disciplines are sought. Papers are welcome from nurses, therapists, and managers as well as research workers, policy makers, health economists, hospital doctors and general practitioners, and anyone working in health care (instructions for authors are on the inside back cover of this issue).

Traditionally, progress in health care has been measured in terms of technological advances. The quiet revolution in quality assessment is unmarked by dramatic breakthroughs. As practitioners utilise, analyse, and share information about their routine practice many patients will get a better deal from existing therapies, interventions, and services. Continuous quality improvement could be a very cost effective way of improving health.

FIONA MOSS


Quality from the management perspective

There is some scepticism in the NHS about the transfer of managerial concepts and techniques from the private sector. Not all of this scepticism is justified, although the NHS is much more complex than most private sector organisations. But there are some lessons which can be drawn from the experiences of the private sector of the United Kingdom economy which are relevant to the NHS and the debate about quality. The economy in the United Kingdom is going through its second major recession within a decade. In the 1980–3 recession many companies were slow to lay off labour, and a significant proportion went into liquidation as a consequence. The managers in greatest demand in that recession were accounting staff.

Those companies which came out of the recession in a position to grow had established tight control on costs and recognised that customers wanted reliability of delivery dates and dependable service quality. In the current recession labour has been laid off at a speed which has caught many by surprise including, one suspects, the government. This seems to indicate that more companies have responded quickly to control costs, but it is becoming clear that many are investing in training, staff development, and product quality for the future.

What lessons might be learnt from this observation by the NHS? The first is that any provider which fails to control costs and balance income with expenditure will not survive: the purchaser will not step in to bail out an excess of expenditure over income. The second is that investing in quality is crucial for developing a secure and viable future. Of almost equal importance is that the managerial effort put into controlling expenditure will distract managers and other staff from the issues which in the medium term ensure success. Furthermore, staff cynicism about “quality” will be high in a unit which is undertaking an exercise in financial firefighting, and this cynicism will be conveyed to patients, the public, and purchasers.

Given the financial pressures experienced throughout the NHS this decade, can the focus be shifted to quality? In many respects history would not give grounds for much optimism. The realignment of managerial responsibilities that followed the introduction of general management in 1984–5 did not reinforce the importance of quality as a concept; that will happen only when the director of quality assurance has the same clout as the director of finance.

First and foremost, the priority at unit level must be financial stability – only then can longer term issues be confidently addressed. The responsibility for achieving this stability lies squarely with trust chief executives and the unit general managers of directly managed units. Secondly, there needs to be an organisational focus at provider level which interrelates resource management, quality assurance, and medical and clinical audit. This integration is important because quality is multi-dimensional but is confounded by the “functional” approach taken by the NHS Management Executive to allocating funds. Not only are the resources for each process quite separately allocated but they are each allocated by a separate part of the management executive. Funds for these three activities should come to units from one source. Achieving an integrated approach to quality is a major challenge for managers. Staff, especially those with a clinical background, have their own views on quality, which differ both between individuals and professions and are often limited to one
field of vision. Each view may be valid, and the task of the manager is to reconcile them and encourage each group to share the issues which concern the others.

Thirdly, district health authorities need to set explicit standards for quality within contracts. For this it is essential to have a five year strategy for improvement in the quality of care and the quality of services with realistic achievable targets for the first two years. These should be worked out through discussion with providers and with a thoroughly informed background about the effectiveness and appropriateness of clinical interventions. Fourthly, purchasers and providers should agree a series of achievable targets which focus on issues which will make a palpable difference to patients.

A sustained campaign throughout provider units will be needed to achieve the necessary changes for an organisational commitment to delivery of consistently good quality care. Preaching “quality” to staff in a unit that has lacked capital investment and programmes for re-equipment for years will fall on deaf ears. Most staff do respond positively to realisable targets; clear, staged objectives; positive feedback about good practice and service; and leadership. Undoubtedly the capacity to achieve change quickly is greater in some areas than others; and these may be some of the areas to focus on initially.

Clinical audit is concerned with the quality of clinical practice. Other aspects of the delivery of care and the running of the hospital also affect the quality of care either directly or indirectly and are the responsibility of the manager. For example, timely and informative communication with general practitioners and with patients is very important. Managers can ensure that enough secretarial and wordprocessor support for this is available and used as efficiently as possible. Letters for outpatients’ appointments, admission letters, and information sheets should be clear, informative, personal, and, of course, available. Staff should be encouraged to be welcoming and helpful to both patients and visitors to the hospital. The environment should be tidy and clean; signposting needs to be clear; food, facilities, and amenities need to be available to patients, visitors, and staff. Appreciable improvements in many of these areas can be made at little or no cost. Other issues, such as waiting times in outpatient departments, are the joint responsibility of managers and clinical staff.

The challenge falls to managers to lead, motivate, and invest in their staff. Also they must ensure that promises are delivered; nothing is more likely to demoralise staff than failed managerial promises or downright hypocrisy.

So is there a “double bind” that is, financial control versus quality? The answer is not absolute, but in general terms the two do not conflict. The provider unit which does not manage its finances cannot deliver on quality, in fact it can probably deliver very little. The unit that can deliver on financial control stands a chance of progressively improving the quality and range of services it offers. Furthermore, many successful private sector organisations have shown that focusing on quality often reduces unit costs.

So can the NHS deliver on quality? The answer is a qualified “yes,” but there is need to look at and publicise successes and not just failures and that means looking at performance over five years, not just one. The climate is changing. The whole process of contracting and the reaction of district health authorities and providers to extracational referrals is focusing on many aspects of quality which used not to be addressed. Opportunities need to be recognised and exploited; the patient’s charter is one such opportunity. The acceptance and development of medical and clinical audit – in all areas of clinical practice, including general practice – is a remarkable step forward.

Finally, managers need to address the issue of the quality of their own work within their organisation. Managers, of course, have a responsibility to respond to issues raised through clinical audit but surely they too should also be involved in regular, systematic, and critical analysis of their own work and perhaps be prepared to share some of the lessons learnt with other colleagues and even clinicians? There are many questions which could be included in “managers audit.” Is there a clear anticipated and well thought through vision of the organisation? Is the vision shared with and understood by staff? Do staff feel valued by managers and in turn trust them? Are the organisational assets being reviewed so that the capital value of the organisation is being maintained? Are the relevant mechanisms in place to ensure resources can be used responsibly and that staff have the authority to call on the resources they need? Above all, does the community view the provider or purchaser with confidence and trust?

Any chief executive who answers “yes” to all these questions is a fool. But chief executives who say, “No, but here is what I am doing to monitor and to improve performance in each of these areas” are in with a chance of success. Particularly if they are working alongside clinical staff committed to clinical audit and quality assurance.

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