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EDITORIALS

Time for a new approach to assessing the quality of hospitals in England

Managing quality is as important as financial management for trust boards

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Politicians, clinicians, and the public are justified in questioning the ability and competence of the NHS to assess and monitor the quality of hospitals in England. Failures in managing quality have recently been reported at Stafford General, Furness General, and Tameside hospitals. Whatever the rights and wrongs of the claims and counterclaims about who was at fault, neither the mechanisms within the hospitals (clinical governance, trust board engagement) nor the external mechanisms for performance management (strategic health authorities until recently) and regulation (Care Quality Commission, professional regulators) have proved fit for purpose.¹

Traditionally the NHS has assessed hospital quality in two ways: inspections and the use of statistical data. Each has its limitations. Although inspections helped to transform appalling conditions in nineteenth century workhouse infirmaries and, in the 1970s and 1980s, care in long stay institutions, their more recent impact is less clear.² This reflects the shortcomings of inspections (such as the absence of experienced clinician inspectors, as occurred at Furness Hospital) and the failure of trust boards to act on the findings (as occurred at Mid Staffordshire NHS Foundation Trust).³

Meanwhile, statistical data have been limited by dependence on hospital episode statistics, which are collected mainly for administrative purposes.⁴ Inevitably, derived measures, most notably hospital standardised mortality ratios, have lacked statistical and clinical credibility because the outcomes depend on how the data are collected and analysed.⁵ This is apparent in the recent Keogh review, in which “failing” trusts were selected on the basis of high mortality according to their hospital standardised mortality ratio or summary hospital level mortality indicator.⁶ With one exception, the two indicators identified completely different trusts. Other approaches to define hospitals using a single composite measure, such as star ratings,⁷ have proved to be no better. The use of “dashboards” containing many indicators recognises the complexity of hospitals, but only safety and patient experience have been considered, with little attention to the third domain, effectiveness.⁸

One benefit of the current furore about hospital assessments is that a consensus has emerged both within the NHS and in

relevant national organisations that a more sophisticated approach is needed. Since April the NHS Outcomes Framework, which the Department of Health uses to assess the performance of NHS England, not only encompasses all three domains of quality but is committed to developing new metrics in neglected areas such as dementia care.⁹ The Keogh review adopted a new approach that uses a wide perspective. It also considered how well quality was managed in trusts, the views of patients and staff, and observations of visiting clinical and non-clinical reviewers.⁶

A similar approach is being developed by the Care Quality Commission for routine surveillance of hospitals.¹⁰ There will be greater involvement of clinicians, as exemplified by the appointment of a senior doctor as chief inspector of hospitals.¹¹ And these developments are likely to be underpinned by the review of safety being led by Don Berwick, which promises to add further insights.¹² Meanwhile, NHS England is exploring a new approach to assessing hospital deaths that promises greater clinical validity, credibility, and relevance than standardised mortality ratios—namely, the proportion of avoidable deaths based on retrospective case record review.^{6 9 13}

Although these developments are welcome, the challenge of rigorous assessment of the quality of highly complex organisations must not be underestimated. Success will be more likely if four key problems are dealt with. The first is to ensure that all three domains of quality (and in time, the equity and environmental sustainability of hospital services) are considered.¹⁴ In particular, effectiveness has not been given sufficient attention in the past, despite the increasing availability of rigorous national clinical audit data.⁴

Secondly, those who assess hospitals must listen more to those who receive and deliver care. Patients, their relatives and friends, and staff have much to contribute and really want to help. If patients and nurses at Mid Staffordshire and junior doctors at Tameside had been listened to, subsequent events might have been avoided. Some websites show one way that such views can be collected.^{15 16}

Thirdly, boards should give as much attention to managing quality as they do to financial management. We have directors

of finance but no board level post for managing quality and few non-executive directors with the requisite skills. Instead, we expect medical and nursing directors to take responsibility for quality, despite most having little specialist training and expertise. We need to develop a cadre of chief quality officers with knowledge and skills in three areas: technical skills (can assess and understand the range of improvement techniques); relational and behavioural skills to provide leadership and vision; and awareness and understanding of current healthcare policy developments that affect quality. Although quality of care, like the use of resources, must remain “everybody’s business,” trusts need someone to provide leadership and inspiration. Chief quality officers won’t of themselves guarantee good quality, but without such figureheads, the improvements that are needed are less likely to occur.

Finally, the aim of assessments must be to stimulate and support improvements in quality, not to name and shame. Assessments must therefore reflect the complexity of hospital activities and the temptation to use a simple single rating for a hospital should be resisted.¹⁷ As HL Mencken warned, “For every complex problem there is a solution that is simple, neat and wrong.”¹⁸

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