

## Quality management in the British National Health Service

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The NHS will work continuously to improve quality services and to minimize errors. The NHS will ensure that services are driven by a cycle of continuous quality improvement. Quality will not just be restricted to the clinical aspects of care, but include quality of life and the entire patient experience. (NHS Plan, July 2000)

What do we mean by quality in the NHS? There are potentially as many definitions as there are groups of individuals who work in and use the health service. For most patients, users and their families the definition of quality is about getting the right service at the right time delivered by an appropriate person to a better than acceptable standard. For most staff groups it means all of that, and additionally meeting the expectations and regulations of the particular professional body that holds their accreditation. For health service managers and senior clinicians it also means ensuring that their organizations can complete mounds of paperwork to demonstrate the ability to meet a host of nationally prescribed standards. These potentially different viewpoints frequently come together under an increasingly emotive and public spotlight as the debates about the way in which the NHS fulfils its roles continue to make political headlines in the UK.

Since coming to power in 1997 the British labour government has made clear its intention to 'modernize' the NHS and has stated that improving quality is one of the core principles of the modernization agenda. Actions taken by the government to demonstrate their commitment have increased the quality dilemmas posed to the people who deliver the service, and ultimately, although it may not yet be recognized, to the service user. These dilemmas can be explored under a number of key themes, as set out below.

### CONSISTENCY AND ACCESSIBILITY

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The UK government perceives any variation in performance across the NHS as a demonstration of poor quality. Several measures have been introduced to

ensure that all services are delivered 'at the level of performance of the exemplar services in the NHS' (Clinical Governance White Paper, 1998). One such is the creation of the National Institute of Clinical Excellence (NICE), a national body whose role is to produce and disseminate high quality, evidence-based guidance on the management of diseases (pharmaceutical usage, use of prosthesis, etc) that must be used to inform clinical and financial decisions made locally. Although only in full operation for one year there is already much public debate about how free NICE can be from government intervention, particularly around guidance on high cost drugs.

In addition a series of National Service Frameworks (NSF) are being developed. Each framework refers to a particular disease or population group and makes clear statements about the standards of service that are expected. The first three NSFs are targeted at mental health, coronary heart disease and older people. Unfortunately there is little additional funding to ensure that the targets can be met.

Whilst most people would acknowledge that measures to standardize performance are helpful, the impact of these interventions may well be to move health services from locally accessible venues. For instance if a hospital cannot deliver certain services to the standard required – because of lack of highly trained specialists in a certain area of work, or lack of money – the service will be moved to another hospital perhaps 50 miles away. It is questionable whether members of the public realize the relationship between the desire for consistent standards and local access to health care. A similar tension arises for individual clinicians. The government emphasis is on ensuring everyone is trained to meet the standards of the best, but clinical expertise can be seen as being dependent on interest as well as technical skills, and there is always an alternative career within the private sector.

## EMPOWERMENT AND STANDARD SETTING

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'The time has now come to free the NHS frontline,' said Alan Milburn, UK Secretary of State for Health in a speech in June 2001. He went on to describe how this would be realized. During 1999 the Commission for Health Improvement (CHI) had been set up to monitor the standards achieved by health service providers, much along the lines of the process of monitoring in schools. Its role is both developmental, visiting each health provider on a rolling programme and advising on improvements, and punitive, publishing the results of performance studies and providing rapid response teams to 'sort out' poor performers. One of the freedoms referred to by Milburn was that the best performers would have less frequent monitoring from the centre, and fewer inspections by CHI. In addition they would have extra resources for certain central programmes and for taking over and turning round the performance of 'failing' hospital Trusts.

Failing Trusts are identified by their inability to meet the targets set nationally on a range of aspects including waiting times (for admission, for appointments, etc.), environment (mortuary standards) and catering. Regular measurements result in a traffic light labelling; too many red lights can potentially lead to the termination of the contract of the chief executive and the intervention of a 'hit squad'. The incentives are pushing managers to aim for the upper end of orange – not to draw attention to the organization in any way, good or bad. Working in the high-pressure environment of health service delivery, and being constantly pushed to deliver targets can result in a culture in which empowerment is difficult to achieve and where staff often have to make uncomfortable decisions. Should Mrs X be discharged when it is known that she is not quite as fully recovered as was expected, but also knowing that to keep her in the bed will result in yet another person on the waiting list for a hip replacement operation? The number of revolving door patients (discharged on day one and returned unwell on day three) is testimony to the pressure on staff to make those decisions. Which one is the 'quality' decision?

Each health organization is expected to set up a process of Clinical Governance: 'a framework through which the organization is accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellent clinical care will flourish.' (Clinical Governance, 1998). The philosophy of Clinical Governance is founded on openness and a supportive environment. Many health service organizations struggle to develop such characteristics while operating in a national system that can be more focused on failure and punishment.

## HIDDEN AGENDAS

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Quality management in the NHS is wrapped around with very strong organizational issues of personality, professionalism and power, and overlaid with the political dimension. The national tussles about how powerful trade unions and professional bodies such as the Royal College of Surgeons impact on the service have always been apparent, but are becoming more confusing. There is a view that the increasing imposition of national standards and the rigour of performance management have a hidden agenda, to enable greater control of some of the most powerful players, the doctors. High profile cases of poor clinical performance have rightly pushed the need to make public the information on the results of hospital departments (perhaps even league tables on individual doctors' success rates), and have also challenged the 'old boy' behaviour of many doctors. Managers have become more confident in their responsibility to ask questions about quality decisions in areas where they may have no technical knowledge. On the flip side the increasing lack of public trust in the NHS is resulting in severe recruitment difficulties.

The most recent structural changes to the management of the service will also affect the current power balance. The commissioning of services in hospitals is becoming the responsibility of Primary Care Trusts, community-based health organizations led by general practitioners. The 'family' doctor will lay down their expectations of the quality of the service given by the powerful hospital consultant.

## THE USER/CITIZEN DIMENSION

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Throughout all of the modernization changes there is a constant emphasis on the role of patients/service users and carers within systems designed to enable improved quality management. Some examples are:

- Patient representatives on Clinical Governance groups.
- Patient-friendly versions of clinical guidelines from NICE.
- Plans for patient choice regarding appointment dates.
- A patient advocacy service in all NHS Trusts.
- Increased rights of redress.
- An annual National Patients Survey that links to financial rewards for NHS institutions.

However, although the requirements are clear there are two issues that indicate that it may prove difficult to realize them. First the record of past attempts, as for over ten years specific requirements to take action to increase public involvement have been generally overlooked or fudged, and the main impact that the public have had on the NHS is visible only when serious mistakes are made. Much of that difficulty stems from a lack of understanding of the complexities within public service delivery; and second, the level of understanding reached about the differing responses of members of the public to the health quality dimension. Do they behave as a citizen, paying for the service through taxation, or as a user who wants immediate effective and efficient treatment even if it can be detrimental to the next person on the waiting list? The person stake in health service quality management creates additional dilemmas for all.

This brief picture of some of the forces interacting in the quality agenda of the British NHS has demonstrated the complexity of the challenge. There is no doubt that the health service needs rigorous, understandable and open systems to manage managerial and clinical performance, but also no doubt that such systems will only work well in a learning and supportive culture. Private sector organizations face a similar balancing act, but can do so without the added impact of public scrutiny and political manipulation.

**CASE STUDY QUESTIONS**

- Quality in the NHS is founded on the relationship between the user, the health professional and the manager. How does the political focus change that relationship and the resultant quality outcome?
- Power and quality – how uncomfortable are they as bedfellows in the NHS?
- How do the quality dilemmas faced by NHS managers differ from those faced by managers in the private sector?