Health Policy

The National Health Service in England considers on the Government's plans to improve quality of health care

Commenting on another of its consultation papers, one notary recently gave the British Government "α for presentation, β minus for deliverability".[1] Early indications are that the Government's consultation paper on quality in the English National Health Service (NHS)[2] could edge up to a β plus or even an α minus, with some more thought about the practicalities of implementation.

The history of approaches to quality in the NHS has been of fragmented initiatives, with little sense of overall coherence. National complaints procedures resulting in pronouncements from the health service ombudsman, local consumer watchdogs, and external visiting bodies such as the Health Advisory Service have coexisted with variable internal and external use of voluntary performance indicators and patchy systems of medical audit.[3] The most systematic approach to a national quality programme came from the previous government, when they introduced the medical (later clinical) audit programme to the service at the same time as the "purchaser-provider split".[4] This structural change was, itself, intended to produce improvements in quality, through the incentives anticipated by competition with other healthcare providers. Commitment to quality improvement was not always manifest in the priorities for performance monitoring, however, where measures—such as the efficiency index (essentially activity per £) and achievement of waiting list targets—overrode indicators of service quality. In its white paper setting out the dismantling of the former government's internal market in health care, the Labour Government signalled that fundamental changes to the approach to quality in the NHS were afoot.[5] *A first class service: quality in the new NHS* sets out their vision. The consultation paper introduces several measures which, taken together, are intended to produce a model of quality improvement which "marries clinical judgement with clear national standards"—that is, the Government is trying to harness national external approaches with local flexibility and responsibility. It proposes to achieve this by:

- Setting national standards (through a National Institute for Clinical Excellence, (NICE) and national service frameworks for selected disease or client group areas)
- Improving systems for local quality assurance and quality improvement (notably the new clinical governance proposals, but also including professional self regulation and lifelong learning)
- Monitoring the implementation of standards (by a new national body, the Commission for Health Improvement, along with routine performance monitoring of health authorities and trusts and a new national survey of patient and user experience).

The NICE will appraise therapeutic interventions and disseminate authoritative guidance throughout the NHS, including guidelines for the management of certain disease conditions and guidance on the appropriate use of new technologies. The NICE will also produce audit tools for use within the service. To achieve this, the Institute will take over a range of functions currently undertaken by different organisations—for example, the National Prescribing Centre, the National Centre for Clinical Audit, national guidelines programmes, and the systematic reviews (Effectiveness Bulletins) funded by the Department of Health.

National service frameworks are intended to be approaches to whole services, rather than simply dealing with clinical practice issues. They will set national standards and define service models for specific services or care groups. They will be modelled on the Calman-Hine framework for cancer services, which is already in place in England.[6] Clinical governance will be a requirement of both healthcare trusts and primary care groups. How this will work in primary care is not yet clearly understood, as general practitioners will retain their independent contractor status. However, there is more clarity for trusts where the chief executive and board will, for the first time, have a statutory duty to account for the quality of their services. They will be expected to have in place:

- A comprehensive programme of quality improvement activities (including clinical audit, evidence-based practice, and internal monitoring systems)
- Clear policies to manage risk
- Procedures to identify and remedy poor performance in all professional groups.

Professionals will be required to participate in national audit programmes where they exist. The Government also proposes to strengthen professional self regulation, with particular emphasis on the medical profession after recent high profile lapses in its public credibility.[7] The document also introduces a new phrase to describe continuing professional development, "lifelong learning", which intends to provide staff with the opportunities to update their skills and knowledge.

The Commission for Health Improvement will be a new statutory body, which will carry out a rolling review programme, assessing local clinical governance arrangements and the adequacy of implementation of NICE guidance and the national service frameworks. It will also be possible to call in the commission to tackle serious difficulties in the service. It is expected that the commission will link with the NHS complaints procedure, but details of how have not yet been worked out. The government is also consulting on a new national performance monitoring framework, which aims to take a broad overview of health and health services, rather than the past focus on service activity. Finally, an annual national survey of patient and user experience is proposed, to find out whether local services are meeting patients' needs, and which could trigger the involvement of the commission.

The consultation paper sets out a highly ambitious agenda. In his introduction to the document, Frank Dobson (Secretary of State for Health), accepts that the "... changes will not happen overnight" and "are part of our 10 year programme of modernisation ....".[2] Commentators,

although strongly welcoming the overall thrust of the paper, have picked out a series of potential problems in implementation. These range from the perverse incentives inherent in external monitoring, as embodied in the proposed Commission for Health Improvement and plans to publish indicator league tables; to the seemingly unrealistic expectations of the annual work programme for the NICE, and the methodological weaknesses in the planned national user survey.[8] However, there is widespread support for the apparent coherence of the proposals, especially given indications that government health policy will be consistent across other relevant areas such as information technology.

For me, the crux will be how well the government walks the tightrope between "big brother" and local professional and organisational responsibility for quality improvement. The devil is, as always, in the detail: we need to ensure that the detail works out in favour of benefits for patients, rather than the lawyers' pockets.

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4 Department of Health. *Working for patients*. London: Department of Health, 1989.
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Comment

Defining appropriateness: the challenge of knowing the difference

In the forward to the consultation document *A First Class Service*,[1] the Secretary of State proposes that "the unacceptable variations that have grown up in recent years must end". I will make that statement the framework of a discussion on measuring and improving performance among healthcare providers, as it pertains to the English National Health Service (NHS) agenda for quality and health.

The Secretary of State's pronunciation about variation contains all the essential elements for an agenda of ongoing amelioration of both services and the quality of life of the populations served.[1] These essential elements are: (*a*) unacceptability; (*b*) variation; (*c*) increasing temporal trends; and (*d*) elimination of variation or halting the rate of its increase. Curiously, these also were the essential elements of many agendas for change in the United States encompassing government sponsored activities—for example, the Agency for Health Care Policy and Research (AHCPR)—and those on the private side—for example, small area variation analysis, and the National Committee for Quality Assurance (box 1). The similarity of these determinants certainly deserves attention.

The Agency for Health Care Policy and Research (AHCPR) was established in 1989 under Public Law. As a part of the United States Department of Health and Human Services, it is the lead agency charged with supporting research designed to improve quality of care, reduce its cost, and broaden access to essential services. The AHCPR's broad programmes of research bring practical, science based information to medical practitioners, to consumers, and other healthcare purchasers.

The National Committee for Quality Assurance is a not for profit organisation that seeks to improve quality of patient care in partnership with and complementing managed care plans, purchasers, consumers, and the public sector. It evaluates the internal quality processes of health plans (through accreditation reviews) and developing performance measures.

Background

The first outcomes based standard of care was issued in Babylon nearly 4000 years ago, during the reign of Hammurabi, King of Babylonia. His code of laws, found on a column at Susa, is one of the greatest of the ancient codes. The penalty for surgeons who failed to meet the government's standard of care was straightforward:

> "If a physician shall make a severe wound with an operating knife and kill (the patient), or shall open an abscess with an operating knife and destroy the eye, the (surgeon's) hand shall be cut off."

From the Hammurabi code[2 3] to the mapping of the genome, we have been interested in uniformity of our practice, its appropriateness, and in understanding the determinants of our behaviour. Fortunately many healthcare reform agendas around the world have embraced the logic of quality improvement, by contrast with the drastic recommendations of Hammurabi's code.

In the United States an early 19th century maverick surgeon, Ernest Codman, set the tone for today's agenda for change in health care. Codman, who died poor and rejected by his colleagues and the medical profession, also defined, perhaps most eloquently, the very core principles of quality improvement. During an address read before the Philadelphia County Medical Society, on 14 May 1913 he said:

> "The object of this address is to stimulate thought on and discussion of the standardisation of a hospital. I take it that the word standardisation implies a general movement toward improving the quality of the products for which hospital funds are expended. As a rule, standards are raised by stimulating the best—not by whipping the laggards."[4]

I cannot think of another short quote that better describes the transition from quality assurance to quality improvement! And, I think that the NHS agenda for change is doing exactly that—looking at the entire system