

Improving Healthcare White Paper Series - No. 4

Quality, Development and Leadership - Lessons to learn from Jönköping

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“... inspiring and challenging.”

“This document is both inspiring and challenging. It’s inspiring in the way it outlines the impressive and sustained approach that Jönköping County Council has taken in the delivery of its healthcare services. It’s challenging because it demonstrates the time, energy and consistency which are required if we are to deliver an NHS which is truly led by improvement and meeting people’s needs.

“The Jönköping work has been shaped by an agenda focussed on quality and safety which places the citizen at the heart of its services. The result has been genuine engagement from senior management to the frontline and real involvement of those who access and benefit from its services.

“The intention of this document is not to recreate Jönköping in Wales - but it is to ensure we learn from their experiences and apply the lessons. Please give the recommendations in this paper your full consideration - they have the potential to help reshape how we deliver our services and to meet the challenges described in ‘Together for Health’.”

David Sissling

***Director General for the Department of Health, Social Services and Children,
Welsh Government and Chief Executive, NHS Wales***

“The Jönköping model underlines the strategic role public health plays in improving the health and wellbeing of a population. The commitment to embedding quality improvement methodology and ensuring the needs of local populations are the key priorities for each organisation. This is making a considerable difference.

“There is much we can - and must - learn from the lessons outlined in this document in order to improve the services we deliver. Jönköping has provided a vision, a signpost and a way to achieve what is possible.”

Professor Sir Mansel Aylward CB

Co-chair, 1000 Lives Plus and Chair, Public Health Wales

“I commend this paper as being both visionary and practical. It clearly demonstrates what can be achieved in a health service community which puts people and the improvement of outcomes at the centre of all that it does. Its’ recommendations set a path for us to follow in Wales so that improvement becomes part of everyone’s daily job.”

Dr Chris Jones

Co-chair, 1000 Lives Plus and Medical Director, NHS Wales

“Jönköping’s commitment to partnership working across sectors, providing an almost seamless pathway for patients is clearly one of the many reasons for its success and one we should be seeking to emulate.

“Another is the active involvement of patients and citizens in quality improvement programmes at every level. The real commitment to listening, understanding and acting on their ideas for improvement and service redesign must be the approach all public services in Wales should be working towards.”

Dr Jo Farrar

Chief Executive, Bridgend County Council

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Improving care, delivering quality

1000 Lives Plus is the national improvement programme, supporting organisations and individuals, to deliver the highest quality and safest healthcare for the people of Wales.

www.1000livesplus.wales.nhs.uk

1. Executive Summary

As NHS Wales continues its pursuit of sustainable, high quality care, there are significant lessons it can learn from other countries - even though there may exist structural, political and financial differences. The healthcare system of Jönköping County Council in Sweden has an international reputation for excellence and provides a unique opportunity for learning and implementation of ideas that have been shown to improve healthcare.

A league table of Sweden's 22 County Councils includes a variety of health and social care indicators and shows Jönköping provides quality healthcare at a relatively low cost. It meets the objectives of the Institute for Healthcare Improvement's (IHI) 'Triple Aim' of better healthcare for the individual, better health for the population and lower cost per capita.

The association of Jönköping with IHI in Boston has spanned 20 years. During this time there has been a constancy of purpose in searching for innovative ideas in healthcare, a supportive local training infrastructure and a "relentless drumbeat" from the top management that asserts "this is the way things are done in Jönköping".

This paper aims to provide an introduction to the approach that Jönköping County Council has taken in its delivery of healthcare. It also begins to explore what can be learnt and applied to improve Welsh healthcare. In particular, it proposes how the 1000 Lives Plus programme can support NHS Wales.

2. Introduction

The 'Programme for Government'¹ sets out how its manifesto commitments will be delivered and the benefits that will result for the people of Wales. It clarifies a vision of improved health outcomes through the enhanced quality and safety of services, improved access and patient experience and preventing poor health and reducing health inequalities.

'Together for Health'² focuses upon real, substantial changes that must be delivered within five years within the context of a number of challenges - increasing demand, increasing patient expectations, financial constraints and recruitment difficulties.

It sets out where the change must happen - why and how - in seven major areas:

1. Improving health as well as treating sickness.
2. One system for health.
3. Hospitals for the 21st century as part of a well designed, fully integrated network of care.
4. Aiming for excellence everywhere.
5. Absolute transparency on performance.
6. A new partnership with the public.
7. Making every penny count.

To enable a transformation in services, NHS Wales must demonstrate clarity of purpose, honest engagement with partners, consistent clear communication, and relentless

¹ Welsh Government, October 2011, *Programme for Government*
<http://wales.gov.uk/docs/strategies/110929fullen.pdf>

² Welsh Government, November 2011, *Together for Health*

ambition. “Everyone should have easier access to a wide range of safe, effective, well-run, fully integrated services, sustainable over the longer term, services Wales can be proud of.”³

This need for change is also rooted in opportunities. NHS Wales should draw upon its foundations but also look to other countries to learn from their experiences to enable world class quality on a solid and sustainable long-term basis.

The similarities between Jönköping and regions of Wales - an integrated healthcare system, strong focus on public health and a broadly socialist tradition - should mean that significant learning can be transferred to support Wales with a driven, focused effort to deliver these actions.

Sweden’s healthcare system is a publicly funded comprehensive system. It has gained an international reputation for strong performance, equity and innovation. Recognising the limits of hospital care, Sweden was amongst the first countries to make a national commitment to primary care and preventative services⁴. Although there is wide variation across the system, superior access and medical outcomes are achieved with moderate resource and cost levels⁵. The Swedish system is highly decentralised and aims to achieve its objectives through public ownership as well as local and regional democracy, operation and accountability.

Since 1982 regionally elected political bodies called County Councils, which typically include several municipalities, have been funding, planning and delivering healthcare services. They base their work on broad principles that guide planning and delivery as well as on goals for quality established by the central government. Healthcare is the dominant focus for County Councils; comprising over 70 per cent of their resources (other responsibilities include cultural activities, public transportation and regional development).

County Councils finance their healthcare expenditure by levying proportional income taxes (in addition to taxation revenue, healthcare financing is supplemented by state grants and user charges). They plan and allocate resources to healthcare, dental care, education and research for their jurisdictions, own and operate all their healthcare facilities and contract with healthcare providers. The Councils employ salaried, community-based primary care physicians although, over the last two years, it has been possible for privately owned practices to win contracts. Hospitals, which are owned and operated by the County Council, employ salaried, hospital-based physicians.

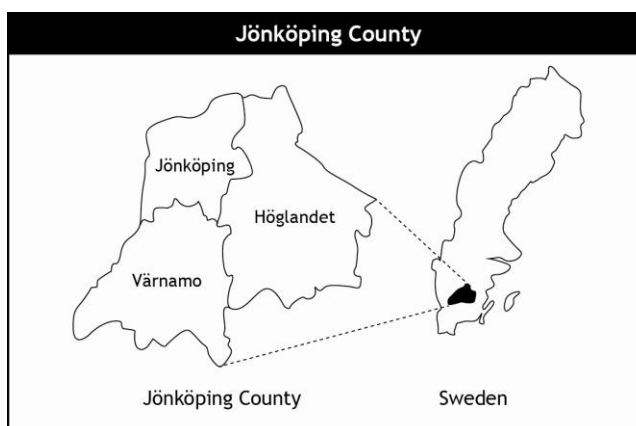
The County Councils have relative political autonomy from central government for decision-making. The budgets are decided by the County Council, but are embedded in a system where the central government takes a ‘Robin Hood’ approach and where wealthier counties contribute significant proportions of their budget to poorer councils depending on a set of indicators.

³ Welsh Government, November 2011, *Together for Health*

⁴ Glenngård, A. H., F. Hjalte, M. Svensson, A. Anell and V. Bankauskaite. 2005, *Health Systems in Transition: Sweden*, World Health Organization, Copenhagen

⁵ Organisation for Economic Co-operation and Development. 2005. *OECD Health Data 2005: How Does Sweden Compare?* Paris.

Jönköping County Council is located 330 kilometres south-west of Stockholm in the southern province of Småland. It has three hospitals and 51 care centres (including primary care clinics, specialised medical services, rehabilitation facilities and pharmacies), with a combined workforce of over 9,900 across 13 municipalities⁶. There are 81 elected members of the Council, including a chair, with elections being held every four years.



Jönköping County Council holds public meetings four times per year, where decisions on tax rates and services are debated with the public and opposition members. The past 20 years have seen political stability in the region. Jönköping County Council is proud of its strong connection to its communities and its vision: “for a good life in an attractive County”, was developed after 400 hours of dialogue with leaders and stakeholders across the region.

The themes that run through the work in Jönköping include:

- The vertical integration of a quality improvement approach to healthcare. The board receive performance reports that are generated from systems implemented by staff trained in change management and who have an ethos of strong quality improvement as an expectation of their employment.
- A corporate approach to systems improvement that enables cross-departmental process development with notable clinician-management co-operation.
- An aggressive and all-inclusive approach to training and education which ensures that every member of the workforce has the skills and understanding to know that improvement is a key part of each person’s role.
- Cohesion and consistency between the delivery of healthcare and public health and social policy.
- A strong and agreed set of values which are manifest at all levels of work, clear leadership which has held to those values and stability which has allowed practice and requisite skills to be embedded.
- A strong link between systems development and the financial reporting required to service any change in systems reporting that might result from the improvement work. This is particularly noticeable with the introduction of the clinical micro systems working.

3. The Year-on-Year Drive for Quality

The drive for quality in Jönköping is based on a centre called Qulturum. It was established as a unit 14 years ago and as a ‘house’ two and a half years after that. It has an annual budget of £1.4m (0.002 % of the healthcare budget, 2011) and employs 20 staff. The building is attractive both externally and internally, and careful attention to detail has been placed on the internal layout to facilitate learning and improvement work. It

⁶ Bojestig, M., G. Henriks and T. Nolan, 2006, *Lessons learned from Pursuing Perfection: Or, How to Solve Tomorrow’s Problem Today*. Presentation at the 11th European Forum on Quality Improvement in Healthcare, Prague, Czech Republic.

operates a comprehensive programme of leadership and quality improvement activities and no charge is made for the internal use of the facility.

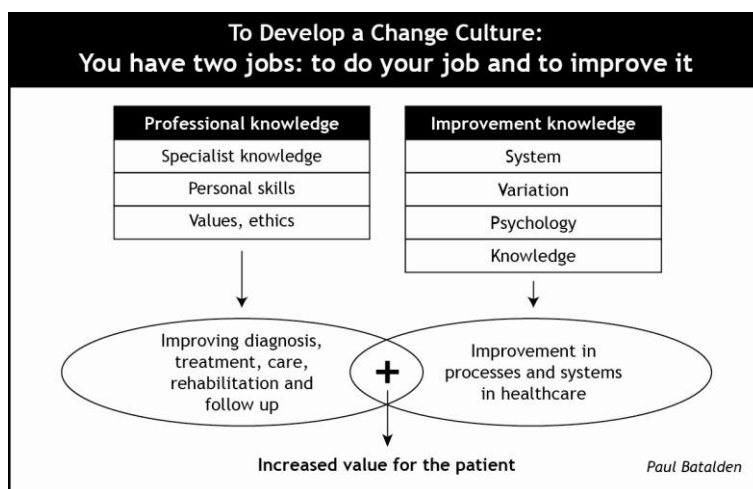
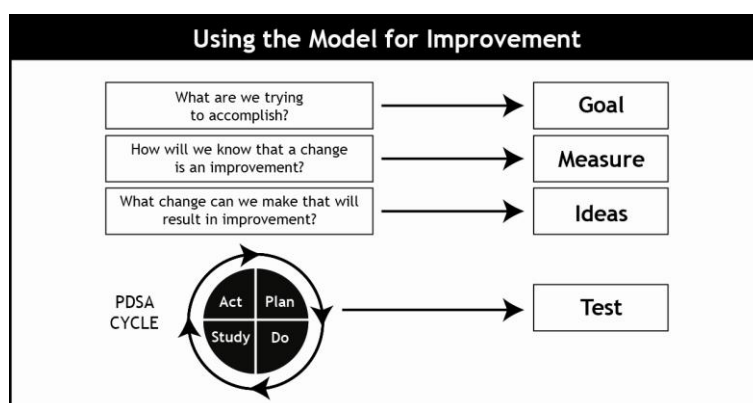
The strategic development of Qulturum is described on its website⁷. In 1992 Jönköping adopted a quality based business strategy based on the Malcolm Baldrige Award under the name QUL (Quality - Development - Leadership), which Qulturum is instrumental in supporting.

An important vehicle for engaging clinical staff is the ‘Development Dialogue’, which came into use in 1994 to describe the flow of activities around a patient and to identify any difficulties or delays. All departments of the hospital and surrounding primary care centres are asked to describe their main groups of patients according to need, and for every group of patients with similar needs work is led by a senior clinician. Throughout the organisation quality improvement is seen as an investment, not a cost.

A significant success of the leadership programme has been the teaching of a common language and systems for all healthcare workers and the leadership programme brings clinicians and managers together at regular intervals throughout their development. To date, nearly 10,000 individuals have attended training events at the Qulturum.

Jönköping was the first county in Sweden to adopt the Balanced Scorecard which was introduced in 1997-97. It is used for budget and annual reports at all levels. The ‘Clinical Value Compass’ and the IHI ‘Triple Aim’ have been important in framing the approach to quality, and from 2002 there has been a strong focus on Edward Deming’s ideas of systems thinking, variation, learning based knowledge and change psychology. There is extensive use of PDSA cycles as an improvement tool, and Quality Dashboards are used at unit and ward level.

All staff are encouraged to recognise that they have two jobs: to do their job and improve it. This philosophy is based on the idea that the combination of the professional knowledge (specialist knowledge, values, skills, ethics) and improvement knowledge (system, variation, psychology, methodology) will result in increased value for the patient. The focus revolves around delivery of a service that patients want and need, rather than what professionals feel they should have.



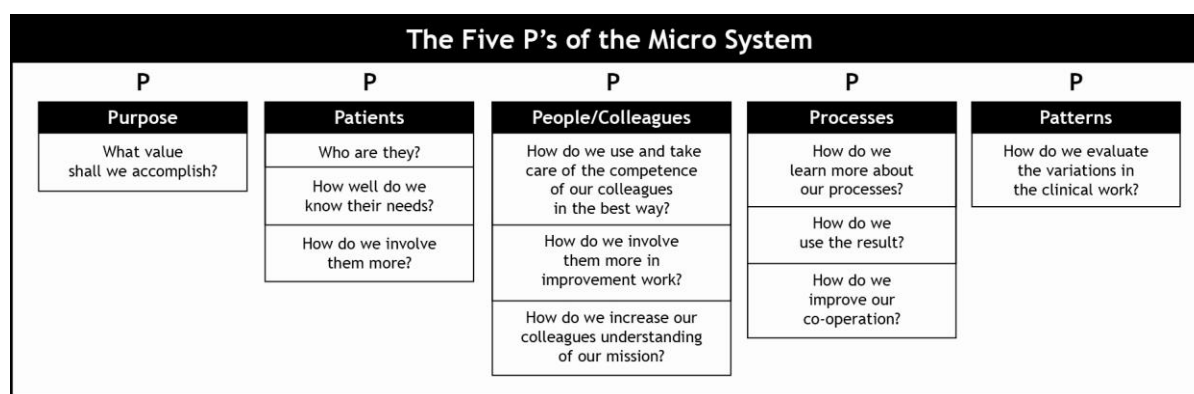
⁷ www.lj.se/info_files/infosida31736/historik_version_feb2007.pdf

There is extensive use of coaching as a development tool, and more recently a social movement approach has been used to create change at scale. Although structured coaching started only two and a half years ago, it is now an extensive programme with coaches training other team members to become coaches and to “see with new lenses”.

From 2004 the concepts of micro, meso and macro systems have been adopted from Paul Batalden, Marjorie Godfrey, Gene Nelson and the medical school in Dartmouth in the USA⁸. The micro system is where patients and healthcare providers meet to create value for the patient. The meso system acts to co-ordinate and facilitate related micro systems and the macro system is the overall management and priority-setting framework for healthcare. The Qulturum frames much of its work with reference to micro systems and has now educated 3,000 employees in micro system development.

The Qulturum uses the definition of clinical microsystems provided by Paul Batalden: “A clinical micro system is a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, and a shared information environment, and it produces performance outcomes.”⁹

To ensure a patient focus to the micro systems work, the Qulturum promotes the 5 P’s approach:



A great deal of care has been taken to craft a consistent quality improvement message in Jönköping. The ethos of the Qulturum is to avoid bringing in outside ‘experts’ whenever possible, preferring to use their own people, thus ensuring consistency of sharing and understanding of values by in-house staff.

Qulturum has a philosophy of working with those teams who come to it for support, but also seeks to work with other teams who have not engaged with it. Every two months there are ‘Big Group’ healthcare meetings where the 14 clinical group chairs meet with the leadership group (which meets 18 days each year) to get a picture of care across the whole system and to reinforce the corporate commitment to quality.

A sister institution, Futurum, started in 2004. It co-ordinates undergraduate training in the county and is also responsible for the steering, administration and financing of clinical research. Qulturum and Futurum work in close co-operation, and have developed research with a focus on quality improvement and healthcare development. Quality improvement teaching is now well embedded in the undergraduate curricula for healthcare professions and the Futurum currently also supports 25 PhD students.

^{8,9} Nelson, E.C., Batalden, P.B., Godfrey, M.M. (Eds), 2007, *Quality By Design: A Clinical Micro Systems Approach*

Since 2000 there has been an understanding that politicians in Jönköping County Council will confine their interest to financial performance and a limited range of high level indicators, allowing the management team significant autonomy. However, there is little doubt that this arrangement, and the healthcare system in Jönköping in general, will come under considerable pressure over the coming years.

In addition to universal demographic and health technology issues, there are financial pressures caused by the redistribution of resources between counties in Sweden, and falling tax revenues because of the global financial slowdown. There is also a commitment by central government to introduce a degree of marketisation in healthcare, so the managerial and political stability that has been a significant feature in the quality improvement achievements in Jönköping may now be subject to pressure.

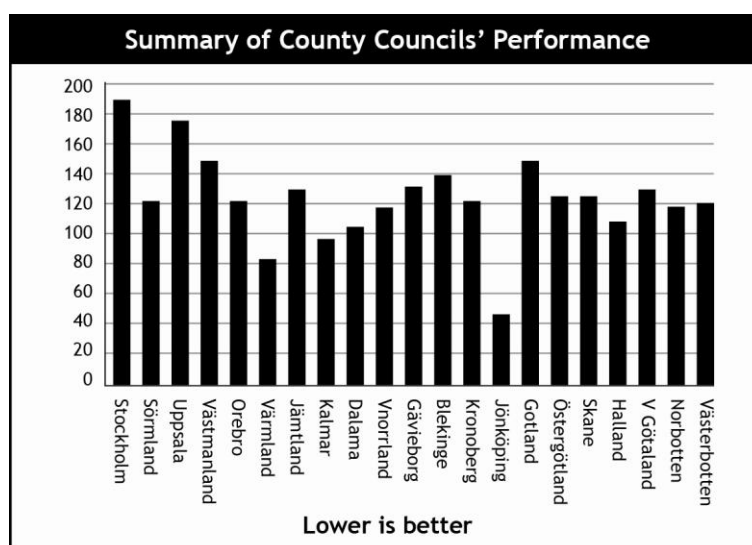
4. The Strategic Approach to Quality

One of the most striking features at Jönköping is the consistent leadership provided by the same individuals over the past two decades. The important triumvirate included Sven Olof Karlsson (retired CEO, 2008), Mats Bojestig (Medical Director) and Göran Henriks (Director of Learning and Innovation).

Whilst the strategic approach to quality has understandably evolved over two decades to keep pace with improvements within the organisation and advances in technical knowledge of improvement methodology worldwide, the same core values and commitment to improvement have remained. It is apparent that the 13 core values for the healthcare system are ‘living values’ which are always kept central to decision making about improvement work, service redesign, and resource allocation. To illustrate this point, Göran Henriks reportedly always carries the 13 values in his shirt pocket.

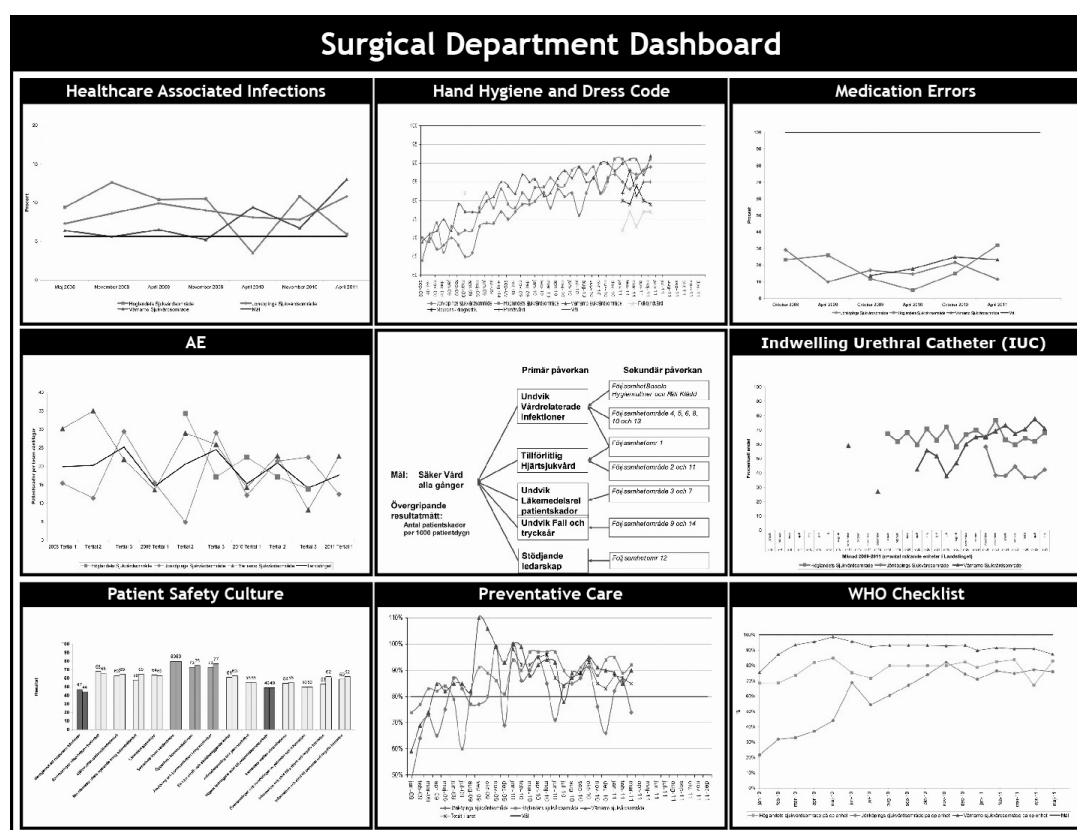
The combination of a stable healthcare management team and the stable political nature of the Council has allowed a level of understanding and trust to develop over many years, which has given the leaders in the healthcare system the time to embed their strategic vision. This level of trust has been enhanced by the excellent performance of Jönköping in a

The 13 Core Values of Jönköping Healthcare System	
• Customer orientation	• Decisions based on facts
• Competence development	• Participation from everyone
• Process orientation	• Social responsibility
• Continuous improvement	• Take preventative action
• Fast reaction	• Learn from others
• Engaged leadership	• Co-operation
• Sustainability	



set of high level indicators in comparison to the other 20 County Councils in Sweden. There has been wide publication and recognition of Jönköping’s standing in this table of indicators at national and international levels and this engendered a level of trust in the healthcare service from the public, and therefore the politicians in the healthcare leadership team.

The management structure will be mostly familiar to those from the UK, although the management boards do not have independent members, with reliance on the County Council to provide independent scrutiny and challenge. Each of the three hospitals has an executive management team, led by a CEO which constitutes a Hospital Board. These three hospital boards report into the CEO Board, which includes professional leads (medical director, nursing director), finance director, and director of learning and innovation. The CEO board reports directly to the County Council via the CEO. Information about services is shared via dashboards, with the data illustrated in a traditional traffic light format. Behind the traffic light on the electronic system is data that allows greater scrutiny. The figure below shows the data for the surgical department:



Importantly, Qulturum and its leaders have also drawn their inspiration from around the world. The European Foundation for Quality Management (EFQM) has clearly influenced their business strategy and there has been an effort to learn from ‘lean thinking’ and from successful businesses in Sweden (Scania) and abroad (Toyota) to translate the learning into healthcare.

Improvement work at Qulturum is prioritised and projects are selected using a variety of methods. The number of potential projects is high and efforts are therefore not wasted on projects that have low impact, or a high chance of failure, and time is also invested in enthusiastic and engaged members of staff. Individual clinicians are engaged by a focus on clinical outcomes, although the engagement is slowly nurtured rather than forced.

Data are primarily for internal use to inform local change, with less emphasis on external monitoring. Improvement methodology has become second nature to all professionals and is embedded in their working practice. Critically, teams are given the freedom to make changes within their own departments and encouraged to bring in ideas for good practice from elsewhere to raise standards.

Over recent years, approximately 80 'National Quality Registers' have been developed, mostly by hospital specialists and they therefore tend to be disease-specific (i.e. heart disease, diabetes, etc). Currently, contribution of data to the registers is voluntary for County Councils and specialists, although a comparative matrix containing information about each indicator in 'traffic light' style is produced periodically. Specialists and County Councils who do not contribute have a 'blank box' and it is felt that over time peer pressure will result in wider participation in data collection and sharing with the central registers.

Staff are actively encouraged to take on new roles and to work differently in the interests of the patient. Examples of this were demonstrated through the medical secretaries taking on roles of quality measurement and visual representation of improvement work and staff enabling patients to carry out their own dialysis, and the development of the role of health coaches for the elderly.

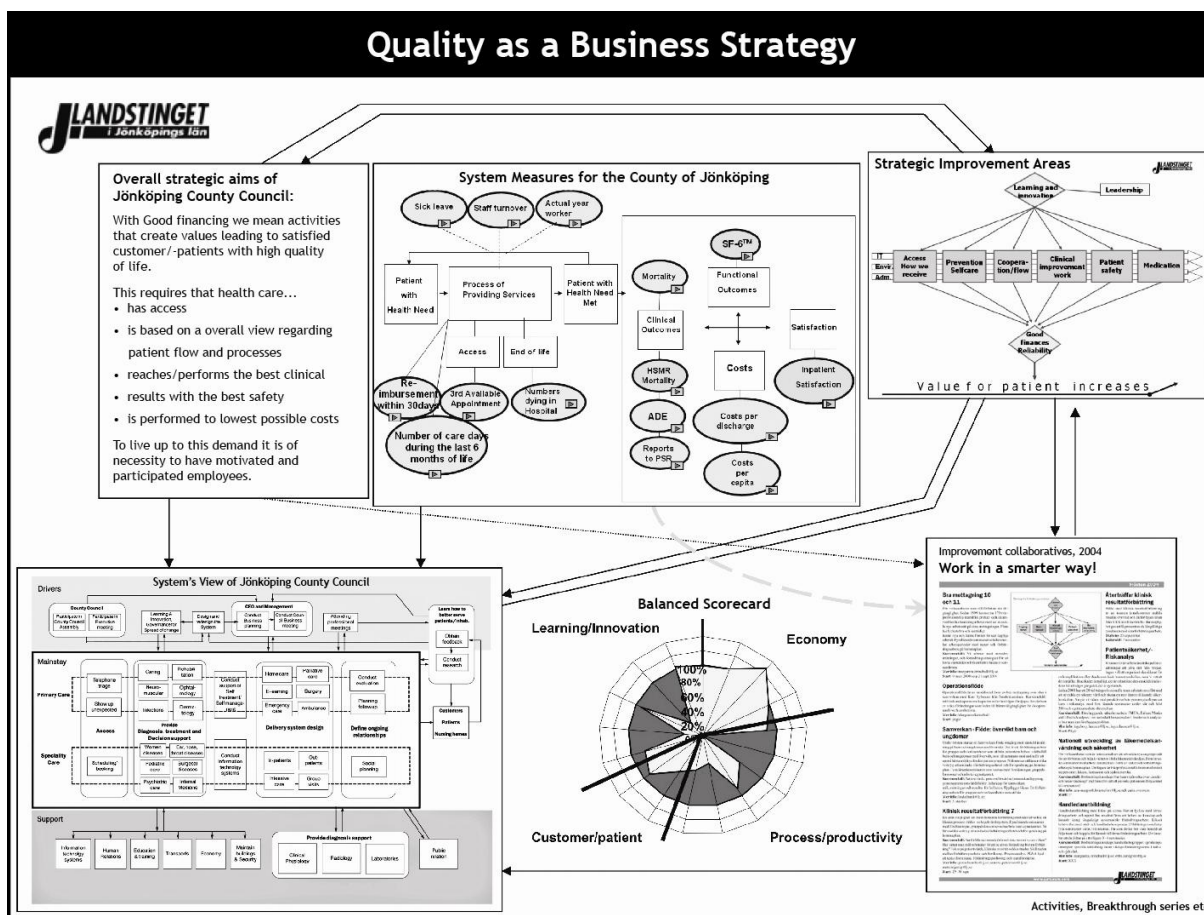
5. The Business Case for Quality

The Qulturum does not have to specifically account for a return on its £1.4m annual cost. The return is assessed at a high level in terms of:

- The overall results of the healthcare organisation (Jönköping has a much better quality/cost index than any of the other 20 organisations in Sweden and its performance is at the top end of the national KPIs).
- The very high number of staff trained in improvement methodology (10,000 staff).
- The very strong influence of the Qulturum in embedding a culture of continuous improvement throughout the healthcare organisation.

An improvement project board in the Qulturum records the number of improvement projects which are taking place in every week of the year.

- The culture of continuous improvement is embedded at the earliest stage when joining the organisation. Students from all professional disciplines come together in their first and fifth terms to study a quality improvement module which is a legal requirement. All staff are expected to have at least six improvement ideas/year. This culture is reinforced by terms and conditions of employment and in the primary care contract where two per cent of remuneration is linked to delivery of improvement projects. The evidence of this culture was very noticeable and included training for accountants which ensures they are much more closely aligned to services in a management accounting rather than financial accounting role.
- Quality is embedded as part of their business strategy:



There is also good evidence of a number of national drivers that clearly resulted in improved resource utilisation, which may not be transferable, but which are worthy of further consideration:

- Smoking and alcohol are very tightly controlled by the government and there is a very low rate of car accidents (reduced primary care attendances and reduced hospital admissions).
- Citizens pay the first £180 for medication, £15 for each primary/secondary care consultation up to a cap of £120 and £8/day spent in hospital. Out of hours calls carry a higher charge than in hours calls. The view is that this reduces inappropriate prescribing and avoidable attendances at primary care and EU and promotes quicker discharge from hospital.
- Social care has to pay healthcare for patients who are medically fit for discharge but who are unable to be discharged because of lack of capacity in social care. Medical patients' average length of stay in hospital is 4.4 days, compared with an average of 10 to 10.5 days in Wales.
- A single clear qualitative service accreditation system.

Finally it is interesting to note that the healthcare organisation's reported expenditure on Information Management & Technology was 3.4 per cent of budget (this compares with an average of circa one per cent in Wales). Responsibility for IM&T strategy is at county level with opt-in co-operation on some large projects.

6. Patients and the Quality Agenda

The Jönköping healthcare system has a long history of involving patients and the wider public in the design of local healthcare.

There is a strong emphasis on client focus and numerous examples of work to ensure services are seen ‘through patients’ eyes’. Perhaps the most striking of these is ‘The Esther Project’, initially based in Höglandssjukhuset, the second largest hospital in the county. This encourages everybody to see their work from the perspective of an older woman, Esther, and to work to ensure that her healthcare is as effective and efficient as possible.

The Esther Project, which started in 1997, covers a population of 110,000 inhabitants and has a shared aim for the elderly population to feel secure and well, with an increased quality of life. The ethos is summed up in their vision statement: “No matter where - we will be there.” The project was successful in focussing clinicians on patient-centeredness, something that occurs to this day. Whilst the first ‘Esthers’ were virtual, in recent years Höglandet has been proactive in recruiting elderly patients (who themselves like to be termed as an Esther) to be the “voice in the room”.

The initial projects focussed around Esther included:

- Develop flexible organisation with patient value in focus.
- Design more efficient and improved prescription and medication routines.
- Create ways in which documentation and communication of information can be adapted to the next link on care chain.
- Develop efficient IT support through whole care chain.
- Develop and introduce a diagnosis system for community care.
- Develop a virtual competence centre for better transfer and improvement of competence through the care chain.

Tremendous service improvements occurred in the first few years of The Esther Project with efficiency improvements, particularly around access arising from service redesign around the patients needs.

Improvements	1998	2003
Hospital admissions	9300	7300
Hospital days for CHF	3500	2500
Waiting times to see a neurologist	85d	14d
Waiting times to see a gastroenterologist	48d	14d

‘Taste of Water’ is a book written by a Jönköping patient who collapsed and was thought to be dying. She recovered and wrote down her experiences of health care stressing the importance of the staff in the emergency room and giving advice - “Talk with me, not to me”.

‘Tillsammans’ (Together) is a patient safety project that provides reflection, ideas and solutions for implementation with the patient at the centre of the redesign. This project has been in place for two years and has influenced developments in dialysis (a co-designed self-dialysis unit now provides for 55 per cent of renal and peritoneal dialysis patients and is expected to grow to 75 per cent), ICU/Surgery and the Emergency Department. The ICU

transfer to surgery project was initiated specifically to answer patient criticisms that they felt a dependency on ICU care as they were transferred leading to feelings of anxiety. Patient groups are often facilitated via 'learning cafes' in which the discussion is undertaken in more informal atmospheres.

Another patient approach is to use the de Bono¹⁰ thinking system of the six thinking hats. This has particularly helped group discussion in mental health and succeeded in developing mobile contact cards for personnel to achieve better admission/discharge procedures.

7. Service Transformation: Public Health

Public health has evidently been high on the political and health care agenda in Jönköping for the past 20 years. Some of the most challenging areas for population health including smoking, alcohol and road traffic accidents have been addressed through legislation: high tax on cigarettes, control of access to alcohol and a well designed traffic system have all been successful in improving health outcomes in these areas.

Government policies have encouraged 'green' activities for its citizens, including camping, while town planning promote walking and cycling through the design of its pedestrian walkways and cycle routes. Housing is built to a high specification across Sweden - a quality home and high living standards are very important to citizens. Historic land ownership and the building programme of the 1930-40s, when the government aimed to provide all families with adequate accommodation, have resulted in high rates of home ownership and a great pride in housing.

Employment rates were good until the early 1990s when financial crises took their toll, but the strengthened financial accountability at that point has given resilience to the Kroner for the current global banking problems and employment has been rising over recent years. Divorce rates are similar to other parts of the western world, but children's welfare remains central to the values of society. Parental responsibilities are valued and supported, e.g. through maternity and paternity rights.

Public health and community priorities provide the foundation for the work programmes within Jönköping's healthcare system. County Councils are informed by expert groups and patients of the health needs of their local population and these are translated into indicators to underpin all quality improvement work across primary care and specialist clinical areas. This ensures that there is a strong link between the strategic aims of the county with clinical processes and performance.

The values of the organisation are deeply embedded into healthcare systems, working practices and recruitment of staff. The importance of equity is demonstrated at national level through revenue redistribution between counties, at organisational level with high numbers of women in upper levels of management, and at individual level through customer choice and involvement in improvement and service redesign.

Dignity and respect for clients is integral to every aspect of care and is clearly demonstrated through the patient-centred focus in everyday care and improvement programmes. Patient stories are widely used to involve clients and improve their care.

¹⁰ www.debonogroup.com/six_thinking_hats.php

'Passion for Life' is a programme designed to encourage elderly people, while they are still active, to take responsibility for a healthy life. Social networks are set up within 'Life Cafes' where groups come together to learn about the World Health Organization themes of healthy eating, socialising, physical activities and safety. The networks have 'circle leaders' who support the groups, empower clients to improve through the use of PDSA cycles and recruit messengers to share ideas and information.

The messages are kept clear and simple, are repeated and clients are encouraged to reinforce their plans for improvements by writing them down. Groups are not too structured as this was found to inhibit empowerment of group members. Evaluation is through a simple questionnaire with three questions about the impact of the programme on their lives. Advertising the programme on TV has been highly successful in recruiting new members.

A new programme with the same methodology has been designed to reduce hip fractures, the focus being on increasing muscle strength and balance through diet, exercise and lifestyle changes.

The success of the public health agenda seems to result from a variety of factors, of which a key one is the importance of the community and individual citizens in improving their own health and well being. There is great pride among professionals in their country and the systems they have established, with principles of equity and respect running through the work programmes. Political direction and legislation are used to drive a health system that is founded on the needs of communities, with indicators tailored to reflect these needs.

Other key success factors in implementing lifestyle change on a wide scale are the clarity and simplicity of the messages, with a strong sense of purpose and repeated in different formats and forum across the community. Various media, especially TV is used to good effect to spread information and promote the well-being agenda, with individuals encouraged to take responsibility for their health. The importance of a healthy lifestyle is strongly reinforced in a physical sense through the environment and designs for daily living.

8. Service Transformation: Primary Care

Primary care has been established with a similar infrastructure in Sweden as in the UK, with care centres in the community comparable to our general practices. GPs work supported by therapists, counsellors and district nurses and are mainly (80 per cent) salaried. There are difficulties with attracting GPs locally in Jönköping and significant numbers of doctors are recruited from outside the area.

There are on average 2,000 patients per GP and 51 practices serve the population of Jönköping with its 350,000 residents. There are 31 practices funded by county taxes and 20 recently established private practices, built solely through private funds and apparently replicating the independent contractor status of the UK. The County Council is promoting the privatisation agenda, possibly to increase competition, raise standards and facilitate patient choice. There is no restriction on where care centres are built and no legal requirements in terms of proximity to a pharmacy.

Care centres are open 8am-5pm on weekdays and 10am-2pm Saturdays. Out of hours care is run by GP co-operatives from 5pm until 10pm; between 10pm and 8am patients attend the hospital emergency room. One telephone number is used for patients to access services during the day or night, with calls automatically transferred out of hours. Patients can move between practices easily, but only register with one practice at a time.

Continuity of care is encouraged, with patients being registered with a GP rather than a practice although online booking by patients can compromise this system. Requests for consultations are triaged by practice nurses within the Centre and patients assess the length of appointment they require when booking online (15-30 minutes, with 45 minutes for mental health appointments).

Care centres experience the same problems with their appointment waiting times as in Wales, often being one to two weeks. Primary care was fully computerised in the 1990s and by 1996 every practice had the same IT system. A new system has recently been installed across the whole Jönköping County healthcare network, with the aim of better connectivity and common codes across the primary care/ hospital interface. This is experiencing significant problems since installation and is clearly a source of irritation for primary care practices.

Funding for the care centres is through the county council taxation system, with 86 per cent of payments made on a capitation system based on age and the Care Needs Index (with numerous social indices). Additional payments are made for compliance with safety, access and quality indicators that are monitored through twice yearly visits to practices. Patients make a payment per consultation of £15 during working hours, increasing to £30 when attending out of hours or emergency department, except for those who are unemployed, who receive care free at the point of delivery. All investigations and treatment are delivered free after this initial payment.

The focus for quality within primary care is determined by the 'Book of Rules', which sets out the necessity for improvement projects within year. Evidence of improvement using PDSA cycles is used to ensure a small payment (two per cent) given for this improvement work. An online set of clinical guidelines similar to NICE provides the evidence base for clinical care.

Integration of primary care with social care does not seem to be strong within the care centres and social workers are not an integral part of the practice team. However, there is multi-agency integration through community groups established to promote healthy living and a focus on social care is critical for the success of The Esther Project. Residential homes appear to be similar in set up to the UK and face the same challenges in maintaining standards and ensuring access to beds.

One privately owned practice in Jönköping consists of three GPs and a CEO. It holds team meetings at 7.45am every morning with all members to plan the coming day's work. Professionals are encouraged to understand each other's roles and to work as teams. Every employee has a mandate to solve upcoming problems and to have a positive focus.

Care is very patient-focused, a very high priority is given to incoming calls and no internal meetings are allowed to interfere with patient time. The practice is extending from three to five evening surgeries per week in order to attract more patients to its lists.

In Jönköping County Council, there is a drive to improve access and to deliver more care in the community. In the past, a shift of paediatric care from hospital clinics and beds has been facilitated by the appointment of paediatric specialists within primary care and aggressive strategies to prevent acute exacerbations of chronic disease - especially asthma. Currently, GPs are coming under increased pressure to perform a full 'work up' of all referred patients, although laboratory and radiological resources outside the hospital are limited. Marketisation will inevitably create discussions about which sector pays for such work.

Primary care practices are invited to the Qulturum Big Group meetings on service improvement and can use the educational resources available, but the hospital setting of Qulturum and the new separation of resources which means that primary care have to pay for learning resources may mean that primary care workers may not seem as involved as their specialist colleagues.

9. Training

Central to quality improvement training is the concept of continuously adding value for patients. The organisation belief system is based on professional knowledge being combined with improvement knowledge to improve treatment, care, systems and processes so as to increase value for patients. Patient stories combined with real time measurement are important in driving improvement programmes and in ensuring that staff has commitment and responsibility to show continuous improvement.

Quality improvement training is integrated into all aspects of the health system as part of normal service delivery. At undergraduate level quality improvement training forms part of the formal curricula and is re-enforced throughout placements during the 11 terms which all potential doctors complete. Two terms within the undergraduate training is fully multi-disciplinary, establishing the culture for multi-disciplinary team training in quality improvement when delivering care post-graduation.

Multi-disciplinary team based training provides staff with the quality improvement tools and skills but is also supported by coaching. Coaching is important in encouraging continuous improvement.

Coaching is deployed not simply for use with staff but involving patients, families and carers through programmes such as Passion for Life. Coaches are required to support staff in improvement work for 20 hours every six months and are a relatively low cost resource as do this as part of their normal role.

The continuity of training also delivers a continuous feedback mechanism to trainers to continually improve their training techniques. Trainers recognise the importance of developing staff to train others, of using sceptics to promote their progress to others

Leadership training is aligned to quality improvement training, with the Qulturum established to deliver both. The human dimension and training in the psychological aspects of improvement and change are seen as important as provision of skills. Staff are actively encouraged to take on new roles and to work differently in the interests of the patient.

Quality improvement training and coaching uses a consistent and evidence-based methodology and recognises the importance of the consistent use of language to re-enforce messages at all levels and with all teams throughout the organisation. The language used is closely aligned to the 13 values of the organisation ensuring common values, common purpose, common language and a sense of “we’re all in it together”. Dissemination of the improvement message uses a wide variety of media, websites, TV campaigns, question and answer sessions, patient stories, real time data, run charts, presentations, coaching, team-building etc. The focus revolves around delivery of a service the patient both want and need, rather than what professionals feel they should have.

Post-graduate training includes PhD students studying improvement techniques and methodology. It should be noted that Jönköping does not have a university but does have a

strong network which enables the University curriculum to be developed with the clinical leaders and quality improvement focus needed in the service.

10. Recommendations

Whilst the learning from Jönköping is not fully transferable to a Welsh context, it does affirm the value of a focus on quality and supports and identifies the actions appropriate for Wales. In some cases, this will require realignment of existing resources.

These recommendations are, in the main, in relation to the 1000 Lives Plus programme. We recognise that much of the expertise for achieving these aims lies in our partner organisations in Wales and we look forward to the joint working in order to deliver success.

(i) A common and consistent approach to improvement

(a) Wales needs a consistent and standard language for improvement

The continuous quality improvement methodology used by 1000 Lives Plus should form the model taught and used in improvement work throughout Wales. This is currently set out in 'The Quality Improvement Guide' and accompanying improvement guides, published by 1000 Lives Plus.

Development and additions to this model will need to be approved by the 1000 Lives Plus National Programme Board (or its successor) and advised by the 1000 Lives Plus Faculty. There needs to be a strengthening of the all-Wales 1000 Lives Plus Faculty and greater support for its members. The role of this Faculty should continue to include leading improvement teaching and the publication of guides to support the work.

(b) National collaborative programmes must reflect NHS Wales' priorities and connect to board agendas

The work programme for 1000 Lives Plus is based on evidence of need and the potential to deliver change. It is approved and monitored by the national programme board for 1000 Lives Plus with clinical leadership from the Faculty. In future it should be ratified by NHS health boards and trusts with progress reported to those organisations at least annually. This will ensure that improvement is seen as a central tool to deliver the reconfiguration agenda.

(c) There should be closer connection between 1000 Lives Plus work and public health

The current work to link the 1000 Lives Plus programme development with the mapping of health and healthcare outcomes must be accelerated. The mechanism requires agreement with Public Health Wales and the local executive directors of public health in Wales.

The 1000 Lives Plus programme should always include at least one project which targets population health. This must link with services which actively promote healthy lifestyle messages through a wide range of media to ensure they complement the message.

(d) There should be an increased focus on research and evaluation to support the effectiveness of improvement work in Wales

1000 Lives Plus will strengthen links with academic departments across Wales to stimulate and align research and evaluation in support of improvement work. It will build on recent successful experience in jointly designed bids for research funding.

(ii) A patient driven NHS Wales

(a) NHS Wales needs new models and methods which place people at the centre of their own health and healthcare

The programme will broaden its current focus to incorporate a range of approaches and methods such as The Esther Project and Together programme which will offer new tools to achieve co-design and enablement for patients and populations.

Working with Welsh Government, it will scope a new programme for 2012-13 to reflect government policy on measuring and improving patient experience.

(b) Improvement guides must reflect the principle of patient centeredness

1000 Lives Plus will review all current improvement guides to ensure a consistent and strengthened approach, which reflects learning from Jonkoping and elsewhere - particularly in respect to a patient centred focus which champions dignity and respect.

As with The Esther Project, there is an urgent need to encourage individuals to take responsibility for their own health and management of conditions, supported with clear and consistent information on how to achieve this. It is vital that NHS Wales uses patient and community social groups as a key resource to ensure that any redesign of services is informed by user experience.

(iii) Developing capacity and capability now - and in the future

(a) The 1000 Lives Plus programme must play an active part in the organisational development of NHS Wales to deliver transformational change

There should be a closer relationship between 1000 Lives Plus and the directors of Workforce and Organisation Development in each organisation. Work is also required to bring together the business methods of NHS Wales and the improvement agenda.

Every opportunity should be taken to ensure that change programmes support primary and community care staff enabling people to avoid unnecessary acute care or escalation of their need for treatment.

(b) Building an improvement driven NHS requires a skilled workforce

1000 Lives Plus will work with health boards and trusts to agree a plan to train 25 per cent of the directly employed and contractor workforce in the continuous quality improvement methodology (at basic, expert or leadership level) by the end of March 2014. In this phase, delivery will be in partnership and include the training of accredited local tutors (approximately 20 per organisation). The plan will include proposals to maintain that rate thereafter through delivery at local health board and trust level.

(c) Measurement needs to be appropriate and widespread

1000 Lives Plus will work with colleagues in Public Health Wales, NHS Wales Informatics Service, National Leadership and Innovation Agency for Healthcare, Development Support Unit and Welsh Government to develop a 'Measurement for Managers' training programme. This will be consistent with the proposed 'Quality Delivery Plan' which is offered and delivered to at least five per cent of the NHS Wales workforce by the end March 2014 (focused on finance, business and functional managers).

NHS Wales staff need real time data systems which support improvement method. These are a strong feature of the current 1000 Lives Plus work but this is at an early stage of development. Current work with NWIS to develop the Care Matrix and, in primary care

with Audit Plus, offer the potential to move from individual bespoke tools and to streamline effort.

(d) Innovation by local teams must be supported and celebrated

1000 Lives Plus will actively support local innovation through its collaborative programmes, methodology, published how to guides and other web based resources as well as in its work with local faculties. It will continue to work closely with “Improvement on Line” and the annual NHS Awards to ensure that innovative practice is accessible and celebrated.

(e) The 1000 Lives Plus programme must work on the principle of subsidiarity

There must be continuous effort to ensure that 1000 Lives Plus catalyses and supports the work of health boards and trusts in NHS Wales. No work should be done nor resource held at an all Wales level that is more appropriate locally.

This will be achieved through:

- Active support for the development of local faculties, adapting the Qulturum model to local circumstances. Each health board and trust in Wales should consider a physical or virtual centre, or centres, for service improvement, places where service leads can meet, share ideas and benefit from methodological support. They could be used as a resource to bring together community and hospital staff in a shared learning environment.
- A balance between core staff and temporary deployment of health board and trust based staff to lead or support individual all Wales projects.
- Assertive support for health boards and trusts in designing and sustaining energetic communications plans to support the local uptake and spread of improvement effort, method and results.
- Facilitation of all-Wales peer groups such as the Associate Medical Directors for Quality.
- Active links with healthcare improvement organisations beyond Welsh boundaries.
- Support and encouragement for local entries to awards and conferences, including the NHS Wales and Health Service Journal Awards and in the International Forum on Quality and Safety in Healthcare.
- An active programme of all Wales learning events and publications.

(f) The 1000 Lives Plus programme needs to develop a wider range of teaching methods to spread will and capability

1000 Lives Plus will investigate the potential future role of coaching, social movement, solution-based and other learner led techniques to accelerate the delivery of learning to NHS Wales staff and to its patients.

(g) NHS Wales should take all opportunities to align with academic and teaching resources

1000 Lives Plus will continue to work with universities and colleges to support the design and delivery of improvement training for undergraduate and postgraduate training based on the shared language for NHS Wales. The existing 1000 Lives Plus Student Chapter should be expanded and given an increased resource.

The national programme board will be invited to manage a review of links with postgraduate training in order to strengthen links with service-based improvements through local faculties and at an all-Wales level.

About the authors



Dr David Gozzard was employed in North Wales as consultant haematologist from 1988-2011, recently retiring to concentrate on his independent consultancy in quality improvement in healthcare. He was medical director of Conwy and Denbighshire NHS Trust, and latterly the North Wales NHS Trust from 2002-2009 and championed its modernisation and innovation programme.

He was the clinical executive lead for the Trust's successful participation in the pilot programme of the Safer Patient Initiative and saw the adverse event rate fall by 66 per cent.

He obtained a Health Foundation sponsored sabbatical to study with the Institute for Healthcare Improvement in Boston in 2007-8 and brought much of his new learning to his position in the 1000 Lives Plus Faculty. His present areas of work include the development of a Haematology Quality Academy in Denmark and work with executive boards as faculty member for the Executive Quality Academy.



Dr Alan Willson is joint director of the 1000 Lives Plus programme, a director of the National Leadership and Innovation Agency in Wales, Honorary Senior Lecturer in Swansea University, an Associate of the Welsh Institute for Health and Social Care at the University of Glamorgan and Visiting Professor at the School of Pharmacy in London. He was recently made a fellow of the Royal Pharmaceutical Society.

He has directed several national collaboratives including critical care, medicines, mental health services and most recently in stroke services. His research interests are medicines management and the spread of improvement. He has published on the evidence base for improving effectiveness of medicines in primary care.

Alan qualified as a pharmacist working in senior pharmacy and then general management in London before coming to Wales. He completed a PhD looking at causes of the high rates of Welsh prescribing.

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