Quality improvement in the English National Health Service

Martin Marshall is the Professor of Healthcare Improvement at UCL. He is also the lead for Improvement Science London, a new initiative to promote the science of improvement across the three London Academic Health Science Centres. Prior to his current role, he was the Clinical Director and Director of R&D at the Health Foundation. An expert in the field of quality improvement, Martin gives his views on important developments in England in the last 10 years and focusses on the role of using evidence in quality improvement.

By: M. Marshall

Martin Marshall

There is a growing body of research evidence which can be used to guide efforts to improve the quality of health care provided for patients.[1, 2] We now have a reasonable idea of what works and to what extent. We understand the importance of aligning good policy making with effective system management and frontline practice. We know that improvement action is more likely to make a difference when the nature of the intervention, the process of implementation and the context are all taken into account. We know that all purposeful improvement efforts have unintended consequences, most of which can be predicted and managed. We know that focusing on the needs of patients is key to success and that they represent a significant underused resource. And we are starting to understand the delicate balance between the internal motivation of the workforce and external drivers for change.

Unfortunately, in the same way as clinicians often fail to implement evidence-base clinical practice, practitioners, managers and policy makers are guilty of ignoring the evidence describing how to improve the organisation and delivery of care.[3] The National Health Service in England, a health system which has been subject to an almost constant barrage of reforms over the last two decades, has had a particular tendency to implement change based more on ideology and political pragmatism than on good scientific evidence. We have seen the publication of comparative performance data, financial incentives, targets and competition enthusiastically implemented by some and fiercely criticised by others. This has led to a state of siege amongst many people working in the NHS and a situation in which any changes, even good ones, are more likely to be cynically dismissed than to be embraced.

Understanding how to make effective change: three examples

But it does appear that in the last few years the situation in England is starting to change as our understanding improves about how to implement reform effectively. Three examples of high profile improvement initiatives implemen-

ted in the English NHS illustrate this change. In each case, the efforts to improve services were initially insufficiently informed by research evidence but more recently have been modified to take the evidence into account.

First, in 2004 a massive financial incentive scheme was introduced as one component of a new contractual arrangement between GPs and the NHS. General practices had the potential to boost their income by more than 25 percent if they delivered against a range of largely evidence based quality indicators. Whilst evaluations of the initiative have demonstrated a number of benefits[4], there is little evidence that this investment has had a marked impact on quality of care outcomes[5] and several commentators have questioned the value for money of the scheme[6].
In addition, there is some evidence that it has diverted attention from important non-incentivised elements of care, particularly continuity of care[4], and that it has damaged the internal motivation of some clinicians. These consequences could have been predicted from the published evidence when the scheme was being designed but they were not. The good news is that in the last few years the scheme has been progressively adapted in line with the evidence, building in a stronger emphasis on patient experience and a recognition that financial incentives are one small part of the armoury available to change clinical behaviour.

Second, since 2004 there have been increasing efforts to encourage patients to choose between providers using comparative information about the quality of care delivered by the providers.[7,8] This has been based on the belief that patients will be able and willing to make rational choices using performance data. As a consequence, there has been a massive growth in the volume (and in some cases, quality) of information made publicly available. Advocates of this consumer-oriented model have been disappointed that whilst patient choice has made differences at the margins, it does not appear to have been a major driver for system change.[9] If they had examined the available published evidence, they would have been able to predict this lukewarm response to information by the public.[10] As a consequence of more recent engagement with the evidence, we are now seeing a more sophisticated approach in England to publishing data, with a stronger emphasis on promoting 'voice' than choice and an appreciation that healthcare providers rather than users are the main audience for comparative data. This has led to more realistic expectations of the consequences of putting data in the public domain.

The third example illustrates the role of performance management in the NHS in England. The professionally-dominated model of the early years of the NHS has been progressively challenged in recent decades, first with the replacement of 'administrators' by general managers in the 1980s and in the last decade with the introduction of strong, top-down performance management against explicit targets.[11] This approach, not best loved by clinicians used to a high level of professional autonomy, has achieved some remarkable improvements in a range of areas, including waiting times and some clinical outcomes.[12] But it has also had significant unintended consequences, most importantly the disengagement and demoralisation of many clinicians – a side effect of heavy handed management which again could have been predicted by examining the evidence.[13] At first, the negative impact of performance management was largely ignored, or dismissed as a price worth paying. But increasingly the consequences of disempowered clinicians became clear and a range of approaches to boost clinical leadership and rebuild professional moral have been intro-

Samenvatting

Er is veel kennis beschikbaar die tot zinvolle verbeteringen in de zorg voor patiënten kan leiden. De kenmerken van de interventie, de wijze van implementeren en de context spelen een belangrijke rol in het breed kunnen toepassen van deze kennis en de focus op de behoeften van de patiënt is bepalend voor het succes. Daarbij geldt dat professionals zich door intrinsieke en extrinsieke prikkels laten motiveren. Helaas wordt evidentie over de organisatie en het zorgverleningsproces te vaak genegeerd.
In Engeland is de laatste jaren gelukkig veel geleerd over effectieve kwaliteitsverbetering. Drie voorbeelden worden besproken. Het eerste voorbeeld betreft een landelijke aanpak voor huisartsen die vooral gebaseerd was op financiële prikkels en het goed scoren op een set indicatoren. Deze is langzaam omgevormd tot een beter systeem met daarin grotere aandacht voor de patiëntervaring en een relativering van het belang van financiële incentives. Het tweede voorbeeld beschrijft het niet-onderbouwde geloof dat patiënten op basis van kwaliteitsinformatie gaan kiezen tussen aanbieders en daarmee het zorgsysteem zouden gaan veranderen. Geleerd is dat veel meer nadruk op de 'voice' in plaats van de 'choice' moet worden gelegd om tot betekenisvolle verbeteringen te komen.
Het derde voorbeeld is de introductie van performance management in de zorg die tot een aantal verbeteringen heeft geleid maar ook tot het verlies van motivatie en betrokkenheid op de werkvloer en daarmee tot perverse resultaten. Hier zien we in Engeland dat er de laatste tijd meer aandacht is gekomen voor het versterken van 'clinical leadership' en het zelfsturend vermogen van professionals.
De auteur maakt met de voorbeelden duidelijk dat in de zorg veelal voorbij wordt gegaan aan wetenschappelijke kennis over de toepassing van nieuwe kennis in de praktijk. Beleidsmakers en wetenschappers moeten zich gezamenlijk hard maken voor een goed onderbouwde aanpak in plaats van zich te laten leiden door (politiek) geloof. Wetenschappers moeten hiervoor een (betere) brug slaan naar beleid en praktijk.

duced. The highest profile example of this process is the current policy of replacing managerially-led organisations responsible for commissioning of services, the Primary Care Trusts, with new Clinical Commissioning Groups which are being established with a much stronger clinical voice.

Conclusions: acting on the evidence

The difficulty associated with using evidence appropriately is not the only challenge for the NHS in England, nor is it a unique problem to the UK. But the extent to which evidence can and is being used, albeit sometimes delayed, in a way that maximises the effectiveness of improvement initiatives and minimises the negative consequences is highlighted by these three examples. Responsibility for using evidence must lie with decision makers in the health service but it also rests with the research community which so often struggles to produce evidence that is relevant, timely and accessible to decision makers. The problem is that practitioners and researchers tend to inhabit different worlds. In the UK the service and academic communities are now increasingly being brought together within defined geographical localities in the form of Academic Health Science Networks. These partnerships are attempting to create new ways of thinking about the challenge of creating, communicating and implementing evidence about service improvement. There are high expectations that over the next decade they will stimulate a step change in the quality of care received by patients in the UK.

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Information about the author

Professor Martin Marshall is professor of Healthcare Improvement at University College London, England.