

Editorial

Increasing the impact of quality improvement science: learning from the past and changing the future

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At a recent *Quality in Primary Care* editorial board meeting we discussed the purpose of the journal. At the end of the exchange one of our members captured the essence of the dialogue in a simple but elegant statement that 'the aim of the journal was to promote the science of improving primary care delivery to patients, families and communities.' What does this restated aim mean for the journal?

As a journal we have always published high quality research articles on primary care improvement across the world, examples of quality improvement projects here and abroad, and more recently position papers describing best practice, views from service users and summaries of current resources on the World Wide Web (Knowledgeshare) or in the literature (Primary Care Quality Digest).

Organisations such as the Health Foundation (www.health.org.uk/) in the United Kingdom and the Institute for Healthcare Improvement (www.ihl.org/ihl) in the United States have been in the vanguard of spreading quality improvement thinking and methods into health care, whether in the acute sector, primary care or more recently into ambulance services. Despite international interest in quality improvement and the endeavour of these and other organisations these efforts have yet to translate into engagement and activity at the front line of clinical care.

After two over decades of improvement efforts from clinical audit to clinical governance to the current emphasis on clinical innovation it seems that we still have a long way to go and much to learn in the field of improvement. It seems that there is variable interest, understanding and knowledge about the science of health care improvement among clinicians and efforts to use this newly developing science to improve care is patchy at best. We know more about clinical engagement but whether we understand clinicians' needs or apply the best evidence to engage clinicians, at present this appears only to lead to variable effects on outcomes.¹⁻³

Over half a century ago the science of improvement was being applied to manufacturing in post-war Japan by improvement gurus such as W Edwards Deming and Joseph Juran.^{4,5} We have our modern day gurus such as Don Berwick, Paul Plsek and Davis Balestracci but improvement science is still in its relative infancy in healthcare: many of the ideas, techniques and methods of application are still being developed and evaluated.⁶⁻⁸

In the context of improvement methods we still do not know what works, how it works and under what circumstances: applying the 'right skill, at the right time, in the right place' applies to these techniques just as it does to clinical care and this is an important part of the 'science'. Just as Deming helped Japanese companies face the crisis of the post-war period, we face a challenge of enormous proportions to provide high quality healthcare in the face of financial stringencies.

To this end we plan to publish a series of articles over the next few months looking at quality improvement methods, techniques, theories and gurus to examine those ideas that are relevant today and how they are, or could be applied. We will examine improvement technologies themselves or combinations of these, evaluation methods and research designs for improvement programmes, and the individuals and groups that have pioneered these developments.

A danger of the exponential development in improvement science is that concepts and techniques are seen as fads and fashions rather than real advances based on reliable evidence.⁹ While there will always be fads that need to be exposed for what they are, rather than lose the learning from the past, we need to 'climb onto the shoulders of the giants of the past', and look critically at what has gone before to more clearly see what might be possible in future.¹⁰

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