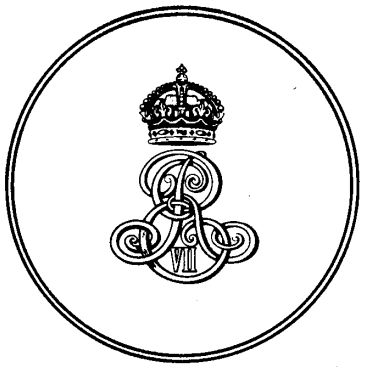

SEEKING QUALITY

A report of a seminar held at the King's Fund Centre

MARCH 1982

C O N T E N T S

S E E K I N G Q U A L I T Y

SECTION I.

INTRODUCTION

The era of steady predictable financial growth for the NHS is undoubtedly over. Yet expectations that the service will continue to respond to changing and increasing needs, promote new treatment advances, and absorb the effects of social and environmental changes, remain. Faced with competing, and often conflicting, pressures and priorities, there is a danger that the standard of services provided may suffer. Thus the search for measures to define, monitor, and hence safeguard, the quality of provision is extremely pertinent.

In the United States, the Joint Commission on Accreditation of Hospitals, (J.C.A.H.) has for many years been engaged in defining and promoting standards of good practice in health care. To determine whether the NHS might learn anything from the American system, in 1981, a small multi-disciplinary team from the U.K., supported by a King's Fund grant, visited the J.C.A.H. in Chicago and took part in two hospital surveys in the U.S.A. On their return to England, the team, with the help of experienced American surveyors, carried out pilot surveys in two health districts in the U.K.

This paper records the proceedings of a seminar held at the King's Fund Centre, at which members of the study team described their impressions of accreditation surveying in the U.S.A. and their attempts at a similar exercise in the U.K., and invited comments and discussion on the possibility of future development of work of this kind in Britain. The people who attended the seminar are listed in the Appendix.

The seminar was chaired by Dr Richard Himsworth who, in introducing the subject for discussion, referred to the importance of regarding words such as 'accreditation' and 'audit', not as threats or attempts to limit clinical freedom, but rather as signalling the start of a process of benign and helpful evaluation of immense potential importance to the N.H.S.

The seminar began with short presentations by three members of the study team which were followed by a period of general discussion.

SECTION 2.

PRESENTATIONS BY MEMBERS OF THE U.K. STUDY TEAM

Short presentations on behalf of the study team were given by Mr Robin Hardie, District Administrator for East Dorset Health Care District, Miss Margaret Day, District Nursing Officer for Tower Hamlets Health District and Mr Max Rendall, Reader in Surgery and Clinical Superintendent at Guy's Hospital. The points they made are classified below under the headings: I. Strengths of the J.C.A.H. approach; 2. Weaknesses of the J.C.A.H. approach; 3. Experience of quality surveying in Britain; and 4. Reflections on the relevance of the American system to the U.K.

2.I. Strengths of the J.C.A.H. approach

a) Generating a commitment to quality

The study team had been impressed by the general commitment to quality encountered in the U.S.A. This, they felt, was promoted by the accreditation process itself which gave a stimulus to professional pride and encouraged evaluation of personal performance against fellow practitioners. Commitment was helped further by professional involvement in the process. For example, nurses set and evaluated their own goals, and reviewed their progress towards achieving them. The J.C.A.H. system thus provided a means of identifying improvements in individual performance. This was important for nursing staff since evidence of such improvement made them eligible for merit awards worth up to 3½% of their salaries.

b) Generating commitment across the institution

Overt goal specification via the accreditation process resulted in commitment to common organisational objectives which united individual departments within a particular hospital. This 'strength' could however also be construed as a weakness see 2.2.e. below.

c) Method of determining standards

Standards were defined by the professionals themselves. They were thus more credible and acceptable to individuals surveyed than any 'externally' derived standards. Also, starting as they did with the aim of ensuring quality rather than efficiency they tended to accord more with professional values than other forms of performance review.

d) Voluntary nature of the scheme

Although there are incentives to become involved in the accreditation system as mentioned above in 2.I.a, the process is voluntary and depends upon the professions concerned setting the standards. As a result the surveyors are not viewed as a potentially threatening inspectorate but rather as educators, consultants and advisors. The British study team had been impressed by the very good relationships developed between assessors and assessed in a very short period. Mrs Day pointed out, for example, that the visit of the accreditation nurse was looked forward to as a highly important event akin to a G.N.C. visit in the U.K. However there the parallel ends since in the U.K., reliance is placed on professional training rather than detailed manuals to assess performance.

2.2. Weaknesses of the J.C.A.H. approach

a) Resources required

The members of the study team had been critical of the volume of paperwork associated with the U.S. accreditation system and of the consequent high costs incurred in providing staff and other resources to sustain it.

b) Mechanistic approach

To ensure uniformity, standards had been very precisely defined. This, coupled with the need for the surveyors to work speedily, resulted in a tendency for the whole process to become over-detailed and mechanistic.

c) Misplacement of goals

The study team felt that as a result of this mechanistic approach, the aim of the accreditation process often seemed to be merely to establish that certain procedures had taken place, rather than to consider more fundamental issues such as the value of the procedures themselves. This relates to a fundamental doubt about the J.C.A.H. system, namely the extent to which it actually measured quality.

d) Did the system actually measure quality?

The team felt that, despite the numerous indicators and precise definitions used, the accreditation process resulted at best in a set of measures only indirectly indicative of quality. They suspected that quality of care was often mechanistically equated with the fulfilment of a set of specified procedures.

e) Lack of consideration of quality beyond the institution

The accreditation process did not encourage the consideration of quality beyond a particular organisational boundary, on a district wide basis for example. As the team pointed out, there is a considerable difference between measuring quality in an institution, and attempting to apply standards across a health district - which is what would be required in the U.K..

Despite the weaknesses of the J.C.A.H. system, the study team felt it offered important pointers on how to proceed in assessing quality in the U.K. The study team therefore visited two English health districts - Basingstoke and Harold Wood - with the intention, not of conducting a full accreditation exercise, but, by using a list of open-ended questions, to stimulate general discussion about quality; to tease out any standards currently being used; and to establish what sort of quality evaluation was already taking place. The main points arising from the English experiment are summarised below.

2.3. Experience of quality surveying in the U.K.

a) Interest in quality

The pilot studies had revealed a high level of interest in issues of quality and a desire for help in determining standards. There was a feeling that the definition and measurement of standards would help N.H.S. workers in their performance and would also provide a useful mechanism for identifying deficiencies and bidding for resources.

b) Evidence of departmental pride

The study team had been impressed by the extent of departmental pride which they uncovered, but their American colleagues missed a wider organisational commitment.

c) Current attempts at assessing quality

A wide range of approaches to assessing quality had been discovered ranging from what the team described as "considerable naivity" to a "practiced approach to standards".

d) Value of the survey process

The pilot studies had identified hitherto unknown areas of good practice and hence had been akin to the J.C.A.H. process in identifying and providing the means to disseminate good practice.

e) Attitudes of clinicians

Amongst clinicians there had been a strong awareness that, in the context of tighter controls over public expenditure, there was, both for professional and political reasons, a need for an initiative in this area. There was also a willingness to explore ways of developing such a project.

The study team had been encouraged by the responses and had therefore tested out some of the actual standards developed by the J.C.A.H. They had found them to be in many instances relevant to the N.H.S.

However, some reservations were also expressed during the pilot studies. There were, for example, differences of opinion on the extent to which standards should be used for comparison between individuals rather than be available solely for self-evaluation. There was a strong feeling that standards should be defined by the professionals themselves but a worry that managers and professionals within the N.H.S. lacked a forum for debate about these issues. There was also a considerable feeling that the scale of the N.H.S. and its managerial organisation actually deterred professionals from becoming involved in considering issues of quality. Professional opinion was that too much policy was centrally determined and was imposed upon local Authorities merely for compliance. Within particular districts, staff did not feel that local management structures supported them in their efforts nor that they promoted commitment beyond individual departments.

2.4. Reflections on the relevance of the American system to the U.K.

The study team felt that the J.C.A.H. system could not be transferred in entirety to the U.K., and indeed that the rigidity and bureaucracy of the system should be avoided at all costs. However it might suggest ways of building on the interest in quality of care which the pilot studies in the U.K. had discovered. The issues involved were sensitive and there were delicate problems to be considered - for example. Who should take the lead in encouraging the interest which already exists ?; How to deal with those who are not interested in assessing quality ?; Could there be a role for an outside team of facilitators ? The team felt however, that the definition of standards, for reasons already discussed, is so important that the difficulties of the task do not constitute good enough reasons for avoiding it.

SECTION 3.

GENERAL DISCUSSION

The presentations by members of the study team were followed by a period of general discussion during which the following were the main themes discussed:

3.I. Advantages of the J.C.A.H. approach

There was further discussion of the advantages associated with the J.C.A.H. system. Members of the study team pointed to additional benefits to management arising from an increased understanding both of the way individual departments functioned and of the professional values of staff working in them. This understanding was in turn important to the professionals themselves since they felt it resulted in a more supportive working environment. The overall effect of the accreditation process was to increase cooperation between management and other professionals and to generate commitment to common goals. The pilot studies conducted in England had indicated to the study team the potential for similar benefits in the U.K. This they felt to be of particular significance for the post-1982 reorganised N.H.S., which would entail closer working relationships between members, managers and professionals.

Other participants at the seminar, who had also witnessed the J.C.A.H. system in action, confirmed the study team's account of the educational value of the process and its potential for generating commitment to particular goals in a multi-disciplinary environment.

3.2. Disadvantages of the J.C.A.H. approach

There was also further discussion of the disadvantages associated with the J.C.A.H. approach. The elaborate paperwork and cumbersome bureaucracy needed to support the system, were again referred to. The study team felt that the costs of the exercise possibly outweighed its benefits and that a much simpler system could be devised. The team's description of the mechanistic way the process was conducted was supported by other participants who had seen the system in operation. A major concern expressed at the seminar, was the possibility of goal displacement. In the desire to meet the requirements of the review process, its fundamental purpose - to improve the quality of patient care - might become obscured. Hence the goals attained might be professional rather than patient-centred.

3.3. Specification of standards

A particular disadvantage of the J.C.A.H. approach, identified by the study team was the amount of detail involved in specifying standards. The consensus at the seminar was that such a level of specification was both dangerous and unnecessary; "national" standards should be avoided at all costs and any guidelines should be susceptible to adaptation and interpretation in the light of locally perceived priorities and circumstances. The scope of the J.C.A.H. system was also considered unnecessary. Rather than seek to cover every area of activity, standards, it was felt, should be defined for particular areas identified as important in collaboration with the professionals concerned. The standards so defined would not necessarily need to be

very technical or precise. It was pointed out that some areas of performance are so obviously in need of improvement that very simple guidelines, if adhered to, could effect significant changes for the better.

3.4. Involvement of professionals

The involvement of professionals in the J.C.A.H. system was an important element in making the accreditation process credible and acceptable to the professionals surveyed. The definition of standards is the responsibility of the Commission, but the staff involved are themselves essentially "field professionals" who draw up and continuously review guidelines in collaboration with other professionals and eminent people. Thus the standards are always up to date and 'belong' to the profession rather than to an 'outside' body. This fact also helps to foster good relationships between surveyors and those surveyed, since it clearly separates the process of standard setting from that of inspection, and gives an 'objective' basis to the accreditation process.

The opinion at the seminar was that similar professional involvement would be essential in any attempts to define quality in the U.K. Indeed because of the environmental differences, discussed below, intrinsic rather than extrinsic examination would be more necessary in Britain than in the U.S.A. There was, however, also a feeling that the definition of standards could not be left solely to the professionals concerned since by so doing important issues might not be considered. Professionals might be reluctant, for example, to consider balancing quality against quantity and compromising on the former, or to question the necessity of certain activities at all. To attempt to overcome the difficulty of defining quality in terms of surrogate indicators it would be necessary to involve more than just professional opinion.

3.5. Relevance of J.C.A.H. approach to U.K.

Participants commented on the differences in the ways of providing health care in the U.S.A. and U.K. which had implications for the extent to which the J.C.A.H. approach could be "transferred".

In the U.S.A. health care is a commodity largely subject to market forces. Since the attainment of the Certificate of Accreditation is necessary to attract patients, upon which, in turn, the livelihood of staff depends, there is, in the U.S.A., an in-built incentive to encourage commitment to the accreditation process. However, in a national health service a similar element of competition between institutions does not exist, and the livelihood of staff is not so clearly linked to the 'success' of the institution. Again, the costs of the J.C.A.H. system are largely met by the institutions themselves which pay for the Commission's services on an agency basis. However British health authorities, which rely on central finance, and have little scope to increase their income, might be reluctant to fund an initiative which would divert resources away from direct patient care.

As a result, participants felt that, in the U.K., even more than in the U.S.A., the search for definitions of quality must concentrate on intrinsic examination involving the professions themselves rather

than on extrinsic assessment. The incentives for such examination would come from professional pride, commitment to patients and the desire to protect and maintain standards. The meeting recognised that such factors would have a variable effect on different individuals and there was some discussion about whether such incentives were adequate without sanctions. This was recognised to be a very difficult problem and it was felt there could be a role for Regional and District chairmen in applying pressure rather than imposing sanctions. However the meeting was optimistic about the power of the above factors to encourage individuals to consider issues of quality if approaches were developed which used them constructively. Some opportunities for such constructive development were discussed as follows:

3.6. Approaches to seeking quality

The meeting pointed out that the J.C.A.H. system represented only one of several possible methods of identifying and improving quality. In the U.K. as well as the U.S.A. and other countries there were other approaches which might be considered and developed. There was general agreement that whatever approaches were adopted in the U.K. they should all have in common: a) the promotion of intrinsic examination by the professions concerned rather than 'external' examination; (Professional involvement in standard setting would be necessary but not sufficient. A wider range of opinion would need to be reflected and Community Health Councils were cited as examples of groups who could play a valuable role in counterbalancing any tendency towards "over-professionalism".) b) sufficient flexibility to allow local circumstances to modify or adapt any general statements.

The meeting identified several ways in which these criteria could be met: Where effective medical and professional organisation exists, the definition of quality could be conducted at the "grass-roots" by on-going peer review. The Cogwheel system, it was pointed out, was designed with this as one of its aims and several participants pointed to the need for a new initiative on this front. The development of clinical budgets could also provide the focus for peer group examination of issues of quality. The Australian system of peer group evaluation was cited as an example of how effective this method of determining standards could be.

The impetus for encouraging the examination of quality could also come from other organisational levels within the N.H.S. The meeting felt there could be a constructive role here for District and Regional Authority Chairmen. As one participant pointed out, regions had already had some success in stimulating a review of services. In the Northern Region a district by district review of psychiatric services had been initiated. The meeting felt however, that the D.H.S.S. was less favourably placed to influence local actions and that the centralised development of 'mechanistic indicators' would not secure clinician involvement.

There were also other bodies which could take a lead in initiating developments in this area and the Health Advisory Service and the Royal Colleges were suggested as examples.

The opinion at the seminar was that the encouragement and stimulus to consider and define quality within the N.H.S. should come, not from any one body or organisation, but be diffused within the

Service. Issues of quality should also be considered during professional training so that a general climate is developed in which the discussion of standards becomes as commonplace as discussion of service 'inputs' and 'outputs'. The meeting felt optimistically that by creating such a climate the problem of encouraging those not already interested in considering quality, mentioned above, would be resolved since they would gradually become persuaded of the benefits to be gained. There was also a feeling that there could be a role for an independent body like the King's Fund to act as a catalyst in drawing together and disseminating information about existing good practices. There was some support for the idea of a 'King's Fund Cookbook of Standards' but disagreement about the feasibility of such a task.

SECTION 4.

CONCLUSIONS

I. The meeting was very impressed by some aspects of the J.C.A.H. approach, particularly the positive way it created a climate in which issues of quality could be discussed, organisational goals agreed, and change effected, in a multi-disciplinary environment. However, it was agreed that the rigidity and bureaucracy of the system were to be avoided at all costs.

2. The differences in the way health care is provided in the U.S.A. and the U.K. discussed in Section 3.5. would prevent the possibility of the wholesale transfer of the approach.

3. The pilot studies in the U.K. had indicated that professionals felt the need to monitor standards and to consider issues of quality, and would welcome help and encouragement in this area.

4. In the U.K., the consideration of issues of quality should not be the function solely of one body or organisation. The stimulus to identify and develop good practice should come from a number of directions but each should aim to secure professional involvement and allow for local diversity.

5. There could be a role for a body like the King's Fund to act as a catalyst or focal point for information on developments.

6. The identification of quality in the U.K. was not achievable by the application of a neat easy organisational solution and any attempt to define standards would meet with some opposition and difficulties. However the pressures on health care resources make the need for such measures indisputable. Despite the difficulties inherent in the task therefore, the meeting concluded that the identification and monitoring of quality in the N.H.S. should be encouraged in all possible directions as a matter of vital importance to the future of the service.

ANN FOSTER
June 1982

Appendix

List of participants at the seminar

	Mr R AKEHURST	Senior Fellow in Health Economics	Institute of Social and Economic Research, University of York
	The Hon Hugh ASTOR	Member of Management Committee	King Edward's Hospital Fund for London
	Dr A BARR	Information Scientist	Oxford RHA
	Dr J BATTEN	Member of Management Committee	King Edward's Hospital Fund for London
	Sir Robin BROOK	Member of Management Committee	King Edward's Hospital Fund for London
	Mr M BUXTON	Research Fellow in Health Economics	Brunel University
	Mr W G CANNON	Director	King's Fund Centre
	Mr S CATLING	Principal - Regional Liaison	DHSS
	Mr V CRISCUOLO	Area Administrator	Dorset AHA
	Dr R CROW	Director	Nursing Practice Research Unit, Northwick Park Hospital and Clinical Research Centre
	Miss N DAVIES	Secretary to Mr D Hands	King's Fund Centre
	Dr A DAWSON	Member of Management Committee	King Edward's Hospital Fund for London
*	Miss M DAY	District Nursing Officer	Tower Hamlets Health District
	Mr M FAIREY	Regional Administrator	North East Thames Regional Health Authority
	Mrs A FOSTER	Project Officer	King's Fund Centre (Rapporteur)
	Sir George GODBER	Formerly Chief Medical Officer	DHSS
	Mr S M GRAY	Formerly Member of Management Committee	King Edward's Hospital Fund for London
	Miss C HANCOCK	Area Nursing Officer	Camden and Islington AHA (T)
	Mr D HANDS	Assistant Director	King's Fund Centre
	Mr M HARDIE	Director-General	International Hospital Federation