QUALITY ASSURANCE PROJECT

REPORTS

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Quality Assurance in the NHS

Current Management Approaches

A summary of visits to the Scottish Office, Welsh Office and 14 English RHAs.

by

Charles D Shaw PhD MB BS MFCM LHSM

King's Fund Centre
126 Albert Street
London NW1 7NF
Telephone 01-267 6111

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Charles D Shaw PhD MB BS MFOM LHSM

Director of Policy, Quality Assurance Project
King's Fund Centre,
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Section 1

INTRODUCTION

Public, political and professional pressures have led to a greater interest in quality assurance in the British National Health Service. This has been galvanised but not monopolised by the Griffiths Report[2], but there has been no national policy or framework prescribed. The development of, and approach to quality assurance has therefore varied widely between districts and between regions.

Both at local and at national level there is also debate as to whether the responsibility for quality assurance should lie with professional groups, with managers or with consumers - or a combination of all three. A survey in 1985[6], of the initiatives taken by national professional bodies confirms that there is considerable interest and some activity towards this being generated by the professionals. The current report aims to reflect managerial perspectives at a level above districts and boards, as seen by officers of the fourteen English regions and the Scottish Office and Welsh Office. Its purpose is to identify practical ideas and what is being done, rather than to highlight what is not being done.

Section 2

METHODS

Initial contacts were made with health departments and the regional general managers who were invited to nominate officers or members to discuss current activity and intentions in quality assurance. Sixteen meetings were held between April 1986 and May 1987. Many of these were with individual officers; one was with a multi-lateral force including the regional general manager, health authority members, and senior managers. Twelve meetings included the chief nursing officer (or deputy), six included the regional or chief medical officer (or deputy), and six included the regional general manager (or deputy). Two included an RHA member; none included a clinical doctor.

Perhaps inevitably, since there was no pilot study, the questions and discussion were initially relatively unstructured, but became progressively more focused in later meetings. This eventually led to a general format in which the results are presented and to some common questions which may be useful to health authorities (see appendix).

Section 3

RESULTS

3.1 Organisation

3.1.1 Policy

About half the regions have made specific reference to quality assurance in strategic plans - many of these in response to an annual review task. Only one region had explicitly defined the dimensions of quality (using Maxwell's criteria[5]); another had delegated its review task to constituent districts to define quality and a strategy for its implementation.

3.1.2 Personnel and Organisation

Organisational, and individual responsibility for quality assurance shows similar diversity. In general it reflects the prevailing view of the authority whether quality is primarily a medical, nursing or planning function. The commonest structure involves the regional nursing officer with a formal quality assurance title and an unwritten assumption that medical aspects would be the responsibility of the regional medical officer. Many of these officers have had the role added to their existing duties but without any defined resources to support it; in some regions (and districts) this officer is supported by a budget sufficient for two full-time assistants devoted to quality assurance. By contrast, in Scotland such matters tended to be implicit in management duties rather than identified in the job title. The same is true of about half the Welsh districts in which no individual director is designated.

3.1.3 Regional/National Forum

Five regions have held at least one one-day meeting for district representatives to discuss local and regional issues in quality assurance. These have been particularly helpful in regions where the officers were not previously known to each other as part of an existing network, (such as of Chief Nursing Officers). The CANO of Gwent has established a national Quality Assurance Interest Group which is not confined to staff with a nursing background. (Contact: Mrs Delia Hudson, CANO, Gwent Health Authority, Mamhilad House, Mamhilad Park Estate, Pontypool, Gwent NP4 OYP). Many regions - and Scotland - have an active network of nurses interested in the subject.

Three regions have established a committee or working party including members and officers of the regional health authority (RHA) to consider performance evaluation and quality assurance. One regional committee includes a community health council (CHC) member. In Scotland, a working group concerned with quality of care and consumer feedback was set up in the autumn of 1986 on which the Department, health boards and clinical staff are represented. North West Thames has established a Quality Council; four teams are examining quality issues within the regional headquarters.

3.1.4 Role of Authority Members

The personal contribution of authority chairmen ranges from acting as "guinea-pig" in an outpatient department to writing to district managers requesting information on consumer satisfaction and to organising a debate among district chairmen on the meaning of quality. In one authority members receive a quarterly report on quality assurance, another has set up a members' special interest group, another has held a seminar on complaints. Member involvement in some regions has been minimal. A pleasant (but so far unproven) initiative has been to take a small group of members, officers and key professional academic and political leaders to discuss quality in North America; two groups have done this and another intends to do so. The visits focused in particular on professional and managerial attitudes and practical means of implementation - especially the use of data systems.

3.2 Management

3.2.1.Planning and Review

In England and Wales the annual review mechanism has been used in various ways, including the issue of guidelines requiring districts to define how they intend to tackle quality assurance organisationally, how they monitor quality, what intentions they have to improve it and what progress has been made so far. There is a general dichotomy between those regions which rely on districts to generate a regional strategy and those which require districts to comply with a strategy prescribed by the region.

3.2.2 Standards

Despite a general expectation of quality at regional and national level, few authorities have defined a 'good service' in general terms. Some specific standards and checklists being developed or in use are as follow:

Ophthalmology, accident & emergency services, continuing care for elderly people (Wessex)

"Personal service" (Trent)

Patient service, drug abuse, day hospitals, cervical cytology (SW Thames)

Terminal Care (NW Thames)

Mental handicap (Wales)

Mental illness, community hospitals (West Midlands)

Small hospitals (S Western)

Community services, mental illness and mental handicap checklist (Trent)

Food hygiene (SE Thames, derived from Wessex)

Adolescent and child psychiatry, neo-natal intensive care, mental handicap, and ward care of the elderly (North Western)

3.3 Information and Resources

3.3.1 Performance Indicators and Statistics

In most regions, Yates and DHSS indicators are scanned for wide variations; in one region, nursing "outliers" are followed up with a personal visit to the district concerned. Regional performance indicator groups or individuals have produced a number of local indicators including:

Nursing and theatres (Yorkshire)
Clinical performance indicators (NW Thames, Yorkshire, Northern)
School of nursing (NW Thames, W Midlands)
GP information on hospital usage (W Midlands)

The Department in Wales has a working group examining the statistical indicators related to quality. In Scotland, a group looking at performance indicators has considered the question of indicators related to quality, while within the national professional advisory structure attention is being given to issues of quality and outcome. But the "DHSS" indicators do not include either country; the Yates Inter-Authority Comparisons include Wales.

Various resource schemes were presented as a means of measuring clinical activity and identifying potential problems of quality - such as wide variations in service utilisation.

3.3.2 Library Services

Regional library services range from total absence to well-established collections including resources specifically for the use of districts in quality assurance. One region has designated the regional library specifically as a resource centre for district and regional officers in quality assurance.

3.3.3 Newsletter

The dissemination of quality assurance ideas includes use of existing newsletters for staff in general, or for individual groups such as nurses. In North West Thames the proceedings of the regional quality assurance forum are published in a dedicated newsletter with the help of their public relations advisers. A bi-monthly quality bulletin is proposed jointly between Trent and Northern regions.

3.3.4 Handbook

Two regions (Oxford[1] and North Western[4]) have published booklets including ideas on the introduction of quality assurance.

3.3.5 External Resources

Oxford region obtained considerable help and advice from the medical staff of a local United States Airforce hospital.

3.3.6 Catalogue of activities

Several regions set out to establish the level of existing activity before attempting to define any future steps. The most effective route towards this appears to be a personal visit by a regional officer to each district. Postal questionnaires do not attract a good response, partly because of problems of definition and partly because of the complexity of the subject.

3.4 Education

3.4.1 Regional Training Schemes

Several regions have introduced training courses for newly appointed consultants which include quality assurance. In North West Thames this is a condition of employment and 20% of all consultants have now attended such courses including seminars on quality and evaluation. While some regional training departments have little involvement in quality, others (such as West Midlands) regularly organise courses and district seminars.

3.4.2 Didactic Seminars

Many one-day seminars have been held on subjects such as:

The Patients' Charter
Quality in nursing
The role of district managers in quality

Many such meetings are a general sharing of initiatives within, and among districts. In the Oxford region a series of two-day workshops has been organised by the region to involve 20-25 officers in each district, as a mechanism for producing a local action plan. North West Thames have commenced a series of introductory seminars, including prešentations to district general managers, directors of personnel, chief nursing advisers and the regional medical committee.

3.5 Medical Advisory Structure

In relation to their potential contribution to quality assurance, regional medical structures have not been much involved in regional initiatives. In North Western region, and North West Thames, the medical advisory committee enabled the development of checklists for services in anaesthesia, dental surgery, obstetrics and gynaecology and neurology and neurosurgery. The regional medical committee in Trent were involved at an early stage in the personal service initiative. In the South Western region, the regional medical committee held a half-day seminar on quality and invited district medical committees to catalogue local activities in quality assurance. The one-year confidential enquiry into peri-operative deaths which spanned three regions did not involve the regional health authorities directly.

In Scotland, arising from a paper presented by the National Medical Consultative Committee to the Scottish Health Service Planning Council in 1985 and discussions between the Scottish Council of the BMA and the Department, a group was established, (now known as the Clinical Resource Use Group), which includes individual clinicians with an interest in the quality and effectiveness of services.

3.6 Research and Development

3.6.1 Regional/National Initiatives

A wide variety of regionally inspired or managed projects included:

1. Defining standards and expectations

Use of WHO tape-slide pack on "Setting Nursing Standards" (Scotland)
Guidelines for medical and nursing care in Nursing Homes (SE Thames)

2. Measuring practice and service

Booklet on the design of patient questionnaires (Wessex)
Perinatal mortality enquiry (NW Thames)
Survey of 50 kitchens and review of environmental health office reports (NW Thames)
Proposed survey of calibration and safety of electro-medical equipment (NW Thames)

Management services survey of accident & emergency and outpatients services (E Anglia)
Guidelines on obtaining and presenting information, based on nursing record audit (SE Thames)

3. Education and training

"Person to Person", a video training pack now commercially available (Mersey)

3.6.2 District/Board Initiatives

Although this study was primarily of regional and national health authorities many inventive ideas were reported from districts and boards. Some of these are regionally funded, others are not:

1. Defining standards and expectations

Standards and assessment of elderly care (City and Hackney)
Standards for terminal nursing care in acute wards (Medway, City and Hackney)
Pre-operative information for general surgery (Canterbury)
Surgical information cassettes for patients (Kingston and Esher)
Outpatient departments (East Dorset)

2. Measuring practice and service

Study on the effect of increased hospital productivity on quality (Wirrall, also three districts in Wessex)
Survey of staff satisfaction (Crewe)
Survey of post-operative wound infection (N Derbyshire)
Computer software for clinical review of community psychiatric nursing, to be made commercially available (Hastings, Medway)
Annual report on the health of the population (S Glamorgan, Clwyd)

Most districts seem to have undertaken customer relations surveys.

Note: for more detailed analysis of the use of tools for measuring nursing standards, see the "Nursing Quality Assurance Directory" produced by the Royal College of Nursing under the direction of Dr Alison Kitson[3].

3. Education and Training

Patient Relations package, to be commercially available (Grimsby)
National 2-day conference on quality assurance (Gloucestershire Nurses)
Regional headquarters quality assurance newsletter (NW Thames)
District quality assurance newsletter for staff and public (Southend, South Bedfordshire)
Quality assurance training by Sainsbury's (Oldham)

4. Quality assurance programmes

RHA-funded quality circles (Southport)
Quality assurance tools for outpatients, A & E, and support services (Hounslow and Spellthorn and N Hertfordshire)
Survey of staff ideas for quality assurance (Doncaster)
Use of DRGs in resource management (West Glamorgan)

Many districts have introduced quality circles.

3.6.3 Universities and Polytechnics

Many regions have made good use of local academic departments, including:

Bristol Polytechnic (Japanese management and services development package)
Health Service Management Centre, Birmingham (performance indicators)
London School of Hygiene and Tropical Medicine (performance indicators)
Newcastle Polytechnic (Monitor assessment system)
Newcastle University (study of child health services)
University of Kent Health Service Research Unit (staff development and service projects)
University of Manchester (service effectiveness)
Universities of Sheffield and York (joint project on health economics)
University of Wales Institute of Science and Technology (patient satisfaction survey tool)

3.6.4 Community Health Councils

The Regions had little direct contact with consumer bodies in relation to quality assurance - but Mersey were invited to a regional Community Health Council conference. However, many CHCs had conducted surveys with (and without) district help.

Section 4

DISCUSSION

4.1 Organisation

4.1.1 Policy

Stated commitment to quality assurance in strategic plans ranges from the minimal to specific intentions to define and monitor standards. However, many authorities who have not yet made explicit statements have in fact made effective steps towards establishing quality assurance. Few regions have clearly agreed whether quality refers to consumerism, safety, technical or other professional aspects of health services; this lack of definition seems to reflect a lack of clear purpose in the field of quality. Although most regions seem to be pleased in principle not to have DHSS prescriptive guidelines, in practice they would welcome clearer advice of what is expected by the management board. The closer relationships which the Scottish and Welsh Offices have with the professions and the service have enabled a more direct involvement in practical initiatives.

4.1.2 Personnel

The identification of responsible individuals - the majority of whom are or were Chief Nursing Officers - appears to reflect the dominant view in individual regions as to whether quality is primarily to do with consumerism, nursing, medicine, planning or simply management. Many individuals have symbolic labels attached but have little resource in terms of budget or staff and very limited authority (for example over medical and technical issues). Several regions have responsibility loosely shared between a nursing officer, medical officer and planning officer, but with little clear definition of their respective roles.

If quality assurance is considered to relate to all services and professions and to require explicit definition of standards, and to involve monitoring of their achievements, it might most appropriately rest with planning and information. This option is applied most clearly in Wessex, but also to a lesser extent in North Western and West Midlands as part of the remit of performance review.

4.1.3 Forum

Regions where nursing officers have generally assumed the role of leading quality assurance have an inherent advantage in that a network already exists within the region. In others a positive effort is required to establish rapport and exchange of ideas between districts. A successful collaborative approach seems to be to gather districts together to present their own ideas, plans and experiences.

4.1.4 Members

Involvement of RHA members is varied. This survey did not make clear whether this was a general reflection on role of members in service issues generally, or whether it was specific to quality assurance.

4.2 Management

4.2.1 Planning and Review

Many regions have delegated to districts the responsibility for initiating strategies for quality assurance but without defining what these strategies are expected to embrace. This apparent deference to local self-determination might suggest uncertainty as to what is really being asked for. The presentation of a paper document can be a misleading measure of a health authority's achievement towards quality assurance. The establishment of a successful programme also requires much preparation in terms of attitudes and organisation before significant results are evident; so lack of visible progress should not be taken to be lack of activity, especially in clinical areas. If such immediate results are required, the first harvest is likely to be the easy targets or the "dressing up" of established activities.

4.2.2 Standards

The National Health Service continues to suffer from a lack of clear agreement on what constitutes a "good" service. This makes the assessment of achievement of quality especially difficult and emphasizes the need to pool district, regional and national guidelines as a basis for shared and explicit expectations. Currently much time and effort is being invested locally in developing, from scratch, yardsticks which are already available, and in "reinventing the wheel".

4.3 Information and resources

4.3.1 Performance Indicators and statistics

The challenge of quantifying quality using routine or ad hoc statistics, has generally resisted solution. Existing data are, however, being effectively used to identify potential problems such as high volume or high risk procedures and activities, and areas showing acute variation in provision and use of service. Until routinely-collected data can identify case mix and severity, practical comparisons of outcome are likely to be limited to local use.

4.3.2 Library services

Quality assurance relies heavily not only on numerical information, but also on access to statements of standards, the research evidence on which they are based, and methods of measuring them. Many regions do not make this available.

4.4 Education

If quality assurance is everybody's business (including managers and clinicians), it should appear in basic and post-basic training. Few regions appeared to have identified the contribution of training departments, the Royal Colleges, and professional bodies to quality assurance.

4.5 Medical advisory structure

Individual or corporate accountability for the technical quality of care - especially of medical practice - is generally ill-defined, (if not avoided) in quality assurance strategies. Except in Scotland, very few initiatives have been in partnership with the formal medical advisory structure. This is inconsistent with the growing expectation among the national professional bodies (and their regional groups) that doctors should - if only for the recognition of training posts - be involved in regular and critical review of clinical work.

Section 5

CONCLUSIONS

This collage of managerial approaches to quality assurance has many failings: it is based on a number of interviews over many months; and comments were obtained from whatever staff the managers nominated - clinical activities may be greatly under-represented for this reason. But it is this kind of diversity which characterises the pattern of quality assurance in Britain.

To an extent, this diversity is constructive; it allows room for initiative and invention. But it also may conceal a lack of clarity on basic questions such as:

- what is expected from quality assurance?
- whose job is it?
- what authority does he/she have?
- how does that job link with clinicians and managers?
- what resources are required?

This new management flavour may have suffered from being institutionalised into annual review tasks, job titles, popular slogans and formal documents before it has been understood. Scotland, without the tasks, titles, slogans and documents, provides an interesting contrast. Which approach is most effective is yet to be seen; but we will not learn from experience unless the experience is available and we are willing to learn. This suggests that the very least the NHS needs by way of national co-ordination in quality assurance is a resource centre and a forum in which to exchange ideas.

APPENDIX

SOME QUESTIONS ABOUT QUALITY ASSURANCE AT HEALTH AUTHORITY LEVEL

1. Organisation	YES	?	NO
Has the Health Authority			
1.1 Formally adopted a definition of the scope of quality?	—	—	—
1.2 Defined a strategy for introducing quality assurance?	—	—	—
1.3 Defined the contribution of members?	—	—	—
1.4 Defined the contribution of officers?	—	—	—
1.5 Allocated an identified budget for quality assurance?	—	—	—
1.6 Provided orientation for members in quality assurance?	—	—	—
1.7 Established a network for quality assurance among districts/units?	—	—	—
2. Management			
Has the Health Authority			
2.1 Defined its expectations of districts/units in quality assurance?	—	—	—
2.2 Defined specific quality assurance targets in annual review?	—	—	—
2.3 Developed explicit operational standards for services?	—	—	—
3. Information and resources			
Has the Health Authority			
3.1 Developed performance indicators specific to quality?	—	—	—
3.2 Made relevant library services available to districts/units?	—	—	—
3.3 Established a newsletter or similar vehicle for disseminating quality assurance ideas?	—	—	—
3.4 Compiled a catalogue of existing activity?	—	—	—

		YES	?	NO
4. Education				
4.1	Is the training department actively involved in quality assurance?	—	—	—
4.2	Is the postgraduate dean/clinical tutor involved in quality assurance initiatives?	—	—	—
4.3	Have any seminars been devoted to quality assurance?	—	—	—
4.4	Do management training programmes for clinicians include practical quality assurance?	—	—	—
5. Clinical initiatives				
5.1	Has the regional/district strategy been developed together with the Regional/District Medical Committee?	—	—	—
5.2	Has the Regional/District Medical Committee formally accepted a responsibility for monitoring the quality of medical care?	—	—	—
5.3	Has the Regional/District Medical Committee sought to catalogue existing medical initiatives?	—	—	—
5.4	Has the Regional/District Medical Committee adopted any specific initiatives in quality assurance?	—	—	—
5.5	Have any other professional groups?	—	—	—
6. Research and development				
6.1	Have any quality-related projects been sponsored by the Regional/District Health Authority?	—	—	—
6.2	Have academic departments contributed to regional/district initiatives?	—	—	—
6.3	Have community health councils contributed?	—	—	—

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