can then be used to initiate and inform change.

In summary, to develop an evidence-based approach to improvement:

• formulate the question
• get the right people around the table
• identify robust evidence
• design a systematic approach
• understand the effectiveness of the intervention, and
• evaluate the response.

And, voila, you have it - evidence-based quality improvement of healthcare.

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