**When is improvement bad?**

The message I got from the two ‘pre-reading’ papers are two issues:

1. The QI process as adopted by the NHS (first paper),
2. Risk vs harm (second paper).

I do agree with the content of both papers.

These are issues in the NHS that I have been studying for a number of years. I’ll take each in turn but my suggested solution is the same for both.

First - QI. I should add that where the NHS, and healthcare generally, use QI (Quality Improvement) as their improvement mechanism, organisations generally, and certainly Quality Professionals, use CI (Continuous Improvement). They are very different in that QI is ‘ad hoc’ and CI is, as the name suggests, continuous. I will explain later.

QI was imported from America and is described, in detail, in ‘The Improvement Guide’ published by Jossey-Bass. From this the NHS have adopted the ‘Model for Improvement’. Unfortunately this is only the second half of the improvement cycle defined in the book. The first half is defining and documenting the ‘process’ that is to be improved. This is not implemented in the majority of NHS QI projects. This makes a bit of a farce of the whole QI activity in the NHS and results in the situations discussed in the first paper.

Second – risk vs harm. In the NHS this comes under the heading of ‘Patient Safety. I have many serious issues with the way that Patient Safety is addressed in the NHS. The NHS have realised that the aviation industry have got an excellent record regarding Safety and have engaged with the industry to learn from their success. But there is a subtle difference between how the two operate. The aviation industry organisations have (mandatory) ‘Safety Management Systems’ (SMS). The NHS doesn’t. They do have teaching syllabus and PSIRF, both very good in their own right but are a long way from suggesting the adoption of a patient safety management system.

The aviation SMS is based on the detailed documentation of all the organisation’s processes. The NHS do have SOPs (standard operating procedures) but these are often cumbersome to read and are not necessarily single process (end-to-end) based.

**An alternative approach to both.**

My solution is called taking a ‘Process Approach’. This is the approach taken by many organisations in the UK and the rest of the World and the aviation industry, and is recommended by both WHO and GIRFT. I don’t have time to go into this approach in any detail here but basically by, for example, department, work area, team, etc., all key processes are listed and activities in the process documented. This documentation, preferably in ‘process map\*’ format, can be used for risk assessment, both desk-top and on-the-job, and audit. A great ‘added-value’ feature.

Importantly a non-conformance reporting system is also established, as part of the process approach, to include all processes and all staff. This is key as its output is used to inform CI projects, risk assessment, audit and staff training. This makes the difference between ‘ad hoc’ and ‘continuous’ improvement. Process improvement activity is informed from the continuous monitoring of process and operator performance.

The Process approach is well documented and tried and tested by many organisations. It is the corner-stone of Quality Management Systems and is supported by ISO 9001, the International Standard for Quality Management.

Documenting processes is not a ‘one-off’ activity. Process documentation should be produced for all key processes, preferably at the Service design stage, and held as registered documents. They can then be reviewed and updated as a result of recorded non-conformance or other changes like technology or other innovations. Error, one type of non-conformance, is rife in the NHS. If you are familiar with the ‘health and safety triangle’ you will be aware of the value of detecting and addressing minor error in orders to remove the risk of major error. This activity must be part of the process management system to be effective and efficient - ad-hoc just does not work. All complaints, internal or external and negative audit results again internal or external, are allocated to a process and time/date and include as a non-conformance. Whistle blowing and all the stress this causes for staff is eliminated and a ‘no blame’ culture evolves, as in the aviation industry. A lot of relevant improvement information can be obtained by the analysis of this data.

There is a lot more to adopting a process approach than I’ve had time to discuss here but one further point that is worth mentioning is that there is a lot of activity towards standardizing the processes. The degree of standardisation for NHS processes required careful consideration.

The success of this approach requires a good understanding of processes and the process approach. My view is that professional designers and quality engineers would need to be employed by the Trusts. Activities like appreciative enquiry etc. will benefit from the availability of current ‘state of the practice’ process documentation and process and operators performance data.

(\*) Process mapping is not the same as process modelling. Most Guides on the subject illustrate examples of process modelling; this includes ‘The Improvement Guide’ discussed above and NHS England’s guides. I think that this error puts people off adopting the activity. They are very different, process mapping is for the process operators (front-line-staff), process modelling is for analysts and software programmers. Good process maps could help the process modellers no end and I would encourage this cooperation. I’m sure we would get better digital applications, including AI, if this were the case.

The two papers:

* [**Overcoming the ‘self-limiting’ nature of QI: can we improve the quality of patient care while caring for staff?**](https://qualitysafety.bmj.com/content/31/12/857)
* [**The harms of promoting ‘Zero Harm’**](https://qualitysafety.bmj.com/content/29/1/4.full)