

Guest editorial

Never mind the quality feel the width ... does the Government really understand the patient's concept of quality in health care?

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A couple of months ago a friend described to me the following story. His 12-year-old daughter came home one Friday with a letter indicating that there had been two cases of meningitis linked to her school, and as a precaution all children in his daughter's year on the advice of the County Schools' Medical Service had been administered a powerful antibiotic. Parents were advised that meningitis was an extremely serious condition and to monitor their child's general health over the weekend, and if any signs of discomfort occurred to contact their general practitioner (GP) immediately. My friend's child did experience discomfort over the weekend with a severe stomach ache and mild fever. At 2.00 pm on the Saturday he went through the process of contacting his daughter's GP. The surgery was shut and a recorded message advised any callers who needed urgent medical advice to contact the deputising service. After listening carefully to various voice messages and further phone calls, he was put through to a call centre operative and asked to give details of the concern he had. My friend questioned the operative if he was medically trained, and the operative replied in the negative explaining that he simply wrote down what the complaint seemed to be and passed the message on electronically to the appropriate deputising doctor on call. Assurance was given by the non-medically trained operative that the doctor on call would be in touch soon. My friend was then left as an anxious parent awaiting a phone call from an unknown service. He waited and finally received the call from the deputising doctor some five hours later at 7.00 pm.

In the intervening period my friend sought advice from a nurse friend who helped clarify the likely cause of his daughter's distress as a reaction to the antibiotic rather than anything more serious. Notwithstanding this advice and subsequent recovery of the child, my friend still asked me if waiting five hours with a child in pain represented quality service in primary care.

The introduction of clinical governance in 1998 was designed to introduce a systematic approach to the delivery of high-quality health care. A duty of quality was placed on NHS organisations in the 1999 NHS Act. This introduced corporate accountability for clinical quality and performance. Clinical governance was to be perceived as a whole system process with the following features:

- patient-centred care needs are at the heart of every NHS organisation. This means that patients are kept well informed and are given the opportunity to participate in their care
- good information about the quality of services is available to those providing the services as well as to patients and the public
- variations in the process, outcomes and access to health care are greatly reduced
- NHS organisations and partners work together to provide quality-assured services and drive forward continuous improvement
- doctors, nurses and other health professionals work in teams to a consistently high standard, and identify ways to provide safer and even better care for their patients
- risks and hazards to patients are reduced to as low a level as possible, creating a safety culture throughout the NHS
- good practice and research evidence are systematically adopted.

Quality as envisioned above was to be an explicit fundamental principle of the new NHS, as set out in the NHS Plan. The aim was to ensure people received high-quality, evidence-based health care wherever they lived.

The voice of the sceptical healthcare consumer might argue that this claim is more political than practical and poses the question about whether the architects of clinical governance really understood what quality actually means to patients.

Research repeatedly reports that from a patient's perspective, quality operates at different levels of analysis. From a patient's perspective quality not only relates to the standards of particular hospitals, trusts or GP services, but also to the competence and practice of individual professionals. Poor quality can result from a lack of co-ordination of all the different services that a patient needs for their treatment, including services that are not specifically the responsibility of NHS management, e.g. efficiency of the out-of-hours deputising services.

Patients' idea of good-quality health care therefore can be very different from the view of managers or professionals. Many studies, including ones I have been involved in that ask patients how services could be improved, tend to emphasise concerns about access, responsiveness, good communication, clear information provision, appropriate treatment and relief from symptoms.¹ It would appear that patients assume that doctors know what they are doing medically. Patients are more concerned about the way they do it. Perhaps when discussing quality improvement this latter issue needs more attention than it currently receives.

The *Which* report on NHS health provision suggests there are still many areas where NHS patients do not get high-quality care in the UK and these include:

- slower access to care than in many other Western countries
- slow take-up of new technologies such as coronary artery by-pass grafting and treatment for renal failure
- poorer outcome rates for surgery than in the US
- some standard practices in surgery in other developed countries are only used in leading-edge hospitals
- poor physical environment
- many hospitals provide low standards of comfort and privacy for patients
- many patients are cared for in inappropriate settings, e.g. children cared for on adult wards
- NHS services are unresponsive to patients' needs and preferences. People find difficulty getting care or treatment at convenient times or locations, or at the hospital or facility they want.²

We also tend to assume that private patients rarely experience problems with poor environment or facilities, lack of privacy and long waits, but are there not also concerns about patient safety and clinical quality? Some commentators have queried the safety of overnight cover in private facilities and arrangements to deal with medical emergencies, as well as whether staff are appropriately trained and qualified to undertake the treatments.

Star ratings

Do star ratings provide a reliable or accurate assessment of the quality of health care delivered in a local hospital or GP surgery? Along with the *Which* report, I doubt whether the data are sufficiently reliable, whether they measuring the right things, and whether targets may be distorting service priorities. Current targets focus too much on easy to measure outputs rather than outcomes, and managerial rather than clinical measures. NHS managers focus on targets, and it is not unusual for particular services to be supported where counting matters, while others are left to languish because their numbers do not. First hospital appointments are important and counted ... but follow-up appointments may not and therefore can be cancelled with impunity.

But most crucially, the current performance measures system in the NHS fails to focus sufficiently on things that are important to patients, or to look at things from the patient's point of view.

Star ratings are supposed to encourage patient choice but do not provide sufficiently detailed information to allow anyone to make a choice based on the factors important to them. Because they cover all the services within an NHS trust, they can hide significant differences in performance of particular services, and individuals within a given trust. There is little information available to patients on the quality or outcome of different treatments, or different providers or specialists.

More choice is being introduced into the NHS, but at present patients are not in a position to assess the quality and safety of these new health services. Increased choice on its own will not drive up quality in the NHS.

Current government focus as published in April 2004 is to move away from national targets to a system based on standards and locally set targets and priorities. The national standards relate to:

- safety
- clinical effectiveness
- governance
- patient focus
- accessible and responsive care
- care environment and amenities
- public health.

These are intended to establish a level of quality of care which can be expected by all NHS patients.

Primary care is where most care is delivered. It is where most patients experience their first contact with the health service. This includes for example the receptionist, the primary care nurse, GP, community pharmacist or midwife and dare I say it yes ... even the out-of-hours deputising service.

In my friend's case the service he received did not feel safe, lacked clinical effectiveness, was poorly managed, lacked patient focus, failed on accessible and responsive care, failed to provide a caring environment or amenable amenities and failed to respond quickly enough to a public health issue.

The government proudly proclaims its strategy is working and quality is improving. My friend and I beg to differ.

REFERENCES

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