View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by LSHTM Research Online

Black, N (2008) Quality improvement in the NHS. BMJ (Clinical research ed), 336 (7654). p. 1143. ISSN 0959-8138 DOI: https://doi.org/10.1136/bmj.a127

Downloaded from: http://researchonline.lshtm.ac.uk/7501/

DOI: 10.1136/bmj.a127

Usage Guidelines

Please refer to usage guidelines at http://researchonline.lshtm.ac.uk/policies.html or alternatively contact researchonline@lshtm.ac.uk.

Available under license: Creative Commons Attribution Non-commercial http://creativecommons.org/licenses/by-nc/3.0/

Editorials

Quality improvement in the NHS

BMJ 2008; 336 doi: http://dx.doi.org/10.1136/bmj.a127 (Published 22 May 2008) Cite this as: BMJ 2008;336:1143

- Article
- Related content
- Article metrics
- Rapid responses
- Peer review
- Download PDF

Nick Black, professor of health services research

Author affiliations

Nick.Black@lshtm.ac.uk

Refinement of current reforms is needed through a new national strategy

Although not always recognised by clinicians and the public, the principal aim of most of the reforms of the NHS in England over the past decade has been not only to increase efficiency and productivity but also to improve the quality of care—that is, its effectiveness, humanity, and equity. For example, establishing the National Institute for Health and Clinical Excellence and national service frameworks was meant to enhance effectiveness; introducing competition and choice was partly intended to improve the patient's experience of care; and adjusting resource allocation to commissioners sought to achieve greater equity.

The multiplicity of changes to the governance, organisation, and financing of services has made it difficult to judge the effects of any single reform on the quality of health care. Despite this, there has been no shortage of people ready to express authoritative opinions, from members of the public and patients' organisations, through royal colleges and trades unions, to the private sector and parliamentarians. Inevitably, such views tend to be partial and to reflect particular interests. An attempt to provide a more independent dispassionate view, based on objective evidence, is therefore to be welcomed and valued.[1]

The Quest for Quality, an ambitious and unique report from the Nuffield Trust, brings together quantitative data from diverse sources to answer three questions. Are the improvements in quality over the past decade as good as could have reasonably been expected? How much of the improvement can be attributed to deliberate reforms? Has a reliable capacity for improvement been embedded in the NHS? Answering such questions was a formidable challenge, given the well recognised shortcomings of routine data in the NHS (lack of data on outcomes, limited ability to adjust for case mix, missing and inaccurate data, and lack of connection between primary and secondary care). In addition, when evaluating any complex diffuse change, it is difficult to establish causal links between specific interventions and outcomes.

Despite the restricted opportunities for quantitative analysis, the report provides a clear and extensive account of the quality reform agenda since 1998, alongside the available data on changes in the health

of the population, healthcare activity, and health outcomes. It considered six aspects of quality and concluded that effectiveness had improved (greater adherence to evidence based clinical guidelines, reduced mortality for the major disease groups), access to care was better (shorter waiting times for many services), facilities and capacity had improved, and progress had been made on reducing hospital acquired infections. In contrast, it recognised some shortcomings, such as little change in patients' experience of care and a widening gap in life expectancy between socioeconomic groups.

Reflecting on these successes and failures, and on the confusion of organisations and activities that have been introduced to improve quality, the report suggests that "what is needed now is refinement, not rejection, of the reforms through the development of a comprehensive English national quality programme." A coordinated approach led by a national quality steering group is advocated, which would ensure that the responsibilty for quality is diffused throughout central and local organisations. A national quality programme should articulate national goals for quality, agree on NHS-wide quality indicators, strengthen national clinical audits, and develop policies for all aspects of public reporting of indicators, including an annual report to parliament.

Few people will disagree with the need for a more coordinated approach that gives a higher priority to consideration of quality. Indeed, members of the public would probably be surprised (and perhaps alarmed) to discover that quality of care is rarely, if ever, discussed by the boards of NHS trusts. They might also question Department of Health funding priorities that allocate a 100 times more money to research than to clinical audit. Concern about the current situation is shared by the Department of Health, which has recently established the National Clinical Audit Advisory Group to help develop policy and strategy with the aim of reinvigorating clinical audit both nationally and locally. Although the report identifies several challenges, there are grounds for optimism given the current confluence of several initiatives—world class commissioning, revalidation of healthcare professionals, risk management of provider organisations, public choice, competition between providers, and marketing—each of which needs better information on outcomes and can help catalyse quality improvement.

Achieving the improvements in quality that clinicians, managers, patients, and politicians seek will depend on meeting several challenges. Firstly, a better accommodation between the centre—trying to direct and control—and the periphery—pursuing local priorities and wanting ownership—will require understanding and compromise from both areas. Secondly, a more holistic approach to considerations of quality will need stronger links between those currently responsible for assessing effectiveness (such as national clinical audits) and those assessing the humanity of care (such as the Healthcare Commission). This is connected to the third challenge—the need for a better balance between, on the one hand, the predominant biomedical perspective that seeks technological solutions to poor quality, such as better drugs, and on the other hand, recognition of organisational and cultural change as key factors to improving quality. And fourthly, regardless of the appropriate solution to any given problem regarding quality, the need for more rigorous approaches that are based on scientific evidence of the cost effectiveness of interventions.

By tackling these and other underlying problems, quality improvement can gain prestige and take its rightful place alongside more highly respected activities such as research and education. The recent report should help in the pursuit of such ambitions.

Footnotes

- Competing interests: NB chairs the DH National Clinical Audit Advisory Group.

- Provenance and peer review: Commissioned; not externally peer reviewed.

References

1. ↵Leatherman S, Sutherland K. *The quest for quality: refining the NHS reforms.* London: Nuffield Trust, 2008.

Back to top