

The Development and Implementation of QMS in Healthcare – Current situation in Scotland and the UK

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Presentation outline

Background – political influences on the NHS

Background – quality definitions

Quality management systems

Quality assurance in Scotland

The important of governance

The important of risk management

The importance of information

Questions for the Ukraine

Background (1)

- 5 July 1948 – NHS established to provide healthcare for all citizens, based on need, not the ability to pay
- Fundamental questions in the early days remain today:
 - how best to organize and manage the service?
 - how to fund it adequately?
 - how to balance conflicting demands and expectations of patients, staff and taxpayers?
 - how to ensure finite resources are targeted where they are most needed?

Background (2)

Forces affecting change in the early 1990s:

- Demands of the individual
- Clinical effectiveness
- Financial pressures

Taken from a talk given by Kevin Woods (now Chief Executive NHS Scotland) in 1994 from work done by the Health Services Management Unit, Manchester University

Background (3)

Two significant changes:

- 1997 Government change
- 1999 Devolution for Scotland and Wales



Policy issues in the UK (1)

1979-1989 – The Thatcher years

Early years:

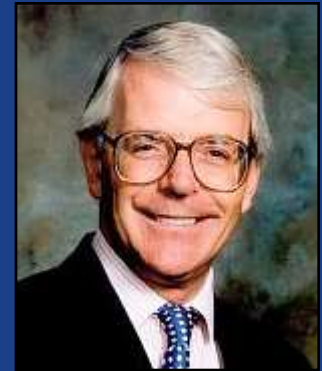
- Growing demand, limited resources
 - Introduction of general management (1983-85)
 - Clinical audit growing in response to need for clinically effective services
 - By 1987 Health Authorities in debt, waiting lists growing and wards being closed – despite evidence of higher spending, steady increases in staff numbers and treatment of more patients
- Result – much dissatisfaction from public, professionals and the media



Policy issues in the UK (2)

1990-1997 – Major years

- Significant cultural shift with the introduction of the internal market
- Shift from “monolithic bureaucracy” to purchasers and providers
- Providers became independent legal entities – NHS trusts and “competed” for business
- By 1995 virtually all hospital healthcare provided by NHS trusts
- GPs commissioning large elements of service



Policy issues in the UK (3)

Perceptions within Scotland

- Conservatives a minority (10%)
- Constant tension
- GP commissioning not significant
- Divergence from England apparent in later years
- Conflict of values

1996 National priorities (Scotland)

- Improving health
- Developing primary care
- Reshaping hospital services
- Promoting care in the community

Taken from a Management Executive Letter (MEL) “Priorities and Planning Guidance for the NHS in Scotland 1997/98”

1997 – Present



Summer 1997
1999

Change of Government
Devolution for Scotland

- Fundamental issues remained the same
- In many ways the stated direction remained the same
- BUT policy changes concerned the method of delivery
- Policy responded to the forces affecting health services
 - modernisation
 - patient focus
 - clinical effectiveness - more openness/audit
 - financial pressures - increased funding
 - cost effectiveness
 - national approach

1999 – Devolution for Scotland

Scottish Parliament after 300 years

Devolved Issues:

- Health
- Education
- Social services
- Roads
- Limited tax raising powers



Consequences of devolution

England

Retention of “independent” trusts

Increased use of private sector

Continued decentralised structure

Commissioning by primary care trusts moving to practice based commissioning

Patient choice

Scotland

Trusts disbanded

No significant increase

Centralised structure

Commissioning by health boards

Patient focus

Consequences of devolution (cont'd)



England

Scotland

“Market” model

Funding distributed by formula to health boards

Health boards funding services they also manage

Foundation Trusts

Managed clinical networks

Authority of managers

Authority of professions

Common features in the UK

- Objectives are similar
- Underlying problems are similar
- Commitment to public funding consistent (i.e. free at the point of need)
- Constant organizational change
- Partnership working with:
 - Patients and public
 - Staff
 - Other agencies, e.g. social services, education, police and so on

Current policy thinking in Scotland

The six dimensions of quality from “crossing the quality chasm” (2001), the Institute of Medicine



Patient centred	Providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions
Safe	Avoiding injuries to patients from care that is intended to help them
Effective	Providing services based on scientific knowledge
Efficient	Avoiding waste, including waste of equipment, supplies, ideas and energy
Equitable	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status
Timely	Reducing waits and sometimes harmful delays for both those who receive care and those who give care

R J Maxwell – Quality assessment in health 1984



Beyond that, I suggest, are six dimensions of quality that need to be recognised separately, each requiring different measures and different assessment skills.

Dimensions of health core quality

- Access to services
- Relevance to need (for the whole community)
- Effectiveness (for individual patients)
- Equity (fairness)
- Social acceptability
- Efficiency and economy

Quality management systems

The British Standards Institution (BSI)

- Set up in 1901 as the Engineering Standards Committee
- BSI is now the National Standards body of the UK
- Global reputation for independence
- Develops and sells standards and standardization solutions to meet the needs of business and society
- Very influential – public awareness low?

BS 5750

My first introduction to a quality management system guidance on the quality system elements of organizations that provide services. Closely linked with service needs and terminology and will enable management to obtain and provide quality assurance.

Used extensively by industry in the 1980s.

ISO 9001

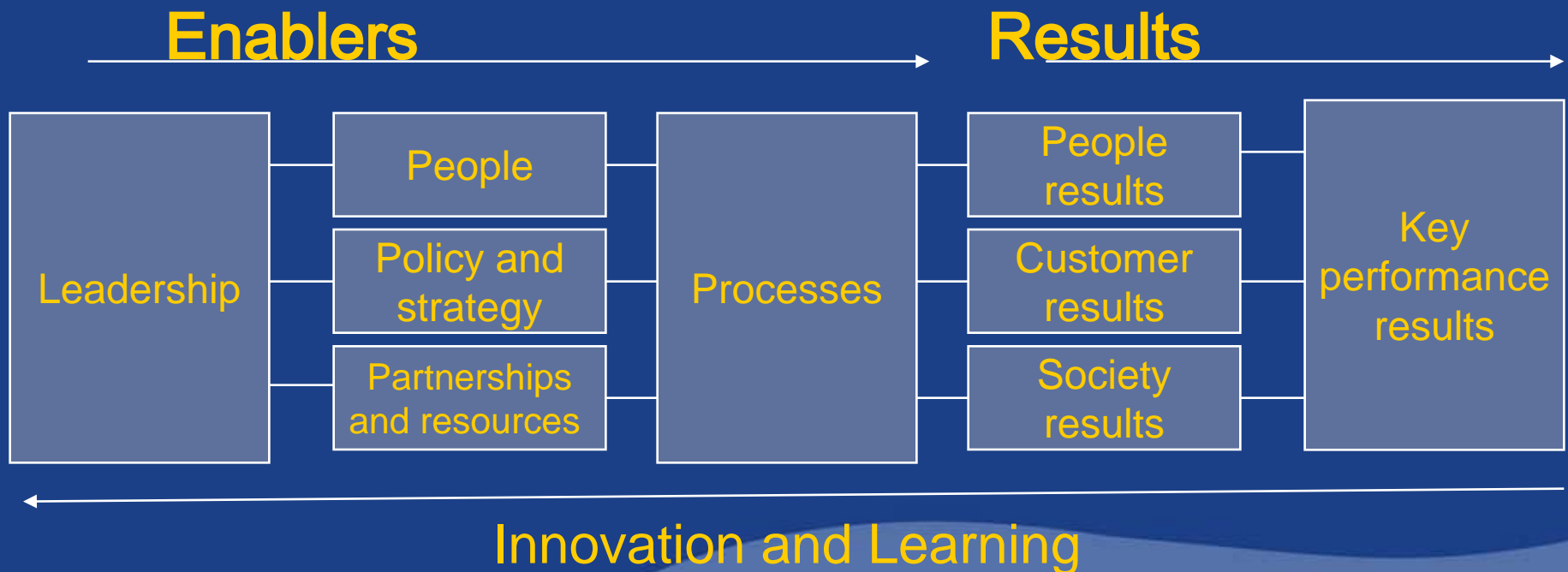
International organization for Standards

- 157 members including Ukraine
- Not used extensively in NHS
- Used historically more in non-clinical services

ISO 9001 (continued)

Based on eight quality management principles:

- Customer focus
- Leadership
- Involvement of people
- Process approach
- System approach to management
- Continual improvement
- Factual approach to decision-making
- Mutually beneficial supplier relationships



- Often known in the UK as the business excellence model
- Many models focus on enablers and processes
- EFQM includes greater emphasis on result outcomes
- Not commonly used in the NHS

CHKS Healthcare accreditation and quality unit (HAQU)



- Part of CHKS
- Formerly the Health Quality Service (HQS)
- Formerly the King's Fund Accreditation Scheme
- CHKS (HAQU) is accredited by the UK accreditation service to award ISO9001 certification
- Corporate member of the International Society for Quality in Healthcare (ISQua)
- Operates an international hospital accreditation programme
- Currently working with hospitals in several European countries

Quality Assurance in Scotland



**NHS Quality Improvement Scotland established
January 2003 comprising:**

- **The Clinical Standards Board for Scotland**
- **The Health Technology Board for Scotland**
- **The Scottish Hospitals Advisory Service**
- **Nursing and Midwifery Best Practice Development Unit**
- **Clinical Resource and Audit Group**
- **2005 Scottish Intercollegiate Guideline Network joined NHS QIS**
- **Scottish Medicines Consortium administered by NHS QIS**
- **Scottish Health Council hosted by NHS QIS**

The NHS QIS Standards Development and Review Process



Standards are:

- obligatory
- apply to all providers of NHS services
- clinical or non- clinical
- process or outcome focussed
- specify clinical targets to achieve a required outcome
- aim to ensure equitable service

Who should use the standards?

- healthcare professionals - set out standard of care to be provided
- members of the public - the level of care they should expect to receive

Format of standards

Title: summarises the area on which the standard focuses

Standard Statement	Rationale	Criteria
The level of performance to be achieved WHAT	The reasons why the standard is considered important WHY	What must be achieved for the standard to be reached HOW

Principles of Standards Development



- Simple language
- Consistent with other recognised standards
- Explicit and measurable, yet realistic
- Mandatory
- Results orientated, focusing on patient outcomes
- Credible and widely disseminated
- Few in number
- Balanced
- Evidence-based

What evidence is used to develop standards?

- Published :
 - Papers and journals
 - International guideline
 - Health technology assessments
 - Systematic reviews
 - Research and audit – clinical organisations
- Unpublished
 - Local documents reflecting local circumstances
 - Patient views
 - Grey literature (unpublished dissertations etc)

Development process

- Draft standards and self assessment tool
- Publish draft standards
- Consultation period – at least 3 months
- Open/focus meetings
- Pilot visits
- Amend draft standards
- Publication of final standards

Standards Development Project Group

- Healthcare professionals, patient and public involvement, Partnership with voluntary organisations, health councils
- Oversee development and consultation of standards
- Recommend external peer review process
- Report on findings to Board
- Adopt open and inclusive process
- Work within agreed policies and procedures

Performance Assessment Process

- Submission of self-assessment tool and supplementary evidence
- Review team considers the self-assessment/supplementary evidence
- Review team meets with staff to validate/clarify information in self-assessment
- Review team reaches consensus on performance against the standards
- Local report prepared

Self-Assessment Tool

Overall Purpose

- To provide a mechanism for Boards to describe how they are performing against the standards.
- A tool for review teams to use as a reference throughout visit

Issues Identified from the Self-Assessment

- Where it is unclear how the Board is performing against the standards
- Where the Board's response indicates local initiative
- Other areas for exploration during the review visit

Key Components

- Focuses on the criteria/standards
- Comprehensive but realistic
- Uses combination of key probing/direct questions
- Provides a picture of performance

Worked Examples

X% patients admitted to a dedicated unit within 24 hours of admission and remain there throughout care

- Approach (a)

- What % of patients admitted to hospital are admitted to the dedicated unit?

- Approach (b)

- What % of patients are admitted within 24 hours of presentation at hospital to the dedicated unit? (please provide data by month over the last x months/years)
- For patients admitted to the stroke unit directly or within 24 hours of presentation at hospital, what % of their inpatient stay was spent in the dedicated unit?

There is a coordinated programme of education for staff, commensurate with their duties, which ensures that all staff are given appropriate training



- Approach (a)

- Please list all the education and training programmes in place and how often these are held.

- Approach (b)

- Has the Board undertaken a training needs analysis?
- Please provide attendance rates for all staff groups to the nutrition education and training programmes in the last 12-month period.
- How are the nutrition education and training programmes monitored and reviewed?

Review process

Pre-Review

NHS board submits completed self assessment framework and supporting evidence

Review team receives completed self-assessment document and supporting information prior to visit

Reviewer studies above documents and makes notes of significant issues

Review Days

Review team meets and agrees roles and responsibilities

Reciprocal presentations between NHS Quality Improvement Scotland and Service; opportunity for initial questioning

Post Review

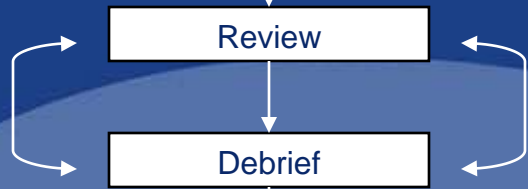
Review

Debrief

Final debrief

Feedback

Report



The importance of governance

The NHS and Crown Immunity

Crown Immunity:

“Emanations of the Crown are not susceptible to prosecution for offences either created by statute or of the common law.”

Crown immunity was lifted in the late 1980s, the NHS could now be prosecuted.

I would argue that until then there was no systematic approach to safety and no culture of safety in the NHS.

During the 1990s, a growth of governance arrangements as Boards of health organizations were made accountable and could be prosecuted.

The Nolan Report



Seven principles of public life:

- **Selflessness**
Holders of public office should take decisions solely in terms of public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.
- **Integrity**
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
- **Objectivity**
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability**
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

The Nolan Report (continued)

- **Openness**
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty**
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership**
Holders of public office should promote and support these principles by leadership and example.

Governance within the NHS

In response to the Nolan Report, the NHS in Scotland established three core values:

- **Conduct**
There should be an absolute standard of honesty and integrity which should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers; in the use of information acquired in the course of NHSScotland duties; in dealing with the assets of NHSScotland.
- **Accountability**
Everything done by those who work in NHSScotland must be able to stand the test of parliamentary and public scrutiny, judgements on propriety, and professional codes of conduct.
- **Openness**
NHSScotland should be open about its activities and plans so as to promote confidence between the NHH Board, NHS Trust or other health organisation and its staff, patients and the public.

The Turnbull Guidance and Risk Management

States that each Board must “ensure that the system of internal control is effective in managing risks in the manner which it has approved”.

Carey, A and Turnbull, N “The Boardroom imperative and internal control”
(1999) Mastering Risk

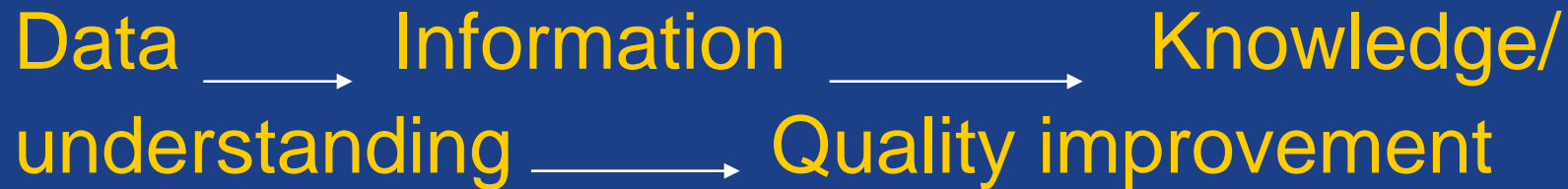
Drawn from Healthcare Governance – issues within the NHS

Dr Annie K Ingram, Professor Alice Belcher (2008)

Information

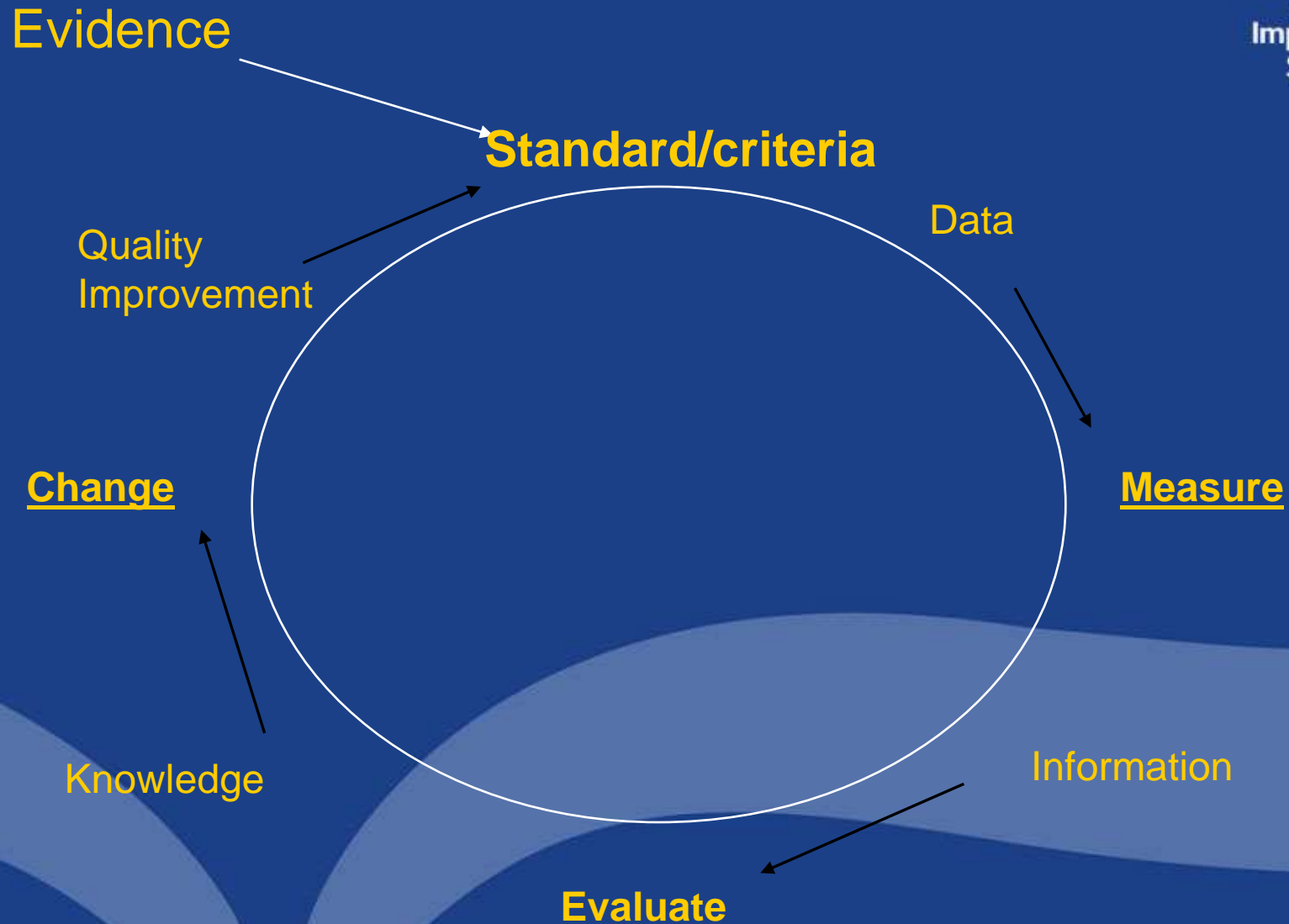
Data	are individual pieces of unlinked information
Information	Data that are processed to be useful; providing answers to “who”, “what”, “where” and “when” questions
Knowledge	Is the consideration of data and information, answers “how” questions
Understanding	Appreciation of “why”
Quality Improvement	Applying evaluated understanding to bring about <u>change</u> leading to improvement

Information



Dr L Holdsworth –The Use of National Data for Quality Improvement (2008)

The Audit Cycle and Information



Quality improvement and the delivery of improved standards fundamentally depend on the ability to have data with which to evaluate performance.

Discussion points

- **Regulation vs quality assurance**
- **Financing public and patient expectation**
- **Affordability of cost effective treatments**
- **Equity**
- **Clarity and consistency of policy direction**
- **Status of advice and guidance**
- **Governance arrangements**
- **Risk management process**
- **Information systems/datasets to support improvement**