Editorial

Lessons from 2012: What the NHS Can Learn from Britain's Olympic Success

Edward J. Maile[a], Alastair M. Blake[b]

[a]Oxford University Clinical Academic Graduate School, Oxford, UK; [b]Chelsea and Westminster Hospital NHS Foundation Trust, London, UK
Correspondence to: Edward J. Maile, Oxford University Clinical Academic Graduate School, Medical Sciences Division, Level 3, John Radcliffe Hospital, Oxford, OX3 9DU, Tel: +44 7969 527 704, Email: edward.maile@medsci.ox.ac.uk

Article history

Received: 18 January 2013
Accepted: 4 April 2013
Available online: 18 May 2013

Provenance and Peer Review

Uncommissioned, editorial review

Keywords

Healthcare policy
Leadership
Teamwork
Management
Patient safety
Evidence based medicine

Abstract

The 2012 London Olympic and Paralympic Games were widely regarded as an organisational and sporting success for the United Kingdom. Therefore, it is prudent to consider what other large, public endeavours might learn from the Games' success.

Team GB worked to develop a positive team culture based around shared values. This is something the National Health Service (NHS) could learn from, as an organisation which can appear to lack this culture. The NHS should also work harder to adopt evidence-based practices, and to adopt them quickly, as is often the case in sport. Sport is the ultimate example of transparent results reporting, and the NHS ought to consider systematic reporting of risk-adjusted performance data, which may drive improved performance. The NHS should pay attention to the experiences of successful Olympic sports with centralised centres of excellence, and to medical data which suggests that better outcomes result from centres of excellence. The NHS and wider government should look to Olympic athletes and place more emphasis on prevention of disease by encouraging positive lifestyle choices. Finally, the NHS should develop private sector partnerships carefully.

We must look to gather knowledge and ideas from every area of life in pursuit of excellence in the NHS. Experience of the Olympics offers a number of instructive lessons.

Introduction

The 2012 London Olympics and Paralympic Games were widely regarded as an organisational,[1] and clear sporting success for the United Kingdom.[2, 3] The Games were a large, mainly publicly-funded,[4] British project. Therefore, it is prudent to consider what other large, public endeavours might learn from the Games' success. One in particular is the NHS, which is currently facing significant challenges.[5]

It is Essential to Foster a Positive Culture Based Around Shared Values

Team GB's performance demonstrated the power of a shared, positive culture as a basis for great achievements. Within the team, coaches and leaders such as Sir Clive Woodward, the British Olympic Association's Director of Sport, ensured that a core set of fifteen values aligned everyone's efforts. These principles focussed on five areas: unity, responsibility, pride, respect, and a passion about performance – all of which are crucial factors in delivering excellence.[6] What's more, these values were grounded in the everyday, making them accessible and comprehensible. A wider positive culture was also fostered; exemplified by the successful recruitment and deployment of 70,000 volunteer 'Games Makers' who performed a variety of roles to ensure the games ran smoothly.

In a healthcare setting, it intuitively follows that positive and supportive staff deliver better care for patients. Despite this, the NHS can feel like an organisation lacking this positive culture. Examples of the power of culture include resuscitation teams who deliver improved outcomes by creating a supportive culture focussed on learning from mistakes.[7] Whilst the evidence base for team-level culture and outcomes is growing, the literature for organisation-level effects is still lacking. One study from the USA failed to show a link between outcomes after CABG surgery and a measure of the organisation's culture.[8] However, in light of the Mid Staffordshire scandal, and the verdict of the Francis report in February 2013, it is important to consider how a negative culture across the NHS could detrimentally affect patient outcomes.[9] To realise these lessons from London 2012, we need to focus on translating the NHS Values from abstract theory to bedside practice.

We Must be Rigorous in Our Use of Evidence-Based Interventions to Improve Results

Athletes compete on results and sports science is, therefore, meticulous; pursuing every millisecond of improvement using evidence-based ideas gleaned from research and testing. Sir Clive Woodward talks about "one percenters" as being the small things which, in combination, make a big difference.[10] This is exemplified by British Cycling who will shave grams from a piece of equipment to save milliseconds.[11]

This fastidious approach to continual improvement using evidence-based interventions is less widespread in healthcare. Despite the pre-eminence of evidence-based medicine

as the pinnacle of clinical practice, change happens at a glacially slow pace even in the face of strong data. On average, there is a 17 year delay before the outcomes of clinical trials are incorporated into frontline medicine.[12] Some of these changes would require significant capital to implement, which is a clear barrier. However, there are many changes which would be almost cost-neutral to implement, and result in significant future savings. For example, the WHO Surgical Safety Checklist is an evidence-based innovation with minimal implementation costs but the potential for increased quality of care and significant cost saving via reduced inpatient stays, reduced litigation, and increased operating efficiency.[13] The NHS should follow the lead of Team GB and work to swiftly implement evidence-based changes, which will lead to improved results.

Prevention is the Solution to Our Financial and Health Problems

Athletes such as Jessica Ennis or Mo Farah are unlikely to develop one of the multitude of chronic diseases driven by a poor lifestyle if they maintain their current life choices. Indeed, Olympic medal-winners possess a relative survival advantage of 8% compared with matched controls.[14]

Therefore, the most obvious lesson is that to control costs the NHS and government should focus on prevention of disease by promoting exercise, healthy eating, and managing lifestyle problems to prevent development in to full-blown disease. This area has previously been described as "an afterthought",[15] but should now be pursued alongside treatment of established disease. If we fail to do this, our ageing population and the looming obesity crisis will stretch the NHS to breaking point.[16]

Reporting Clinical Performance

Sport is the ultimate comparison of one individual's performance against another. During their training for London 2012, Team GB athletes quantified and analysed their performances to aid further improvement. The British Cycling team used video cameras and computer analysis to capture data for the power output of each leg joint whilst riding – data which were subsequently used to make improvements to each rider's set-up and training regime.

However, in the NHS, many doctors are resistant to collecting and utilising data about individual clinician's performance.[17] Common criticisms focus on the potential for easily available data to be meaningless and lacking nuance when comparing different doctors' caseloads.[18] Furthermore, there is anxiety around using inappropriate performance data to facilitate the increasing levels of patient choice seen in the NHS. Clinicians may feel that in current cultural climes, data is used to grade individuals against one another for the purposes of commissioning work, as opposed to improving clinical outcomes. Despite these problems, gathering and publishing clinician's performance data has been associated with improved outcomes for Cardiac surgery in Northwest England.[19] An alternative approach is to publish results data for clinical centres. In the United States, risk-adjusted renal transplant results by centre have been systematically publicly reported since 1991.[20] Concurrently, between 1991 and 2008, the average graft survival for all centres increased from 79.5% to 93.2%,[20] although this may be correlation not causation.

Challenges to collecting appropriate data aren't a reason to stop – they should drive us to work harder to improve the type of data and the methodology we use to collect and analyse it.

Centres of Excellence

Team GB's two most successful teams, the Rowing and Cycling teams, had purpose-built training centres for developing excellence. At the Manchester Velodrome the British Cycling team collected the best athletes, equipment and coaching staff in one place, which Performance Director David Brailsford argued was a key determinant of the team's success.

Whilst developing centres of excellence within the NHS is nothing new, the idea still faces criticism on many fronts. Members of the public are averse to the loss of local services, even when care quality may be low.[21] Meanwhile, some clinicians remain sceptical about the applicability of 'Centres of Excellence' as a means of improving quality outside of niche sub-specialities.[22] However, experience so far does not reflect these concerns. Following the reorganisation of stroke care in London from 34 hospitals to 8 Hyper Acute Stroke Units which assess every suspected stroke case, 30 day mortality nearly halved from 15% in 2008 to 7.6% in 2011, with the average inpatient stay simultaneously decreasing from 15 days in 2009–10 to 11.5 days in 2010–11. Patient satisfaction increased and the overall result was that five of the six highest performing stroke services in the UK were in London.[23] These data are compelling and suggest that adopting evidence-based consolidation of services is essential for improving patient outcomes and reducing spiralling costs.

Partnerships with Non-Public Organisation Should be Developed Carefully

The Olympics were delivered by a coalition of public and private organisations. However, this was not without difficulty as a private security company contracted to provide security for the games, failed to deliver the personnel it had promised which required the armed forces to fill the shortfall.[24]

Similar failures have occurred in the NHS. For example, a private-sector company contracted to provide out of hours general practice services in South West England, was recently ordered to improve care by the Care Quality Commission. This followed inspections which revealed it was failing to meet four essential standards of quality and safety.[25]

The private sector undoubtedly has great expertise to offer, and in the right circumstances, public-private partnerships should be pursued. However, the London games' experience should remind us to develop these relationships carefully, with the correct safeguards in place. This is especially important in the context of the Health and Social Care Act which has eased private entry into the UK healthcare sector.

Conclusion

Diffusion of knowledge and sharing of ideas and best practice is essential to driving continual improvement of the NHS. We should look to gather knowledge and ideas from every area of

life and analysis of the London 2012 Olympic Games offers a number of instructive lessons.

Ethical approval

No ethical approval required for this publication.

Conflict of interest

No conflicts of interest have been declared by the authors.

Authors contribution

EJM: Conception, data interpretation, drafting and critical revision, final approval.

AMB: Conception, data interpretation, drafting and critical revision, final approval.

Funding

No funding source declared by authors.

1 Gibson O. London 2012 Olympics were 'absolutely fabulous', says IOC chief. 12 August 2012 [online]. http://www.guardian.co.uk/sport/2012/aug/12/london-2012-olympics-absolutely-fabulous (Accessed: 22 Dec 2012).
2 London 2012 Olympic Games. 2012 [online]. http://www.london2012.com/medals/medal-count/ (Accessed: 22 Dec 22 2012).
3 London 2012 Paralympic Games. 2012. [online] http://www.london2012.com/paralympics/medals/medal-count/ (Accessed: 22 Dec 2012).
4 Rogers S, Blight G. London 2012: what's the real price of the Olympic games? Visualised. [online]. http://www.guardian.co.uk/sport/datablog/interactive/2012/jul/26/london-2012-price-olympic-games-visualised (Accessed: 27 Dec 2012).
5 The King's Fund. How. The King's Fund, 2012.
6 Gibson O. Sir Clive Woodward draws up list of 'standards' for GB Olympic athletes. 12 July 2011 [online]. http://www.guardian.co.uk/sport/2011/jul/12/sir-clive-woodward-standards-olympic (Accessed: 11 Feb 2013).
7 Edelson DP, Litzinger B, Arora V, et al. Improving in-hospital cardiac arrest process and outcomes with performance debriefing. Arch Intern Med 2008;168(10):1063–1069.
8 Shortell SM, Jones RH, Rademaker AW, et al. Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. Med Care 2000;38(2):207–217.
9 Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. Robert Francis QC. February 2013.
10 Gibson O. Sir Clive Woodward draws up list of 'standards' for GB Olympic athletes. 12 July 2011 [online]. http://www.guardian.co.uk/sport/2011/jul/12/sir-clive-woodward-standards-olympic (Accessed: 20/12/13).
11 Williams O. Olympics track cycling: Will technology win the war for GB? 2 August 2012 [online]. http://www.bbc.co.uk/sport/0/olympics/19089259 (Accessed: 20/12/13).
12 National Patient Safety Agency. NHS Evidence. Report number: 10/0008, 2011.
13 Balas EA, Weingarten S, Garb CT, Blumenthal D, Boren SA, Brown GD. Improving preventive care by prompting physicians. Arch Intern Med 2000;160:301–308.
14 Clarke PM, Walter SJ, Hayen A, Mallon WJ, Heijmans J, Studdert DM. Longevity of Olympic medallists in the modern era: retrospective cohort study. BMJ 2012;345:e8308.
15 Department of Health. Cm7775. London: Stationery Office; 2009.
16 Foresight. Government Office for Science. 2007.
17 Tavare A. Where are we with transparency over performance of doctors and institutions? BMJ 2012;345:e4464.
18 Adab P, Rouse AM, Mohammed MA, Marshall T. Performance league tables: the NHS deserves better. BMJ 2002;324:95.
19 Has the publication of cardiac surgery outcome data been associated with changes in practice in northwest England: an analysis of 25,730 patients undergoing CABG surgery under 30 surgeons over eight years. Heart 2007;93(6):744–748.
20 Porter ME, Baron JF, Chacko JM, Tang R. Harvard Business School, 2012.
21 Rose D. A&E shutdown farce: The backlash from doctors, experts and patients begins as closures will lead to 'more dead babies'. 15 September 2012 [online]. http://www.dailymail.co.uk/news/article-2203809/A-E-shutdown-farce-backlash-begins.html (Accessed: 27 Dec 2012).
22 Edwards N. The benefits of centralised emergency services are less than clear. 14 June 2012 [online]. http://www.hsj.co.uk/opinion/columnists/the-benefits-of-centralised-emergency-services-are-less-than-clear/5045457.article (Accessed: 27 Dec 2012).
23 Porter ME, Mountford J, Ramdas K, Takvorian S. Reconfiguring Stroke Care in North Central London. Harvard Business School, 2012.
24 UK Parliament. Home Affairs Committee – Seventh Report – Olympics security. September 2012.
25 Care Quality Commission. Review of Compliance – Serco Limited and Cudmore House. July 2012.