Editorial

Quality of care and performance indicators

After the Commission for Health Improvement (CHI) published its report into the Chesterfield and North Derbyshire Royal Hospital Trust in December, patients refused to be sent there for treatment. But the hospital was later given three-stars in the government rankings, and was within national targets for death rates within 30 days of non-elective surgery. CHI has admitted its mistake, but says death rates at the trust are “significantly higher” than the national average.1

There is little argument about the responsibility for modern governments to regulate the quality of health care. Doctors and nurses are obviously in a position of considerable power over patients and it is no longer assumed that they, and the organizations they work for, are entirely beneficent. This is not new. George Bernard Shaw described professions as a ‘conspiracy against the laity’ and others have argued that the traditional paternalistic approach makes people dependent and creates its own problems. In addition, increasingly potent medical interventions make the balance between good and harm more critical.

It is therefore unarguable that performance-monitoring of organizations and people within the health services should occur. There has been an increasing concern about the robustness of some of these measures, notably the star system for Trusts and Primary Care organization.

On this subject the Healthcare Commission’s web page states:

‘The Healthcare Commission is the independent regulator of NHS performance and as such is responsible for the production of the Star Ratings data on NHS trusts performance annually. The Government is responsible for setting priorities, which in turn determine the indicators relating to key targets. [Don’t you hate that use of the word ‘key’—have we ever had any ‘non-key targets’?]

‘Performance indicators are information collected to show how health trusts are doing in relation to some of the main targets set by the Government for the NHS, as well as other broader measures of performance. They include information from surveys of staff and patients, and other measures useful to patients and carers.

‘Ratings do not provide a comprehensive picture of every aspect of a NHS organisation’s performance. In particular, in their current form they do not include many measures of the outcomes of healthcare treatment (for example, whether there are variations between trusts in the quality of treatment or care for specific conditions). They are unlikely, on their own, to provide the information a patient would need to make choices about his or her treatment.2

The Healthcare Commission therefore includes a lot of caveats about the usefulness of the star system, especially when it comes to robust measures of treatment. This concern has been echoed elsewhere in the scientific press, where some workers have shown that, using only outcome measures, only about 40% of trusts would maintain their present star position.3 Other work has suggested that the star rating has little to do with the characteristics of the Chief Executive, the person held to account when stars are lost.4 Further authors have suggested that the star system is so important to the development of trusts, notably the move to foundation status, that they should be ‘beyond reproach’.5 The commentator on the last cited article, from the Healthcare Commission, makes the rather disingenuous plea that she ‘hope(s) BMJ readers will take the opportunity to help us design something better’.6

It seems a pity that the commentator did not manage to look at a recent excellent monograph by the Royal Statistical Society on performance indicators in the public services.7 They make the point that, given the government’s dual role as director of the service and measurer of performance, it ‘must be done with integrity and shielded from undue political influence, in the way that National Statistics are shielded.’

They go on to say that ‘Because of their usually tentative nature’ performance indicators should be used to screen for good or bad practice, rather than be over-interpreted.

They put forward eleven specific recommendations for the use of performance indicators in public services, which we, in public health, would do well to espouse. So much so that I outline them here:

‘All performance monitoring (PM) procedures need a detailed protocol.

A PM procedure must have clearly defined objectives, and achieve them with methodological rigour. Individuals and/or institutions monitored should have substantial input to the development of the PM procedure.

A PM procedure should be so designed that counter-productive behaviour is discouraged.

Cost-effectiveness should be given wider consideration in both the design and evaluation of PM procedures. Realistic assessment of the burden (indirect as well as direct) of collecting quality-assured PM data is important, for PM’s benefits should outweigh the burden.

Independent scrutiny of a PM procedure is needed as a safeguard of public accountability, methodological rigour, and of the individuals and/or institutions being monitored. The scrutineers’ role includes checking that the objectives of PM are being achieved

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without disproportionate burden, inducement of counter-productive behaviours, inappropriate setting or revision of targets, or interference in, or over-interpretation of, analyses and reporting.

Performance Indices (PIs) need clear definition. Even so, they are typically subject to several sources of variation, essential or systematic—due to case-mix, for example—as well as random. This must be recognized in design, target setting (if any) and analysis. The reporting of PM data should always include measures of uncertainty.

Investigations in a range of aspects of PM should be done under Research Council sponsorship, including study of the relative merits of different dissemination strategies for the public release of PM data.

Research should also be undertaken on robust methods for evaluating new government policies, including the role of randomized trials. In particular, efficient designs are needed for when government departments, in accordance with budgetary or other constraints, introduce (or ‘roll out’) a series of PI-monitored policies.

Ethical considerations may be involved in all aspects of PI procedures, and must be properly addressed.

A wide-ranging educational effort is required about the role and interpretation of PM data. But don’t take my word for it: buy the monograph or download it from www.rss.org.uk/archive/performance/index.html.

Given the analogy that statistical significance is important but, in a health service context, clinical significance is what we are more interested in, it would be useful to have a measure of uncertainty which included clinical significance. This would allow one to judge if one hospital really should be shunned by patients, and put extra significance on clinically relevant measures.

References