

## Guest editorial

# NICE quality standards: improving healthcare quality in the English NHS?

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The UK's National Institute for Health and Care Excellence (NICE) is best known in primary care for its production since 2001 of evidence-based clinical guidelines covering a wide range of clinical conditions.<sup>1</sup> More recently, NICE guidelines have become further integrated into UK primary care through their development into performance measures for the Quality and Outcomes Framework (QOF) payment for performance scheme.<sup>2</sup> NICE have, however, been developing other quality improvement guidance over the last few years and a key aspect of their current work programme is the development of quality standards for healthcare, social care and public health.<sup>3</sup> NICE were first tasked to develop quality standards for the English National Health Service (NHS) in the Darzi Review of 2008 and the first four standards were developed in 2009/10 using a pilot process that drew upon the existing methods of NICE clinical guideline development.<sup>4</sup> In 2010, the profile of NICE quality standards was raised significantly with the new coalition government emphasising the centrality of NICE quality standards in the 'new NHS' in its 2010 policy paper *Liberating the NHS* and in the subsequent 2012 Health and Social Care Act.<sup>5,6</sup> As of June 2013, NICE have published 32 quality standards (30 healthcare; two social care) and have a further 29 standards in development.

In terms of answering the question 'what is a healthcare quality standard?', there exists no standard definition in the same way that there is an accepted definition of a clinical practice guideline.<sup>7,8</sup> Nonetheless, it is generally agreed that a standard should be a measurable aspect of healthcare quality. A target standard may be set prospectively and stipulate a level of care that providers must strive to meet. An achieved standard can be measured retrospectively and details whether a care provider met a predetermined standard.<sup>9,10</sup> Such standards can be minimally acceptable standards to ensure safe practice, or be 'optimal' or aspirational standards designed to encourage and support a move to better practice.<sup>7</sup>

NICE quality standards aim to provide clear descriptions of high priority areas for quality improvement in a defined care or service area with the standards being described as being 'aspirational but achievable'.<sup>11</sup> They can thus be seen as being 'optimal' standards.<sup>7</sup> The need for standards to be measurable is reflected in the fact that each standard contains a concise number (six to eight) of quality statements with accompanying quality measures. The standards themselves are evidence based: they are derived from existing NICE guidance (usually NICE clinical guidelines) or other NICE-accredited guidance and address Darzi's categorisation of quality into effectiveness, patient safety and patient experience.<sup>4</sup> Each quality standard takes about 10 months to produce and is developed by a multidisciplinary Quality Standards Advisory Committee (QSAC).

The QSAC's key tasks are to agree prioritised areas of care or service provision for the topic under consideration and to draft appropriate quality statements and measures. Areas prioritised for quality statement development should: be areas of care where there is evidence or consensus that there is variation in the delivery of care to patients or service users (in particular aspects of care or services that are not widely provided and/or not considered to be standard practice, but that are feasible to provide); focus on key requirements for high-quality care or service provision that are expected to contribute to improving the effectiveness, safety and experience of care or services and be measurable.

This approach can be illustrated by a review of the recent quality standard for the epilepsies in adults.<sup>12</sup> The existing NICE clinical guideline on the epilepsies was used as the evidence source and a set of nine statements was produced.<sup>13</sup> These cover the key points on the pathway of care for an adult person with epilepsy considered to be most in need of improvement. The emphasis is on ensuring patients receive a correct and timely diagnosis of epilepsy (e.g. referral to a specialist and use of specialist investigations) and

that on-going care is planned and treatment reviewed as necessary (e.g. care planning, review by epilepsy specialist nurse and re-accessing secondary or tertiary care).

Moving onto the important question of ‘how quality standards are to be used in the NHS?’ there are two main answers. First, NICE sees quality standards as an important link between clinical guidelines and the work it now carries out to develop quality indicators for the QOF for general practice and also for NHS England in the form of its Clinical Commissioning Group Outcomes Indicator Set.<sup>2,11,14</sup> Identifying measurable standards of care is an important first step in the process of developing and testing indicators for use in existing clinical information systems. Second, they have been accorded a high profile in the English Health and Social Care Act to ensure that the NHS delivers the best possible outcomes for patients.<sup>3,6</sup>

NICE quality standards are not mandatory but it is expected that they will be used by four key groups: (1) patients, carers and the public as information about the quality of care they should expect to receive; (2) healthcare professionals in monitoring and improving services; (3) provider organisations to demonstrate the quality of care they provide; and (4) commissioning groups to ensure that high-quality care or services are being commissioned through the contracting process.

Given that the English NHS was only restructured in April 2013 it is too early to determine the impact that NICE quality standards are having in terms of improving healthcare. However, a review of the standards themselves and their stated uses does raise interesting issues as to their likely use and impact. The first issue is whether the quality standards represent a new set of guidance in their own right or whether they are simply another way of implementing NICE clinical guideline recommendations. NICE already issue ‘key priorities for implementation’ with their clinical guidelines and, for example, a comparison of the epilepsy quality standard and the ‘key priorities for implementation’ of the epilepsies guideline reveals significant overlap. In addition, the disease-focused approach of the quality standards mirrors the focus of clinical guidelines and may not fit well with the need for commissioners and providers to deliver services rather than single disease pathways. In this context, a quality standard for the care of adults with chronic neurological conditions (e.g. Parkinson’s, epilepsies, multiple sclerosis) might be more useful in terms of highlighting and promoting the need for correct and timely diagnosis and on-going specialist care across a range of conditions. Finally, it needs to be emphasised that quality standards are inherently reductionist: they reduce a full pathway of care to a small number of points where care is considered to need improving. These specific areas may then be

prioritised for further indicator development with a potential future focus on measuring and reporting for accountability or pay for performance purposes.<sup>2,14</sup>

Such an approach, of prioritising key points on a care pathway for implementation, is a widely used quality improvement strategy. Nonetheless, experience from the USA and elsewhere is that one needs to be cautious about measuring and incentivising parts of a care pathway with the expectation that this will necessarily lead to an overall improvement in the quality of care, including health outcomes, for patients.<sup>15–17</sup> To conclude, if NICE quality standards are indeed central to the English Health and Social Care Act then there is clearly a case for an independent evaluation of their use and impact.

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#### PEER REVIEW

Commissioned; not externally peer reviewed.

#### CONFLICTS OF INTEREST

Tim Stokes acted as a consultant clinical adviser to NICE on its Quality Standards programme 2009–2013. The views presented here are the author's own and do not necessarily represent those of NICE.

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