A Note to Mr Robert Francis QC from Sir Donald Irvine, December 2011

Formatted: Left: 1", Right: 1", Width: 8.5", Height: 11"

1.I recently took part in a meeting of physicians and managers from ten not-for-profit high performing hospitals in the US, convened by physicians at Mayo Clinic. They wanted to consider whether they could co-operate on adapting clinical governance to provide evidence of individual physician performance at the workplace for their medical staff undertaking the American Board of Medical Specialties' Maintenance of Certification (MOC). MOC is basically a form of voluntary revalidation in a doctor's chosen field of practice. Almost all the hospitals present required MOC as a condition of employment. My job was to describe progress with the development of relicensure/revalidation in the UK.

2. I have looked again at the clinical governance and general management arrangements at Mayo, at nursing practice there, and visited the new Amplatz Childrens' Hospital in nearby Minneapolis to review an interesting example of Always Events in enhancing the patient-centredness of patient care .

3. What I offer you here are some examples and personal reflections on differences between the two systems on both sides of the Atlantic at the high performing end, with specific reference to things I think we should adopt here. I will use Mayo as the example, but emphasize that one would find the same principles in action in all of the most successful high performing US hospitals. I can attest to that through personal experience of, for example, the Henry Ford Health System at West Bloomfield, Cincinnati Childrens, the Dana- Farber Cancer Institute and Griffin Hospital (Planetree) in Connecticut. Most people in my profession who have knowledge of both systems would say that the very best of American medical care is the best there is. In his evidence to you Sir Liam Donaldson seemed to be encouraging you to be looking outwards for good ideas. Below are some of the messages I think are important.

The Hospitals: Some General Points

4. Core Value.

"*The needs of the patient come first*". That is the single, overarching organizing principle for Mayo. It has been so for over 100 years, and is now part of Mayo DNA. It has the effect of unifying everyone, whatever their profession, around a shared purpose. Wherever you go, you cannot escape it – in the hospital, the medical school and in research. What happens to patients matters from their point of first contact with Mayo to their last consultation. The effect, from the CEO and Board of Trustees down, is a relentless focus on clinical quality and on being sure that patients have the best experience.

A nice non-clinical example is the patients' main car park, which staff and consultants are not allowed to use, which is the nearest to the hospital entrance!

The contrast with even the best NHS hospitals, with their competing values and priorities imposed on them from on high, is quite stark.

5. Reputation and the Brand.

The core value is inextricably linked to the *institutional reputation* for quality in all its dimensions, which in turn is linked to the Mayo brand. That matters because Mayo, like all these high performing hospitals, whether for profit or not, compete vigorously.

This contrasts with the NHS where the brand is nationwide "NHS", and thus easily tarnished by poor performance in some participants. One result is that individual hospitals and general practices have much less incentive, or opportunity, to shine in their own right compared with their US counterparts. I think this is because, in the command structure of the NHS, they look instinctively upwards towards the Department of Health rather than feel the need to engage vigorously with the communities they serve.

6. Professional culture.

The Mayo culture is patient-centred and driven by the pursuit of excellence. It is professionalism which encourages maximum performance, rather than reliance only on regulatory compliance a point made in evidence to you by Sir Bruce Keogh. At Mayo, if a doctor or nurse does not embrace the culture, and reflect it in their practice, sooner than later they will go. *Persistent underperformance has direct consequences for the individual.*

Contrast this with the culture in the NHS where too often poor practice is tolerated, something patients are expected to put up with. The consequences for such practice are exceptional- with a heavily unionized workforce jobs tend to be protected. You have had plenty of evidence of the toleration of substandard practice at Mid Staffs and elsewhere.

7. Management

Mayo management reflects the primary focus on quality for the patient. Quality of care, and therefore the strength of the brand, is the main thing the Board of trustees thinks about. Staff are very well supported but discipline is strict. There are no trade unions to apply restrictive or self-protective practices.

The medical input is strong. Mayo is physician led. The CEO and every departmental head is a physician who maintains an active role in Mayo clinical practice, education or research, and who is co-partnered by a manager. Even in hospitals where the CEO is not medical, the medical input is much more prominent in the US than in the NHS. (But I remember, in the early days of the NHS, that the boards of teaching hospitals the NHS inherited had a very strong presence of medical big hitters until they were pushed out in the management reorganizations of the seventies).

Clinicians, doctors and nurses, are expected to take personal responsibility for the quality of their own practice, and that of fellow team members, and to be accountable for their actions. It is seen as important to recognize that teams are made up of individuals, and that systems are under human control.

The focus on quality is reflected in systems. For example, in dealing with the complex problems that are Mayo's main clinical business, the management of care is synchronized to a degree that I, like many others, have never seen before, because 'the needs of the patient come first'. The electronic clinical

record system is amazing. Through a facility called Ask Mayo Expert the lead clinician has immediate access to some 3,500 Mayo specialists from across the spectrum of medicine via the electronic record system directly. And clinicians who may be consulted by a colleague about a patient become, as a consequence, directly involved in one form of continuous informal peer review through their scrutiny of the medical record – a built-in early warning system for possible performance problems.

Mayo publishes a range of data giving comparative analyses of outcomes, compliance with clinical guidelines, and patient experience and satisfaction. They and other high performers see such data primarily as a basic management tool for their own organisation. Publication is associated with explaining to and reassuring current and future patients that they can trust the brand, and all it stands for in terms of quality. In my experience this form of engagement with the public is exceptional in NHS hospitals and general practices although things may be beginning to move now. Too often, I have found, local NHS management will collect data because they have been told to by the central NHS, and do nothing with it other than pass it up. Sharing it with local people who are patients – or potential patients- to tell them about their quality of care is exceptional. It is another window on the relative lack of patient-centredness in the NHS.

Lastly, every Mayo patient has a personal physician-usually the physician to whom the patient has been referred-who is in overall charge whilst the person is under Mayo care. Thus, however big the clinical team may be, the buck stops with a named individual. It is that doctor's responsibility to have oversight of all aspects of the patient's care. The patient and the relatives know who is in charge and therefore who to go if they have concerns. This practice is common in all good hospitals. In the US American people talk far more frequently than Britons do about 'my physician'. I see that the RCP made the point in their final submission to you. Ironically, it is another example of a practice that used to be commonplace in the early days of the NHS, but was gradually managed out.

8. Nursing

As with the physicians, Mayo has a strongly motivated nursing workforce. Mayo is designated as a Magnet Hospital. Magnet is a seal of quality for nursing given by the American Nursing Credentialing Centre, an affiliate of the American Nursing Association. The award, not generously given, clearly induces a sense of pride in the nursing workforce and is therefore good for patients and nursing morale. And of course it is good for the brand.

As I understand it, there are no comparable incentives to demonstrate excellence in nursing in the NHS.

Revalidation/MOC/Relicensure

9. At the meeting there was much detailed discussion about MOC arrangements at the workplace in US hospitals. Not all US physicians are board certified and of those who are a proportion have not been through MOC. Relicensing by the state medical boards is now on the agenda.

10. Alongside the hugely fragmented regulatory system for US physicians, the national UK system of licensing through the GMC and the general plan for revalidation looked pretty good. On the other hand,

as I have shown, the US high performing hospitals have much better management at the workplace as a foundation for maintaining the quality of practice. For us, success will depend on having clear standards, robust evidence of performance and rigorous appraisal, something that I would expect any NHS management worth its salt would want anyway to manage its business effectively. The devil is in the detail, in particular whether we are prepared to use revalidation (as was intended back in 1999) to help push NHS hospitals and general practices towards the kind of proactive quality management culture and systems I described earlier at Mayo and the like. In a paper on revalidation to the Health Select Committee earlier this year I described what more needs to be done. As you may have seen, they have been very supportive. I hope you will be too.

11. I was very pleased that Stephen Dorrell was open to my rather old proposal for a review of the GMC by the Health Select Committee and even more so when he decided to add the nurses as well. I hope you will encourage his committee to press the two regulators to publish annual data on the standards of professional practice they are using to underpin continuing licensure, and analysis of the results of fitness to practise cases – and revalidation when it starts – so that we can all see on a year by year basis how effective that part of the regulatory system is in protecting patients. That kind of ongoing public scrutiny should help keep the pressure on all the regulators – personal professional and institutional- and in turn on the professions and NHS management, to keep their focus firmly on patient-centred quality.

Demonstrating Success in the UK

12. I commend to you once again the work of the adult UK cardiac surgeons through their professional society (SCTS). You have had their 2011 report - Maintaining Patients Trust: Modern Medical Professionalism. Not without difficulty, they have produced workplace data collection and management, and the means of national and international comparative analysis, which demonstrates just what can be done when surgeons and managers work together. In the course of their journey they have become far more patient-centred, and now see the demonstration of excellent surgery as a hallmark of their professionalism. At the moment they are a one off on both sides of the Atlantic. They would make an excellent case history if you were looking to demonstrate what success looks l

13. Using the resources we already have, the NHS needs to be more ambitious about how it can make care better and safer for all patients. As our cardiac surgeons have shown, and as I have tried to illustrate from the example of Mayo and others, for patients it is the mindset that links together absolute patient-centredness, modern professionalism, imaginative management and the publication of the results of care that is fundamental. A reputation for excellence is a very powerful motivator.