The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

BRIEFING PAPER

THE QUEST FOR QUALITY: REFINING THE NHS REFORMS

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BACKGROUND: THE STATE OF QUALITY

Just over a decade ago, the New Labour Government came to power promising modernisation and renewal of the NHS, in a process that would install quality 'at its heart' (Department of Health, 1997). What followed in England was an ambitious and wide-ranging series of reforms that sought to improve quality of care. New Government bodies were formed, explicit standards of care were set and independently monitored, services were reshaped, and new provider payment methods introduced. The information infrastructure has been developed, buildings have been refurbished and the workforce enhanced. Importantly, these reforms have been supported by substantial increases in spending on health.

Summary

- Quality in the NHS in England has improved significantly since 1997. Increased funding and a dynamic reform reform programme have enhanced both the resources available and the impetus for quality improvement.
- It is less clear, however, whether the gains made are commensurate with effort and investment.
- *The Quest for Quality: Refining the NHS Reforms* analyses data in six key areas:
  - effectiveness
  - access
  - capacity
  - safety
  - patient-centredness
  - equity.

  It provides comprehensive regional and international comparisons for measuring progress.
- The report calls for the establishment of an English National Quality Programme for the NHS, to
  - develop a coherent, integrated approach to quality improvement
  - refine the reform agenda, to ensure that quality improvements are more reliably delivered.
- The National Quality programme should be led by a quality steering group, to guide coordinated action. Among its responsibilities should be:
  - articulation of quality goals
  - agreement of benchmarks and indicators for public reporting
  - strengthening the clinical audit programme
  - evaluation and refinement of the reforms from a quality perspective.

Overall, it is apparent that quality has improved. What is less clear, however, is whether the gains are commensurate with investment and effort. In evaluating the NHS reforms of the past ten years, three questions are important:

- Are the improvements seen to date as good as could have reasonably been expected, given the scale and complexity of the NHS as an institution and the sustained period of under-funding that the NHS had endured in the preceding decades?
- How much of the improvement reflects advances in medical knowledge, changes in population behaviour, or developments in healthcare delivery (also seen internationally), rather than the specific impact of NHS reforms?
- Has a reliable capacity for system improvement been embedded in the NHS?

In *The Quest for Quality: Refining the NHS reforms*, authors Sheila Leatherman and Kim Sutherland have provided a well-rounded picture of the state of quality of care in the NHS since 1997. This current report is the culmination of a decade of work in this area, supported by the Nuffield Trust and others. Their findings, based on data collected and analysed across six key areas, are summarised below.

- **Effectiveness and appropriateness**: there is now more effort in the English NHS to achieve evidence-based standards of care for a number of clinical conditions; mortality rates for the major disease groups have dropped, though there are continuing deficiencies in care for a range of clinical areas.
- **Access**: waiting times for hospital admission, outpatient and cancer care have reduced significantly but ongoing problems remain with some specialties, diagnostics and community aftercare.
- **Capacity**: there have been significant increases in the number of staff, renewed and new facilities, and investments in medical technologies; some inadequacies still remain, however.
- **Safety**: progress on reducing the number of hospital-acquired infections but continuing difficulties in monitoring how safe health services are.
- **Patient-centredness**: a steady state in patient-reported experience of care
- **Equity**: while healthcare remains available to all and largely free at the point of use, there is a widening of the gap in life expectancy and infant mortality between more deprived populations and England as a whole.

These findings should be qualified by three main observations. Firstly, international data reveals trends – particularly with respect to indicators of health outcomes and mortality rates – that are strikingly similar to those seen in England. Such consistency is remarkable given the considerable differences in approach and levels of investment across comparable countries. Secondly, time series data reveals few, if any, dramatic changes in trends as a result of reforms or investment. Thirdly, variation within England in the quality of care (unjustified by medical need) is commonly observed, most notably in the effectiveness and equity of care provided and capacity.

Moving forward, quality improvement efforts should be informed by the multifaceted approach used to improve care in cardiovascular disease (see Case Study opposite).

Case study: cardiovascular disease

The recently published Coronary Heart Disease (CHD) National Service Framework Progress Report (DH, 2008) announced the accomplishment of meeting targets for reducing mortality from heart disease five years early – cutting deaths from cardiovascular disease for people under 75 by 40 per cent. Several factors were described as contributing to saving more than 22,000 lives per year:

- delivering thrombolysis more quickly for heart attack patients
- a reduction in waiting times for heart surgery, with no patients waiting over three months for heart surgery
- a doubling of prescriptions for cholesterol-reducing statins.

How were these outcomes realised? A wide-ranging combination of interventions was implemented, including:

- priority-setting
- defining clinical standards and targets for achievement
- a substantial commitment of resources (£735 million) to enhance facilities, technology and the workforce
- an action plan and process for clinical standard-setting, published in the National Service Framework for CHD in 2000 and implemented by clinical leadership from the Department of Health, with clinical networks throughout the UK
- the use of markets to provide additional capacity where necessary
- performance monitoring against clinically valid measures
- Quality and Outcomes Framework (QOF) incentives for better blood pressure monitoring, and use of statins
- National Clinical Audit (MINAP).

This example also illustrates that National Service Frameworks should be dynamic frameworks, constantly integrating and reflecting updated practice.

THE NEED FOR A NATIONAL QUALITY PROGRAMME

The multitude of reforms that have been introduced over the past decade are insufficiently integrated into a coherent national strategy. What is needed now is refinement, not rejection, of the reforms, through the development of a comprehensive English national quality programme. The Government has asserted that the NHS aspires to be a 'world class' health system. To be legitimately considered as such a health system – particularly one organised as a national health service – requires a well-defined and competently executed programme to boost quality of care. This programme should have two fundamental objectives:

1. Developing a coherent and integrated approach to improving quality. This means moving away from swings between centrally-driven and patchy locally-driven change towards a refined and stable reform agenda that recognises and builds upon the nationalised health system properties of the NHS. Reforms should be implemented and co-ordinated at four levels; nationally, regionally, within local organisations and in individual professional–patient encounters.
2. Refining a set of reliable reforms that use evidence, rather than ideology, to drive the quality agenda. It is now time to ascertain what works, and equally importantly, what does not. This, of course, is challenging. Rigorous evaluation of the reforms in England is scant and the evidence base emerging internationally must be applied with some caution, given contextual differences between countries. Nevertheless, available evidence can serve to inform refinements of the reforms constructively.

The principles adopted by a national quality programme should include:

- **concentrate efforts** where there is most potential to save lives, reduce illness, improve quality of life and lessen suffering
- **build upon** the **strengths** of the National Health Service; a national system where policy, resources, and execution can be aligned
- move away from an agenda dominated by national initiatives to one that focuses on **regional**, **institutional** and **patient-level actions** – supported and galvanised by national leadership
- **correct flaws** in existing policies that may work against the improvement of quality locally
- create and sustain a **balanced portfolio of reforms** incorporating professional, governmental and market mechanisms
- emphasise **evidence** over ideology – to inform the selection and implementation of 'levers for change' and boost investment in evaluation of the NHS reforms.

Using these principles as the foundation, suggestions for specific tasks for development over the next three-year period are outlined in the Blueprint for an NHS National Quality Programme (see box opposite).

Priorities for the quality agenda as identified in 1998

- Clarification about the underlying assumptions regarding professional self regulation versus government regulation
- Attention to incentives – defining importance, what exists and what needs to be defined
- Definition of clinical governance in operational terms
- Inclusion of primary care in all of the quality initiatives
- Design of a strategy to increase capacity, including data and information technology, human resources, and analytic expertise
- Engagement with the public through new communication and education capabilities.

Source: Leatherman and Sutherland, 1998

Blueprint for an NHS National Quality Programme 2009–12

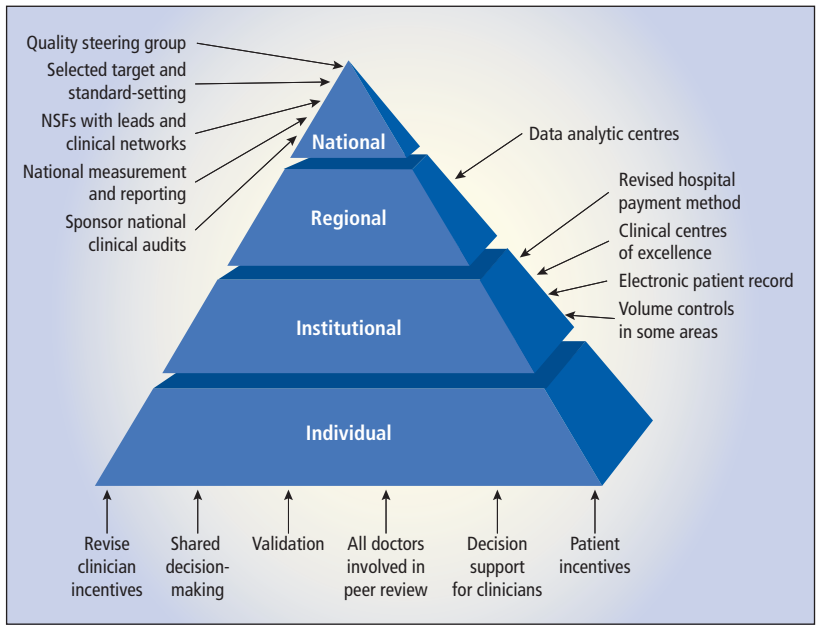
- Form a national **Quality Steering Group**
  - articulate national goals for quality
  - agree NHS-wide set of care quality indicators
  - submit an annual report to nation
  - strengthen the national clinical audit programme
  - evaluate and refine the reforms for more impact on quality of care.
- **Identify priorities** and resources to improve the nation's health
  - identify national priorities to reduce avoidable morbidity/mortality
  - analyse the resources required to tackle them
  - identify locally-defined priority areas.
- **Standards and target-setting**
  - broaden the scope of NICE
  - continue the development of care standards, such as in the National Service Frameworks
  - set targets for reducing unjustified variation.
- **Data and informatics** to support the national quality programme
  - develop a national strategy for reporting key indicators of quality
  - create a single locus for holding information on quality at the Department of Health/NHS executive
  - develop electronic aids to help with clinical decision-making
  - develop indicators of quality of care to support public reporting.
- **Clinical leadership** and professionalism
  - encourage rigorous peer review and clinical audit
  - support and develop appraisal and revalidation of professionals.
- **Patient and public engagement**
  - develop the 'expert patient' and shared decision-making approaches to care
  - encourage the use of patient-reported information on the outcomes and experience of their care.
- **Refine incentives**
  - refine payment by results and tariffs, together with GP and consultant contracts
  - introduce pay for clinical participation, data provision and self-improvement.
- **Regulation**
  - distinguish the role of safeguarding and assurance from the roles of other bodies for organisational support and development.

LEADERSHIP FOR THE NATIONAL QUALITY PROGRAMME

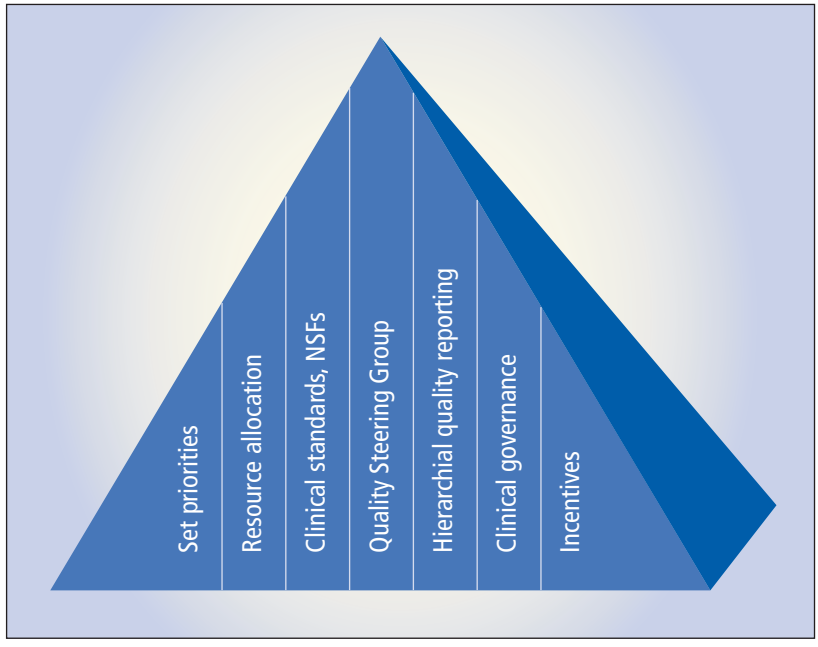
The National Quality Programme has the potential to bring together and strengthen the multiple organisations and individuals engaged in improving quality in the NHS. For the programme to succeed, it will need leadership – in the form of a steering group that is able to guide coordinated action in the pursuit of quality. The steering group should address several broad problems that currently jeopardise the formation of a coherent national quality improvement strategy:

- The duty for quality in the NHS is diffused broadly within central government and quasi-governmental bodies, throughout regional offices and hundreds of institutions, with final accountability at the level of thousands of individual providers.
- There is no single authority able to lead the quality agenda through the processes of defining priorities, marshalling resources, leveraging the power of regulation and incentives, implementing the requisite clinical informatics and data collection and reporting capabilities, or directing the policy and implementation of public reporting. These need to be coordinated to maximise their potential for change.
- There is no single credible and independent voice to report on the state of quality of care to the nation. As a result there can be unhelpful public debates about the veracity of data, and distraction and delays in implementing much-needed actions for quality improvement.

Proposed English National Quality Programme



Vertical integration of quality reforms



The managerial and governance arrangements for the National Quality Programme deserve considerable study and debate. However, critical responsibilities should include:

- **articulation of national goals** for quality in the NHS; goals may derive from various sources, including both national priorities and detailed data illuminating problems of overuse, underuse and misuse of healthcare resources.
- agreement of an **NHS-wide set of indicators** of the quality of health care for monitoring, benchmarking and public reporting.
- publication of an **annual national quality report** to Parliament and the public that provides data measures that are consistent over time, and incorporates international data to facilitate comparisons.
- the strengthening of the national **clinical audit programme** as a linchpin for measuring and improving quality of care in the NHS.
- development of a **strategy for public reporting** of indicators that would focus on:
  - defining the most useful content and format for multiple audiences
  - harmonising the multiple diverse public reports that currently exist
- commission **evaluation** (formative and summative) of policies to improve quality and make recommendations as to how policies might be refined.

CONCLUSION

Ten years ago the Government pledged to undertake an ambitious programme of reforms to make the NHS a healthcare system deserving of the confidence and loyalty of the English public. The building blocks for significant change are in place and there is no doubt that efforts have resulted in progress.

We are now at the point where efforts to improve quality of care should be better co-ordinated and strengthened to create more solid progress in improving the quality of care for patients, and achieve more benefits for the investment made in the NHS.

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THE QUEST FOR QUALITY

This briefing paper is based on *The Quest for Quality: Refining the NHS reforms – a policy analysis and chartbook.*

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Published by The Nuffield Trust, May 2008
ISBN-13: 978-1-905030-33-0. 260 pages.

For information or to order copies of the book visit
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