

Managing health care in England: lessons and challenges

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What is running health services all about?

High quality care at least cost



Quality of care

A high quality health service would provide care that is.....

- **Safe** (does no harm)
- **Effective** (does good!)
- **Humane** (treat people with respect and is timely)
- **Equitable** (available to everyone in need regardless of their sex, age, ethnicity etc)

And balanced by cost....

- Is **efficient** (care provided in a way that ensures greatest benefit at least cost)
- but.....trade-offs inevitable as not possible to maximise all dimensions
- So.....societies must decide what they are prepared to forego (eg some inequity to achieve efficiency)

And sustainability

- Impact of health services on carbon footprint
 - Primary angioplasty for acute myocardial infarction v thrombolysis
 - Increased carbon emissions x 3.24
(Zander et al 2010)
 - Mobile breast screening v central facility in an English health district
 - Less car use: 75 tons carbon dioxide a year
(Bond et al 2009)

Three stages of managing quality

- **Defining** good quality care
 - What care should be provided?
- **Assessing** quality
 - What is the quality of care being provided?
- **Improving** health care quality
 - How can quality be improved?

Assessing quality in England

- Different domains of quality require different methods
 - Effectiveness
 - clinical audit data (quantitative, prospective)
 - Safety
 - case record review (quantitative, retrospective)
 - adverse event reporting (quantitative, prospective)
 - critical incident inquiry (qualitative)
 - Humanity
 - patient surveys (quantitative)
 - observation, interviews, focus groups (qualitative)
 - Equity
 - routine and clinical audit data (quantitative)

Improving quality in England

- Education (re-education)
- Incentives
- Re-design
- Regulation
- Legal action

(a) Education (or re-education)

- Tends to be first response but often inappropriate in that staff know what should be done
- Staff tend to take 'short cuts' to be more 'efficient'
- Methods
 - Traditional: seminars, lectures etc
 - Guidelines: need to create short, concise user-friendly versions; consider issuing guidelines to patients
 - Cost-awareness: info on cost of tests, treatments etc

...education not confined to staff

- Increasingly focus on educating and supporting patients as the 'co-producers' of health
 - Self-management eg Expert Patient programmes
 - Particularly with long-term conditions
- Shared decision-making effective in reducing demand and improving outcomes
 - Software providing individualised risk prediction and personal utilities

Shared decision making: the evidence

Elwyn G et al BMJ 2010;341:c5146

- Implementation has proved difficult and slow
 - Need good scientific evidence on options
 - Guidance on how to weigh up pros and cons
 - Supportive clinical culture
- 55 RCTs on impact
 - Patients better informed and less passive
 - Adhere better to chosen treatment
 - Tend to defer surgery (RR 0.8, CI 0.6-0.9)
 - Surgical rates reduced by 25%

(b) Incentives

- Two main types
 - Financial (based on market/competitive ideology)
 - Quality and Outcome Framework (QOF) in primary care since 2004
 - Commissioning for Quality & Innovation Payment (CQUIN)
 - Best Practice Tariff (BPT)
 - Socio-behavioural (appealing to desire of staff to be well regarded by peers)

Impact of incentives

- Professionals
 - tend to respond more to socio-behavioural
 - financial effective for specific changes (eg immunisation)
 - people respond better to rewards than fear of penalties
- Organisations
 - respond to financial incentives eg reimbursement
 - impact on availability and utilisation
 - little evidence of impact on other aspects of quality
- Patients
 - can motivate behaviour change (eg uptake of screening)
 - co-payments can deter use (both of appropriate and inappropriate care)

(c) Re-design

- **Change availability of a service**
 - limited drug list to avoid misuse and contain costs
- **Change access to a service**
 - justify need for diagnostic test; allow or prohibit direct referral; telemedicine and telecare
- **Change staff responsibilities**
 - nurses take over checking BP from doctors
- **Pre-authorisation and concurrent review**
 - GP referral management systems
 - surgeon has to get permission from purchaser before operating
- **Computer-based reminders**
 - screening test; immunisations; drug interaction

- Scope for re-designing processes of health care are enormous
- Staff often already aware of problems and 'know' the answers
- Involving staff gains their commitment and ownership

(d) Regulation (individuals)

- Entry
 - Licencing
 - legal requirement to practice (GMC, NMC etc)
 - compulsory for individuals to enter a profession
 - Certification (and recertification)
 - assurance fit for specialist practice
 - control entry to specialty by Royal Colleges
- Retention
 - Revalidation (NHSE and PHE)
 - Ensure professional up to date and allowed to retain their licence
 - Assure employers and public still fit to practice

Regulation (institutions)

- Certification (DH/NHSE)
 - Eg permission to acquire expensive technology
- Accreditation (Royal Colleges/ind orgs)
 - Usually focuses on inputs/structures
 - Usually voluntary (and payment required)
- Approval/rating
 - Inspection (Care Quality Commission)
 - regular/routine or reactive
 - announced or unannounced
 - Surveillance/monitoring (CQC)
 - Quantitative data eg waiting times; outcomes

Impact of regulation

- Some evidence of effectiveness of
 - Targets in reducing waiting time
 - Inspection can motivate change
 - Licensing of professionals improves quality
- Potential adverse aspects of regulation
 - Expensive
 - Need to be repeated frequently as judgement becomes out of date
 - Antagonises those regulated and creates resistance
 - Easily discredited by false negatives
 - Can be taken over by those being regulated (eg surgeons decide to be regulated on basis of post-op mortality whereas patients might be more concerned about long term QoL)

(e) Legal action

- Use of legal action (litigation) varies internationally
- Debate as to benefits/costs as regards quality improvement
 - Costs
 - Defensive care, avoiding high risk cases and encouraging unnecessary interventions (eg Caesarean sections)
 - Diverts resources from the many to the few
 - Fear may create workforce shortages
 - Benefits
 - Fear keeps practitioners and providers alert/up to date/careful

Does quality improvement work?

- Evaluation is difficult as generally not possible to experiment (RCTs) with interventions
- Difficulty of attributing causality
- Cost-benefit of interventions uncertain given assumptions that must be made (eg length of any benefit)

Factors associated with success

- Participants recognise need for change
- Correctly diagnose the problem
- Support and involvement of respected opinion leaders
- Sense of ownership by participants
- Focus on improving quality rather than reducing costs
- Combination of approaches, changed regularly to ensure persistence of effect

Need both technical and relational interventions

- Technical
 - Scientific evidence/guidelines; quality assessment data; monitoring mechanisms
- Relational
 - Organisational culture; leadership; clinician engagement; staff motivation; transparency; good communication; ward-to-board involvement; patient-centred