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Health Policy Matters

HELPING DECISION MAKERS PUT HEALTH POLICY INTO PRACTICE

This issue **PROMOTING QUALITY IN THE NHS**

Introduction

For patients, quality counts. In the NHS the public until now has taken quality for granted. But today we can no longer be complacent. In a wealthy country like ours, we expect an NHS which has both the capacity and the capability to deliver care matching the best international standards.

For the first time in the history of the NHS the government has put the pursuit of quality at the top of the development agenda. So there is now a real possibility of making the modern practice of continuous quality improvement an operational reality for all, rather then the hobby of a few. Of course, much of this is new ground – hence the challenges explored in this bulletin.

But we should go for it. This is an idea whose time has come.

Sir Donald Irvine CBE,
President, General Medical Council

Policies to improve quality and performance

The Department of Health has introduced co-ordinated policies intended to increase the quality of NHS care. The issue of quality needs to be a key priority for the NHS – many NHS processes and a considerable amount of its practice is of poor and variable quality. In this issue of *Health Policy Matters* we discuss some of the challenges and provide advice to local decision makers on implementation.

The NHS quality framework, as laid out in *A First Class Service: Quality in the new NHS*,[1] comprises several connected elements including:

- National Institute for Clinical Excellence (NICE)
- National Service Frameworks
- Clinical Governance
- Continuing professional development and lifelong learning
- Improved professional self-regulation
- Commission for Health Improvement (CHI)
- Performance Assessment Framework (high level performance indicators and clinical indicators)
- Patient and public involvement (including surveys)

This is supported and further developed in the NHS Plan and the establishment of the National Clinical Assessment Authority and the National Patient Safety Agency.

The quality initiative contains a set of mechanisms for setting, delivering and implementing standards and monitoring their implementation. These are carried out by a combination of external activities (which make demands on health care organisations) and internal ones more under local control (which aim to create a culture of quality).

The quality initiative aims to change professional practice and how services are delivered, recognising the relative lack of progress made by professional organisations and managers by themselves.

It is novel in that chief executives explicitly are now responsible for quality; national standards are being developed which will be applied not only to hospitals but also to GPs and dentists; and the robustness of quality systems will be reviewed by CHI. In partnership with the Audit Commission, CHI will also review the implementation of national standards and publish data relating to the performance of health care organisations for the public.

The quality initiative presents NHS staff and the public with some exciting opportunities to tackle quality. But will it meet expectations?

This issue of *Health Policy Matters* has been written by Trevor Sheldon, Alan Maynard and Ian Watt from the Department of Health Studies at the University of York.

It explores some of the challenges of quality - a key NHS priority - and provides some helpful advice for local decision makers on developing practical systems for tackling the quality agenda.

Full text is available on our website at: www.york.ac.uk/depts/hstd/pubs/hpmindex.htm

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Will it work?

What the evidence shows

This is an ambitious programme for improving quality in the NHS; the overall framework appears elegant, adopting an optimistic and rational view of behaviour. The strategy, however, owes little to existing knowledge of what works in quality improvement, which is rather more pessimistic.[2]

The results of evaluations of Continuous Quality Improvement (CQI), for example, have been varied, with more rigorous studies showing little effect.[3] An overview of the lessons of a decade of CQI experience in US health care reported that it had not had the impact hoped for by advocates and that no examples of major success stories were found.[4] Similarly, the impact of the publication of performance data on behaviours is uncertain, there being little evidence that consumers or health care professionals trust and use them.[5]

Health care organisations are different from many in the industrial sector, where organisational restructuring, re-engineering and CQI have had more demonstrable success. The NHS has a social role, it needs to individualise services and most importantly perhaps, it is dominated by strong professional bureaucracies that constrain change and make it hard to negotiate a 'new clinical order'. In addition public and professional conceptions of quality do not always coincide.

The NHS quality initiative seeks to improve the results for patients by transforming the culture of health care organisations, itself an unclear concept. Whilst research has shown in some areas that performance appears to be affected by culture,[6] in other areas it has not.[7] Most importantly it is not clear how organisational culture can be transformed particularly by predominantly top down initiatives.

Introduced too quickly?

The fact that it is likely to be very difficult to deliver an effective and efficient quality improvement programme for the whole NHS should not deter policy makers; it should, however, influence the expectations and pace of policy development and implementation. Informing policy with insights from reliable research evidence is hindered by the great haste with which the quality agenda has been developed and implemented. This has not permitted piloting or initial evaluation to help test and refine the approach. For example, there was no simulation of the likely behavioural effects of the Performance Assessment Framework (see *Health Policy Matters*, Issue 3).

More recently, the traffic light system announced in the NHS Plan[8] is being implemented without sufficient appreciation of the likely behavioural consequences. Models of governance are being evolved at the same time as they are being implemented and monitored and the pressure on CHI to deal with headline hitting scandals, of immediate concern to politicians and senior civil servants, may crowd out important, complex and time-consuming developmental aspects of its work. Insufficient attention has been given to disinvestment in less cost-effective interventions as NICE recommends the coverage of new expensive technologies, or to ways of ensuring that NICE guidance does not lead to resources being diverted away from more cost-effective technologies which have not been considered by NICE.

Human and financial resource requirements

Have we got sufficient staff with the right skills?

There is increasing evidence that levels of staffing (e.g. nurse: patient ratios), staff skills and level of work satisfaction can significantly affect the quality of care and patient outcomes.[9] However, the NHS faces a serious shortage of staff, with high vacancy and turnover rates in midwifery, nursing and clinical grades. This staffing shortage, exacerbated by EU work directives, is only gradually being addressed by the drive to increase recruitment and retention. The quality agenda may be limited in its impact by the lack of well-trained staff. Of course, adequate staffing is not a sufficient condition for delivering on quality; there are examples of well-staffed organisations which do not meet quality standards. However, trying to push existing staff to deliver an increasing number of targets (only some of which are directly linked to quality) may increase levels of stress,[10] so lowering morale and consequently compromising quality.

There is also a significant lack of the skills needed to successfully implement the quality agenda, such as people who can collect, analyse, interpret and act on information about performance and those with clinical leadership skills necessary to be able to drive the agenda forward.

Financial resources

Financial resources will be needed for:

- establishing the various organisations and funding their activity e.g. CHI, NICE
- the time of staff who are involved in quality improving activities (e.g. governance and audit) and time for staff to reflect and learn, which is often difficult in an environment where individuals are asked to do extra clinics or lists to meet national targets
- the development of the information gathering infrastructure (e.g. IT systems)
- the analytic capacity needed to handle the information being collected
- changing practice and the organisation of care in the light of guidance
- overcoming organisational or system barriers to quality improvements (e.g. the push for increased patient involvement in their care will be difficult to achieve in the light of current consultation times in primary and secondary care)
- the workforce planning implications for the delivery of the modernisation agenda.

Table: Tasks to improve implementation of the quality agenda

Issues to be addressed	Tasks	Who and how
Few NHS organisations have established integrated quality systems.	Establish that relevant infrastructure and robust systems are in place for all the elements of an integrated quality system e.g. setting up systems to monitor clinical performance and information systems dealing with clinical information about the patient's experience and outcomes.	Develop a multi-disciplinary quality team involving patient representatives, all professional groups and a link to R&D, reporting to the Chief Executive and to the Board, which should have quality as a standing agenda item. Decisions should be confirmed and owned at Board level.
NHS staff at all levels have little relevant background, training and support. Care is often fragmented and overly complex with poor teamwork. Organisations lack the capacity to measure, interpret and deal with practice and quality variations.	Invest in the training and development of all staff (including clinical leadership skills) so that they can use the quality systems and bring about appropriate changes in practice. Allocate dedicated time and new resources to this activity. This includes the development of effective clinical teams which are responsive, communicate effectively, have creative approaches to problem solving and manage conflict constructively.	All Trusts, PCGs/PCTs should have access to a well-trained and supported information and analytic capacity to monitor compliance with standards and performance. When poor practice is identified, it should be dealt with firmly, but in a supportive manner. The aim should be to help individuals overcome the reasons for poor performance which often reflect organisational structures and culture.
Organisations do not sufficiently involve their users and the general public in quality monitoring and improvement.	Adopt a systematic approach to obtaining user views in order to identify strong and weak areas, solutions and to support their implementation.	Involve user groups, the new patient councils and Patient Advocacy and Liaison Service (PALS) framework and analyse complaints with rigorous surveys.
There are few mechanisms to ensure dissemination of new intelligence from relevant research from the NHS R&D programme.	Develop existing arrangements to ensure there is a 'knowledge and implementation officer' function to regularly access, disseminate and apply evidence of clinical and cost-effectiveness and other relevant research.	The knowledge and implementation officers should have appropriate methodological skills, be adequately supported, be accessible to all staff and linked to management.
There is little explicit planning for how to prioritise the use of resources and prepare for disinvestment as well as investment.	Establish a mechanism for determining priorities in the context of NICE and National Service Framework guidance. This should be able to determine what services are reduced to make way for new health interventions and/or to decide not to fund the recommended activity where there are sensible reasons.	When diverging from national recommendations justify this explicitly (e.g. if relative cost-effectiveness is not demonstrable) and record the decision.
Organisations often pay insufficient attention to workforce issues and to innovative approaches to improve recruitment and retention.	Explicit attention should be paid to improving the well-being of staff and teams in health care organisations as part of the quality agenda. Indicators of workforce morale should be reviewed at Board level.	HR directors should be part of the quality team.

There is a high expectation that the NHS will be able to implement the quality framework without sufficient recognition of the human and financial resources required.

A quality paradox

There is a paradox that implementation of the quality agenda is likely to increase the perception that quality is declining and may in fact cause it to fall. Firstly, as quality is targeted, more deficiencies will be revealed as previously hidden poor performance is uncovered. Furthermore, as guidelines and explicit standards are established, people's expectations of quality will rise and it will be easier for them to make successful complaints and litigate.[11] Whilst this is to be expected the danger is that government will, as a consequence, introduce even more initiatives to deal with the problem - 'initiative inflation'. For example, rather than see the organ retention scandal at Alder Hey hospital as a challenge for clinical governance, a committee of enquiry was established and a new Retained Organs Commission set up. The quality regime will inevitably lead to further exposure of service failures – current proposals will not be able to reverse this spiral. A whole systems approach that encompasses all aspects of quality may help avoid 'initiativitis'.

Secondly, the introduction of more external mechanisms for quality assurance may displace existing informal mechanisms used within health care organisations and professional groups to promote quality.[12] Whilst these mechanisms are rarely adequate by themselves to achieve the expected quality standards, we must be careful that they are not devalued or displaced but rather added to by the new formal approaches. The challenge is to try and increase accountability, including the wider sharing of information on performance with others in the NHS and the public, without undermining trust by staff

and the public - the core 'social glue' which holds together a relatively inexpensive and efficient publicly funded health service.

Getting prepared

Despite all the potential pitfalls in the development and implementation of the quality agenda, it offers some exciting opportunities to tackle quality explicitly. Health care organisations in general and probably primary care providers in particular are not, however, well prepared.

One of the key messages of this issue of *Health Policy Matters* is to recognise quality as top of the agenda and that poor quality usually results from faulty systems not from faulty people, so it is the systems that must be fixed.[13]

Prioritisation of quality at a corporate level will also need to be reflected by change lower down the organisation.[14] Organisations will need to skill up for quality, be aware of the effects on morale and so keep everyone on board and most importantly – **be realistic**.

There are so many initiatives and the task is so complex that the danger for organisations is to take on too much. Staff in the NHS are trying to cope with many, sometimes competing, priorities, such as embedding quality systems in the organisation whilst also dealing with national imperatives on waiting lists and activity levels. Too much emphasis is being given to the 'transitional agenda' (getting from A to B in the quickest possible time). Instead, organisations need to focus on the 'transformational agenda' (e.g. the organisational culture – changing the way things are done – and building up effective teams) which takes time. The NHS Plan is a ten-year plan and we will not achieve everything overnight.

A summary of some of the tasks is shown in the Table.

References & resources

1. NHS Executive. *A first class service: quality and the new NHS*. London: Stationery Office, 1998.
2. Sheldon TA. It ain't what you do but the way that you do it. *Journal of Health Service Research and Policy* 2001;**6:**3-5.
3. Shortell SM, Bennett CL, Byck GR. Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. *Milbank Quarterly* 1998;**76**:593-624.
4. Blumenthal D, Kilo CM. A report card on continuous quality improvement *Milbank Quarterly* 1998;**76**:625-48.
5. Marshall MN, Shekelle PE, Leatherman S, Brook RH. The public release of performance data: what do we expect to gain? A review of the evidence *JAMA* 2000;**283**:1866-1874.
6. Shortell SM, Zimmerman JE, Rousseau DM, Gillies RR, Wagner DP, Draper EA et al. The performance of intensive care units: does good management make a difference? *Medical Care* 1994;**32**:508-25.
7. Shortell SM, Jones RH, Rademaker AW, Gillies RR, Dranove DS, Hughes EF et al. Assessing the impact of total quality management and organisational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. *Medical Care* 2000;**38**:207-217.
8. Department of Health. *The NHS Plan*. London: The Stationery Office, 2000 (cm. 4818-1).
9. Aiken LH, Sochalski J, Lake ET. Studying outcomes of organizational change in health services. *Medical Care* 1997;**35:**NS6-NS18.
10. Williams S, Michie S, Pattani S. *Improving the health of the NHS workforce: report of the partnership on the health of the NHS workforce* London: Nuffield Trust 1988.
11. Walshe K, Sheldon TA. Dealing with clinical risk: implications of the rise of evidence-based health care. *Public Money & Management* 1998;**18**:15-20.
12. Power M. *The audit society: rituals of verification* Oxford University Press, 1997.
13. Leape LL. IOM medical error figures are not exaggerated. *JAMA*, 2000;**284**:97.
14. Latham L, Freeman T, Walshe K, Spurgeon P. Wallace L. *The early development of clinical governance: a survey of NHS Trusts in the West Midlands*. Project report 11. Birmingham: Health Service Management Centre, 1999.

Websites

www.cgsupport.org
Clinical Governance Support Team
www.chi.nhs.uk
Commission for Health Improvement
www.casu.org.uk
Controls Assurance Support Unit
www.doh.gov.uk/ncaa/index.htm
National Clinical Assessment Authority
www.nice.org.uk
National Institute for Clinical Excellence

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