

COMMENT

Quality in Healthcare and the Quest for Improvement

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Abstract

Improvement in the quality of healthcare is desired by everyone. Delivering this however, is hindered by lack of clear, widely embraced perceptions of what is encompassed within quality and how improvement can best be brought about. This paper, written from the viewpoint of a clinician now with a responsibility for this field in Scotland, presents a multidimensional concept of quality, as encompassing effectiveness, safety, patient centeredness, timeliness, efficiency and equity. This approach allows views about the relative importance of the various components to differ but also to be reconciled and the different standpoints made coherent. The principal kinds of interventions, aimed to improve one or more aspects of quality, are presented and the need for much greater evidence about their value, alone or in combination is noted. Nevertheless, there is increasing recognition of the importance of emphasising the human factors of attitude, culture and behaviour that provide the best assurance of quality of care to individuals. NHS Quality Improvement Scotland has a key role in searching out knowledge about how improvement is achieved and in engaging with patients and NHS staff to ensure that the necessary advances are achieved in Scotland.

Introduction

As a practicing surgeon, I was clear that quality in patient care equated to clinical outcome and that improvement meant lower mortality and better neurological function. This view seemed justified, even reinforced by the dramatic advances that I observed over the period of my career. Mortality after serious brain injuries and haemorrhages, which used to claim a third of victims, fell to a few percent during that time. Operations for major intracranial tumours, following which substantial neurological deficit was accepted as the price of survival, now carry a mortality of much less than 1% and preserved, even improved, function is (rightly) expected.

More recently, I have come to appreciate that there are broader views about what is important in thinking about quality of care today. Several other factors are coming to the fore, perhaps because of this success in dealing with the direct effects of much pathology, perhaps because the widening of perspective is according their importance overdue recognition.

The quality of healthcare is, of course, relevant to everyone. It is vital to people receiving care and for clinicians it has always been embedded in their professional ethics and duties. Quality, more generally, is also important to patients and the public at large, their political representatives and those charged with organising and managing the provision of care. Quality improvement consequently is now an explicit aim in most healthcare systems. Nevertheless, there is not a widely agreed and shared understanding of what is meant by 'quality' in the context of healthcare.

The lack of consensus about what is encompassed within quality, and a limited evidence base¹ lead to uncertainty, indeed sometimes to heated controversy, about how improvement is best brought about. The aim of this paper is to examine the relevant concepts as a basis for a rationale for promoting improvements in healthcare in Scotland. It draws heavily on the work of many other people, especially in NHS Quality Improvement Scotland (NHSQIS), from whom I have learned much over the last year.

What Do We Mean by Quality in Healthcare?

Clarity in terms of what is meant by quality in healthcare is not helped by dictionary definitions of the word such as 'degree of excellence, relative nature or kind or character, general excellence'.² Which characteristics? Relative to what? Not surprisingly viewpoints differ.

Clinicians, understandably, as a matter of course still emphasise the 'clinical' outcome of care. Patients, of course, wish an optimum outcome but also, and increasingly, they regard the nature of the experience as important. The quality of performance of the underlying systems, structures and processes that support the provision of care to individuals has clear relevance to organisations and communities.

A simple definition of quality in healthcare is '*Doing the right things right to the right people at the right time.*'³ A more complex definition, that tries to respond to some of the complexity and diversity of views is: '*The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.*'⁴ Yet this definition, in trying to be more specific, also begs more questions. What are desired health outcomes? Desired by whom? Are outcomes that are measurable more important than those that cannot be measured? How do you assess current professional knowledge?

Instead of trying to define an abstract concept of 'quality', it is more valuable practically to get agreement about the ways in which it can be recognised, described and compared. Integral to this is agreement about the key ways in which quality can be expressed.

The Institute of Medicine in North America proposed that there are six main aspects or dimensions within the overall concept of quality.⁴ (Table I). These have become widely accepted and influential and, indeed now form the framework for the approach to improving quality in the Scottish Government's very recent statement of its vision for the future of healthcare.⁵

Table I

Dimensions of Quality in Healthcare

- Safety - care provided in a way that avoids harm or exposure to unnecessary risk
- Effectiveness - care that produces the optimum outcome for a patient - the aspect commonly equated with/emphasised in 'clinical outcome'
- Patient centredness - healthcare based on partnership between healthcare professionals, patients and, where appropriate, their families, that is delivered with compassion and responsive to patients' needs, values and preferences
- Timeliness - healthcare provided at the time it is needed within an appropriate setting
- Efficiency - healthcare which reflects value for money
- Equity - healthcare provided on the basis of clinical need, delivered in a way to reduce differences in health status and outcomes across various groups.

(From Lohr KN. Medicare: a Strategy for Quality Assurance. Washington DC: National Academy Press, 1990. 2 volumes Ref 4)

These dimensions are usefully comprehensive. From the perspective of a patient all of them need to be covered. Yet the existence of several facets poses challenges for healthcare systems and for individual healthcare professionals, and there are even potential tensions and trade-offs between them. An undue focus on one dimension may have an adverse effect on another. For example, the promotion of safety or clinical effectiveness through greater specialisation and concentration of services may be at the expense of patient centredness in terms of ease of access. A preoccupation with efficiency - especially expressed as numerical and financial targets - can seem inimical to providing quality of care to the individual, yet in practice can translate into more people receiving care sooner, with a better clinical outcome. An additional dimension proposed in the United Kingdom adds capacity (that healthcare systems are sufficiently well resourced to enable delivery of appropriate services) reflecting the historical context of the NHS.⁶

Judgments have to be made on the balance to be struck between different dimensions; and such judgments will differ according to the perspective of the person making the judgment, eg at the level of a health system from a population perspective, or at the level of an individual.⁷

A recent and high profile example of this in England and Wales was the way in which issues of equity and cost effectiveness, addressed in the guidance issued by the National Institute for Health and Clinical Excellence (NICE) for the use of drugs for Alzheimer's Disease, were seen to be in opposition to personal experience as described by patient and carer groups. This contributed to the undertaking of a judicial review of the process.⁸

Further complexity arises from the practice in many health systems of spreading responsibility for the various dimensions of quality among different people and agencies. This is not necessarily unhelpful, but for it to work there needs to be clarity about how the parts fit together and about the relative value of different approaches.

What is Known about the Best Ways to Achieve Quality Improvement?

Endeavouring to improve quality, in particular in clinical outcomes, is not new. Clinicians, in doing the best that they can for a patient, have always sought to use existing knowledge to best effect and to find new ways of treating particular conditions. Processes to promote this, such as clinical guidelines and audit, have been widespread for many decades. What has changed is that quality improvement has become a key objective of healthcare systems and of governments.

In the past, in most healthcare systems, the approach to quality improvement has been ad hoc, informed more by history than by an explicit understanding of the best ways of achieving and sustaining better quality, reliability and safety of patient care. What were previously seen as separate activities are now increasingly being looked at together as components of something bigger which, if applied appropriately, can have more impact. There is also a greater focus on implementation. The production of a clinical guideline or an audit report is not seen as an end in itself but as a step in achieving change, and needing to be accompanied by a range of interventions, designed to promote adoption and use.

Theories abound on the best means to meet the challenge of improving quality in healthcare. Clear guidance about what to do is needed but scarce. A 2004 review⁹ observed that the literature was large, diverse and complex. A review of theories of quality improvement found that the empirical evidence for their effectiveness and feasibility is limited.¹ These authors concluded that it is, therefore, not easy to draw conclusions about the relative merits of specific theories, still less to identify one that is comprehensive.

The lack of a single, overarching theory of quality improvement reinforces the need to ensure that the different methods that are available are underpinned by evidence. The Health Foundation, a United Kingdom charity, in its 'Quest for Quality and Improved Performance Programme' (QQIP) aims to draw together the work currently underway on the relative effectiveness of different approaches to quality improvement.¹⁰ To facilitate collation of the evidence, QQIP has grouped interventions under five headings (Table II).

The conclusions that will emerge from analysis of the effectiveness of different approaches will need to be used in at least two ways: first, to assist in developing an overall framework for quality improvement in healthcare; and second, to guide the choice of approach or approaches to specific activities. Within the spectrum of interventions defined by QQIP, it is the last two, aimed at the use of information and delivery of care that bear most directly on clinical practice.

Yet it could be said that, so far, the majority of interventions have had a focus upon organisational structure and process. Although these are essential foundations in healthcare, organisational culture and professional attitudes and behaviour are at least as important.

Table II

Principal Approaches to Improving the Quality of Health Care

- patient - focused interventions (e.g. promoting health literacy, improving access and the care experience)
- regulatory interventions (e.g. licensing, accreditation of professions and institutions)
- incentives (financial and non-financial)
- data-driven and IT - based interventions (e.g. reporting on performance and feedback, decision support tools, clinical audit)
- interventions aimed at the working of an organisation and its staff (continuous quality improvement, culture change, clinical governance, safety and risk management)

(The Health Foundation. Quest for Quality and Improved Performance(QQUIP). London: The Health Foundation. Available at <http://www.health.org.uk/qquip>)

Human Factors

The importance of focusing on the role of people reflects a fundamental feature of healthcare: the fact that key decisions and actions affecting outcomes are taken by individual clinicians in the treatment of individual patients. Team working and the increasing use of technology may have altered the way this operates, but they have not changed it fundamentally. The achievement of improvement in the quality of care depends critically upon influencing clinical professionals, their actions and on clinical responsibility and leadership.¹¹

Unfortunately, recent surveys¹² have shown that there is widespread disengagement and disenchantment among doctors and clinicians in all healthcare professions, particularly from what are perceived as political or managerial initiatives. This has been exacerbated by recent developments in regard to training, careers, regulation and employment such as: Modernising Medical Careers, Trust, Assurance and Safety¹³ and Agenda for Change. It is vital to the quality of clinical care that this is addressed.

Promotion of Improvement - the Role of Organisations such as NHSQIS

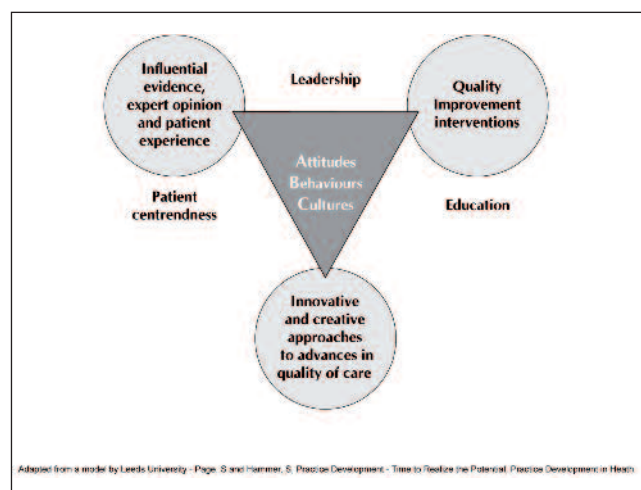
Promotion of (re) engagement is central to the quest to improve the way in which services are planned and care is delivered. Even using a limited definition of quality improvement, a key first step is agreement about what is the 'right thing'. Delivering it at the right time to the right people, and in the right way, is then, about influencing systems and behaviours. This is where the role of a quality improvement agency becomes crucial, marrying the traditional biomedical evidence-based approach with a more sociological perspective, understanding why people do things and how they can be helped to do the right one. Engagement with a wide range of partners, including clinical

professionals, managers, the wider health and social care team as well as researchers and policy makers, and, crucially, patients and the public is pivotal. The role is akin to what has been referred to in the research field as 'knowledge brokering'.¹⁴

In order that information from areas such as policy, research, experience, and expert opinion, along with public and patient expectations, influences the delivery of health care appropriately and effectively, an intermediary is required to bring together the different perspectives and priorities. Such an intermediary needs to be active in networking, problem solving, innovating, to be trusted and credible, a clear communicator, understanding of the culture of the varying environments, able to find and assess relevant research in a variety of formats, a facilitator, mediator and negotiator, able to bridge between national and local roles. This depicts very well the role of a quality improvement agency such as NHSQIS. (Figure 1).

Figure I

Framework for Improvement in Quality of Clinical Care



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NHSQIS (www.nhshealthquality.org) was established as a special Health Board in 2003, to bring together and advance on the work of several previously separate bodies in Scotland. It collaborates with other leaders in the field which include the Health Foundation in the UK (www.health.org.uk), and the Institute for Healthcare Improvement, (www.ihl.org) whose promotion of a safety - focused culture has been strikingly successful in North America and in pilot work in the UK.

NHSQIS asks five crucial questions. How can the outcome of care for patients, including issues like quality of life, be improved? How can we help to ensure that high standards are consistently delivered? How can we ensure that everyone has fair access to health services? How can patients' experience of using health services, including issues like waiting times and the quality of communication with NHS staff, be improved? How can it support NHS staff to provide the most effective care and make the best use of resources?

It pursues its objectives in a range of ways: providing advice and guidance on effective clinical practice, setting clinical and non clinical standards of care and monitoring of performance. It works in partnership with Health Boards and many other organisations to support NHS staff to improve services and very importantly to promote patient safety and implementation of clinical governance.

Conclusions and the Future

In Better Health, Better Care⁵ the Scottish Government's action plan on priorities for health and wellbeing in Scotland, the focus is on the pursuit of activities in the six dimensions of quality to ensure that care is safer, more reliable, more anticipatory and more integrated, as well as timely. The Action Plan identifies the role of NHSQIS, along with other partners in NHS Scotland and internationally, as ensuring that quality improvement methodologies are widely implemented in NHS Scotland.

NHSQIS will address these challenges. It will continue to seek to bring together frontline healthcare professionals, researchers and decision makers, patients and the public and to embrace responsibility for intellectual and practical leadership in providing the knowledge required and promoting its use in improving the quality and safety of healthcare of people in Scotland.

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