

Project Paper

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Introducing quality assurance

CHARLES D SHAW

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INTRODUCING QUALITY ASSURANCE

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PREFACE

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PREFACE

Increasing interest in the quality of health services and the appointment of officers with designated local responsibilities has generated an urgent demand for ideas on implementing quality assurance, especially from district officers.

This collection, in the interests of consistency and timeliness, is one individual's view of relevant literature and activity. It reflects the initial emphasis of the King's Fund Quality Assurance Project on acute general hospitals, but this should not be seen to detract from the importance of quality assurance in primary and long-term care. There is much more that could be written, and by many more people; but this is a first attempt to summarise the basics of a broad and rather nebulous subject.

Hopefully, the growing experience of quality assurance in the United Kingdom will be incorporated in later revisions. Comments and practical suggestions would therefore be welcome.

I am grateful for the formative comments on this document from members of the Quality Assurance Project, its Steering Committee, and many individuals who have chosen, or been chosen, to tackle this worthy but challenging subject.

Charles D Shaw
Co-Ordinator, Quality Assurance Project
King's Fund Centre, July 1986



THE CONTEXT OF QUALITY ASSURANCE

CHANGING TRADITIONS

Many people now question traditional assumptions not just of the health service but also of almost every institution, service or product. The public is generally better informed (by virtue of communications technology as well as consumer organisations and formal education); employees have negotiated for, and expect, more information and involvement about their work; and managers are shifting emphasis away from the product itself towards the customer as final arbiter of quality. Traditional institutions such as the church, the police and medicine are being drawn towards a more open, participative style in order to maintain their influence.

In the specific field of health care, the growing interest in quality is common to most developed countries; what differs is the means by which it is expressed and the mechanisms by which quality is monitored. Some countries, such as Australia, Canada and the USA have formal organisations which act as national champions of quality, independent of the government or paying agencies; others, such as Spain, are developing similar systems but with clear direction from government. The British National Health Service has always been constrained by central budget allocation, but has otherwise been relatively unregulated either voluntarily or by statute about how it should perform its task.

Attitudes are now changing. The question is no longer whether we should make an issue about the quality and effectiveness of the service, but about who, if anyone, will take the lead in assuring it.

INFLUENCES ON BRITISH HEALTH SERVICES

Arguments for (and against) a more formal approach to quality and effectiveness in health care are generally political, public or professional.

Some political issues

- NATIONAL HEALTH SERVICE: as the country's largest employer (and a public body) the NHS and its performance cannot expect to escape regular attention, especially in relation to public spending.
- RESOURCE CONSTRAINTS: the argument that resource constraints threaten the quality of health care is logically appealing but extraordinarily hard to prove; it also underlines the fact that we have few baselines or yardsticks with which to measure quality.
- MANAGEMENT ACCOUNTABILITY: increased emphasis, following the report of the Griffiths enquiry, on individual accountability has led to greater attention to personal performance.

- WORLD HEALTH ORGANISATION AGREEMENT: Britain is party to a commitment by European member states of the WHO that "by 1990 all member states should have built effective mechanisms for ensuring quality of patient care within their health care system" [25].
- PRIVATE MEDICINE: the growth of private hospitals and nursing homes has provided more scope for comparison; it has also encouraged the development of explicit minimum standards (for the purpose of registration) which the NHS itself might reasonably be expected to achieve.

Some public issues

- CONSUMER BODIES are growing in number and in influence; some (such as the National Association for the Welfare of Children in Hospital [18] and the Association of Community Health Councils of England & Wales [3]) have published explicit lists of what patients and their relatives ought to expect of health services.
- INFORMATION generally is more available to the public about individual health services; this ranges from the Good Birth Guide by Sheila Kitzinger [14] to the Performance Indicators by the Department of Health and Social Security [6] (previous Inter-Authority Comparisons, produced by the Health Services Management Centre, Birmingham, had not been available to Community Health Councils); arguments continue in favour of general practitioners' advertising of the special services they offer [10].
- THE GRIFFITHS REPORT [8] encouraged the consumer as a legitimate judge of quality.
- DISSATISFIED PATIENTS AND RELATIVES are increasingly willing to turn to formal complaints procedures and to the Ombudsman (who publishes a worrisome but salutary regular report [12]); similarly the annual reports of the medical malpractice insurance bodies remind us that we regularly make the same mistakes and that patients are prepared to seek redress (but the scale of this compared with North America is demonstrated by our annual premia for individual doctors of under \$500 compared with premia in the USA which commonly reach \$50,000).

Some professional issues

- TRAINING AND EDUCATION: the rapid growth of knowledge and skills expected of a competent clinician means they have to move faster to keep up to date; the challenge of training students to competence is being overtaken by the challenge of keeping older graduates equally competent. Recent educational policy papers in nursing have also pointed to the need for on-going professional education and training, as well as nationalisation and up-grading of first-level teaching programmes [20, 24]. This is also true of the non-clinical professions and underlines the role in quality assurance of continuing education and training programmes.

- EXTERNAL PRESSURES increasingly question professional assumptions of self-regulation; the public appetite for involvement, the demand of managers for control of resources and the willingness of the DHSS to introduce specific limits (such as in the approved list of prescribable drugs) increasingly drive the professions to more overt accountability.

EVIDENCE OF NEED

The notion that health services should not only be good, but also be shown to be good, is unlikely to go out of fashion. Most elements of British health services function well (and, compared with nearly all developed countries, extremely economically). But there is ample evidence nationally of a margin of unsatisfactory performance which could be improved.

For example:

- COMMUNICATION: a quarter of all cases of "malpractice" handled by medical malpractice insurance agencies involve failure of communication between professionals, or between them and their patients.
- MORTALITY: the chances that conditions which are generally considered to be amenable to treatment will prove fatal are three times higher in some areas of England & Wales than in others [4].
- DRUG INTERACTIONS: 24% of elderly people admitted to a teaching hospital were on drugs which were contraindicated or interacting [7].
- PRE-ANAESTHETIC ASSESSMENT: 24% of patients having a general anaesthetic for ECT had no physical examination in the previous month [1].

QUALITY RELATED COSTS

A valuable concept in industry is the cost of over-using resources or simply "not getting it right first time". In health care, elements of this can be identified in terms of resource costs to the health authority quite separately from the human cost and inconvenience to the patient. For example:

- DETECTABLE CONDITIONS: the costs of managing congenital dislocation of the hip or Down's syndrome which could have been avoided or treated early.
- EXTRA MATERIALS: unnecessary or excessive use of drugs, intravenous fluids, investigations, CSSD, supplies, cleaning equipment.
- EXTRA MORBIDITY: illness delaying discharge caused or exacerbated by treatment (such as some drug reactions, post-operative infection or wound breakdown).

- EXTRA SERVICES: "routine" out-patient reattendances.
- EXTRA IN-PATIENT DAYS: waiting for treatment or for investigations to be done (or reported); waiting for authority for discharge; inefficient use of ambulance services [15].
- INAPPROPRIATE ADMISSIONS: not clinically required, or to inappropriate beds (eg general medical rather than geriatric) causing longer eventual stay.
- OPPORTUNITY COSTS: theatre lists, outpatient clinics, X-ray screening sessions cancelled at short notice; inefficient organisation of community aids loans.

THE OVERALL VIEW

The case for active and regular review of the performance of the health service and of its staff has been proposed by a succession of national reports including:

- The organisation of medical work in hospitals ("Cogwheels Report") [13]

"Consideration of published studies of clinical practice should be a regular part of divisional activity. These could be used, in appropriate cases, as a basis for comparing local performance with results achieved elsewhere and for arriving at possible local applications." - paragraph 68.

- Competence to Practise ("Alment Report") [2]

"In our view it is a necessary part of a doctor's professional responsibility to assess his work regularly in association with his colleagues." - paragraph 9.12.

- The Royal Commission on the NHS [22]

"We are not convinced that the professions generally regard the introduction of audit or peer review of standards of care and treatment with a proper sense of urgency." - paragraph 12.56.

- Report of the Committee on Nursing ("Briggs Report") [19]

"Long-term and short-term objectives should be identified in order that the quality of patient care can be improved and resources can be used to the best effect." - page 215

- Nurse Manpower: Maintaining the Balance [9]

"In recent years the importance of the nursing contribution to the provision of health care in hospitals and in the community at large has been repeatedly demonstrated. The quality and quantity of nursing care depends on successful manpower planning." - page 5

CONCEPTS OF QUALITY

DEFINITIONS

Watertight definitions of "quality" and related words are too elusive to merit the time of practical people. But some common ground is essential and the following may be helpful.

"Quality", in health services or in individual patient contact, is more than consumer satisfaction; it includes elements of:

- APPROPRIATENESS: the service or procedure is what the population or individual actually needs;
- EQUITY: a fair share for all the population;
- ACCESSIBILITY: services are not compromised by undue limits of time or distance;
- EFFECTIVENESS: achieving the intended benefit for the individual and for the population;
- ACCEPTABILITY: services are provided such as to satisfy the reasonable expectations of patients, providers and the community;
- EFFICIENCY: resources are not wasted on one service or patient to the detriment of another.

The key issue is appropriateness. For example, suppose that following a confusion of nistology reports a patient undergoes an unnecessary operation. The ward may be comfortable, the staff may be skilled and attentive, the procedure meticulously performed, no complications occur and an early and comfortable discharge is carefully organised with the community care team. Nonetheless, if the procedure or service is inappropriate it cannot be "good". Likewise, nursing in bed a patient who is capable of mobilisation may be competently performed, but yet inappropriate to the situation.

"Quality assessment" is the measurement of provision against expectations. "Quality assurance" is the same, but with the declared intention and ability to correct any demonstrated weaknesses. Efficacy is the probability of benefit from a technology or service under ideal conditions of use. Since few services function in ideal conditions, the concept has most application in research. "Effectiveness" is the probability of benefit from a technology or service under normal conditions of use. For example, screening for cervical cancer may be efficacious, but not effective in a local circumstance. "Efficiency" relates the impact of a service to its production costs (in terms of time, money, human and physical resources).

"Clinical audit" may be described as the sharing by a group of peers of information gained from personal experience and/or medical records in order to assess and improve the care provided to their patients. It differs from "research" in that it does not aim for a universal truth about a practice but it does focus on the performance of individual practitioners and the service to individual patients.

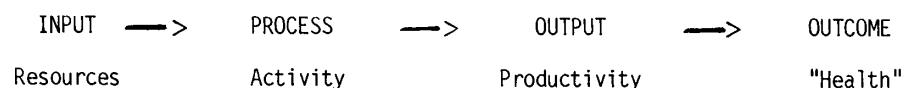
PRINCIPLES

THE PRODUCTION LINE MODEL

One way to consider health services is to consider them as a production line generating "health" from a defined set of resources (or inputs). This has four main elements:

- INPUTS: resources in terms of manpower, equipment and money
(a traditional and relatively easily quantified measure)
- PROCESS: how the resources are organised
(such as in clinics, theatres and domiciliary visits)
- OUTPUT: productivity or throughput
(such as clinic attendance rate, discharge rate)
- OUTCOME: achievement of intended results

Figure 1 : Production line model of health services



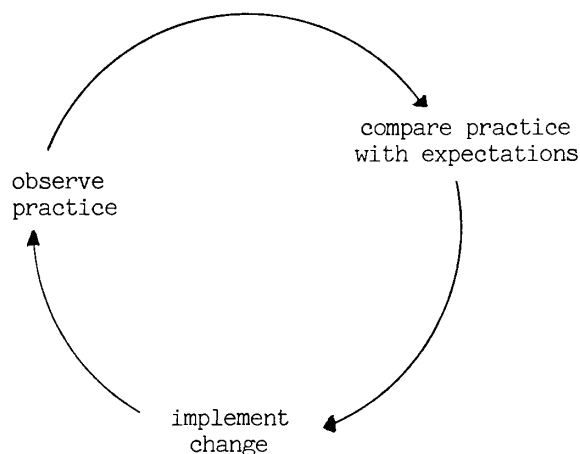
Even if these four elements can be measured, the relationship between them is variable and badly defined, the quality of care is hard to quantify, and in many conditions the ideal outcome is not agreed. Although results are ultimately the criteria by which any service should be judged, the outcome of health care is, in practice, often difficult or impossible to measure. For example, long-term results for an individual patient inevitably reflect the interaction of many social and personal factors and may not be directly attributable to health care. For this reason, some authors prefer to focus on selected "intermediate" outcomes which can be more readily related to the care given (for example, immunisation rates as a proxy for the prevention of infectious diseases). In many circumstances, however, a quicker and cheaper assessment of care is based upon examination of, for example, what was done to the patient. Justification for this approach relies heavily on evidence that what is assumed to be good process will produce a good outcome. When available, this evidence is often based upon clinical trials and assumptions of what seems to be "bad" process, such as

in the experience of the Ombudsman, medical defence organisations, or national surveys. Even this evidence may not be valid when the clinical circumstances of staff, techniques and equipment, are different. More often, however, there is little more than anecdotal evidence for the effectiveness of clinical process. Unfortunately (since it is probably the commonest measure used for day to day management of the NHS), there is even less evidence defining the relationship of resources to clinical outcome.

THE CYCLE OF QUALITY ASSURANCE

Quality assurance may be seen as a cycle of activity with three principal stages as in Figure 2 below:

Figure 2 : Cycle of quality assurance



The first stage is to observe practice, and ask "What is happening?". The next stage is to compare this with what we think ought to be happening, and ask "Is this reasonable?". This implies there is agreement on what "standards" we expect of the health service; in practice this is often far from clear, and is very rarely sufficiently explicit to be easily measured. If it seems that actual practice does not fulfil expectations, then we can decide what ought to change. Examination may show that everything is perfect, but that would be a little unusual. If change is introduced, the first stage should be repeated to see if this produced the desired effect. It is essential to close the loop of the quality assurance cycle by ensuring that the information and assessment are used to good effect, and not abandoned as "orphan data". The end product of quality assurance is not the demonstration of problems, nor the suggestion of solutions to those problems, but the implementation of appropriate change.

DEFINING EXPECTATIONS

The cycle of quality assurance requires the ability to measure (such as by observation or performance indicators), a defined standard (such as a required norm, an agreed target or other expectation) and the ability to change (such as by implementing specific procedures).

Although much recent effort in the NHS has been put into generating measures from existing data, there are very few statements of what constitutes a "good" health service. If expectations are unclear, their achievement cannot be measured.

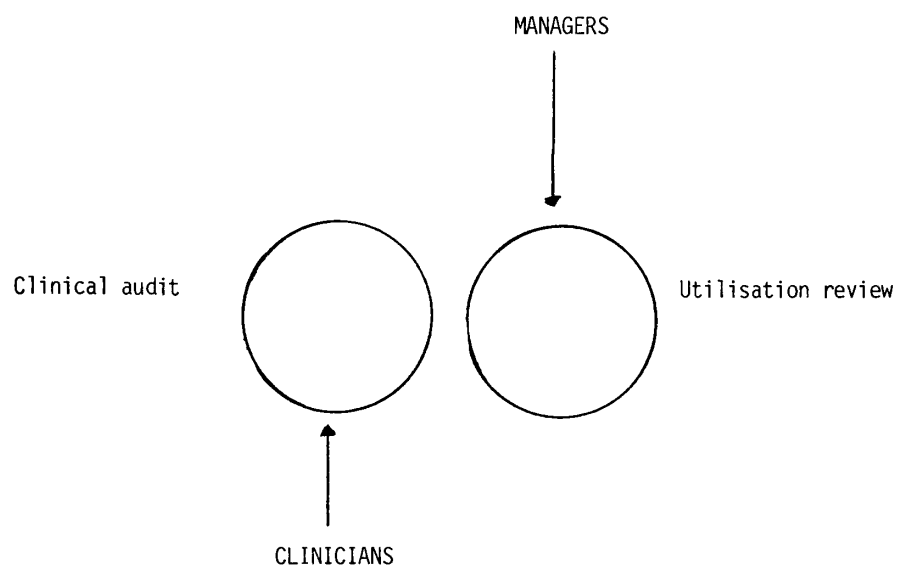
One of the most difficult - and educational - steps in quality assurance is to discuss and agree a specific level of local expectation which can be explicitly stated. This level may well alter when local practice is examined; one of the commonest discoveries of such scrutiny is that very few people are doing just what they thought they were doing.

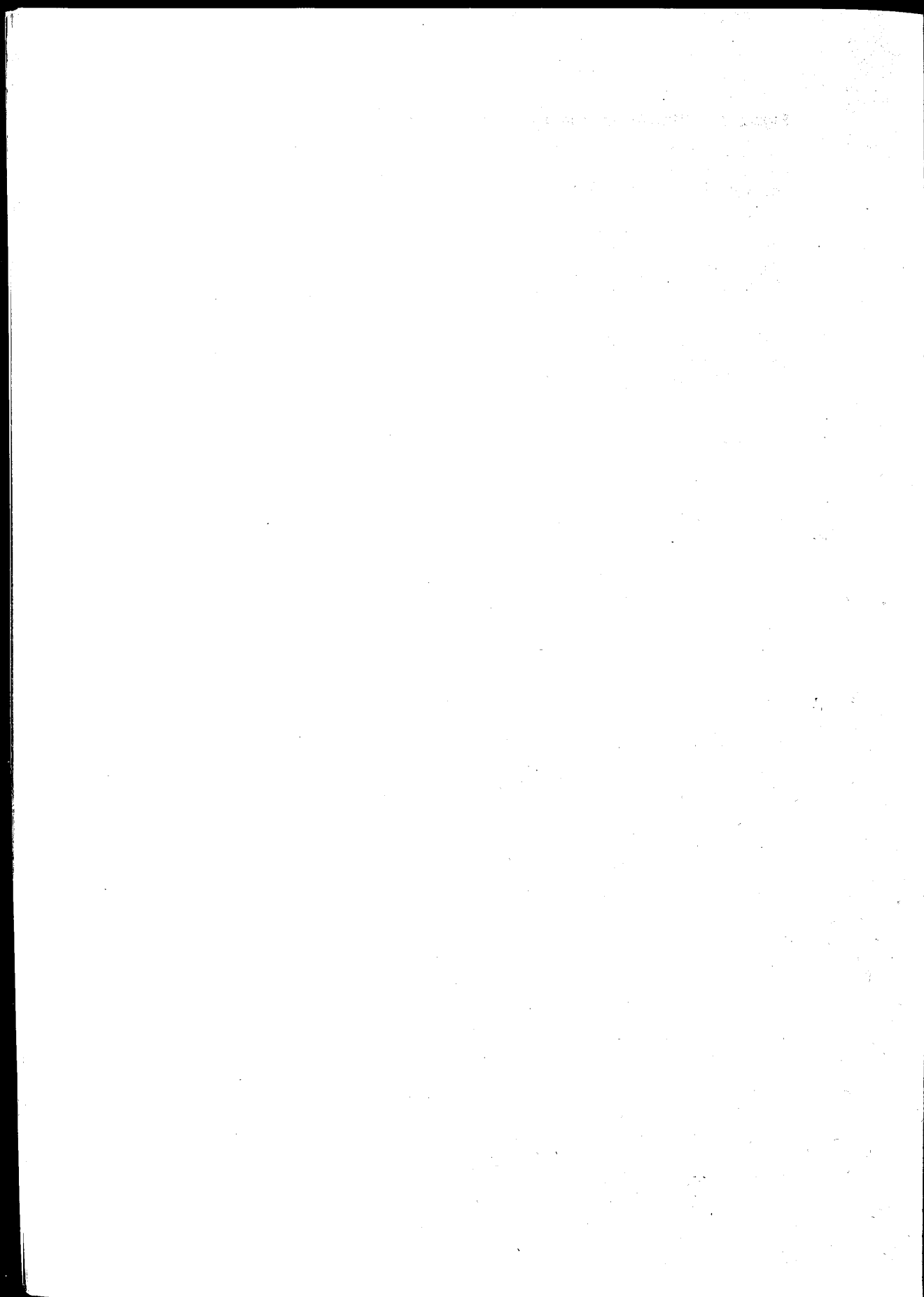
RESPONSIBILITY

There is potential for conflict between clinical judgement and managerial control of direct patient services. Given that the focus of quality assurance legitimately ranges from resources (inputs) through to results (outcome), it is not surprising that managers and professional clinicians tend to approach the issue differently. The manager traditionally analysed resources (such as budgets) and utilisation (such as turnover), while the clinician looked at clinical activity and outcome (often quite anecdotally).

David Bowden (District General Manager, Brighton HA) summarises the managerial activity of "utilisation review" as top-down, and the clinical activity of "clinical audit" as bottom-up (Figure 3). The two already overlap and will do so increasingly with the introduction of management budgeting, performance indicators and reliable clinical statistics. But until clinicians are comfortable with a managerial role and are confident about self review, managers would be unwise to force the pace of clinical audit.

Figure 3 : Clinical and managerial roles





TEACHING AND LEARNING QUALITY ASSURANCE

Given that quality is everybody's business, all health personnel need an introduction which may not as yet be included in basic training. This is particularly true of those officers with specified district responsibility for quality assurance. Objectives of formal or informal training may include the following:

- | | |
|----------------------|---|
| KNOWLEDGE | <ul style="list-style-type: none">- of the significance of quality assurance (public, political and professional)- of principles and methods of quality assurance- of existing activities/structures and their potential- of existing sources of data/information- of specific examples of quality assurance in practice (ie relevant literature) |
| ATTITUDES | <ul style="list-style-type: none">- that quality is identifiable and achievable- that quality can be improved- that quality is everybody's business |
| INTERPERSONAL SKILLS | <ul style="list-style-type: none">- to negotiate a local strategy- to translate principles into local practice- to implement change within organisations and among individuals- to respect and develop staff contributions- to teach/act as catalyst for all health disciplines- to handle the "poor performer" |

TECHNICAL
SKILLS

- to collate data from financial, administrative and clinical sources
- to design and implement local surveys and research
- to evaluate results of surveys and research
- to use common coding systems required for the interpretation of managerial and clinical statistics
- to use performance indicators on micro-computers
- to present information succinctly and clearly

CURRENT CONTRIBUTIONS AND MECHANISMS FOR QUALITY ASSURANCE

In an average health authority, a variety of personnel and mechanisms do, or could, contribute to a coherent programme of quality assurance; these local resources may be supplemented at regional and national level. This outline is intended to draw attention to these resources rather than to describe them in detail.

LOCAL PERSONNEL

- **AUTHORITY MEMBERS:** since the Authority has a statutory responsibility to provide local health services, it is also responsible for satisfying itself of the quality of those services; few members are qualified to interpret technical details of quality but they should expect to have evidence that those who are technically qualified do effectively monitor quality; members have, and should exercise, the right to ask questions.
- **MANAGERS:** quality assurance, like safety, should be seen as a legitimate task for all staff; this can be actively reinforced by visible commitment among senior managers, such as in evaluating and discussing their own work.
- **INFORMATION SPECIALISTS:** objective, formal review of services and of individual professional practice relies heavily on accurate, timely data which are well presented; this involves the librarian, records officer and information officer and, especially in clinical specialties, the specialist in community medicine; the latter is trained in the collection, analysis and presentation of data and should provide a credible contact between clinicians and managers.
- **FINANCE OFFICERS:** systems designed for budgeting control (such as specialty costing and theatre costing) often generate, as a by-product, quality-related data such as utilisation patterns of diagnostic and therapeutic services, and how long patients wait in the theatre suite.
- **EDUCATORS:** quality assurance is generally seen by the professions as implicit in the process of identifying and meeting educational needs; training officers, nursing and clinical tutors are well placed to introduce or reinforce the measurement and promotion of quality in service.
- **HEALTH EDUCATION OFFICERS:** health education is one mechanism towards equality of access to services, and towards reconciling public expectation and actual provision; as such it legitimately includes not only the marketing of health, but also the evaluation of services from the public viewpoint.

- SAFETY OFFICERS: an unnecessarily hazardous environment for patients and staff is a negative indicator of service quality; fire, safety and infection control officers each contribute to quality assurance.
- OCCUPATIONAL HEALTH STAFF: as well as assisting the well-being of individual members of staff, an occupational health service also helps to protect patients from staff who present a risk by virtue of physical or mental illness.
- FORMAL AND INFORMAL LEADERS: regardless of their official position in the organisation, the most valuable catalysts of quality assurance are the enthusiasts who have the interest, the will and the ability to stimulate others by example.
- NOT-SO-LOCALS: several districts have added skills and objectivity to their quality assurance programme by trading selected personnel across the borders with neighbouring districts; another possibility is to seek expertise in quality assurance from outside the NHS in local service industries (such as hotels or banking) or manufacturing industries.

CURRENT LOCAL MECHANISMS

- MEMBER VISITING: given a clear purpose, and clear criteria for judgement, systematic visiting by members is one method of monitoring services.
- ANNUAL REPORTS: few districts produce a formal annual report, but some performance-related statistics are provided to the authority and the public routinely; these include data on waiting lists, perinatal mortality and standardised mortality ratios (if only in relation to Resource Allocation Working Party [RAWP] figures); such information is likely to be required increasingly by annual ministerial reviews.
- STAFF APPRAISALS: regular, structured discussion of objectives and achievements of individual staff provides an opportunity for managers to monitor and develop good practices and attributes.
- COMPLAINTS PROCEDURE: common characteristics of procedures are defined in HC(81)5 [5]; many districts now also have an accessible mechanism for handling clinical complaints, and there is some pressure to make this a national requirement.
- PATIENT SATISFACTION SURVEYS: broadly, surveys divide into the relatively amateur surveys by individual authorities (or Community Health Councils) and the larger and more professional surveys by research units and commercial pollsters. These often demonstrate that the public are better equipped to judge diligence than competence.

- MATERNITY SERVICE LIAISON COMMITTEE: as recommended in "Maternity Care in Action" [16] such committees not only monitor maternity services but also include consumer representatives.
- POLICY AND PROCEDURE COMMITTEE: locally agreed practices and organisation provide an explicit statement of the expected quality of service.
- INFECTION CONTROL: infection control is an appealing starting point for quality assurance in that it is clearly relevant to patient care (and staff safety), it embraces the work of clinical and non-clinical staff, it is relatively measurable and it can lead to specific improvements in practice (in terms of effectiveness and economy) by the adoption of agreed policies and procedures; ideally, the medical staff committee would regularly receive reports from and take an active interest in the committee or group responsible for infection control.
- DRUG AND THERAPEUTICS COMMITTEE: nationally, the typical district committee consists of nine members (including a pharmacist, nurse and GP) and meets quarterly; functions include monitoring procedures for ordering and distributing medications, monitoring drug costs (for example, of the top 50 items), monitoring adverse reactions, developing guidelines and auditing prescribing; examples of the latter include the numbers of different drugs used by clinical firms in common categories such as diuretics, analgesics, antimicrobials and beta-blockers; improvements in the cost and quality of prescribing have been attributed to effective drug and therapeutic committees.
- ETHICAL COMMITTEE: in many districts such committees are limited to considerations of medical research; in others they provide a multi-disciplinary forum for reconciling consumer and provider viewpoints on issues such as terminal care and resuscitation policies.
- CLINICAL REVIEW: most clinicians review their work at least to the extent of informal discussions with colleagues, and nurses and midwives are also introducing peer review; some health professionals, especially in maternity units, have concluded that, in order to be effective (in terms of implementing change where indicated), review needs to be objective, repeatable, and comprehensive rather than subjective, unstructured and anecdotal; more formal review demands adequate records, the facility to retrieve and collate data from them and time to present the information - all of which require a general commitment by health service managers to support professional workers in quality assurance.

Clinical review may be assisted by anyone who has an interest in quality assurance, but it should remain essentially an internal exercise by professional workers within their own area of expertise. Even so, it can be seen as threatening initially but often becomes engrossing and of acknowledged educational value thereafter. These teething troubles may be

less if early studies examine an issue:

- which is clinically relevant ie with self-evident significance to patient care, rather than a theoretical exercise
- for which data already exists or is easily collected
- on which there is likely to be agreement on criteria for performance
- which is amenable to improvement (it is better for morale to go for an early success than to tackle a venerable but relatively insoluble problem).

Some examples are given in Table 1.

Table 1 : Some examples for clinical review

CRITICAL EVENTS	cardiac arrest, status asthmaticus.
COMPLICATIONS	pressure sores, anastomotic leaks, nosocomial infection.
ERRORS	missed fractures in accident & emergency, prescribing/drug distribution errors.
COMMON PROCEDURES	physiotherapy for frozen shoulder, post-gastrectomy Ryles' tubes.
DELAY PATTERNS	referral, diagnosis & treatment of malignancy, congenital handicaps referred after age 4, orchidectomy following torsion of testis.
UTILISATION	emergency laboratory tests, pre-op investigation in healthy patients, cross-match, transfusion.
COMMUNICATION	recording of pre-anaesthetic assessment, letters between GPs and consultants, recording of information given to patients.

- ANNUAL MANAGEMENT REVIEW: the extension of annual review to unit level gives an opportunity for formal monitoring of some managerial aspects of quality assurance (such as hygiene, safety, waiting lists, resource utilisation and service planning); but attempts to apply similar managerial leverage over clinical accountability would be likely to be counterproductive.

- QUALITY CIRCLES: Some districts have successfully applied the idea of groups of staff from all levels to identify and resolve problems as a mechanism of quality assurance; this is a logical extension of participative management and allows staff as well as managers to pool views on problems, analyse contributory factors and identify solutions.
- SERVICE REVIEWS (operational and strategic planning): the population-based equivalent of clinical review of individual patients is the joint concern of planners, managers and epidemiologists; despite the sometimes justified early doubts about the accuracy and relevance of performance indicators, data are now improving and the age of quantitative measures of service effectiveness is here to stay; some examples of local indicators as applied to clinical services are given in Table 2.

Table 2 : Some indicators of effective clinical services

INDICATOR	POSSIBLE SOURCE
Incidence of Down's syndrome, neural tube defects	Child health computer, Office of Population Censuses and Surveys
Immunisation uptake by locality, school, practice	Child health computer, Office of Population Censuses and Surveys
Cervical cytology uptake	Recall system
Deaths from preventable diseases	Office of Population Censuses and Surveys (SD25)
Prevalence of decayed, missing and filled teeth (DMF scores)	School dental inspections
Deaths from manageable diseases	Local death registration certificates, Office of Population Censuses and Surveys
Cancer deaths at home	Local death registrations
GP referral rates to consultant clinics	Patient Administration System, out-patients
Waiting time for clinic appointment	Patient Administration System, out-patients

EXTERNAL MECHANISMS

- COMMUNITY HEALTH COUNCILS: as consumer "watchdogs", CHCs have a legitimate interest in the public's view of the health service; their most commonly quoted contribution to quality assurance is in doing surveys of perceived problems (such as waiting lists, out-patient clinics, ambulance transport); but many work directly with staff such as on Maternity Service Liaison Committees and on producing information packs for patients.
- STATUTORY INSPECTORATES: several inspectorates can give expert and objective opinion (based on explicit criteria) on elements of NHS services; these include environmental health, health and safety at work, ionising radiation, fire prevention, and medicines handling and manufacture.
- REGIONAL BRANCHES OF PROFESSIONAL BODIES: several Royal Colleges and faculties organise or support local initiatives in quality assurance through a regional network; these are primarily focused on professional performance but may demonstrate issues of direct relevance to NHS managers and planners; examples include the Royal College of General Practitioners' "quality initiative" in which local faculties may be willing to collaborate with health authority staff on specific projects, and the Confidential Enquiry into Peri-Operative Deaths (CEPOD) which is a highly structured pilot project the conclusions of which will be fed back to health authorities and others via an annual report.
- OTHER LOCAL AUTHORITIES: other bodies such as the Family Practitioner Committee (especially via the Local Medical Committee) and the Local Authorities (such as the departments of social services and education) may provide informed comment and contribute to planning of the health service.
- RESIDENTIAL HOMES: since many past or future customers of the NHS are in these homes, the health authority has a direct interest in them even without any formal contractual use of their beds; regulation is now defined by the Registered Homes Act 1983 and guides to good practice are offered by the National Association of Health Authorities (for nursing homes) [17], by "Home Life" (for residential homes) and by "Better Care for the Elderly in Hospital" (for general care of the elderly) [21].
- ACCREDITATION OF TRAINING: professional bodies responsible for all levels of professional training visit NHS facilities to assess their suitability; each institute, society, college and faculty has its own very general criteria (eg that medical records should be "adequate"), but there is no national consensus on minimum standards for any service or department; nevertheless, reports of these visits may have implications beyond training. A summary of requirements for post-graduate medical training is published by the Scottish Council for Postgraduate Medical Education [23].

- VOLUNTARY BODIES: patients' associations and special interest groups such as MIND and MENCAP may be willing and able to contribute to the assessment of quality either informally or as representatives on formal visits and review mechanisms.
- DEVELOPMENT AGENCIES: the failure of the NHS to disseminate good practice and to curb poor practice suggested a need for semi-independent agencies, especially in long-stay services; the Health Advisory Service visits and produces annual reports (and examples of good practice) on geriatric and psychiatric services; the National Development Team does likewise for mental handicap services (using relatively explicit assessment criteria); and the Management Advisory Service now has a national remit to examine and make recommendations on any service or issue at the request of individual health authorities.
- MENTAL HEALTH ACT COMMISSION: the Mental Health Act 1983, requires the establishment of local review and appeal procedures; detailed criteria for assessment have now been proposed.
- HEALTH SERVICE COMMISSIONER: a valuable by-product of the Ombudsman's enquiries is the annual report which outlines the (sadly recurrent) pattern of patients' complaints [12].
- EXTERNAL QUALITY ASSURANCE OF LABORATORIES: an independent monitoring system is available in biochemistry, haematology, microbiology and serology; nearly all laboratories in the UK participate on a voluntary (but encouraged) basis.

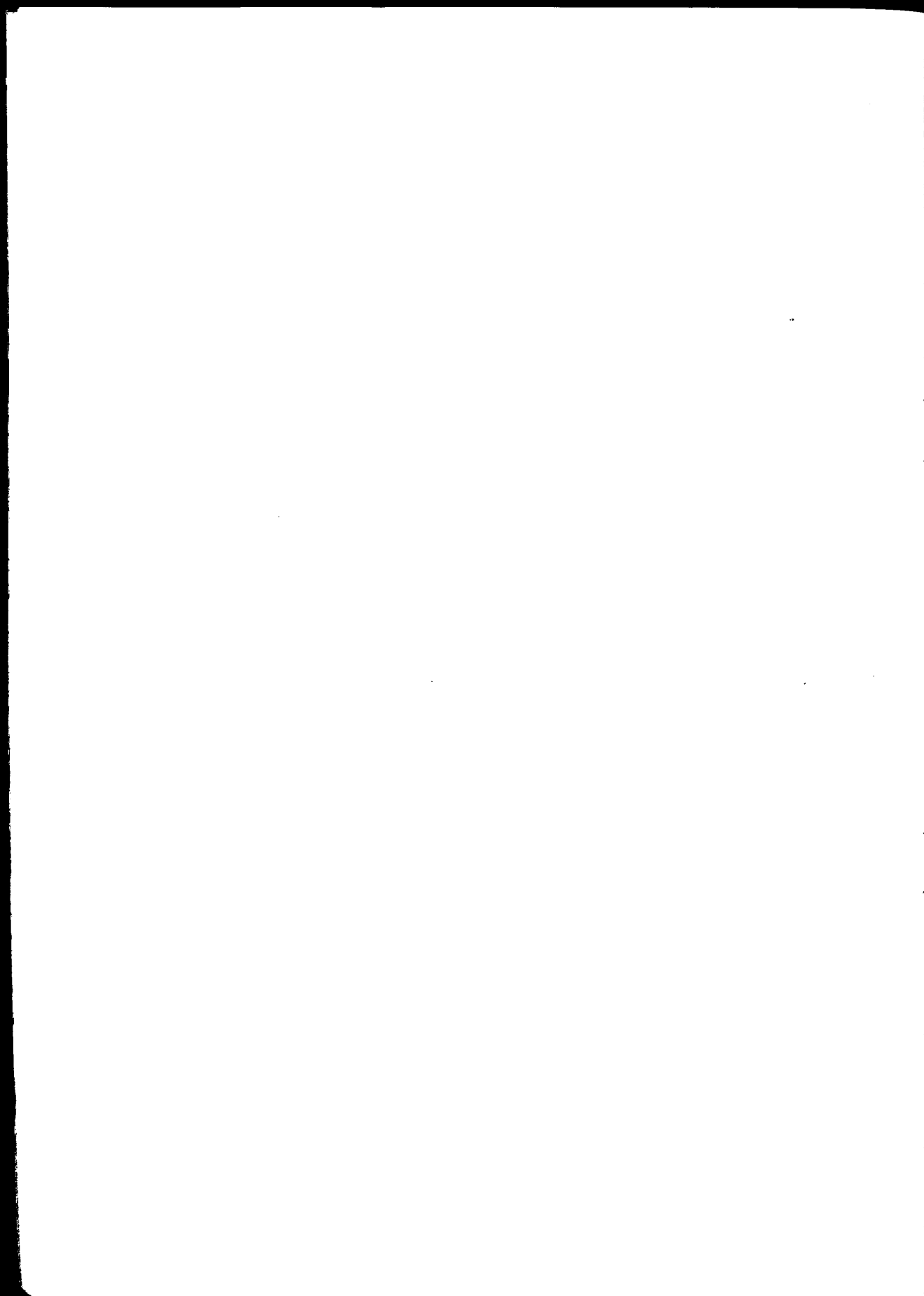
OTHER RESOURCES

A variety of other sources can provide statistical or documentary support to quality assurance locally; in view of the relative absence of explicit service standards in this country, some overseas sources are also quoted; addresses and references are listed in appendices.

- NATIONAL STATISTICS: comparison with other regional or national patterns can help to put local data into context; examples include Hospital Inpatient Enquiry and registration data (eg mortality, malformations, malignancy, births) from the Office of Population Censuses and Surveys (OPCS); also the health departments produce national summaries of statutory returns including resources and activity in hospital, community and preventive services (such as in the annual Health and Personal Social Service Statistics); unfortunately the publication of complete national statistics depends on the speed at which the slowest district can (or does) produce the appropriate local data.

- PERFORMANCE INDICATORS: despite legitimate concerns over the relevance and accuracy of early indicators, there is no doubt that direct and objective comparison of performance against the national pattern is a powerful stimulus to account for and, if necessary, to correct local deviations; considerable efforts are now being directed nationally and locally, and by managers and clinicians towards developing acceptable numerical measures of practice and of effectiveness; since these are likely to become a permanent feature of managerial, if not of clinical analysis, staff should be encouraged to become familiar with relevant existing regional and national indicators ("Inter-Authority Comparisons" of John Yates and the "Performance Indicators" of the DHSS) and to be able to use the computer system for which they are designed.
- NATIONAL REPORTS: published results of national or regional studies of specific aspects of health services are valuable for comparing local performance and for highlighting good and bad practices; although they occasionally lead to formal health department circulars many are merely deposited ineffectually in libraries, or do not even reach the relevant people.
- OVERSEAS SOURCES: explicit standards and expectations of services make quality assessment easier, more objective and more repeatable; the task of developing such standards locally can be reduced by starting with existing models such as those used in hospital accreditation systems in Australia and North America; these concentrate on the organisation of departments in hospitals, including those for mental health and long-stay patients; the Canadian Department of Health also produces a series of pamphlets on the planning and management of special care units in hospital; the scope and source of these guidelines are illustrated in Appendix I.
- LIBRARY SERVICES: medical, nursing, planning and even municipal libraries may provide relevant literature and advice at district and regional level; some national organisations such as the Royal College of Nursing and the Royal College of General Practitioners have libraries with a special interest in quality assurance, and others hold relevant material.
- THE KING'S FUND QUALITY ASSURANCE PROJECT: this provides an information service - the Quality Assurance Information Service (QAIS) - primarily for the UK and specific to quality assurance in health services; the QAIS Enquiry Service also provides bibliographies on specific subjects; and, in conjunction with the DHSS, regular abstracts of quality-related literature; for details of the Project and Quality Assurance Abstracts see Appendix III.

- OTHER NATIONAL ORGANISATIONS: the Institute of Quality Assurance is concerned with the promotion of quality in manufacturing and service industries; it produces relevant literature, runs short courses and maintains a national network of membership groups. The Department of Trade and Industry, as part of the National Quality Campaign, provides useful training and reference materials free on request. (See Appendix II).
- OTHER OVERSEAS ORGANISATIONS: the International Society for Quality Assurance (ISQA) was founded in 1985; it has few resources to date but organises annual conferences and welcomes support; the King's Fund Quality Assurance Project acts as the UK base. The European Regional Office of the World Health Organisation has promoted training courses and workshops in quality assurance in Europe and published the results; it also publishes, through the Netherlands National Organisation for Quality Assurance in Hospitals a free quarterly newsletter on the subject; correspondence from the UK should be addressed to the King's Fund project. (See Appendix II).



POTENTIAL PROBLEMS

The following are commonly quoted as hurdles in establishing a more formal review of clinical work, but many of the principles apply equally in non-clinical review.

GENERAL ISSUES

PROVING EFFICACY: can we justify spending time and money on "quality assurance" without proof that it will improve quality? In many instances, a better outcome cannot be proved to be a direct result of clinical intervention, let alone of quality assurance. Where there is objective research evidence linking a particular clinical activity with a better result, we may be justified in assuming that the measurement and promotion of that activity will lead to better care. Without such evidence, quality assurance remains an act of faith. Nevertheless, it would be cynical to doubt that the dramatic reduction in maternal mortality owes at least something to the reports of the confidential enquiries over the last thirty years.

MAINTAINING CONFIDENTIALITY: many methods of medical and nursing audit involve sharing information on individual patients with professional colleagues who would not otherwise be involved. Since audit is an educational activity, the ethical justification for this may be seen in the analogy of basic professional training. Another fear is that audit may generate information, such as adverse opinions on care, which may be subpoenaed. In reality, audit is generally a combination of clinical records and professional judgement, both of which are already subject to subpoena. Certainly, no evidence to the confidential enquiry into maternal deaths has yet been obtained by a plaintiff by this device.

EXPECTATIONS

AGREEING STANDARDS: unlike many countries, Britain has done little to define a "good service" in terms which are measurable and understandable to patients, professionals, planners and politicians. "Good clinical practice" has also tended to remain implicit and subjective but guidelines are now emerging in topics such as drug abuse, safety of medicine, and coronary artery by-pass grafts. Without such benchmarks quality is difficult to measure but the quest for agreed criteria and standards is one of the most educational aspects of self-review. Such standards must be sufficiently flexible to permit valuable innovation, and should reflect the legitimate concerns of clinicians, managers and consumers.

MEASURING

FINDING INFORMATION: "Quality assurance" is much less specific in meaning or universal in use than most clinical terms. It is therefore difficult to look up; nor is there much written which is applicable to the nature of practice in this country. The King's Fund Quality Assurance Project's Quality Assurance Information Service (QAIS) offers an Enquiry Service on specific topics of quality assurance within health care services.

A further problem of information is the variable quality of clinical records, efficiency of retrieval and validity of statistics derived from them. The existence of the problem may be seen as a good reason for audit, but it also disheartens the enthusiast who hopes to reach an early conclusion about the outcome of care. Poor records are the commonest surprise in clinical audit.

CHOOSING A METHOD: without ready access to helpful literature or to a knowledgeable local colleague, it is hard to know where to start, who should select topics, who to compare with and what to do with the results. Some sophisticated methods require computers, lots of data and lots of time; simpler methods analyse a batch of records with a common diagnosis, treatment or complication as a part of established clinical meetings.

LOOKING FOR HELP: audit takes time. Professionals need clerical and administrative support to identify cases for study, track down the records and, perhaps, to screen the records for pre-selected data. Busy people find it hard to pause long enough to demonstrate how effective is their activity.

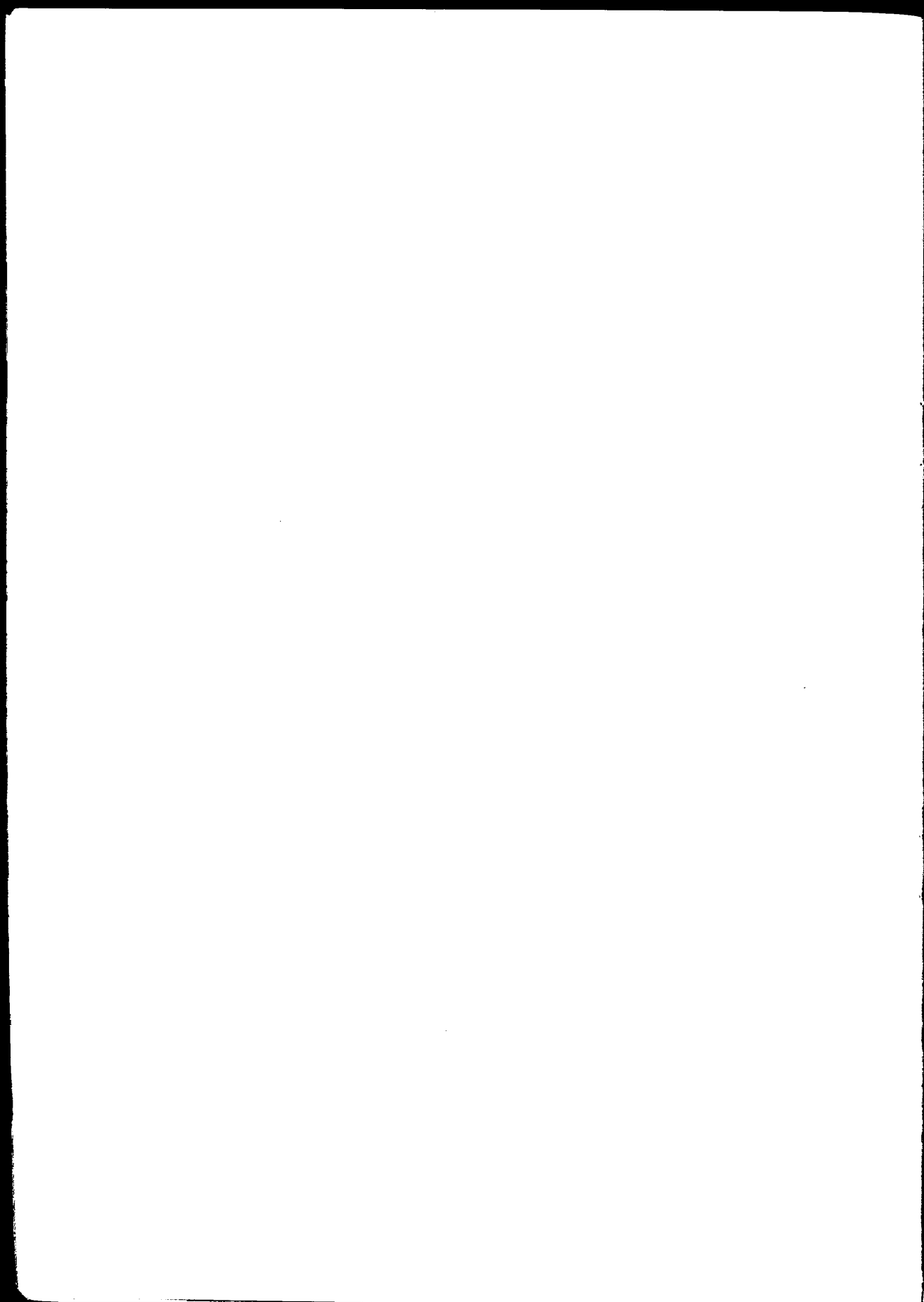
IMPLEMENTING CHANGE

RECONCILING ATTITUDES: regular assessment and peer review are now accepted elements of training but they remain foreign, even threatening, to some established practitioners. The most enthusiastic participants include some of the least needy. Even the most successful audit groups begin with uncertainty and need to build reassurance.

PROFESSIONAL ORGANISATION: to be acceptable, clinical audit should be led by the professions; to be effective it requires a structure able to effect change within its own ranks or to make cogent recommendations to others. In hospitals this implies an active and supportive medical or paramedical advisory structure which is not always present. Even a receptive environment needs a local ring leader.

POSTGRADUATE TRAINING: apart from being educational in itself clinical audit can also help to model continuing education according to evidence of local need. Although many of the Royal Colleges and national specialist bodies expect some form of active clinical review for the recognition of training posts, this is not often incorporated into the local postgraduate programme.

MANAGERIAL CONTROL: apart from doctors, health personnel have a hierarchical management structure through which the health authority may expect accountability for the quality of services. An effective management structure linking a variety of clinical and non-clinical departments is needed to consider and respond appropriately to the evidence of quality assessment. Quality assessment without the power or the will to implement change is of little value. (See also "Responsibility", page 14).



TOWARDS A HEALTH AUTHORITY STRATEGY

CONSIDERING THE SCOPE

If quality assurance is to permeate through a health authority, as opposed to one or two departments, seeds need to be sown in many places. It might be helpful to draft a strategy, for the formal approval of the Authority, defining the scope of "quality", the various routes towards quality assurance, and some specific targets. This strategy could be described under three headings - direct, indirect and external mechanisms:

- **DIRECT ACCOUNTABILITY:** requires a management system which works effectively with all of the above, asking appropriate questions, providing information and implementing agreed solutions. Each authority needs to define the role of the members and officers, as well as the relationship of the planning and annual review system to quality assurance. In particular, the contributions of epidemiologists, records officers, tutors and training officers require co-ordination, possibly by the nomination of a senior individual with district-wide responsibility.
- **INDIRECT ACCOUNTABILITY:** involves the delegation of responsibility for monitoring technical quality to professional groups. Lay managers are not qualified to make technical judgements but they can ask that someone else does. Critical analysis of clinical work is already inherent in ward rounds, staff meetings, case presentations and continuing education; this existing activity could be strengthened by more explicit analysis of common practice, follow-up of deficiencies, and regular reporting to the professional advisory structure.
- **EXTERNAL ACCOUNTABILITY:** includes the advice and criticism of visiting agencies such as the Health Advisory Service, National Development Team, Management Advisory Service, Royal Colleges (and others concerned with recognition of training posts), and statutory inspectorates (such as for environmental health, radiation, health and safety at work). There is a national external quality assurance system covering most elements of laboratory work. And national publications of working parties and research highlight lessons to be learned from success and failures around the country.

DEFINING A MATRIX

The strategy should take stock of existing assets (such as the examples on pages 19 to 27) and recognise the gaps. For the purpose of generating a list of ideas, this could be done in a matrix combining the three elements of the quality assurance cycle (Figure 2, page 13) with the three approaches described above. This might lead to the matrix in Table 3:

Table 3 : Strategy Matrix

	DIRECT ACTION	INDIRECT ACTION	EXTERNAL ACTION
DEFINE EXPECTATIONS	Define targets in annual plans etc	Agree policies eg antibiotics, theatre use	Set up library of standards
MEASURE PRACTICE	Infection rates Use of PIs Complaints Accident reports Patient surveys	Provide data for self-audit	Invite inspection
RESPOND TO ASSESSMENT	Training Budgeting incentives Modify policies Report results	Define structure & formal role of professional advisory mechanism Clinical tutors	Review response to last 10 reports

Participants at recent workshops at the King's Fund College have proposed that a district strategy would involve:

- designing and establishing the quality enhancement function as a support to managers and providers
- making quality a concern of general management at all levels
- reviewing systematically current needs and services in order to identify priorities for quality enhancement
- ensuring consumers and representatives of the community make significant contributions to the debate about quality
- building in ways of learning from experience and change and its impact on services

Current activity around the country provides a growing menu of initiatives.

CATALOGUING THE POSSIBILITIES

Organisation

- POLICY: explicit statement by health authority explaining and defining commitment to quality.
- PERSONNEL: allocation of specified officers to specified roles.
- FORUM: regional or district working party, conferences, seminars, or mechanisms for sharing ideas and monitoring progress.

Complementary to a scheme of what should be done is a definition of who should do it (and, perhaps, who should not); in particular the scope of any health authority members' subcommittee or of a district quality committee should be clear in relation to the responsibilities of individual officers. Similarly the role and authority of the district officer responsible for quality assurance must be clear in relation to line managers, especially at unit level. In any event, the definition of one officer with overall responsibility for quality should not detract from the individual obligations of all staff.

Management

- OPERATIONAL/STRATEGIC PLANNING: integration of quality assurance.
- ANNUAL REVIEW: formal action tasks in quality assurance.
- PERFORMANCE APPRAISAL: systematic staff development programme.
- STANDARD SETTING: adoption of explicit criteria of quality; operational policies.
- COMPLAINTS PROCEDURE: define mechanisms for handling clinical and non-clinical complaints at unit, district and regional level.
- EXTERNAL REPORTS: define mechanisms for receiving and responding to reports such as from Royal College assessors, the English National Board, Health Advisory Service, Community Health Council and DHSS hazard notices.

Information

- STATISTICAL: access, accuracy and presentation of performance indicators, clinical information, etc.
- LIBRARY: access to quality assurance documents.
- GUIDANCE: catalogue existing activities and personnel, perhaps produce quality assurance newsletter.

Education

- INTEGRATE ROLES: of schools of nursing, post-graduate deans, clinical tutors, management training, etc.
- DEVELOP TRAINING MATERIALS: eg for customer relations.

Professional Advice

- POLICY: seek formal acceptance, especially by medical staff, of responsibility to review quality of clinical care.
- ORGANISATION: develop adequate structure to fulfil responsibility (eg Cogwheel divisions).

Research and Development

- REGIONAL: sponsorship of information/monitoring systems and ad hoc studies.
- DISTRICT: local initiatives with regional application (eg patient surveys, studies relating shorter hospital stay to final outcome).

Choosing an initiative

To help in selecting priorities for action, quality assurance officers at the King's Fund College have offered the following criteria:

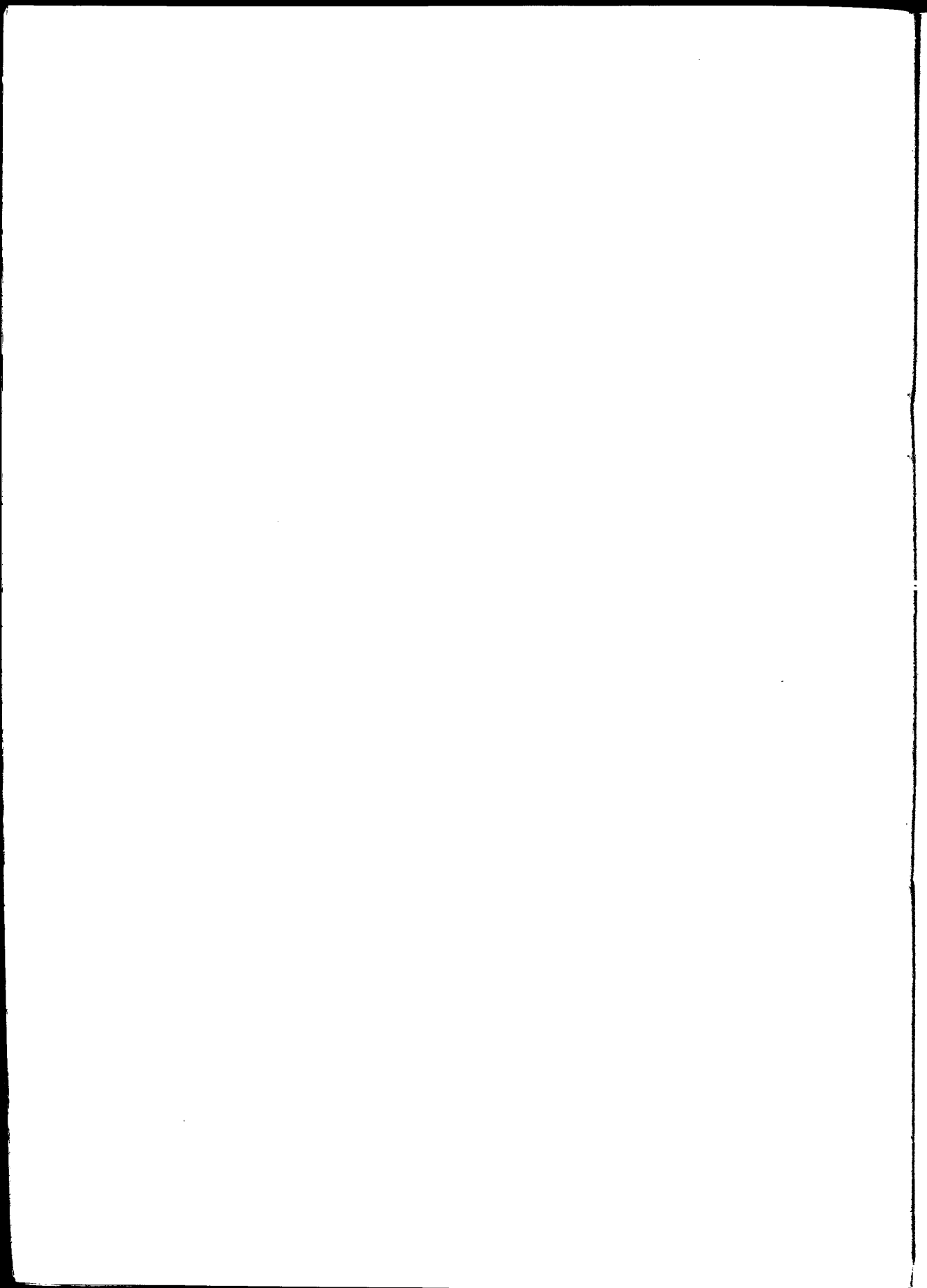
- Is the initiative likely to improve the health or reduce the suffering of the population?
- Is the gain in service improvement likely to justify the effort required?
- Do existing management priorities create the need and the opportunity for the initiative?
- Are explicit standards and relevant information about the service in question already available?
- Is the initiative likely to involve consumer representatives and be welcomed by them?
- Are the relevant providers likely to welcome the initiative?
- Is the initiative likely to generate wider interest and support for quality enhancement?

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Third Report
London: HMSO, 1974 p5
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The new good birth guide
Harmondsworth: Penguin, 1983
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Quality Circles
Senior Nurse 1985 Dec vol 3 no 6 p24-26
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Maternity Care in Action Parts I, II, III
London: DHSS, 1982, 1984, 1985
- 17 NATIONAL ASSOCIATION OF HEALTH AUTHORITIES
Registration and inspection of nursing homes: a handbook for health
authorities
Birmingham: NAHA, 1985
- 18 NATIONAL ASSOCIATION FOR THE WELFARE OF CHILDREN IN HOSPITAL/CONSUMERS'
ASSOCIATION
Children in hospital: an action guide for parents
London: NAWCH/Consumers' Assoc, 1985
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Chairman: Professor Asa Briggs
Great Britain. Parliament.
London: HMSO, 1972 (Cmd. 5115)
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The education of nurses: a new dispensation
Chairman: Dr Harry Judge
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London: HMSO, 1979
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Edinburgh: SCPME, 1982
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Project 2000: A new preparation for practice
London: UKCC, 1985
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Targets for health for all (Target 31)
Copenhagen: WHO Europe, 1985



APPENDIX I

OVERSEAS HOSPITAL ACCREDITATION STANDARDS

Explicit standards for the organisation of hospital departments are defined by various hospital accreditation agencies. Accreditation guides produced by the Australian Council on Hospital Standards, the Canadian Council on Hospital Accreditation, the American Joint Commission on Accreditation of Hospitals, and the Department de Sanitat i Seguretat Social (Catalona), are described below. The American standards are the most detailed, and those from Catalona the simplest (but in Spanish). All four accreditation guides contain chapters on:

Anaesthetic Services	Medical Records
Dietetic Services	Pharmaceutical Services
Emergency Services	Radiology Services
Governing Body/Management	Rehabilitation Services
Laboratory Services	Social Work Services

Other chapters held in common cover:

Environmental Services	(Australia & Canada)
Library Services	(America, Australia & Canada)
Nuclear Medicine	(America & Canada)
Nursing Services	(America, Australia & Canada)
Special Care Services	(America, Australia & Canada)

Each guide also has unique chapters, and these include:

Infection Control	(America)
Medical & Dental Services	(Canada)
Obstetrics Unit	(Catalona)
Operating Room Services	(Australia)
Pastoral Services	(Canada)
Physio-, Occupational & Speech Therapy Services	(Australia)
Respiratory Care Services	(America)

The American guide also has a chapter specifically on "Quality Assurance".

All four guides use a similar format: first, a statement of "principle" (Canada & Catalona) or "standard" (America & Australia), then the relevant "standards" (Canada & Catalona), "required characteristics" (America), or "criteria" (Australia). These are often followed by further notes (America & Catalona) or "interpretations" (Australia & Canada). There are some variations, eg the Canadian guide contains longer "notes" than the others and the Catalonian guide has least notes and the shortest chapters. Unlike the Canadian guide, not every "criterion" in the Australian guide is followed by an "interpretation". The American guide is for use in conjunction with the accreditation survey report so there is a scale of marks for each "required characteristic" and space at the end of each chapter for recording descriptions or comments to assist in self-assessment.

Copies of these four sets of accreditation standards, and details of other published materials, can be obtained by writing to the appropriate agencies (addresses in Appendix II). The three English language guides are available in the King's Fund Centre Library **for reference only**; publishers' permission for reproduction has not been secured for any of the documents.

Non-acute hospital manuals are also produced by the American Joint Commission on Accreditation of Hospitals on psychiatric facilities, long term care facilities and hospice services. The Canadian Council on Hospital Accreditation has recently published a new document on standards for accreditation of psychiatric centres.

PAMPHLETS PRODUCED BY THE CANADIAN DEPARTMENT OF HEALTH

Guidelines for standards in special care units in hospitals are available for:

Addiction Services	Intensive Care Units
Adult Psychiatric Services	Long Term Adult Institutional Care Units
Burn Unit	Nuclear Medicine in Hospitals
Child & Adolescent Psychiatric Services	Palliative Care Services
Child & Adolescent Services	Patient Hostel Care
Computed Tomography	Pulmonary Function Laboratories
Day Surgery Units	Perinatal Intensive Care Units
Dental Care Units	Regional Renal Failure Programs
Diabetic Care Units	Rehabilitation Medicine Units
Diagnostic Ultrasound Facilities	Respiratory Technology Services
Diagnostic Imaging Services	Spinal Cord Injury Units
Emergency Services	Stroke Services
Geriatric Unit/Day Hospitals	

The general format of these pamphlets is an overview of the objectives of the guidelines and the specialty concerned, followed by a point-by-point description of the service and recommended standard of service.

A small supply of these pamphlets has been provided to the King's Fund Centre by the Department of Health and Welfare of Canada and copies may be obtained from the Quality Assurance Project at a cost of £1.00 each (including postage and packing).

APPENDIX II

SOME USEFUL UK ADDRESSES

THE INSTITUTE OF QUALITY ASSURANCE

[A non-profit organisation operating as a professional qualifying body and learned society for the promotion of education and training of persons in quality assurance - primarily within industry, but with a growing interest in the field of health care; founded the BRITISH QUALITY ASSOCIATION, which has recently formed a Health Services Working Group]

IQA and BQA are both at: 54 Princes Gate, Exhibition Road, London SW7 2PG
Tel: 01-584 9026

THE NATIONAL QUALITY CAMPAIGN

[A Government sponsored campaign to stimulate quality awareness at top management level and encourage initiatives in improving facilities for UK industry and other bodies to pursue quality in performance; the campaign is led and co-ordinated by the Department of Trade and Industry]

Contact: Standards & Quality Policy Unit, Department of Trade & Industry,
4th Floor, 20 Victoria Street, London SW1H 0NF Tel: 01-215 4154

SOME USEFUL OVERSEAS ADDRESSES

AUSTRALIAN COUNCIL ON HOSPITAL STANDARDS (ACHS)

35 Clarence Street
Sydney 2000, Australia

AUSTRALIAN MEDICAL ASSOCIATION (AMA)/ACHS PEER REVIEW RESOURCE CENTRE

[Established by the AMA and the ACHS to provide an independent body to advise on peer review activities within the health services; it also publishes the quarterly journal "AUSTRALIAN CLINICAL REVIEW"]

71 Arundel Street, Glebe
New South Wales 2037, Australia

CANADIAN COUNCIL ON HOSPITAL ACCREDITATION (CCHA)

1815 Alta Vista Drive
Ottawa, Ontario K1G 3Y6
Canada

INTERNATIONAL SOCIETY FOR QUALITY ASSURANCE IN HEALTH CARE (ISQA)

UK Contact: Dr Charles Shaw, Co-Ordinator, Quality Assurance Project,
King's Fund Centre, 126 Albert Street, London NW1 7NF
Tel: 01-267 6111

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH)

[Also publishes the "QUALITY REVIEW BULLETIN"]

875 North Michigan Avenue
Chicago, Illinois 60611
United States of America

NATIONAL ORGANISATION FOR QUALITY ASSURANCE IN HOSPITALS (CBO)

[Set up to support ongoing quality assurance activities in the Netherlands and to take the initiative in getting quality assurance off the ground in those hospitals where it did not exist; under the auspices of WHO, Europe, CBO publishes the "EUROPEAN NEWSLETTER ON QUALITY ASSURANCE"]

PO Box 20064
3502 LB Utrecht
The Netherlands

THE SWEDISH PLANNING AND RATIONALIZATION INSTITUTE OF THE HEALTH AND SOCIAL SERVICES (SPRI)

The Karolinska Institute
Box 27310, S-102 54 Stockholm
Sweden

DEPARTAMENT DE SANITAT I SEURETAT SOCIAL

[Publishes "ACREDITACION DE CENTROS ASISTENCIALES"]

Direccio General d'Assistencia Sanitaria
Travessera de les Corts 139
Barcelona 08028
Catalona, Spain

APPENDIX III

QUALITY ASSURANCE PROJECT

STAFF

Charles D Shaw PhD MB BS MFCM LHSM : Project Co-Ordinator
Maria Lorentzon MSc SRN SCM : Deputy Co-Ordinator
Anne Holdich Stodulski ALA : Library Projects Officer
Paula Harvey : PA/Secretary to Co-Ordinator

BACKGROUND

The Management Committee of the King's Fund set up this project, based at the King's Fund Centre, at the end of 1984 to stimulate the assessment and promotion of quality in health care in Britain. For this purpose "quality" is accepted as defined by a combination of criteria of service including:

- effectiveness;
- acceptability (to consumers & providers);
- equity (of access and distribution);
- economy.

This generally excludes efficacy, clinical trials and resource inputs unless they are directly related to improving the process and outcome of the service.

"Quality Assurance" (QA) is the process of assessment in order to maintain or improve quality. Since this presents a very broad field, initial emphasis in gathering information about current activity will focus on acute hospital services. This is not to deny the relevance and later inclusion of long-term, primary and community care, which are already included in the literature information system.

OBJECTIVES

The overall purpose of the project is to:

- ascertain current activity relevant to QA in Britain;
- collate and disseminate information to assist the development of QA;
- identify unmet needs in training, research and development and commission or otherwise promote activity to fulfil these needs;
- encourage QA nationally among individuals and statutory, voluntary and private organisations.

The work of the Project is guided by a Steering Committee which, in 1986, is Chaired by Professor Ian McColl MS FRCS .

TARGETS

In the short term these objectives imply specific actions for the project, including:

- make contact with interested organisations and individuals;
- establish and make available an information system on relevant literature and activities;
- highlight priorities for research and development in QA and commission work where appropriate;
- collaborate with other organisations at home and abroad.

CONTACTS

Contacts have been made with a progressively widening range of UK organisations to establish their approach to issues of QA. These include national statutory, commercial and voluntary organisations concerned with management, planning and education of health services as well as individual health authorities and staff. In particular, we have held meetings with members of thirty-five of the Royal Colleges, institutes, societies and other national bodies representing health professions. Community Health Councils have responded to an invitation to tell us of practical steps towards quality assurance from the viewpoint of the consumer.

Outside Britain, links have been developed with the International Society for Quality Assurance, WHO (Europe), the National Association for Quality Assurance in Hospitals (The Netherlands), the Joint Commission on Accreditation of Hospitals (USA), the Australian Council on Hospital Standards, the Canadian Council on Hospital Accreditation, and others who may, by experience, contribute to the development of QA in this country.

RESEARCH AND EDUCATION

Experience to date suggests that the greatest need is for effective practical models which can be easily and cheaply applied in the average setting. Priorities already identified include explicit standards for a "good" service, methods of appraisal (including self-appraisal) of performance, valid tests of patient satisfaction, means of improving communication and attitudes between staff and patients, and the practical organisation of QA within a health authority.

The Steering Committee has defined criteria for commissioning research into quality assurance with a preference for serving needs identified by the Project rather than fortuitous enquiries. High priority is given to developing methods (which could subsequently be transferable within the UK) of defining and measuring standards within acute hospital services.

KING'S FUND COLLEGE

An urgent need, highlighted by the emphasis and implementation of the Griffiths Report, is for guidance on the introduction and teaching of QA at district and regional level. To this end the project is assisting the College in designing a course for senior NHS personnel who have this specific responsibility. The subject is also incorporated into existing management training programmes at the College.

QUALITY ASSURANCE INFORMATION SERVICE (QAIS)

One major problem for those embarking on quality assurance is the lack of easily available information on the experience and expertise within this country, and so the King's Fund - through this Project - aims to provide a national clearing house for such information. Thus the Quality Assurance Information Service (QAIS), developed by Anne Holdich Stodulski, Library Projects Officer, is a major aspect of the work of the Project.

The QAIS collects information on any type of published information relating to all aspects of quality assurance in health services. The primary focus is upon material published in the UK, but other overseas English language material, excluding that from North America, will be considered for inclusion. It is not the intention to build a dedicated literature collection to support the QAIS, so the problems of document delivery will be examined to discover how local resources could be used.

One unique aspect of the work of the QAIS is its involvement with the DHSS Library. In the early stages of planning this Information Service the DHSS Library was approached with a view to developing a co-operative arrangement for the QAIS, reflecting an important interest in both organisations in quality assurance information. Although the QAIS is funded by the King's Fund and based at the King's Fund Centre it is very much a joint venture, with the QAIS being mounted on DHSS-DATA - the computerised database of the DHSS Library. In addition, work on other products of the service will be shared jointly, eg the bi-monthly abstract journal - Quality Assurance Abstracts - is published by the DHSS.

QUALITY ASSURANCE ABSTRACTS

Quality Assurance Abstracts (QAA) aims to cover all types of literature dealing with all aspects of quality assurance in health care. This information will be primarily from the UK but a wide range of English language sources will also be used. Material published in North America is generally excluded.

Each of the 6 issues per year will contain around 150 references to documents, with descriptive abstracts. In addition, author and keyword indexes are included in each issue and these are cumulated annually as the seventh issue of the volume. The terms used in the keyword indexes are taken from the DHSS Thesaurus of Health Care Terms.

Quality Assurance Abstracts can be obtained only from: DHSS (Leaflets), PO Box 21, Stanmore, Middx HA7 1AY at an annual cost of £10.50 (remittance with order please). All enquiries regarding subscriptions should be made to DHSS (Leaflets) at the address given above.

ENQUIRY SERVICE

The QAIS also offers an enquiry service, run from the King's Fund Centre, which is aimed at health workers and others with a professional or occupational interest in quality assurance in health care. Enquirers or persons wanting information about other other aspects of the QAIS should contact: Anne Holdich Stodulski at the Quality Assurance Project.

INFORMATION EXCHANGE

Complementary to the work of the Quality Assurance Information Service and the QAIS Enquiry Service, the Information Exchange aims to put enquirers into contact with other people already working in relevant areas of quality assurance.

The information held is primarily concerned with current interests, initiatives and activities in the UK, but also includes references to relevant overseas organisations. Surveys and quality assurance schemes undertaken by individuals/small groups in the UK are included whenever possible. National professional initiatives are often given as further sources of information, but examples of individual activities resulting from such initiatives are not detailed.

The emphasis is on providing contacts for enquirers to follow up for themselves - who is doing what, and how to find them. Information is provided in the form of contact name, address and number, with a very brief of the area of interest/work. More detailed information may be available as part of future expansion of the service.

Enquirers, persons wanting to know more about the Information Exchange, or anyone willing to pass on information about their own work, should contact Paula Harvey at the Quality Assurance Project.

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