

The National Quality Agenda and its implications for specialist societies

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Quality and the National Quality Board

The focus on quality heralded in 2008 by Lord Darzi was welcomed enthusiastically by the Royal College of Physicians (RCP).¹ As the professional body that has always aimed to improve the quality of care by continually raising medical standards, it approved of any move away from assessing care by activity measures alone. However, to translate the aim into specific goals and targets that can be supported by managers and politicians, as well as by clinicians, is more challenging. The National Quality Board (NQB) was set up in 2009 to provide leadership for this agenda. It is chaired by the chief executive of the NHS and includes the chief medical and nursing officers, the NHS medical director, the president of the RCP (in a personal capacity) and the chair of the National Institute for Health and Clinical Excellence (NICE). Its Clinical Prioritisation Committee makes evidence-based recommendations on the areas to prioritise for quality improvement. It will commission and evaluate reviews of quality in healthcare. These will include the interface between health and social care, an area which has emerged as particularly important to the lay members of the NQB. Evidence will be evaluated within Lord Darzi's three domains of patient safety, effectiveness (now both clinical and cost effectiveness) and patient experience.¹ Consultation with stakeholders will include the royal colleges and specialist societies, giving clinicians a real opportunity to influence future developments. The NQB will provide advice and oversight of the various developing tools for quality assessment, such as NICE quality standards, indicators for quality improvement and quality accounts. The NQB will also address practicalities, in its work stream of system alignment, considering how quality improvement actually occurs and what obstacles to change exist.

Quality agenda – impact on commissioning

It is the role of the commissioners to assess health needs, to design services and to then manage their performance (including quality). They are keen to 'look across the system' to whole pathways of care and whole populations, and this may involve transferring some aspect of diagnosis and care from secondary to

primary settings in accordance with recent Department of Health (DH) policy, for example chronic obstructive pulmonary disease where prime goals are a reduction in avoidable hospital admissions and better long-term management. Quality criteria here may not be confined to how acutely ill patients are managed in hospital. They can cover treatment plans, smoking cessation efforts, inhaler technique and whether care is available close to a patient's home. The specification for services will be agreed locally but may well be based on national standards. Incorporating quality standards and measures into the contract should enable the primary care trust (PCT) to get the best care from providers, or to disinvest or tender out any contracts if they do not reach standards. The expertise to write the outcome-based specifications and to adjudicate in the tendering process often needs to be gathered from local clinicians.

Impact on acute trusts

There are already a large number of measures and indicators directed at the practice of acute trusts. A typical large district general hospital might have around 100 measures in its medical directorate alone. This could mean that for a whole trust, the monitoring costs for governance are considerable. Typical local metrics might include analyses of complaints, data from the monitoring organisation Dr Foster, audits, clinical performance indicators (CPIs) and patient reported outcome measures (PROMS). PROMS and CPIs are currently only used in surgery and are obtained by patients completing a questionnaire after

Conference programme

The national quality agenda: view from the National Quality Board
Margaret Goose, lay member, National Quality Board

The national quality agenda: impact on commissioning
Sian Williams, manager, IMPRESS, British Thoracic Society
Nabella Bari, co-respiratory GP lead, NHS Tower Hamlets

The national quality agenda: impact on acute trusts
Andrew Goddard, consultant gastroenterologist, Derby Hospital

Specialist society impact on the national quality agenda
Finbarr Martin, president elect, British Geriatrics Society; acting national director, Health Care of Older People; consultant geriatrician, St Thomas' Hospital

Mark FitzGerald, consultant physician, Musgrove Park Hospital, Taunton

This conference took place at the Royal College of Physicians (RCP) on 23 September 2009 and was organised by the Clinical Effectiveness and Evaluation Unit, RCP

their operation, so they too represent a significant administrative cost. PROMS and CPIs are in their infancy and there is debate about validating them. However, if a meaningful measure is used systematically it can improve performance by making clinicians aware of their successes and by revealing who might cease an activity or be offered further training (Fig 1).

Coordinating the data and responding to them is likely to require a specific quality steering body in the trust supported by dedicated IT and audit staff. Securing funding for this governance work is hard but the payback is significant. Disasters can be pre-empted, for example in Mid Staffordshire, where detecting the abnormally high death rate earlier could have led to a review of practice and saving of hundreds of lives. On a reg-

ular basis, governance can pay for itself with the money obtained through the Commissioning for Quality and Innovation (CQUIN) framework (Table 1). Complying with a series of CQUIN measures agreed with the PCT can increase income by 0.5%. Data of this sort are summarised in the trust's annual quality account, which will include effectiveness, safety and the patient experience.

How a specialist society can impact on the National Quality Agenda

Rather than leaving priority setting subject to political imperatives, specialist societies can identify the most significant clinical

Fig 1. Figure showing how after a measure was introduced for a medical procedure with known high variability, there was a progressive improvement overall in performance (data presented at conference).

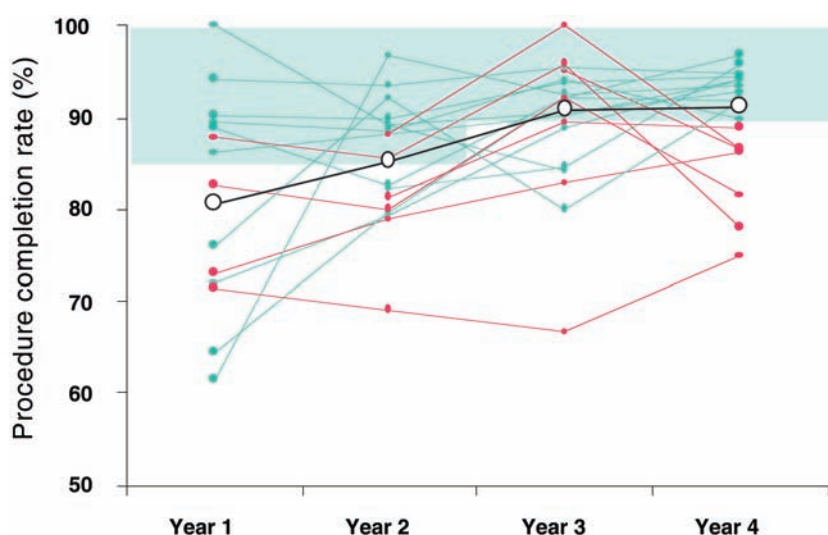


Table 1. The mechanisms of quality.

Quality standards (approximately 20 annually)	Indicators for Quality Improvement	Quality accounts	Commissioning for Quality and Innovation	Quality observatories	Clinical Excellence Awards	Quality Outcomes Framework
NICE	NHS Information Centre	Provider	PCT	SHA	Advisory committee	NICE
'Qualitative statements with quantitative measures' ¹	Set of indicators (approximately 200) drawn from national data to be used by clinical teams to measure quality	Annual report from service providers on their quality, priorities for improving it, and progress in the previous year. Format published 2010	Incentive payment to service providers linked to quality and innovation measures. Agreed locally by PCT	Regional centre of expertise, driving up quality by supporting use of indicators and quality accounts	Given to NHS consultants to reward exceptional contribution to patient care. Refocused to reflect three dimensions of quality laid out by Lord Darzi ¹	Reward and incentive programme for general practice surgeries. Specialist societies can comment on indicators chosen
1 Markers of high-quality, cost-effective patient care across a pathway or clinical area						
2 Derive from best available evidence						
3 Produced collaboratively by NHS, social care and other partners, and service users						

NICE = National Institute for Health and Clinical Excellence; PCT = primary care trust; SHA = strategic health authority.

issues in their areas and suggest means to address them, for example, falls and fractures, which are numerically a huge problem in the UK. The British Geriatric Society (BGS) was aware that many of the predisposing factors are potentially treatable if appropriate screening is done when a person at risk presents. By intervening early, patients should have a better chance of preserving their independence and preventing secondary fractures. A national audit showed how poorly integrated falls and bone health services were, with limited case finding or referral services for fallers.² A subsequent audit of fragility fractures in patients attending emergency departments showed wide variations in care, implying that much improvement was possible. Thus a national hip fracture database was set up, funded by Healthcare Quality Improvement Partnership, and a commissioning toolkit was issued via the DH. The toolkit has a care pathway and proposed service models, provides an evidence base and economic assessment and suggests clinical governance arrangements and performance metrics. All this was seen as the positive outcome of a worrying audit that was brought to the attention of the DH by the specialist clinicians who then continued their energetic involvement to help clinical services improve.² Specialist societies also influence practice by producing up-to-date clinical guidelines, providing input into NICE guidance, and promulgating good practice through continuing medical education activity. Their quality indicators can influence practice when commissioners link them to tariff payments.

What should specialist societies do to influence the quality agenda positively?

- Set the national standards – evidence-based guidelines which need to be grounded in clinical practice, and not necessarily to the definitive level of NICE.
- Help develop relevant metrics. Measures that relate to significant aspects of good clinical care are absent for many areas of specialist medicine and are urgently required. Topic areas where quality improvements cannot be measured risk being de-prioritised for investment.
- Engage with the DH's consultations. Quality is now an area where there is an imperative to deliver timely progress and Sir Bruce Keogh, the NHS medical director, is keen to continue dialogue. Specialist representatives with personal experience of the DH know that it is not looking for detailed critiques, but for suggestions that will work.

References

- 1 Darzi A. *High quality care for all: NHS Next Stage Review final report*. London: DH, 2008.
- 2 Gentles H. Falls and bone health: improving the quality of care. *Clin Med* 2008;8:312–4.

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