

Assessment for improvement: a view from the coal face

Doctors think about quality of care from their own perspective – from experience and some wisdom gained from seeing many thousands of people over a lifetime of clinical practice. So how do doctors judge good quality care? They hope for a correct diagnosis, a treatment plan and an improvement in the clinical well-being of the patient. To cure or at least help the patient live better with a chronic condition; unpleasant symptoms may be controlled, an improvement of the quality of life achieved, and there may even be a reduction in disability, morbidity or mortality.

THE CURRENT SITUATION

From the patients' point of view, they assume that the technical competence is there and have faith in doctors' diagnostic skills. They want timely access, safe care, to be treated with humanity, with adequate explanations and to feel listened to. They also increasingly want to feel more involved in decisions about their care.

Patients, like consultants, want good clinical outcomes, however, the process of the delivery of care will be experienced by patients in ways which can mean the experience is not good, such as not getting adequate explanations. A report of patients' views, *'Is the NHS getting better or worse?'*, has been published by the Picker Institute (2005).

Clinicians often feel they do not have any responsibility for the system in which care is delivered, or feel they cannot influence it. The workload, and just getting through it, can make the delivery of medicine very mechanistic, and it is often treated as such by management – rather like a factory delivering units of care. But to be really patient-centred is to look at the service

from the point of view of the patient and, in doing that, it can be seen how the system of delivering care could be so much better. For example, patients wait – they wait for everything. They wait for tests to be done, for diagnostic results to come back, for assessment and treatment by therapists, for social services – the list goes on. Clinicians are so used to this it seems normal, but taking an overview from the patients' perspective means working on system improvement, e.g. doing today's work today and using improvement techniques to get better patient flow.

Despite clinicians wanting to achieve good clinical outcomes, there is a dearth of measurement. There is a lack of good outcome measures for all condition; outcomes are certainly not measured in every patient. The amount of clinical information that is fed back to clinicians about their clinical practice varies wildly across the NHS. In some trusts there will be real-time information, but in others, no clinical data is aggregated or shared.

The amount of time and effort clinicians put into documenting clinical diagnosis for clinical coding and therefore hospital episode statistics data also varies. The primary diagnosis may be broadly accurate, but there is often a failure to capture secondary diagnosis. For all the desire to see 'intelligent information' being used to measure and improve clinical care, in practise, it is a long way from being realized. At the moment, clinicians are often not supported enough to create proper documentation of clinical work. They do not make it a priority because, for them, it does not make any direct difference. The new financial system of Payment by Results (Department of Health, 2004) may focus minds but, at present, that seems a distant issue for most clinicians.

IMPROVED PATIENT CARE

There are many levers to improve the quality of care experienced by patients, including education of professionals, good management systems, a strong voice for patients and the public, good standard setting, and external assessment. Public debate around the results of external assessment can act as a powerful lever for change; that the business of the NHS is held up for public scrutiny, i.e. accounts to those who both pay for and use the services, is right. There is then a responsibility for health-care organizations to change if assessments find room for improvement – and even the best can always get better. This is the basic principle of the audit, cycle, 'closing the loop', which clinicians understand.

There is, however, a dissonance between clinical practice and using the results of external assessment for improving services. How many clinicians have looked at the results of the national patient surveys conducted over the past 3 years by the Commission for Health Improvement and now the Healthcare Commission, or looked at the results for their own hospital trust? Are these being discussed at directorate meetings?

The new standards from the Department of Health, covering seven domains. These domains – safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health – will form the basis of external assessment. But how many clinicians know about these standards and the prompts being devised by the Healthcare Commission (Healthcare Commission, 2005)?

CONCLUSIONS

Have they been translated into clinical relevance? What role will clinicians

play in a trust's self-assessment? There is a huge challenge for health-care organizations to engage with clinicians at both operational and strategic level. They need to develop and value committed clinical leaders. Trusts need to communicate with frontline clinicians about standards and how each can play a part in meeting them, otherwise assessment will go on, divorced from

clinicians, and there is a danger that it will only be managerial in nature. It will seem like a paper exercise, with clinical work going on regardless.

The author has worked in external inspection and knows it can be a powerful lever for change and, as a full-time physician, experiences the day-to-day challenges of trying to deliver a quality service.

Clinical leadership is essential, to engage with systems improvement and to help deliver the quality improvements where it really matters – in the direct care of patients. **HM**

Dr Linda Patterson

Consultant physician and former Medical Director of the Commission for Health Improvement

KEY POINTS

- Doctors and patients have different perspectives on quality of care.
- Care to patients can be improved by changes in the delivery of care.
- Lessons from external assessment must be fed back to front-line staff, if real change is to happen.
- Clinical involvement is essential in improving care to patients.

Department of Health (2004) *Payment By Results*. DH, London. <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en> (accessed 29 April 2005)

Healthcare Commission (2005) *The Annual Check*. Healthcare Commission, London. <http://www.healthcarecommission.org.uk> (accessed 29 April 2005)

Picker Institute Europe (2005) *Is the NHS Getting Better or Worse?* Picker Institute, Oxford. http://www.pickereurope.org/news/Press_release_Is_the_NHS_getting_better_or_worse_18_April_05.pdf (accessed 29 April 2005)