

Perspectives on Quality

Coping with more people with more illness. Part 2: new generation of standards for enabling healthcare system transformation and sustainability

JEFFREY BRAITHWAITE^{1,2}, CHARLES VINCENT³, WENDY NICKLIN^{2,4,5},
and RENÉ AMALBERTI⁶

¹Australian Institute of Health Innovation, Macquarie University, Level 6, 75 Talavera Road, North Ryde, NSW 2109, Australia, ²International Society for Quality in Health Care, 4th Floor, Huguenot House, 35-38 St Stephens Green, Dublin 2 D02 NY63, Ireland, ³Department of Experimental Psychology, University of Oxford, Anna Watts Building, Radcliffe Observatory Quarter, Woodstock Rd, Oxford, OX2 6HG, UK, ⁴Queen's University, 99 University Ave, Kingston, ON K7L 3N6, Canada, ⁵University of Ottawa, 75 Laurier Ave E, Ottawa, ON K1N 6N5, Canada, and ⁶Haute Autorité de Santé, 5 Avenue du Stade de France, 93210 Saint-Denis, France

Address reprint requests to: Jeffrey Braithwaite, Centre for Healthcare Resilience and Implementation Science, Australian Institute of Health Innovation, Macquarie University, Level 6, 75 Talavera Road, North Ryde, NSW 2109, Australia. Tel: +61-414-812-579; Fax: +61-298-502-499; E-mail: jeffrey.braithwaite@mq.edu.au

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Abstract

In Part 2 of this two-part contribution made on behalf of the Innovation and Systems Change Working Group of the International Society for Quality in Health Care (ISQua), we continue the argument for refashioning health systems in response to ageing and other pressures. Massive ageing in many countries and accompanying technological, fiscal and systems changes are causing the tectonic plates of healthcare to shift in ways not yet fully appreciated. In response, while things remain uncertain, we nevertheless have to find ways to proceed. We propose a strategy for stakeholders to pursue, of key importance and relevance to the ISQua: to harness flexible standards and external assessment in support of needed change. Depending on how they are used, healthcare standards and accreditation can promote, or hinder, the changes needed to create better healthcare for all in the future. Standards should support people's care needs across the life cycle, including prevention and health promotion. New standards that emphasise better coordination of care, those that address the entire healthcare journey and standards that reflect and predict technological changes and support new models of care can play a part. To take advantage of these opportunities, governance bodies, external assessment agencies and other authorities will need to be less prescriptive and better at developing more flexible standards that apply to the entire health journey, incorporating new definitions of excellence and acceptability. The ISQua welcomes playing a leadership role.

Key words: massive ageing, ageing population, health system reform, standards, elderly, external assessment

Introduction

Our previous, companion article argued that ageing populations and the rise in chronic conditions require a transformation in health and social care systems and a new conceptualisation of safety and quality. In this second article, we consider the implications of these changes for standards and accreditation. While we appreciate that standards are only one component of a much wider transformation, the International Society for Quality in Health Care (ISQua) believes, and the evidence indicates [1–4], that standards can play an important enabling role.

This article addresses a number of issues that together suggest that standards for quality and safety must be profoundly revised to reflect and support a new future. We first consider what role standards play in determining the safety and quality of care. We discuss whether, and the extent to which, standards can play an active role in anticipating and bringing about a transformed system. We then consider the new standards that are needed and suggest that we may require a more sophisticated and flexible approach to monitoring standards. Then, we discuss the themes and concepts that integrate throughout these standards and the challenges ahead for leaders and organisations.

What role do standards play in improving the quality of care?

Standards define a desirable or acceptable level of quality of care [5]. There are many quality and safety standards, ranging from ‘micro’ standards and principles focusing on a specific technique (such as a surgical check list or hand hygiene guidelines) to the ‘meso’ that deal with resources, leadership and collaboration and to the ‘macro’ that focus on systems-wide policies and structures [6–8].

Licensing and regulation standards generally focus on basic safety elements that must be in place to provide care and service; such standards offer prescriptive guidance on specific requirements, processes and procedures. Often acting in a complementary way, many quality and safety standards in health and social care are standards of excellence. Within accreditation programs, such standards encourage teams to move beyond compliance with basic safety levels and aspire to continually improve and adapt the care they provide. At present, most quality and safety standards are defined by and written with a particular focus on an organisational type, or sector or disease.

The very concept of standards has been criticised from a variety of perspectives. We must be aware of information overload and the burden standards, and external evaluation, can place on services. Standards to be achieved are ‘work-as-imagined’ rather than ‘work-as-done’ [9] and no standard, even of the simplest task, can ever reflect the adaptations and variability inherent in the real world of work (similarly no map, however sophisticated, can ever fully reflect a landscape). The distinction between work-as-imagined and work-as-done offers a corrective to the naïve but frequently implied idea that workers simply have to follow standards to achieve safe, effective performance. The context and flexibility are key. The reality is that the efficiency and effectiveness of organisations would deteriorate if staff followed standards precisely as written [10].

The sheer abundance of standards is a challenge for individuals and organisations. An elective hip operation for instance ideally requires staff to follow up to 75 different standards in the first 24 h of care [11]. Standards are often written as quasi-legal documents whose purpose is to defend the organisation rather than to guide staff in their work. Healthcare needs to do much more to make standards useable and to enable standards to be adjusted and refined in

a continual interaction with the work as actually done by those providing the care and service [12].

However, the fact that there are deficiencies in the content and application of standards does not mean that we do not need them. All large systems that achieve reliable performance use a mix of formal and informal rules and standards and monitor performance according to those standards. Such standards guide work and also demonstrate accountability to stakeholders and users of the system. Standards can enable improvement and change. Intelligently produced standards accept that the standard cannot capture or fully define the work-as-done—nor should they [12]. Standards define the core objectives and recommended practices (based on evidence), accepting that there will be many routes to achieving these aims.

Can standards and accreditation support systems transformation?

Standards can either hold transformation back or encourage it to move forward. Today, standards set by accrediting and regulatory bodies often fall behind due to the pace of innovation and change. They are too often a lagging indicator, not a harbinger of change. An appropriate question is do the standards reflect past acceptable practice and previous evidence, or do they anticipate the new systems that are needed? Since the new millennium, levels of health knowledge have accelerated; the half life of medical specialty knowledge is now <5.5 years [13, 14]. The excellent standards of today can quickly become relics of the past, or even the adverse events of tomorrow [10].

If only basic safety standards are required, then the expectation is only to be ‘good enough.’ Such an approach may constrain and limit the ingenuity and creativity of staff. One cannot climb the ladder of improvement if the ladder has only one bottom step of basic safety. Many standards however encourage individuals and organisations to aspire to excellence, to set a course for improvement. An aspirational approach to standards is essential if one wishes to facilitate quality improvement, innovation and organisational change. Standards must be a stretch, yet achievable and realistic. Perhaps a new generation of standards, if sufficiently flexible and far sighted, could go further and contribute to the evolution and shape of the future health and social care system [2, 15, 16].

On the other hand, setting unrealistic standards could undermine monitoring and accreditation; chief executives of health systems and staff would rightly simply reject the burden imposed. However, accreditation organisations could potentially compile and publish more future-oriented standards, reflecting themes of the transformed system, in the spirit of consultation and engagement and with a view to shaping the evolution of healthcare. The aim would not be to mandate a particular organisational form or stipulate one best way of meeting excellence, which would be arrogant and mechanistic; the health system is a complex adaptive system, not a rigid machine [17]. Rather the aim would be to anticipate the future needs of patients and families and orient future health and social care systems to the coming reality. The remaining sections of this article offer some suggestions about the form a new generation of standards and approaches to health and social care system transformation and thus accreditation might take.

What changes to standards will be needed?

All standards require responsive and significant adjustment to enable and sustain transformation of the health and social system, although the changes may be more necessary at the meso and macro levels.

Lets look at examples of areas in which the next generation of standards needs to be adapted or new standards developed.

Reflect the person's health journey overall

With more ageing patients than ever before, episodes of care and treatment are shortening, while paradoxically the health journey of the person is life long. We will need to monitor, assess and evaluate health and social care across the entire continuum of care, following the person's life journey (from cradle to grave or pregnancy through to palliation). A key priority is to emphasise prevention and population health—reducing smoking rates, obesity and environmental pollutants [18] and promoting healthy behaviours [19]. This is intersectoral, collaborative work. This in turn necessitates co-operation and communication with providers, care recipients and their families. Standards will therefore need to place a much stronger emphasis on maintaining ongoing relationships between health professionals and the care recipient (and family), mindful of the fact that many adverse events arise from an accumulation of issues over a long time period. Life-long health journeys will necessitate active life-long partnerships, building the 'plan of care' or 'plan of health' with the person and his or her family.

Emphasise a new intensity of coordination of care

Hospital length of stay is declining rapidly [20, 21]. Patients are discharged from their provider sooner and sooner [22]. This is a natural adaptation to the growing number of persons requiring care and balancing the demands for quality care and cost-effectiveness. Compounding this there is a concomitant increasing acuity in the home and community of those discharged quickly (or never admitted), increasingly requiring more intense home care and community support—impacting on home, community, primary care services and relatives or other carers.

These changes are significant for many quality and safety standards. Coordination at discharge (which must begin before admission) becomes a priority for the systems-level management of the person's journey. Standards are already in place for day surgery; however, they may need a stronger emphasis on the provision and coordination of aftercare. Dedicated staff need to be identified to perform a system navigation role and to inform and support users of the system to coordinate with staff across primary care and community settings. New and revised standards might prompt organisations to provide these services. Quality and safety indicators will need to consider data gathered days or weeks after discharge to complement the collection of long term outcome indicators [23, 24].

Reframed home and community-based care

There is an urgent need to develop well-coordinated systems of home and community-based care, reflecting their position within the entire health and social care system, responsive to individual needs and to local circumstances, such that the burden of care coordination is shared between the health providers, care recipients and families. People with chronic conditions will be managing more of their own care and receiving more support from family and community providers of care. Such services require a stronger emphasis on the psychological and social components of well-being with a concomitant focus on wider community support and engagement.

Standards of quality and safety for application at home and in the community need to reflect psychological health and cognitive impairment, the role of the family caregivers, how the patient will

be engaged in the domains of care they require and incorporate a greater emphasis on autonomy and participation of the care recipient. This includes the acknowledgement of the enabling of social skills (e.g. driving and ambulation) and community services [25].

Standards also need to reflect and enable new forms of care. For example, Jönköping county in Sweden has introduced scheduled, recurrent visits to isolated patients by mail delivery staff or taxi drivers who maintain social links and report, or alert local providers, on medical problems. A community-empowered board or committee might monitor the quality and supply of services for frail elders, the most expensive phase of most lives.

With the increasing need for those requiring care and caregivers to understand, deliver and monitor their own healthcare, the language of standards, respecting the health literacy of the users, will need to be understandable and more widely accessible. The patient and the caregiver will be accessing and applying these standards for the future and should be co-designers and co-owners of the standards.

Reflect the role of information technologies

The national healthcare agenda is similar everywhere—to improve efficiencies, reduce costs and deliver high-quality performance-based care with seamless transitions, while simultaneously meeting stricter legal and regulatory requirements. There is an increasing reliance on new technologies to meet these goals. We are witnessing the rapid introduction and implementation of a variety of technological systems.

The most rapidly ageing countries such as Japan, Canada and Switzerland are investing heavily in technological solutions to the delivery of healthcare as well as addressing the social connections of older people with the wider community [26]. The goals are to contribute and enable the autonomy of the individual and develop a quality approach to the evaluation and use of such IT innovations.

While these innovations have considerable potential, they come with multiple risks and potential drawbacks. Revised and new quality and safety standards must reflect the vital role of information technology, appropriately infused with e-health and changes in practice stimulated by the genomics revolution [27, 28]. This will help provide high-quality, routinely collected data to support population health and patient-reported outcomes.

Defining excellence in a time of rapid change: less prescriptive and more flexible standards

While some may argue that the system works best on an all-or-none principle—meet the standard, or not—to be meaningful, standards should support the identification of strengths and areas for improvement, be constructive and guide change.

A fundamental problem arises when new standards raise the bar unreasonably high such that they cannot be met, or can only be reasonably met in a few health centres or programs, with other providers struggling to meet them. Non-compliance or a difficulty in achieving standards is discouraging and represents a risk. In reality, we have little idea of the gradation of adverse effects depending on the distance of the practice from standard.

In a time of rapid transformation, we will need to alter our approach to standards, defining both excellence and acceptability. First, we will need to focus more on providing a good overall standard of healthcare over much longer time periods rather than effectively sampling a person's health journey when we examine specific

episodes in single organisations. Second, we will need to have a much more flexible approach than simply assessing standards as being ‘met’ or ‘not met’; more subtlety is needed, often in the form of a grading scale. As within most accreditation programs, both current and future standards need to be reconsidered in light of a quality improvement philosophy, with gradation of acceptable risk and acceptable level of achievement of the standard. If we set aspirational standards, particularly for future healthcare systems that are always evolving, then systems of monitoring must explicitly allow for a gradual meeting of new standards over time.

Challenges ahead for accreditation organisations and healthcare leadership

Accreditation has long been designed with a focus of standards applied to a specific care delivery setting or disease. In this new vision of the health and social system, our aim should be to set standards for a safe and effective health journey (inclusive of prevention) overall, rather than a focus on discrete components that fail to connect properly. This is especially true in the person’s own home where, inevitably, the autonomy and capacities of the individual and family will be the deciding factor in the care delivered.

This new generation of standards will ideally enable and ease the transition across the health and social systems, yet pose considerable challenges for accreditation and regulatory organisations. These organisations must cope with, and anticipate, rapid changes and innovations in multiple areas of health and medicine. Genomics, precision medicine, artificial intelligence—the landscape of healthcare is shifting and transforming on many fronts. Health services will no longer be considered in isolation but will be more closely integrated with wider social endeavours. A population’s health is a product of intersectoral effort including social care and the efforts of other sectors, such as those that aim to alleviate poverty and those that attempt to provide good housing. This will require an approach to accreditation with a stronger emphasis on collaboration and coordination of people, agencies, stakeholders and initiatives.

Today, most standards are developed in isolation or in parallel by agencies such as government, accreditation bodies and specialised professional groups. To maximise impact, optimise resources for standards development and improve alignment, communication and coordination, there must be collaboration amongst all those groups. We can no longer afford to work in parallel or isolation. Silos will need to be bridged at the very time that care is increasingly being delivered in more complex, and often more fragmented, ways [17].

A profound revision of the education of governments, boards, leaders and managers will be needed as they each contribute to effectively transforming the health and social care system. Leaders will need new skills, expertise and more flexible ways of thinking and acting. The ability to provide a vision and lead others towards the vision is fundamental. The rapid rate of change requires those in charge to possess capabilities, including the ability to deal with complexity, ambiguity and uncertainty while demonstrating adaptability, all with a driving commitment to metrics and improvement [17]. This requires professional development plans for all governance members. Command and control models are behind us, or they should be; distributed, flexible leadership is the model of the future [29, 30].

Looking further to the wider preparation of the healthcare workforce, it is clear that universities and professional colleges will also need to address the problems of the ageing population and the management of chronic conditions within professional training. Courses

will need to emphasise the overriding aim of preserving autonomy and quality of life across the health journey rather than simply treating disease. Health and social reform has led to an increased emphasis on interprofessional healthcare models for older adults [8, 31–33]. Multidisciplinary models and interprofessional healthcare will underpin much of the progress we desire and need.

Implications for ISQua, standard setting and accreditation organisations

This article has outlined a number of key features in the transformed system that must be comprehensively reflected in the next generation of standards. Some leading standards-setting groups are already adopting these, but many are not. As we see it, the task is to develop standards according to principles which ensure that they:

- Are person centred (inclusive of the person, their family and those providing care and service);
- Are focused on health and quality of life with a ‘plan of health’ that is developed in partnership with the individual (co-production);
- Reflect the person’s entire health journey and require collaboration and co-operation both within and between organisations providing care;
- Recognise the person’s home as the locus of health and care;
- Are understandable, useable and relevant to the person, the care-givers and the providers—considering readability, literacy, utility, meaningfulness and practicality;
- Reflect information technology as fundamental to enabling innovation and quality improvement;
- Appreciate the impact on education of professionals, practitioners and leaders;
- Define quality and risk across time, rather than as an event;
- Incorporate new indicators to measure effective performance and outcomes and to evaluate quality across the continuum;
- Have a gradation from acceptable to excellent;
- Support and reflect the culture necessary to foster innovation, tolerance of risk and failure and flexibility.

Conclusion

Massive ageing and the reality of living longer are a threat to health systems only if we let it be so. It can be a platform from which to lever transformative change. Massive ageing challenges our long-held vision of how health and social care should be delivered and forces us to face the future. A new vision and direction for standards and measurement of quality are a potentially powerful force in realising this transformation. These changes will go far beyond mere better care for the elderly, although that has been the stimulus for our work in these companion articles; instead, the changes we propose must apply to all citizens regardless of age, income or socio-economic status.

Standards, one of the ISQua’s core interests, can be a fundamental means through which we will propel the needed transformation. We will need more research on the benefits, contributions and limitations of external assessment and standards. We will also need to emphasise the role of empowered providers and care recipients and their supporters. Involving providers and those requiring health and social care in the development of standards and accreditation is an essential approach. We must ensure that standards, accreditation and external evaluation organisations are positioned to play their

part, alongside ISQua in its leadership role, in the coming transformation of health and social care.

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