High-performing organisations are those that continually strive for, achieve and maintain excellence over time (see box 1). Healthcare systems in industrialised countries, whether publicly or privately funded, are all struggling to cope as healthcare systems become increasingly complex and as demand continues to grow. Leading organisations must develop new models of care in the face of these challenges, making a shift from volume to value.

Value, as defined by stakeholders and by the Triple Aim, is:

• achieving high quality care
• achieving cost effective delivery of care
• meeting stakeholder expectations including those of patients, and
• shifting from providing episodes of care to providing or orchestrating the whole package of care, and to a focus on health prevention.

What are we aiming for in NHSScotland? What does good look like?

Through the study of organisations who have achieved high performance, nine key attributes of high-performing organisations and their component elements have been identified; see Figure 1 for more detailed descriptions and examples.

However, although the nine key attributes are known, they - and their resulting high levels of performance and reliability - are rarely achieved. There are a number of reasons for this, including the interdependencies of the key attributes but most importantly, because each organisation is a dynamic system, with a unique array of elements, relationships, interactions, and behaviours. Therefore, there is no one single model or best way to achieve service excellence. Each organisation must find its own way.

As a result, learning about high-performance is best achieved by studying the journey of those organisations that have accomplished it. The key is understanding the process of how quality was improved and the conditions under which the success was realised including:

• context and environmental factors under which decisions were made
• strategies, structures and processes that were critical to successes
• leadership processes and strategic investments taken over time, and
• challenges and barriers encountered/overcome 1.

Box 1: Definitions of high-performing organisations

“Organisations that over time continue to produce outstanding results with the highest level of human satisfaction and commitment to success.”3

“Organisations that have created effective frameworks and systems for improving care that are applicable in different settings and sustainable over time.”1

Case studies of organisations identified by their peers as exemplifying high-performance (either organisationally or in particular areas) have been compiled. Organisations studied include Birmingham East and North Primary Care Trust and Heart of England Foundation Trust in England, Kaiser Permanente in the United States, and Jönköping County Council in Sweden, among many others. Studies of groups of case studies have identified some key learning points, including1–4:

• Quality is a system property that requires a focus at multiple levels within the organisation.
• Quality is a social process and so we must focus on the ‘sociology’ as well as the ‘science’ of improvement.
• High-performing organisations have an impatience, rather than satisfaction, with current performance and are constantly trying to improve on their last success.
• Benchmarking is an invaluable process; it helps to identify what ‘good’ looks like in health care organisations.
• An enabling structure and enabling culture is core; performance measurement in isolation, without accompanying culture change, is not sufficient to drive improvement.
• The journey to high performance is a multi-phase and multi-year (possibly decade-long) journey.
Leadership
Strong leadership that provides role models for organisational values
e.g. The CEO promotes the concept of distributed leadership, suggesting that all staff members - with or without formal leadership titles - should develop and exercise their ability to lead.
(Trillium Health Centre, Mississauga, Canada)

Strategy and policy
Leaders set clear priorities for improvement
e.g. Programmes are about excellence in service and quality and not just clinical quality but quality more broadly.
(Henry Ford System, Detroit, USA)

Structure
Roles and responsibilities for improvement are clearly articulated.
e.g. Taking responsibility for problems: Members leave the System Quality Forum meetings with to-do lists and a sense of ownership.
(Henry Ford System, Detroit, USA)

Resources
Organisation provides time for staff members to learn new skills and to participate in improvement work
e.g. Preserving the space to work on improvement (i.e., support, attention and time) is critical.
(Veterans Affairs New England Healthcare System, USA)

Information
Clinical and administrative data are readily available to support improvement
e.g. ‘You can’t manage what you can’t measure’ so adopted the principle that measuring performance is an essential work in progress.
(Henry Ford System, Detroit, USA)

Communication channels
Organisation has vehicles to communicate with stakeholders regarding priorities, initiatives, results and learning
e.g. Cascading communications are used extensively to engage staff members in discussions on service excellence and how their individual and unit activities link with corporate goals.
(Henry Ford System, Detroit, USA)

Skills training
Includes training in improvement methods, team and group work, project and meeting management and epidemiology
e.g. Integrating improvement knowledge and skills into clinical education.
(Jönköping County Council, Sweden)

Clinical involvement
Clinicians are involved in planning improvement initiatives and participate as team members
e.g. Mechanisms and initiatives (with accompanying resources) to improve clinician participation and communication (task forces, funds, financial subsidies, dedicated time, etc).
(Calgary Health Region, Calgary, Canada)