Chapter 1

Health care quality in England

The English NHS takes health care quality seriously and makes great effort to be a system that learns. England has internationally pioneered many initiatives, including clinical guidelines, continuing professional development and use of patient surveys and patient-reported outcomes. Professionalism was for many years the base upon which quality monitoring and improvement activities rested. Over time, though, the governance model shifted toward a quality management approach, more reliant upon transparency and regulation. There has been a proliferation of national agencies, reviews and policies that address quality, leading to a somewhat congested and fragmented field of actors. This chapter recommends three key actions for England. First, greater emphasis on bottom-up approaches, led by patients and clinicians, should be encouraged. As the same time there is scope to simplify the range of institutions and policies regulating health care quality at national and local level. Finally, renewed focus on the quality at the interfaces of care, as well as on community-based services, is needed.

Continuously improving the quality of care is a deeply established and widely shared commitment in the English National Health Service (NHS). This chapter assesses the governance model, institutions and policies in place to assure, monitor and improve health care quality in England. Comparisons with quality monitoring and improvement activities in other OECD health systems are drawn and, based upon these, recommendations for strengthening arrangements in England are proposed. In some cases, these recommendations are to go further with quality initiatives that the NHS has pioneered, so that the international community can continue to learn from England's capacity and willingness to innovate.

Analyses that quantify quality and outcomes in the English NHS are available elsewhere (The Health Foundation and the Nuffield Trust, 2013 and 2014). This report does not seek to replicate these quantitative assessments. Instead, the report's primary aim is to help policy makers, clinicians and patients answer the question "How can the governance model, institutions and policies that make up England's quality architecture evolve to deliver ever better health care"? The chapter opens with a brief description of how health care in England is planned, financed and delivered, focussing on the changes introduced by the 2012 Health and Social Care Act. The health care needs of the population, other challenges that the health care system must meet, and broad outcomes achieved by the system are also outlined. Section 1.2 then examines separate elements of the quality architecture (such as use of guidelines or professional licensing) in detail, in a format that follows other volumes in the OECD's *Health Care Quality Review* series.

1.1. The planning, financing and delivery of health care in England

The governance, organisation and financing of the health service in England underwent significant reform following the Health and Social Care Act 2012, which came into effect in 2013 and changed the governance and accountability structures at primary, secondary and specialist levels in the health service. This section describes the current governance and organisation of the NHS as the backdrop to the assessment of care quality. The resumé is deliberately brief, since full accounts of the changes to the NHS in the last decade and before are available elsewhere.[1]

The allocation of responsibilities for steering the NHS effectively changed significantly with the 2012 Health and Social Care Act

Leadership and policy setting in the NHS starts with the Secretary of State for Health, who has overall responsibility for the work undertaken by the Department of Health (DOH). The National Health Service Act 2006 specifies that the functions of the Secretary of State for Health must be exercised "with a view to securing continuous improvement in the quality of services provided to individuals". Regarding the outcomes of care, the Act also specifies that the Secretary of State "must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of services". These provisions are reiterated in Section 1 of the Health and Social Care Act 2012. This Act created new bodies responsible for commissioning the majority of health care services in England – the National Health Service Commissioning Board (usually referred to as NHS England) at central level, and Clinical Commissioning Groups (CCGs) at local level. The 2012 Act states that NHS England and CCGs are under identical duties to the Secretary of State in terms of securing continuous improvement.

With the passing of the Health and Social Care Act in 2012, there was a significant shift in the role of the DOH in the governance of the NHS. Many of the DOH's former functions for commissioning care, and responsibility for the NHS delivering high quality services and improving outcomes, were passed to NHS England. This constituted a significant reduction in the functions of the DOH, with the intention that the DOH become a more strategic body focused on improving public health, tackling health inequalities and reforming adult social care, whilst giving other NHS bodies greater freedoms. The primary goal of these reforms was to limit political micromanagement of the NHS, and to discharge responsibility for quality and budget allocation – formerly core parts of the DOH's mandate – to NHS England.

The intentions of the Secretary of State are communicated to NHS England via a mandate. The current mandate focusses on eight priority areas: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people to recover from episodes of ill health or following injury; ensuring that people have a positive experience of care; treating and caring for people in a safe environment and protecting them from avoidable harm; freeing the NHS to innovate; optimising the broader role of the NHS in society, such as contributing to economic growth; ensuring good financial management and improving value for money; and, robustly measuring progress, and reducing inequalities or unjustified variation in outcomes (Department of Health, 2014). In responding to this mandate, NHS England's principal function is to develop an effective and comprehensive system of health commissioning to drive continuous improvements in quality and outcomes. NHS England comprises a national support centre, 4 Regional and 27 Area Teams. It has a budget of GBP 98.4 billion (2014-15), most of which (GBP 65.8 billion) is reallocated directly to CCGs to enable local commissioning, with the remainder being used to commission services at national level. Most national commissioning relates to specialised services provided in a few hospitals and needed by relatively few patients.

The principal document setting out the intended direction for the NHS is the *NHS Five Year Forward View*, which was published in October 2014. The plan was developed with input from the main stakeholders in the NHS – NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority, as well as from patient groups, medical practitioners, and experts. The plan seeks to identify areas of strength as well as address areas where change is needed, alongside the models of care which should be worked towards.

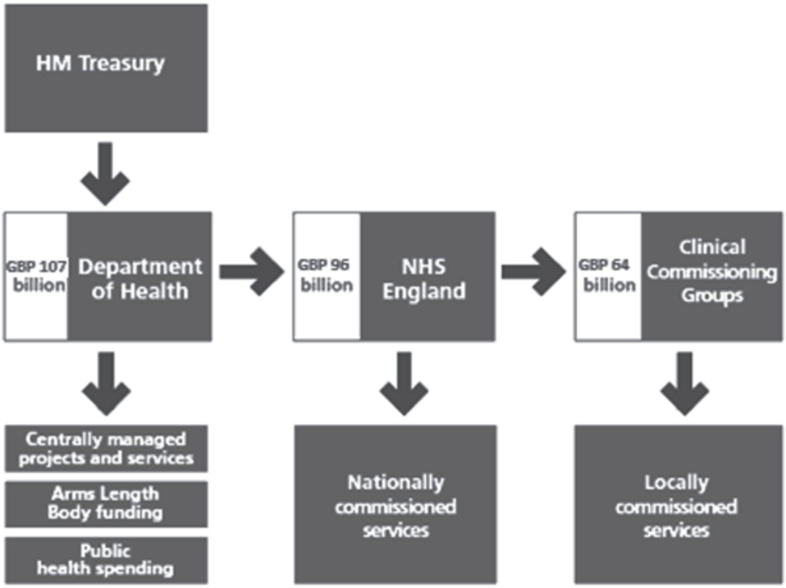
The main areas that the plan covers are prevention and public health; patient-led care; breaking down barriers between levels of care (notably family doctors and hospitals); building systems responsive to local needs; and, sustainable efficiency and funding models. As well as assessing the NHS' challenges and need for change, the plan offers clear ideas of new models of service organisation that could form part of this change. Options suggested include Multispecialty Community Provider services, that would combine GPs, nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care. Other suggestions include smaller hospitals partnering with other hospitals, midwives taking charge of some maternity hospitals, and transferring more control over the NHS budget to the recently established Clinical Commissioning Groups.

Strategic leadership around public health provision is delivered by *Public Health England*, which includes supporting local government, working with NHS England on commissioning key specialist services and national public health programmes, and providing leadership in response to public health emergencies. There are, in addition, 12 *Special Health Authorities*, which provide a particular health service to the whole of England, for example the *NHS Blood and Transplant Authority*. These bodies are independent from the NHS governance system. They can be subject to ministerial direction, however, in the same way as other NHS bodies.

Since April 2013 commissioning for the NHS has been split between *Clinical Commissioning Groups* (CCGs) and NHS England. Almost all funding for services within the NHS flows from the HM Treasury, through the Department of Health, to NHS England. NHS England then directly commissions primary care and specialist services at a national level, and transfers resources to Clinical Commissioning Groups for the commissioning of local services (see Figure 1.1). The 211 Clinical Commissioning Groups (CCGs) in England manage around two thirds of the NHS commissioning budget. CCGs plan and purchase urgent and emergency care (for example Accident and Emergency services), elective hospital care, community health services (beyond GP-provided care), maternity and infant care and mental health services. More recently, CCGs have been invited to commission GP services, in order to deliver better integrated care.

Through the services that they commission, the CCGs are responsible for providing health care for their catchment population. All GP practices have to be members of a CCG, a structure that was set up with the intention to move commissioning closer to population needs, drawing on GPs' appraisal of the health needs of the patients in their catchment area. Every CCG board must also include one hospital doctor, nurse, and member of the public.

Figure 1.1. Flow of resources in the NHS



Note: All figures are based on HM Treasury Spending Review 2010.

Source: NHS England (2014), *Understanding The New NHS*, available at: www.england.nhs.uk/nhsguide/.

CCGs are supported by *Commissioning Support Units*, *Strategic Clinical Networks*, *and Clinical Senates*. Commissioning Support Units include transactional services such as payroll and IT support, to providing population-level data to inform commissioning decisions, as well as strategic decision making around, for example, service redesign. In 2014 there were nine Commissioning Support Units in England, which can be used by CCGs as they wished, depending on the services and support that the CCG needs. Strategic Clinical Networks are hosted and funded by NHS England, and focus on priority service areas – for example cardiovascular, mental health, cancer – and advise local commissioners (CCGs and Health and Wellbeing Boards) on these specific conditions, or on patient groups, with a view to making improvements in an integrated, whole-system approach. *Clinical senates* are led by clinicians and provide multidisciplinary input – including medical, nursing and other allied health professionals' perspectives, as well as patients' and other volunteers' – to help strategic commissioning and decision making by local commissioning authorities and NHS England. A review of the future role of these bodies is underway.

Commissioning of social care, and of public health services, has been moved to Local Government Authorities (typically City Councils and County Councils), with funding for these services flowing more directly to local authorities, rather than through NHS bodies or the Department of Health. *Health and Wellbeing Boards* support this task, and also are tasked with increasing strategic planning and co-operation between health and social services. Health and Wellbeing Boards are forum for local commissioners – CCGs, Local Government Authorities, and Healthwatch Local, representatives from adult and child social services, the Director of Public Health for the local authority, and any other persons invited to provide specific expertise. As described in Section 1.9, *Healthwatch Local* is a body representing patient and public opinion, as a point of contact between individuals, community groups, and voluntary organisations concerning health and social care. At a national level the views of patients and the public are represented by *Healthwatch England*, which supports the establishment of local Healthwatch organisations, and aims to represent local views and experiences of care and use them to influence policy, for instance with the Department of Health, Secretary of State, and other national statutory bodies.

NHS *Foundation Trusts* are public, but semi-autonomous, providers of health care services (which are commissioned primarily by CCGs). Compared to NHS Trusts, Foundation Trusts have a fair degree of independence, both in terms of governance and financing, which is overseen by a board of governors (which can include local people, patients and staff). As described in Section 1.4, they are also subject to oversight from *Monitor,* the *Care Quality Commission* and other bodies. Foundation Trusts provide care typically covering a set geographic area, and/or a core set of services.

NHS Trusts which have not achieved Foundation Trusts services have a similar function in terms of care delivery – providing particular services to a given geographical area – but have less independence in the way that they are run. These trusts are managed by the *NHS Trust Development Authority*. The Trust Development Authority (TDA) is responsible for overseeing the performance management and governance of NHS trusts that have not yet achieved foundation status. This includes clinical quality and managing trusts' progress towards foundation trust status, which all non-foundation trusts are encouraged to achieve. Plans to bring together Monitor and TDA under a single leadership with the operating name *NHS Improvement* have recently been announced.

Reforms to enable commissioning from the private sector began in 2003, when "independent sector treatment centres" for hip and knee surgery, cataracts and other procedures were established. Commissioning of services from the private and independent sector has continued since. Under the recent reforms the majority of commissioning is from public providers, principally NHS Foundation Trusts, but commissioning authorities are allowed to buy services from both private and non-governmental providers. "Any Qualified Provider", which was introduced starting from April 2012, gives patients the power to choose from a list of approved service providers – NHS, private and voluntary – for care that would then be paid for by their commissioning authority. In monetary terms the share of contracts awarded to non-NHS providers remains marginal. Only 6% of NHS-funded care in 2013/14 was sourced from the private sector. The Office of Health Economics Commission on Competition in the NHS published a report in 2012 which concluded that, based on available evidence, competition at regulated prices had improved the quality of some NHS services and that competition can help the integration of care.

The NHS, as other OECD health systems, is facing unprecedented demand and cost pressures

The NHS in England is now, like many other OECD health systems, facing the challenges of a shifting set of patient needs, and changing population health status. England's aging population, a growing burden of chronic disease, and changing population health status – notably a rise in overweight and obesity and the chronic conditions associated with this – are putting strain on NHS resources, and NHS traditional structures. When the NHS was established in 1948 infectious disease was broadly speaking the main challenge, and hospitals were the principal centres of care delivery. Today, care for people with long term conditions accounts for 70% of the money spent on health and social care in England, and much of this is spent on primary care, community care, and social care.

England's elderly population is projected to rise significantly in the next quarter century. The average (median) age is expected to rise from 39.7 years in 2010 to 39.9 years in 2020 and 42.2 by 2035 (ONS, 2011). Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia (NHS England, 2014b). Between 2012 and 2032 the percentage of the population aged 65-85 is expected to increase by 39%, and the population over 85 to increase by 106% (total population increase of 5% is expected).

The burden of chronic conditions is rising, linked both to the aging population, and to lifestyle factors. Three million people in England are diagnosed with diabetes, and 7 million are understood to be at risk of becoming diabetic. Between 2006-07 and 2010-11 diabetes prevalence increased by 25% (DOH, 2012). An estimated 15 million people in England suffer from at least one long-term condition. The prevalence of chronic kidney disease, hypothyroidism, chronic obstructive pulmonary disease (COPD) and dementia has also been rising. Multiple morbidities are also a cause for concern. In 2012 the number of people with one long term condition was projected to be relatively stable in the ten years to follow, but the number of people with multiple long term conditions was expected to rise by around a third, from 1.9 million in 2008 to 2.9 million in 2018 (DOH, 2012).

In addition to the pressure that the NHS is facing given this demographic and epidemiological shift, there have been considerable financial pressures in recent years. Following the 2008 financial crisis, significant cuts to government spending have been made as part of efforts to reduce England and the United Kingdom's budget deficit. The NHS, schools and overseas development were the only public services to be protected from these cuts. The NHS has not, as a consequence, been subject to budget reductions of a similar scale to some other public services. Nonetheless, in real terms budget increases have been very small, particularly given the demand-side pressures on the system. For instance, allocations to NHS England for 2013/14 were GBP 65.5 billion which was to be distributed to local commissioners. This represents a nominal growth of 2.6%, and a real term increase of 0.6% compared to 2012/13. Monitor, NHS England and independent analysts have calculated that without an increase in efficiency measures in the NHS, and without real terms growth in funding, by 2020-21 there will be a GBP 30 billion a year gap between NHS resources and patient needs (NHS England, 2014). Signalling the significance of these pressures, health system managers report that they feel more intensively managed on ensuring access and achieving financial balance than on quality indicators[2] in the current climate, despite the high profile accorded to quality improvement initiatives over recent years.

While the NHS budget has not been directly affected by cuts to public spending, spending on social care has fallen, which might be expected to have an impact upon health care needs and the health system. In 2013-14 spending on adult social care (by councils with adult social services responsibilities in England) was GBP 17.2 billion (HSCIC, 2014). This represented an increase of 0.5% in cash terms from 2012-13, but the equivalent of a 1% decrease in real terms. In some areas, spending falls have been reported as even more significant. For example, a QualityWatch report stated that between 2009-10 and 2012-13 spending by local authorities on social care for older adults fell by 7% in cash terms, and by 15% in real terms (QualityWatch, 2014). This fall in spending included significant cuts in residential care for older adults (13% expenditure reduction, 15% in real terms) and services in the community, with a 23% reduction in spending on home and day care services alone.

There are also some emergent signs that NHS services may not be adequately resourced to deal with shifting needs for care. Staffing levels in primary and community care, for example, may be a cause for concern. While the NHS workforce has grown by more than 160 000 clinicians since 2000 (more than 21 400 since 2010), hospital consultants have increased around three times faster than GPs (NHS England, 2014). There has been a trend towards a more specialised workforce, even though need for more holistic care for multiple conditions, closer to the community, is increasing fastest. However, there has been an increase of 41% in nurses working in GP practices in the last decade (NHS England, 2014).

The government has maintained the number of undergraduate medical training places at a level sufficient to support continued increase in the medical workforce in England. Between September 2013 and September 2014, the number of doctors working in the NHS increased by around 2 500 Full Time Equivalents (FTE). This growth is set to continue across primary and secondary care with a specific commitment to make available an estimated 5 000 additional doctors in general practice, by 2020.

Quality and outcomes data specific to England is limited, but suggests mixed performance compared to international peers

There is some evidence of real improvement in the performance of the English health system, as well as some areas where under-performance continues. In 2014 avoidable deaths overall were reported as being down by 20%, compared to 1990, an impressive achievement, but nonetheless one that would be expected of generally well developed health systems in OECD countries.

Other available indicators suggest that there is still scope for improvement. Countries that England could consider to be peers, notably Australia, Norway and Sweden, perform better than England on cervical cancer 5-year survival. Australia, Canada, New Zealand amongst others also perform better than England on five-year breast cancer survival. However the proportion of women screened for breast cancer has increased significantly, and for cervical cancer somewhat; and both are above the OECD average. On average 60% of women aged 20 – 69 were screened for cervical cancers in OECD countries (OECD, 2013a), compared to around 73% in England (for women aged 25-64). The rate of breast cancer screening is higher than cervical screening in the OECD, at 61.5%, and higher still in England, at 77% of women aged 53-70 (the OECD indicator covers women aged 50-69).

1.2. Governance of health care quality monitoring and improvement

Quality has been a key consideration across the English health system for many years. Consistent and system-wide Clinical Governance as an organising principle sought to bring about a new organisational culture focussed on continuous quality improvement. A renewed vision, reaffirming quality as the core organising principle in NHS services came about in 2008 with publication of *High Quality Care for All – NHS Next Stage Review* (Department of Health, 2008). This defined quality as comprising three components, clinical effectiveness, safety and patients' experience, in line with the definitions used by the OECD and other international organisations. Individuals' and organisations' accountability for quality and continuously improving care is now a system-wide responsibility, enshrined in legislation under the Health and Social Care Act 2012.

Ensuring quality, and achieving continuous quality improvement, have been a priorities in the English NHS for many years

Strong emphasis on achieving minimum standards of quality and assuring continuous quality improvement has been evident in the English NHS for many years. In the 1990s, concerns about poor standards in paediatric heart surgery in Bristol led to the establishment of Clinical Governance as the system's core organising principle. This created a framework in which NHS organisations were "accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Scally and Donaldson, 1998). Importantly, Clinical Governance sought to change culture and practice by establishing new norms – it did not mandate any specific structure or process to achieve its aims.

This approach, relying upon "professionals' innate desire to improve services" (Maybin and Thorlby, 2008), was continued in *High Quality Care for All,* Lord Darzi's review of the NHS published in 2008 (Department of Health, 2008). As well as stressing the primary value of professionalism as the driver of quality health care, this review also encouraged greater attention to clinical outcomes and greater flexibility in the design and delivery of services, in order to better meet local needs. A new focus on patients' assessment of clinical outcomes, patients' experience of care and patient choice was also introduced, and a conceptual framework describing quality as comprising the three pillars of effectiveness, safety and patient experience was established.

These and other initiatives introduced several fundamental principles into the NHS, such as the professional duty of clinicians to stay up to date and engage in on-going development, recognition of the value of audit cycles to improve local performance, establishment of a culture of transparency and effective use of information. These principles were taken up with a sense of urgency and commitment at every level of the health system – it is fair to say that English NHS has internationally pioneered many quality approaches, or implemented them more widely and deeply than many other OECD health systems. As will be explained in more detail in latter sections, the NHS is a global leader in the development of evidence-based clinical guidelines; resources for continuing professional development; use of patient surveys and patient reported outcome measures; data-linkage, transparency and public reporting; as well as reporting and learning from adverse events. The work being undertaken in England to make NHS services available 7-days a week is aimed at improving quality of care and patient safety. While the resource implications of this change are yet to be fully worked out, the policy has the potential to be internationally innovative.

NHS England's business plan and Outcomes Framework are entirely quality-led

As described in Section 1.1, accountability for continuously improving health care quality is clearly set out in English law. The relevant parliamentary Acts of 2006 and 2012 specify how the Secretary of State for Health must act "with a view to securing continuous improvement in the quality of services provided to individuals" and place NHS England and CCG under identical duties in terms of securing continuous improvement.

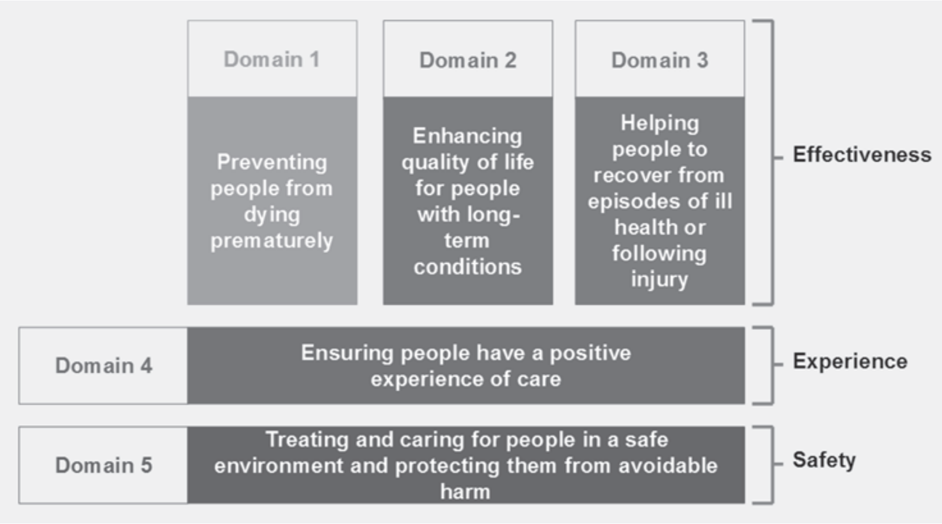
NHS England's business plan for 2015/16, *Building the NHS of the Five Year Forward View*, states that the over-arching ambition of NHS England's business is to improve health and wellbeing, secure high quality care, and put the NHS on the path to a sustainable future. This includes four priorities to improve health (specifically cancer, mental health, learning disabilities and diabetes) and four priorities to redesign urgent and emergency care, primary care, elective care, and specialised services in a more patient-centred fashion. Leaders of the NHS in England have published planning guidance for the NHS – *The Five Year Forward View in to Action: Planning for 2015/16*. This is based on the need to deliver high quality, timely care, whilst also setting out the steps to be taken in 2015/16 to fulfil the vision set out in the *Five Year Forward View*.

Achievement of these goals is supported by the *NHS Outcomes Framework*. The Outcomes Framework uses the three core elements of quality (effectiveness, safety and patient experience) to identify five high-level domains which the NHS should be looking to improve (Figure 1.2). A set of the indicators used to monitor progress in each domain is also specified, consisting of ten over-arching indicators, and around 30 additional indicators which go into more detail within each domain (Department of Health, 2011). Translation of the Outcomes Framework from central to local level exists as the *CCG Outcomes Indicator* set. This, developed with support from the National Institute for Health and Care Excellence (NICE), is intended to allow CCGs to compare themselves with peers, and use the information to inform commissioning decisions and contract management.

The domains addressed in the NHS Outcomes Framework have the virtues of being simple and clear, whilst being applicable at every level of the NHS. A prominent weakness, however, concerns how the framework addresses multi-morbidity and integrated care. Better integrating and co-ordinating care is a priority for the NHS, particularly for individuals with more than one long term condition, yet the only metric in the framework that captures this is a "placeholder" (in development) indicator around improving peoples' experience of integrated care. Questions that can reliably capture this are the subject of on-going research and additional indicators should be brought into the framework as soon as they are identified. It is also striking that the Outcomes Framework is entirely built around quality. Other system objectives barely feature, or do not feature at all. Timeliness and accessibility of care appear minimally (with two indicators related to access to GP and dental services, and to psychological therapies), whilst productivity and financial sustainability do not feature at all.

The NHS Outcomes Framework is only one part of the accountability framework between the NHS, NHS England, government and the public. The NHS Mandate, by which NHS England is held to account, contains broader goals than the Outcomes Framework. The NHS Constitution also sets out what staff, patients and the public can expect from the NHS, particularly in terms of access and timeliness. For example, it sets out a maximum of an 18 week wait from GP referral to consultant led treatment for non-urgent treatment and the right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. On finances, the NHS is also held to account for adhering to financial rules, for example, ensuring that organisations balance their books. All of these aspects are brought together in NHS planning and assurance – both between NHS England and commissioners (CCGs), and between the Trust Development Authority and Monitor with providers.

Figure 1.2. The NHS Outcomes Framework



Source: http://www.england.nhs.uk.

Nevertheless, the Outcomes Framework’s near-exclusive focus on quality may, paradoxically, not always support achievement of quality goals. Clinicians and health system managers, at central and local level, need to balance multiple system objectives simultaneously. Often, these will be in synergy (and, in particular, quality and cost control should not be thought of as being in opposition). Nevertheless, if sets of objectives are managed through distinct, unrelated frameworks there is a risk that they may come into conflict. In contrast, a unified framework, that integrates performance management of multiple objectives, would allow the space and flexibility needed to deliver across all of them. One example of an assessment framework that integrates multiple objectives comes from Sweden. There, the *Quality and Efficiency in Swedish Health Care* report is a regular publication comparing the performance of local health services across a range of performance indicators (see Box 1.1). Canada offers another illustration (see Box 1.7). England should consider whether a framework that integrates performance management across all health system objectives in a unified manner would better support clinicians and managers in delivering optimal care.

Box 1.1. Monitoring health system performance in Sweden

The National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions (SALAR) regularly publish counties' performance across more than 150 indicators of health care in its *Quality and Efficiency in Swedish Health Care* report. These include measures of access (such as ambulance response time, availability of primary care by phone), effectiveness (such as implant survival after hip replacement or meeting rehabilitation needs after stroke), safety (such as polypharmacy rates in the elderly or hospital acquired infection) and patient experience (such as reported respect and consideration in primary care or holding of end of life conversations). Efficiency measures are included in the same publication, such as cost per contact within the primary care system and cost per DRG point produced in hospitals. Data are presented for both local health authorities as well as individual clinics and hospitals.

The publication avoids reductive categorisations of performance and makes clear that the indicators presented are merely signals of the quality of care, and cannot be taken as definitive verdicts on good or bad performance. In particular, the Report notes that *"Perceptive interpretation of healthcare data requires general knowledge about the subject, time for analysis and in-depth study – often familiarity with local conditions as well. County and healthcare representatives are in the best position to interpret and evaluate their own outcomes. Any guidelines or reliable knowledge bases that are available in the area should serve as a springboard for local interpretation and discussion."* The report is widely acknowledged to have been a very powerful tool for encouraging municipalities and counties appearing at the bottom of the ranking to lift their standards.

Further information and source of quote: "Quality and Efficiency in Swedish Health Care – Regional Comparisons 2012", available from http://www.socialstyrelsen.se/publikationer.

A *Public Health Outcomes Framework* also exists, which focuses on the respective role of local government, the NHS and Public Health England to improve and protect health, deliver improved health and wellbeing outcomes, and reduce health inequalities in local communities, as well as an *Adult Social Care Outcomes Framework.* Although some efforts have been made to align priorities across these three frameworks (the placeholder indicator around improving peoples' experience of integrated care is shared between the NHSOF and Social Care Outcomes Framework for example), they are not as aligned as might be expected, given recent reforms to more closely integrate these sectors. Organisations at local level with cross-sectoral objectives and activities, such as Health and Wellbeing Boards, may find themselves struggling to deliver on three disconnected performance frameworks that do not mesh more closely. Steps should be taken to bring these three frameworks more closely together with the eventual ambition, perhaps, of merging them into one unified health and social care outcomes framework.

Authorities at national level are very prominent in setting and monitoring England's quality agenda

In contrast to other OECD health systems that are highly regionalised, or made up of various health insurance plans, England's quality governance is strongly centralised. In terms of steering, in addition to NHS England, *NHS Improving Quality* is expected to lead quality improvement across the system by providing improvement and change expertise. The *National Quality Board* was also established to bring together stakeholders responsible for leading quality improvement across the five domains of the NHS Outcomes Framework.

In terms of setting the standards of excellent care, the *National Institute for Health and Care Excellence* (NICE) is internationally renowned. It conducts clinical effectiveness assessments of new technologies and, increasingly, established treatments whose value for money requires reassessment. It also produces standards and guidelines for a wide range of clinical, social care and public health activities, and works with other organisations in the health and care system that have a monitoring role to review adherence against them. The *Healthcare Quality Improvement Partnership* (HQIP) promotes quality improvement through audit and confidential enquiries. HQIP manages the National Clinical Audit Programme, comprising more than 30 condition-specific clinical audits (such as the National Confidential Enquiry into Patient Outcome and Death).

NHS England's Patient Safety Domain team analyses reported patient safety incidents and develops alerts or actions to reduce future occurrence, having taken these functions on from the *National Patient Safety Agency* which was abolished in 2012. Bodies such as the *Care Quality Commission, Monitor*, the *General Medical Council,* the *Nursing and Midwifery Council* and other bodies described in Sections 1.3 and 1.4 regulate the professionals and organisations providing health care. The *Medicines and Healthcare Products Regulatory Agency* assures safe use of medicines and devices. Finally, *Healthwatch England* represents the voice of service-users and has statutory powers over most of the agencies listed above.

Significant effort has been made, however, to ensure that quality monitoring and improvement is a local activity as well. Clinical Commissioning Groups have a statutory duty to assure and monitor the quality of the services they purchase on behalf of local populations. In addition, local *Health and Wellbeing Boards* have powers to influence CCG decisions to ensure that effective services are bought. Local *Quality Surveillance Groups* have also been established. These act as virtual teams across a health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, commissioning, and regulatory activities. By collectively considering and triangulating information and intelligence, QSGs work to safeguard the quality of care that people receive. Finally, *Healthwatch England*, that represents the voice of service-users, is represented at local level by 150 branches that work in partnership with other local organisations.

External system reviews are frequently called upon where there are failings in care

Distressing and widely reported lapses in standards, such as the deaths attributable to poor care at the Bristol Royal Infirmary in the late 1980s and early 1990s and at Mid-Staffordshire NHS Foundation Trust in the late 2000s, triggered scrutiny and a strategic review of quality assurance mechanisms at the highest level. Multiple external reviews of the framework within which clinicians operated were commissioned. These included Professor Ian Kennedy’s inquiry into the Bristol Royal Infirmary (released in 2001), Dame Janet Smith’s inquiry into Dr Harold Shipman (final report released in 2005), the Francis Inquiry into Mid-Staffordshire (2013), the Cavendish Review of unregistered health and social care assistants (2013) and the Berwick Review of patient safety (2013).

There have also been a number of NHS- or government-authored reviews, such as the Keogh Review of 14 hospitals with reported high mortality rates (2013) and a review of how patient complaints are handled, by Ann Clwyd MP and Professor Tricia Hart (2013). Other bodies issue announcements on patient safety, accountability of named responsible clinicians, applying the Francis recommendations to children’s services and other matters.

External, independent reviews of exceptional and unacceptable failings have fundamentally changed the NHS, in order to prevent future failings in the quality of care it delivers. Undeniably, however, the overall volume of requirements, guidance and alerts being issued by central authorities is now very large. Dame Janet Smith’s review into Dr. Harold Shipman ran to six volumes, for example, and the Francis Report into Mid-Staffordshire contained 293 recommendations. The government has published comprehensive responses to each external review (*Hard Truths,* the response to the Mid-Staffordshire inquiry was two volumes). Whilst this is a reflection of the high priority given to quality and DOH has commissioned research to understand the impact of the Francis Report on providers, it is perhaps worth asking how much of these publications the average front-line clinician or manager would be familiar with. As will also be made clear in Sections 1.4 and 1.8, England's quality architecture is now considerably more complex, and possibly fragmented, than in earlier years when models such as Clinical Governance were consistently communicated and embedded at all levels in the system.

Nevertheless, the response to the Mid-Staffordshire public inquiry (into system wide failings that allowed serious failings in care to go unchecked) has included important reforms aimed at securing patient safety. This has included increasing staff numbers, reviewing and revising the Care Quality Commission's inspection model, and encouraging NHS staff to speak up over safety concerns through the "*Freedom to Speak Up Guardian*".

A shift towards regulation and quality control has become increasingly evident in England's quality governance model

In broad terms, quality governance in England has gradually shifted from being professionally-led to a model that increasingly emphasises external inspection and transparency, underpinned with regulations and requirements set by central authorities. In addition to the inspections and requirements imposed by the Care Quality Commission, Monitor, the Health and Safety Executive and other external regulators (described in Sections 1.3 and 1.4), specific activities have been mandated by central government, such as the requirement for all services to use the Friends and Family Test to gather patient feedback (described in Section 1.9). Norms, which may have previously been assumed to be inherent professional attributes, have become legally embodied requirements, such as being open with patients about their care and treatment, including when things go wrong. A shift in the language used of some commentators around quality improvement and aspirations for care in England is also apparent. A recent initiative seeking to improve early detection of cancer was interpreted by some as a move to name and shame, or root out, general practitioners with low referral rates.[3]

A governance model that emphasises quality management and quality control can be said to reflect the Taylorian or industrial approach.[4] The model is appealing because of its scientific approach to determining standards and its robust, verifiable means of dealing with poor performance. Taylor's model has been criticised, though, for disregarding employees' creativity and inherent pleasure in performing well. The extent to which a technique developed in an industrial setting can be successfully applied to the highly individual and relational activity of health care also remains a pertinent question.

In the field of health care, a quality governance model that is over-reliant on regulation and central control risks instilling a tick-box mentality in organisations and in individuals, focussed on meeting others' requirements rather than building one's own cycles of quality improvement.

Such a system may also become pre-occupied with identifying failings and put insufficient effort into identifying and spreading excellence. Most importantly, however, an approach which feels largely top-down may not get buy-in from professionals, whose conscientious scrutiny of their own and their colleagues' work is ultimately the best, and perhaps only, tool capable of identifying and addressing poor quality health care in a complex, busy and high-risk endeavour such as the NHS.

In this context, it is perhaps worth noting that in a survey of more than 800 doctors following publication of the Francis Review by the Medical Protection Society (a membership organisation that helps doctors with ethical and legal problems that arise from their clinical practice), two-thirds of hospital doctors believed that its proposals to introduce criminal sanctions on health care professionals in cases of wilful neglect would "create a culture of fear" (MPS, 2013).

There is also the risk of expecting too much from regulation. Given that the NHS employs just under 1.4 million staff who interact with 1 million patients every 36 hours in extremely diverse contexts, it would appear impossible for external regulation to guarantee the effectiveness, safety and patient-centredness of each of these contacts. Although every health system must find a balance between top-down quality management approaches and bottom-up quality improvement techniques, England's reliance on the former is perhaps now greater than is observed in other high performing health systems.

Contrasts with systems such as Norway's are instructive (see Box 1.2). As explained in Section 1.4, England has recognised the risk of over-reliance on external regulation and is taking steps to implement a more balanced array of quality monitoring and improvement techniques.

Box 1.2. Governance of the quality of health care in Norway

Norway has a high performing, high quality health care system and keeps spending as a percentage of GDP close to OECD averages. The Norwegian health system is broadly similar to that in England, with list-based GPs making up a strong and effective primary care sector, a hospital sector structured similarly to that in England, and continuing efforts to expand community and mental health care. Likewise, many elements of Norway's quality architecture would appear familiar to English visitors, such an active national HTA and guidelines development programme, judicious use of financial incentives, leverage of patient choice, prominent patient safety campaigns and a national reporting and learning system.

The governance model surrounding health care quality, however, is very different to that seen in England. Various parliamentary acts clearly establish provision of high quality health care and continuous quality improvement as a core priority, but the main governance model applied is one of quality improvement, led from the bottom-up. Norway's four regional health authorities are responsible for providing specialist health services and its 428 municipalities for providing primary and community health care services. A limited number of high-level strategic reviews set out the government's broad intentions for reform, with regional and municipal authorities left to design and implement local solutions as they best see fit. The 2012 Co-ordination Reform, with its clear and ambitious vision to shift the health system away from a dependency on the hospital sector, illustrates this well.

Regulation is lighter-touch and largely devolved from central authorities. The Norwegian Board of Health Supervision is the national regulator of all health, social and child care services. It is a small organisation, however, with 120 staff at its main office in Oslo and around 250 staff in 18 regional offices. The actual work of inspection is almost entirely devolved to County Medical Officers, who have combined responsibility for supervising both health services and health professionals. Around 400 service quality audits (of which around two thirds are in primary care services) and a similar number of professional fitness to practice investigations are carried out each year. The board was recently peer-evaluated by the European Partnership of Supervisory Organisations, who concluded that its current procedures maintained high-quality supervision and professional standards.

Norway has not introduced a compulsory accreditation system for health care providers and continuing medical education for professionals is not formally compulsory either. In both cases, best practice is established in regulations or guidance, and organisations and professionals are expected to meet it. All providers are expected to have an internal quality assurance system in place that enables continuous quality monitoring, for example, as well as internal systems to report and learn from adverse events. Similarly, all clinicians are expected to always practice according to sound professional standards, which includes an obligation to remain updated within their speciality. The 2014 *OECD Review of Health Care Quality* in Norway noted that much of the success of this lighter-touch regulation model depended on a high level of consensus across stakeholders on the priorities and direction of reforms for the Norwegian health system, as well as high levels of trust between those paying for, supervising and providing health care (OECD, 2014b).

1.3. Professional training and certification

The training and regulation of clinical professionals, which is a UK-wide activity, has moved from being largely self-regulated to a situation where the public verification of a professional's up to date knowledge, skills and probity is the most important priority. The recent introduction of regular revalidation of a doctors' licence to practice is an example of this (a process that will be extended to nurses and midwives in December 2015). The United Kingdom has implemented more stringent regulation around professional training and certification than most other OECD health systems.

The General Medical Council and Nursing and Midwifery Council set the standards which doctors and nurses must meet

The General Medical Council (GMC), established in 1858, is an independent body that maintains the register of individuals who meet specified criteria to be able to practice as doctors in all four countries of the United Kingdom. In addition, it regulates and sets standards for medical undergraduate education and, since 2010, post-graduate training. As of 2012, the GMC is also responsible for a licensing and revalidation system for all practising doctors, separate from the registration system.

Licensing and revalidation requires doctors to demonstrate to a peer that they are up to date and fit to practise by providing information in six areas: continuing professional development; quality improvement activity; significant events; colleague feedback; patient feedback; and a review of complaints and compliments. The information is discussed and reviewed at an annual appraisal based on the GMC's core guidance for doctors "Good medical practice", and a continuing professional development (CPD) plan is agreed for the year ahead. Completion of a cycle of five successful annual appraisals is expected to lead to revalidation of the doctor's licence to practice every five years. Local "responsible officers" are tasked with assuring their organisations and NHS England that their doctors are up to date and fit to practise.

While the GMC is ultimately responsible for revalidating doctors' licences, the process relies heavily on clinical governance systems in organisations and in particular on NHS England. NHS England has a dual role. As the Senior Responsible Owner for the implementation of revalidation in England, it is required to develop national systems and policies to support the work of local responsible officers in implementing revalidation. It is also responsible for the National Performers List. Doctors, dentists and ophthalmic practitioners must be on this list before they can provide primary care services. Legislation sets out the checks that are made on application to the list to ensure that performers are up to date and fit to practice, and performers are required to participate in an annual appraisal managed by NHS England.

For nurses and midwives, the Nursing and Midwifery Council (NMC) is the regulator who sets professional standards and that holds a register of individuals who are qualified and fit to practice. From late 2015 onwards, nurses and midwives will need to demonstrate that they remain fit to practice by going through a process of revalidation every three years. The process will require nurses and midwives to submit a form confirming that they have met the required practice and continuous professional development. Midwives follow the same process as nurses, with the additional requirement of intention to practice and supervision (they meet with their local Supervisor of midwives and notify their Intention to Practise on an annual basis). The recent Kings Fund review of Midwifery regulation in England (2015) and subsequent decision by the NMC to accept the recommendations will result in a revision of the statutory function of Supervision of Midwives. This will shift supervision to a purely non-regulatory function and the additional layer of regulation currently provided will cease.

A number of other regulators exist; all are overseen by a regulator of the regulators

The *General Dental Council* regulates dentists and dental care professionals. It sets standards for practice and holds a register of those legally entitled to provide dental treatment in the United Kingdom. All registered professionals must undertake mandatory continuing professional development, within five year cycles, to maintain their registration. The *General Pharmaceutical Council* regulates pharmacists, pharmacy technicians and pharmacy premises. As for the General Dental Council, it sets standards for practice and holds a register of those legally entitled to provide pharmacy services in the United Kingdom. It also sets standards for the education and training of pharmacists and ensures, through inspections, that educational standards are being maintained at pharmacy schools. Registered individuals must renew their registration with the Council every year, which involves completing a declaration stating that they meet all its professional, fitness to practise and ethical standards.

The *Health & Care Professions Council* regulates a number of health professionals such as Arts Therapists (Art, Drama and Music), Chiropodists/Podiatrists, Dieticians, Occupational Therapist, Orthoptists, Paramedics, Physiotherapists, Prosthetists/Orthotists, Radiographers, Speech and Language Therapists. As well as maintaining a register of individuals meeting the required professional standards, the Council publishes standards for education and training and holds a register of approved education programmes. Registrants must undertake continuing professional development, within two-year cycles; prior to re-registration (every two years), a randomly selected 2.5% of registrants from each profession are required to submit a log that shows how their CPD has met the required standard. Biomedical scientists and clinical scientists (including individuals working in clinical laboratory medicine, public health and national blood and transplant services, genetics and embryology, clinical physiology specialities, medical physics and clinical engineering) are also regulated by the Health & Care Professions Council. Other professional regulators include the General Chiropractic Council, General Optical Council, General Osteopathic Council, and the Pharmaceutical Society of Northern Ireland.

Overseeing the GMC, NMC and the other regulators described above, the *Professional Standards Authority* exists to improve the quality of professional regulation. Its lawyers review all of the regulators' decisions, to verify that they are acting in the interests of the public and not the professions'. A small number of regulator decisions are challenged each year. It also provides specific advice to government when commissioned to do so, undertakes special investigations and has an international advisory role.

England has a large number of professional regulators in comparison to other OECD countries. In addition, there are inconsistencies with respect to the professional groups that are formally regulated – hearing aid technicians have a professional regulator, whilst audiologists do not. Some groups performing high risk procedures such as clinical perfusionists are unregulated, whilst professionals whose work is unlikely to cause harm, such as arts therapists, are regulated. There is considerable scope, therefore, to consolidate the regulatory landscape. In the Nordic countries, all health care professionals are regulated by a single agency, such as Norway's *Statens Autorisasjons-Kontor for Helsepersonell* (www.sak.no). As well as efficiency gains, there may also be quality gains to such a rationalisation – bringing together performance data from several professional groups may point to quality concerns (or quality excellence) at the organisation where they work.

Better engagement from doctors and nurses will be essential if relicensing is to have value

An increasing number of countries are moving toward systems of formal relicensing for health care professionals (Merkur et al., 2009). Support for such systems relies upon the argument that awarding of a licence to practice at the end of medical education is not sufficient to ensure high quality care across a career of 40 years or more, particularly considering the rapidly changing nature of health care delivery. There is in fact little evidence, however, demonstrating the value of formal, compulsory relicensing.

Given this absence of demonstrated benefit, it is essential that clinicians feel properly engaged in the process, to avoid revalidation being another example of externally imposed regulation that has little value in creating a culture of quality improvement. At present, this is not the case. Research from the King’s Fund found that doctors were confused about the purpose of revalidation (King’s Fund, 2014). Many reported their impression that the primary purpose of revalidation was to prevent criminal activity (such as that of Harold Shipman) rather than contribute to professional development and better quality health care. Other research by the (now disbanded) NHS Revalidation Support Team suggested some incipient benefits, however, including an impression of increased accountability and self-scrutiny amongst doctors (Revalidation Support Team, 2014). This report recommended clearer communication of the intent of appraisal and revalidation and a more powerful role for patients as a means to strengthen the value of revalidation.

In order to better build engagement, clinicians must also feel that revalidation, and other aspects of the regulation of their practice, are proportionate rather than heavy-handed and geared to supporting excellence, rather than merely identifying failings and taking corrective action. At the moment, there is a risk that professional regulators are perceived as uniquely performing the latter. The GMC’s increasing role in supervising post-graduate education is a step in the right direction, which will enable it to have a more active role in supporting doctors’ continuing professional education. Its sponsorship of the awards celebrating excellence (such as the BMJ Awards) is also encouraging. Other regulators should also look to see how best they can support, rather than simply sign-off, clinicians’ continuous professional development, working alongside the Royal Colleges as appropriate.

The Professional Standards Authority has considered how regulation can best support professionals’ practice in its 2010 publication *Right-touch Regulation* (CHRE, 2010). This report advocates for the minimum regulatory force required to achieve the desired result and, in particular, recommends a risk-based, proactive approach to regulation. Currently, professional regulation in England is neither. It is not risk-based in that all professionals are subject to the same licensing and revalidation regime, which is summative and retrospective. Efforts should be made to monitor professionals’ standard of practice in a more proactive manner.

Consolidating regulators and sharing (possibly anonymised) performance data across professional groups is one way this could be done.

More broadly, trust in professionals' integrity and pride in their work should be emphasised as a key driver of system excellence

England's current regulatory approaches, being particularly reliant on regulation and external scrutiny, should be balanced with new initiatives that support professionalism as a key driver and guarantor of excellence. Importantly, relying on "professionalism" does *not* mean scaling-back transparency or adopting a "the doctor is always right" mentality. Instead, it is a fundamental attribute in clinicans', managers' and others' attitude to their work that should be encouraged as being elemental in driving high-quality care. Avedis Donabedian, Professor of Public Health at the University of Michigan made this clear when discussing health care quality as early as 1966: "It is the ethical dimensions of individuals that are essential to a system's success"[5] (Donabedian, 1966). More recently, Lord Darzi's central message in his 2008 report was that professionals must lead and own the quality assurance and quality improvement agenda. Others have also made this call. The Berwick report on patient safety (HM Government, 2013) reiterates in several places the need that "pride and joy in work, not fear, infuse the NHS" and for staff that are "buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities". The recently published NHS Five Year Forward View (NHS England, 2014) also states that a high quality health service "ultimately happens when a caring culture, professional commitment and strong leadership are combined".

Reliance on professionalism requires a high degree of trust, since it can be difficult to quantify and observe. As well as being challenging to quantify, professionalism can also be difficult to create. Employers and regulators must look, therefore, to build synergies between supporting professionalism and strengthening their individual accountability to the public. Public reporting of performance (at service or individual level) is a good mechanism to achieve these twin aims, but is also an illustration of how delicate such synergies can be. On the one hand, open comparison of performance is an important incentive toward ever better care. On the other hand, if analysis of the data is not perceived as valid, or if the use and interpretation of data is perceived as a primarily a mechanism to identify and "root out" bad performers, public reporting may demotivate professionals and erode public trust.

As described in later sections, the English NHS is taking steps to achieve an appropriate balance between professionalism and external regulation. An important element in this approach is investment in clinical leadership programmes. These seek to underpin professionalism by supporting staff to have the necessary attitudes, knowledge and skills to deliver continuously improving care. The NHS Leadership Academy, for example, offers a range of tools and training programmes to improve leadership behaviours and skills to staff across the NHS at various stages in their career. Some NHS regions have also created Fellowships in Clinical Leadership, where Fellows are expected to lead projects that focus on quality improvement, integrated community and primary care, patient safety, or clinical development and education. Peer-reviewers engaged in CQC inspections can also take learning and good practices back to their home organisation.

It is important to note that professionalism and clinical leadership go hand-in-hand with a stronger patient voice, as described in Section 1.9.

1.4. Inspection and accreditation of health care facilities

Health care providers in England are subject to a number of regulatory regimes. Chief amongst these are the *Care Quality Commission* (CQC), *Monitor*, and the *Trust Development Authority* (TDA). Plans to bring together the last two of these under a single leadership have recently been announced.

The CQC inspects all health and adult social care providers in England

The CQC was established in 2009 to regulate and inspect all health and adult social care services in England, including hospitals, adult social care, general practice, mental health care services, ambulances and community-based services. As well as assessing the quality of care given by these providers, the 2008 Health and Social Care Act also states that its broader purpose is to encourage improvement of health and social care services; provision of health and social care services in a way that focuses on the needs and experiences of people who use those services; and the efficient and effective use of resources in the provision of health and social care services.

In its current inspection process, the CQC asks five questions of every service and provider: are they safe? Are they effective? Are they caring? Are they well led? And, are they responsive to people’s needs? This results in a rating against four levels (see Box 1.3). Where poor care is identified, the CQC will then also assess whether a Fundamental Standard has been breached (also described in Box 1.3). Importantly, distinct services within a hospital (emergency care, critical care, medical services, surgical services, maternity services, paediatrics, palliative care and out-patient services) are assessed separately. Hospital inspection teams are made up of professional and clinical staff and "experts by experience" – that is, people who have experience of using care services whether as patients or carers.

Box 1.3. The CQC's fundamental standards of care and assessment of providers

The CQC summarises its assessment of providers by placing them within one of four categories:

- *Outstanding*: providers who follow best practice guidance (such as National Institute for Health and Care Excellence guidance) for most services and are compliant with the fundamental standards.
- *Good*: may follow some best practice guidance and are compliant with the fundamental standards.
- *Requires improvement*: not compliant with the fundamental standards in some areas.
- *Inadequate*: widespread non-compliance with the fundamental standards or serious ongoing breaches in specific areas.

The fundamental standards against which the CQC assesses all health care providers are that:

- Care and treatment must be appropriate and reflect service users' needs and preferences.
- Service users must be treated with dignity and respect.
- Care and treatment must only be provided with consent.
- Care and treatment must be provided in a safe way.
- Service users must be protected from abuse and improper treatment.
- Service users' nutritional and hydration needs must be met.
- All premises and equipment used must be clean, secure, suitable and used properly.
- Complaints must be appropriately investigated and appropriate action taken in response.
- Systems and processes must be established to ensure compliance with the fundamental standards.

Box 1.3. The CQC's fundamental standards of care and assessment of providers *(cont.)*

- Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
- Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed.
- Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

A provider meeting all fundamental standards will not automatically be rated as good, however. The CQC now seeks to go beyond merely assessing compliance with minimum standards by undertaking a more comprehensive assessment of the quality of care, including highlighting where care is good or outstanding.

Source: www.cqc.org.uk.

Where quality concerns are identified, the CQC has legally-recognised powers to issue warning notices; impose, vary or remove conditions on registration; suspend or cancel registration; or prosecute offences or give penalty notices in lieu of prosecution. Where there is serious and persistent inadequate quality of care, the CQC may recommend that providers be put into a special measures programme (see Box 1.4). CQC's role in special measures is to provide a rigorous and independent view of where care is failing, and whether care has improved. The CQC also has a role in recommending when providers are taken out of special measures.

In addition to on-site inspections (some of which are unannounced) the CQC also undertakes continuous, pro-active monitoring of quality and outcomes in hospitals. In doing so, it makes use of a set of 150 indicators including information from staff, patient surveys, mortality rates and hospital performance information such as waiting times and infection rates. The CQC also administers a set of standardised national patient surveys (for inpatients, outpatients, maternity services users, community service users and others) to feed into this monitoring process.

Box 1.4. Basildon and Thurrock University Hospitals (BTUH) NHS Foundation Trust's experience of special measures

The BTUH Foundation Trust provides secondary care services for a population of around 450 000 people in the South-East of England. It was part of the first wave of Foundation Trusts created in 2004 signaling that – at that time – it was a successful and well-regarded hospital. A number of concerns around the quality of care, however, soon became apparent. Bed numbers were low, meaning that patients faced lengthy waits on corridor stretchers, wards were under-staffed, infection rates were high and the Trust's standardised hospital mortality index (SHMI) rose to become the second highest in the country.

As part of the Keogh Review of Trusts with high SHMI, BTUH underwent an inspection in May 2013. This led to it being placed in a "special measures" regime in July of that year. Special measures involves action by the CQC and Monitor, and are recommended "when there are problems with the quality of care provided to some or all patients that the leadership of the trust cannot fix in a reasonable time without additional help" (*Special measures: a guide for patients,* available from http://www.nhs.uk). In the case of BTUH, the regime comprised the appointment of an Improvement Director, publication of an agreed Action Plan (with monthly updating on the *NHS Choices* website), and partnering with a nearby high-performing Trust to facilitate peer-support and learning.

Just under a year later, at a CQC inspection in March 2014, BTUH was rated "Good" – evidence of rapid and substantial improvement in the quality of care. The Trust's SHMI had fallen from 1.12 in March 2012 to 1.07 (and fell further to 0.98 in July 2015); the share of patients reporting that they would recommend the hospital has risen from around 40% in April 2013 to around 70% (and stood at 80% in April 2015). Staff satisfaction has also risen, and the number safety incidents reported to the National Reporting and Learning System (see Section 1.11) has risen from being the third lowest within BTUH's peer-group to the third highest, signalling a more open and quality-conscious culture. In addition, BTUH was the first Trust in the country to receive an "Outstanding" rating for its Maternity services. BTUH was taken out of the special measures regime in June 2014 and the Trust maintained its "Good" rating at its most recent CQC inspection of March 2015.

Several activities contributed to the transformation in the quality of care at BTUH. Some 200 extra nurses were recruited to address under-staffing on wards and additional bed-capacity was built, with a focus on improving the flow of patients through the Emergency Department. Governance was modernised, seeking to reconnect hospital managers with staff and patients. Daily "Stepping Up Now" meetings illustrate this in practice. These are short, informal gatherings facilitated by a member of the senior management team, where staff can pose questions, voice concerns and receive updates on the Trust's progress.

Locally, views on the value and utility of the regime are mixed. On the one hand, imposition of the regime was not sensitive to the fact that several initiatives to transform the quality of care were already making progress, since appointment of a new Chief Executive in September 2012. Neither did the regime substantially alter the speed or direction these reforms. In this context, central authorities' decision to apply special measures was a difficult message to communicate to staff and to the public. On the other hand, the regime did serve to unequivocally call attention to the fact that there were deep-rooted problems in the delivery of care at BTUH, and to convince resistant stakeholders that urgent and far-reaching reforms were necessary.

Box 1.4. Basildon and Thurrock University Hospitals (BTUH) NHS Foundation Trust's experience of special measures *(cont.)*

Nationally, the CQC reported significant progress in ten of the eleven trusts placed into special measures at the same time as BTUH, when reviewing them a year later (CQC, 2014). Five (including BTUH) were seen as no longer requiring special measures; a further three have been taken out since. An independent analysis of mortality rates to at the same trusts found that, on average, mortality trends shifted downwards after the imposition of special measures, significantly more rapidly than across the rest of the country. Three trusts did not show falling mortality rates, however (Dr Foster, 2015).

"Monitor" takes action to improve providers' performance in response to CQC assessments

Established in 2004, *Monitor* is responsible for ensuring that NHS providers are well-led in terms of financial stability and quality of care, and that competition and patient choice are not compromised by a Trust's activities (http://www.monitor.gov.uk). A linked role is in ensuring that essential services continue in the event that a provider fails. Monitor also publishes the national price tariff.

Monitor requires that all FT hold CQC registration as a condition of receiving a licence. Where the CQC judges that care is poor, Monitor is able to fine the Trust, suspend directors or governors, appoint interim directors, or revoke a provider's licence. As of April 2015, the CQC is able to issue a warning notice to NHS providers where it appears that the quality of care needs significant improvement. Monitor is able to modify the provider's licence to include appropriate conditions in response to this warning notice and, if licence conditions are breached, subsequently fine the provider or revoke its licence.

Beyond reacting appropriately to CQC's judgments on the quality of care within an FT, Monitor also engages in some aspects of quality assessment itself. Its 2014-17 strategy sets out that it sees its role as encompassing prevention of quality problems (for example, by setting standards of quality governance), detection of specific quality failings relating to financial sustainability and/or poor governance (through its Risk Assessment Framework, for example) and correcting them (by using its enforcement powers fix quality problems, for example). Monitor has a close working relationship with CQC, sharing information and discussing any steps it intends to take as a result of quality concerns that it identifies.

For hospitals that are not Foundation Trusts, the *NHS Trust Development Authority* acts in a similar vein (http://www.ntda.nhs.uk). The

Authority is responsible for providing leadership and support to these hospitals. This includes monitoring their performance, providing support to help them improve the safety and wider quality and sustainability of their services, and providing assurance of their clinical quality. In June 2015, plans to bring Monitor and the Trust Development Authority under a single leadership were announced, in order to achieve closer working between the two organisations.

A more balanced approach to quality governance is now being sought

The risk of relying too much upon regulation and control has been recognised in the English NHS, in part because of external reviews such as the Berwick Review and the Francis Report. A more balanced approach is now being sought, combining locally-led quality improvement activities, a bigger role for clinical leaders, greater transparency and an appropriate degree of external regulation. Regarding the last of these elements, the CQC has been asked to move beyond inspecting compliance against minimum standards to a more nuanced assessment of the quality of care (using the five key questions and four categories of assessment, as set out earlier). It is also expected to place new emphasis on identifying and showcasing excellent care.

This better-balanced set of approaches is necessary and correct. The challenge, though, will be to ensure that it is communicated consistently; understood by all managers, clinicians and patients; and implemented in a sustained manner across all services. Speaking to health system managers, clinicians and representatives of CCGs, however, this does not yet appear to be the case. Key stakeholders report, for example, that their main aim is to "stay under the radar" of the CQC and other inspectors.[2] Hence, even though England's quality governance has sought to move beyond a compliance and regulation regime to one of inspection and improvement, this shift is a recent one and it is clear that substantial and sustained work will need to be done to convince front-line clinicians and managers of the change in approach.

More will need to be done to build and embed the newly intended governance model. Language is important and policy makers, managers and clinicians at all levels of the system should shift away from discourse that emphasises failure or blame. Initiatives that emphasise the opposite, such as the Chief Nursing Officer's *Compassion in Practice* (Department of Health, 2012), should be embedded system-wide. In parallel with the CQC, other regulators such as the GMC and NMC should invest resources in identifying, promoting and publically celebrating excellence amongst their constituents. Rebalancing the regulators' work would be a natural complement to their current agenda, send a strong signal about the high value placed on professional and organisational success and would be internationally innovative.

The CQC's recent publication *Celebrating good care, championing outstanding care* presents 12 brief case studies where providers in a range of care settings have received "Good" or "Outstanding" ratings, and is a promising development. Longer and more detailed case studies of how excellence was achieved, blueprints or implementation pathways, and syntheses of insights and lessons learned will enrich the material available to local clinicians and managers wanting to learn from high-performing peers. Likewise, links to change and improvement resources and signposting other excellence awards, will help establish the CQC's role as one of encouraging organisational development and excellence.

Inspection and accreditation should also better reflect patients' experience of care

Regulatory approaches typically base themselves upon easily defined services and institutions. While separate ratings for distinct service areas such as emergency care, surgical care and critical care have the advantage of detail and granularity, they reflect organisational structures and not the complex reality of chronic disease or complete health care episodes. More and more health system activities and functions (such as commissioning) are trying to overcome traditional organisational boundaries and better reflect the patient pathway, and accreditation and inspection should do the same. At present, few OECD health systems accredit patient pathways, but some third-party organisations are now offering this service (see Box 1.5). If England were to systematically implement a disease-based or population-based, approach to accreditation (whilst maintaining institutional inspection and accreditation), this would be internationally innovative. The CQC's intention to undertake thematic reviews, looking at the quality and outcomes of care for elderly people for example, is an incipient step in this direction and should be encouraged. All elements of the patient pathway (primary care, acute care and social care) could be looked at, with standards developed around measurables such as timeliness, information exchange and patient involvement in their care.

Box 1.5. Inspection and accreditation of patient pathways

Accreditation the integrated bundle of services needed by particular patient groups remains uncommon in OECD health systems. In Germany, disease management programmes offered by health insurance agencies must be accredited by the Federal Insurance Office, and a similar arrangement exists in the Netherlands (see, for example, van Doorn et al., 2014).

In the United States, independent non-profit organisations, with well-established reputations, such as Joint Commission International and the National Committee for Quality Assurance are increasingly offering this type of accreditation. The JCI's Clinical Care Program Certification (CCPC) programme evaluates the acute or chronic disease management provided by hospitals, ambulatory care, home care, and long term care centers. Examples of programmes include acute myocardial infarction, heart failure, stroke, asthma, chronic obstructive pulmonary disease, pain management, palliative care, low back pain, chronic depression, and HIV/AIDS. Areas evaluated include patient safety, support for self-management amongst patients and caregivers, clinical outcomes, and programme leadership and management.

The NCQA assesses programmes of care for people with asthma, diabetes, chronic obstructive pulmonary disease, heart failure and ischemic vascular disease. Standardised performance measures, which include preventive care aspect such as tobacco use, influenza vaccination and pneumococcal vaccination, are assessed against its Standards and Guidelines for the Accreditation and Certification of Disease Management.

Source: www.jointcommissioninternational.org and www.ncqa.org.

Improving the monitoring of quality across the interfaces of care and patient pathways is also addressed in Section 1.7.

1.5. Authorisation of medical devices and pharmaceuticals

England has effective and well-established systems for authorising use of new devices and treatments, as well as for monitoring safety post-authorisation. England also actively supports research and development into new treatments, seeing this as an integral element in providing high quality health care.

The Medicines and Healthcare Products Regulatory Agency verifies the safety and effectiveness of drugs and devices

The Medicines and Healthcare Products Regulatory Agency (MHRA) was formed in 2003. It assesses and authorises medical products for use across the United Kingdom, as well as operating post-marketing surveillance to monitor and investigate adverse drug reactions or untoward incidents with medical devices. The Agency's *Yellow Card Scheme* is a long-established mechanism to support post-marketing surveillance, founded in 1964 after recognition of the congenital malformations linked to thalidomide (withdrawn from UK sales in 1961). Patients and carers, as well as health professionals, can use the Scheme. The Scheme's links to the *National Reporting and Learning System* for adverse events (NRLS) are set out in Section 1.11. The MHRA also participates in a Europe-wide system for health care product approval, capable of verifying the quality of any industry application on behalf of all member states.

Recent evolution of the MHRA's role has included monitoring sales of medical products via the internet, and prosecuting counterfeit or otherwise illegal sales where necessary. Following the abolition of the Health Protection Agency on 1 April 2013, the Agency incorporated the National Institute of Biological Standards and Control (NIBSC). It thereby assumed responsibility for vaccines, blood products and other substances which cannot be characterised chemically and which require special testing measures to ensure their safety and efficacy. The MHRA also part-funds the *Clinical Practice Research Database* (CPRD). This brings together a number of anonymised databases (such as prescribing records, laboratory results and disease registers) to support observational and interventional health services research.

England has made significant effort to pioneer development and use of new treatments

The United Kingdom, being home to major pharmaceutical companies such as GlaxoSmithKline and AstraZeneca, has always sought to be a global hub of pharmaceutical research and development. At times, however, the authorisation process for drugs has been criticised for being disproportionately slow, onerous or costly, potentially stifling incentives to innovate.

Various initiatives, at system level, are trying to encourage the development and use of new treatments, whilst ensuring that the necessary checks and safeguards remain in place. The *Early Access to Medicines Scheme* was launched in 2014, for example. This allows manufacturers to submit an application to the MHRA for a compound to be designated as a "promising innovative medicine". If approved, certain patient groups will be able to have access to the medicine at an earlier stage in its development, and before formal granting of market authorisation. The development of 15 Academic Health Science Networks in 2013 is another example. These bring together the clinical, academic and business communities in an effort to develop and systematise innovations more quickly.

1.6. Development and use of standards and guidelines

Standards and guidelines describing best practice care are well-established in the NHS and appear widely-used. In particular, the National Institute for Health and Care Excellence is an internationally recognised pioneer in the field of health technology assessment and dissemination of practice guidelines, that many countries have looked to when strengthening these functions in their own health system. Nevertheless, more could be done to support patients and carers to better use clinical guidelines and standards as partners in their care.

Newly introduced fundamental standards of quality and safety apply to every health care provider in England

The Care Act 2014 set in legislation the fundamental standards of care that providers must meet. New Fundamental Standards regulations will come into force for all providers of health and social care in April 2015. The new fundamental standards are:

- Care and treatment must be appropriate and reflect service users' needs and preferences.
- Service users must be treated with dignity and respect.
- Care and treatment must only be provided with consent.
- Care and treatment must be provided in a safe way.
- Service users must be protected from abuse and improper treatment.
- Service users' nutritional and hydration needs must be met.
- All premises and equipment used must be clean, secure, suitable and used properly.
- Complaints must be appropriately investigated and appropriate action taken in response.
- Systems and processes must be established to ensure compliance with the fundamental standards (good governance).
- Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
- Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed.

- A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity (Duty of Candour).

These standards are useful in that they address the principles of good care, and are applicable in all care encounters. Coupled with the expected outcomes of care that are specified in the NHS Outcomes Framework, they offer a clear map for what NHS care should look like and achieve. One criticism, however, as with the NHS Outcomes Framework, is that the Fundamental Standards do not directly address the integration of care. Fundamental standards, such as the need for safe transitions of care, are not explicitly included. This is in contrast to fundamental standards established in other OECD health systems, such as Australia's (see Box 1.6).

Box 1.6. Australia's National Safety and Quality Health Service Standards

Australia's Commission on Safety and Quality in Health Care published a set of service standards in 2011. They are more limited than England's standards since they apply only to hospital care. They also focus on the processes of high quality care rather than the principles, as England's do. Nevertheless, they are an important advance in thinking about the fundamentals of health care quality in the hospital setting, useful and applicable to all OECD health systems. The ten standards address:

1. Governance for Safety and Quality in Health Service Organisations, and specifically the quality framework required for health service organisations to implement safe systems.
2. Partnering with Consumers, and specifically the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.
3. Preventing and Controlling Healthcare Associated Infections, and specifically the systems and strategies to prevent infection of patients within the health care system and to manage infections effectively when they occur to minimise the consequences.
4. Medication Safety, and specifically the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.
5. Patient Identification and Procedure Matching, and specifically the systems and strategies to identify patients and correctly match their identity with the correct treatment.
6. Clinical Handover, and specifically the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.

Box 1.6. Australia's National Safety and Quality Health Service Standards *(cont.)*

7. Blood and Blood Products, and specifically the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.
8. Preventing and Managing Pressure Injuries, and specifically the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.
9. Recognising and Responding to Clinical Deterioration in Acute Health Care, and specifically the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.
10. Preventing Falls and Harm from Falls, and specifically the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

Source: http://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/.

NICE is an internationally recognised pioneer in the development of practice guidelines.

The National Institute for Health and Care Excellence (NICE) is an internationally recognised pioneer in the development of practice guidelines, publishes national guidance and advice to help improve health and social care in England. This guidance covers four broad areas: the use of health technologies and health technology assessment; clinical practice; guidance on health promotion and prevention; and guidance for social care. NICE's guideline assessment process includes an assessment of the available effectiveness and economic evidence. Each published guideline is disseminated to all registered stakeholders and relevant national leads, and published online.

NICE also produces Quality Standards, which are usually based on NICE guidelines, but can also draw on other NICE accredited sources. The Quality Standards are a concise set of prioritised, specific, precise and measurable statements, designed to drive and measure priority quality improvements within a particular area of care. For instance the quality standard for "Diabetes in adults" includes quality statements, linked to a quality measure, across 14 areas including nutrition and physical activity advice, care planning, glycaemic control, medication and psychological problems. The Health and Social Care Act (2012) places a duty on NHS

England to have regard to NICE Quality Standards and commissioners have to refer to them in the planning of services they commission according to their population needs.

Compliance with Quality Standards is monitored through a range of mechanisms – depending on the specific Quality Standards – which are designed to drive quality improvement in the NHS. These include national clinical audits funded by NHS England, the *Best Practice Tariff* (see Section 1.10)*,* CQUIN (see Section 1.10) and the *Clinical Commissioning Group Outcome Indicator Set* (see Section 1.7). The *National Clinical Audit and Patient Outcomes Programme* (NACPOP) supports the local monitoring of relevant NICE clinical guidelines and quality standards, seeking to reflect emerging health policy and best practice defined by NICE in the selection of topics for national clinical audit.

Standards, guidelines and new models of care increasingly reflect the patient pathway, but more could be done to ensure that they are understood and used by patients and carers

NICE clinical guidelines increasingly relate to a whole pathway, making recommendations which span all stages of care from diagnosis to treatment. A large number of other NHS initiatives also aim to improve the co-ordination and integration of care for particular patient groups. These include:

- Strategic Clinical Networks which bring together clinicians, providers and commissioners in one locality to improve pathways of care for particular patient groups, for example children and young people with asthma.
- NHSIQ's Integrated Care and Support Pioneers programme, which encourages local areas to demonstrate the use of ambitious and innovative approaches to deliver person-centred, co-ordinated care and support.

Although NICE guidelines and these initiatives are increasingly developed with the patient perspective in mind, key stakeholders have reported that more could be done to ensure that they are oriented toward patients and used by them. A limited number of patient-decision aids, for example, are available through the Right Care Programme, and NICE has recently published two and endorsed several others. These should be extended, better publicised and better integrated into the websites and software used by clinicians and patients to encourage their use. This will be particularly important for patients with chronic conditions who make use of community and social care services. In many cases, these services may be paid for by patients themselves, out-of-pocket. Hence, ensuring that the standards and guidelines that describe best-practice care are understandable to the consumer is vital.

1.7. Development and use of quality indicators and other performance data

Over many years, the English NHS has developed an extensive array of quality and outcomes indicators across most spheres of its activity and, more recently, the Health and Social Care Act 2012 stressed the importance of framing quality in terms of the outcomes that are achieved for patients. The design, collection, analysis and dissemination of quality indicators has been led as much by professional groups as by government and is enabled by the relatively sophisticated information infrastructure that underpins the NHS. Perhaps as a result of this long history and capability, however, the range, format, reporting level and frequency of indicators used across the NHS is now extremely complex. At the same time, the lack of indicators pertaining to community services and the interfaces of care is a deficit that needs to be addressed.

An extensive array of indicators of the quality of care exists

Key sets of indicators to monitor health system performance and outcomes, such as the NHS Outcomes Framework, the Clinical Commissioning Group Outcomes indicators (in Section 1.2), and the CQC's "intelligent monitoring" set of 150 indicators (in Section 1.4), have already been discussed. An *Acute Trust Quality Dashboard* has been developed to provide a provider-level view of certain key quality indicators to inform discussions within local Quality Surveillance Groups. In addition, a system of Quality Dashboards exists, exhibiting additional data for specialist clinical areas such as renal dialysis, or child and adolescent mental health. These dashboards are intended to provide additional real-time (quarterly) data at hospital level, to support clinicians and commissioners in monitoring the quality and outcomes of particular services. At a higher level, the *NHS England Quality Dashboard* provides a summary overview of trends and outliers. Benchmarking with peers allows identification of Trusts that are statistically worse than their peers in England for a particular indicator. Indicators include waiting times for cancer diagnosis and treatment, hospital mortality ratios, hospital acquired infections and other adverse events, cancelled operations rates, PROMs and Friends and Family Test outcomes. NHS England also requires health care providers to prepare *Quality Accounts*. These public facing documents published by each provider annually alongside their financial accounts offer a synthesis of quality of care data, including providers' participation in national clinical audits and data on key quality indicators (see also Section 1.8).

In addition to these reporting frameworks, the Health and Social Care Information Centre (HSCIC) manages an indicator portal. This includes the *NHS Choices Dataset*, which is oriented toward patients and is intended to support transparency. *MyNHS* is a public-facing website that draws upon these data to provide information on the performance of services (hospitals, GP practices, etc.) and consultant outcomes across 12 specialties. It includes indicators of the quality and safety of a hospital, as well as information about facilities provided, such as the cost and availability of car parking. Patient feedback measures are also included. The HSCIC also produces the *Summary Hospital-level Mortality Indicator* (SHMI), which was used to identify hospitals with persistently high rates, examined in the Keogh Mortality Review. Variable Life-Adjusted Display (VLAD) charts can be used to visualise the SHMI at patient level within diagnosis groups for individual NHS trusts, and is intended to allow visualisation of patient outcomes in a more detailed way than national cross-sectional aggregate reporting of the SHMI.

There is also a set of over 60 national audits, in part carried out by HQIP (see Section 1.7), in part led by the Royal Colleges or professional bodies. In December 2014 the HQIP provided a report on self-reported quality assessment of the national clinical audits, observing encouraging indications of the impact of the audits through reported use of audit data at various levels in the system to inform quality improvement and dissemination of audit outcomes. For example, the National Joint Registry (which is managed by HQIP, collects information on joint replacement surgery and monitors the performance of joint replacement implants across England, Wales and Northern Ireland) provides annual audit findings and in-depth studies.

An advanced information infrastructure enables relatively sophisticated quality monitoring

Compared to other OECD health systems, England has a particularly strong infrastructure for the collection, analysis and dissemination of health data. 87% of patients now have an electronic *Summary Care Record*, which has information on medications, contraindications and allergies. It is available across the health care system, although most use occurs in the hospital pharmacy, community and intermediate care sectors, and in out-of-hours GP care. Extension to emergency care services is being piloted.

Primary care information systems are particularly advanced. Electronic prescribing is common, nearly all laboratory results and most correspondence is now electronic, and diagnostic and procedure coding is also widespread. A variety of coding systems continues to be used, however (such as SNOMED or READ codes). The *GP 2 GP* system allows complete GP held records to be transferred from one practice to another electronically, regardless of the practice system. Increasingly, patients are able to book appointments and request repeat prescriptions on-line or, in some cases, seek clinical advice.

A 2012 document entitled *The Power of Information* set out a long-term vision for how individuals' clinical records could best be used to support their care, including self-care, and support wider societal goals such as research and innovation. Better linkage of data across clinical and administrative databases, whilst protecting data privacy, was identified as a crucial step to make future progress. The *care.data* initiative was set-up in response to this report, with the aims of supporting patient choice, improving outcomes, increasing accountability and driving economic growth through world-class health services research.

The legislative framework for health information governance was also strengthened. Provisions in the Health and Social Care Act 2012 were designed to clarify the role of the Health and Social Care Information Centre so that information can be collected, held securely and made available to those who need it, with safeguards in place to protect individuals' data. The Health and Social Care (Safety and Quality) Act 2015 also makes provision about the integration and sharing of individuals' information for the purposes of providing health or social care services.

The National Information Board (NIB) "Framework for Action: Personalised Health and Care 2020 Using Data and Technology to Transform Outcomes for Patients and Citizens" was published in November 2014. It considered what progress the health and care system has already made in using data and technology to transform outcomes and what can be learnt from other industries and the wider economy. It sets outs how frontline staff, patients and citizens can take better advantage of digital opportunities.

Efforts are made ensure indicators' translation into action, but dissemination and publication could still be improved

Considerable effort is made to ensure that data are not collected for data's sake. The quality indicators described above map onto NICE quality standards and guidance as far as possible, for example. The *Indicator Assurance Service* of the HSCIS also validates indicators and reviews their clarity and consistency, in order to avoid duplication or inconsistency across indicator sets. Regular reviews of the scope and consistency of NHS indicators is intended to identify opportunities for further consolidation and more streamlined internal and public reporting.

Nevertheless, more could be done to improve the accessibility and use of quality related indicators. At the moment, quality data is published by the HSCIC, NHS Choices (*MyNHS*), the CQC, HQIP and other audit studies. NHS England also intends to publish quality statistics and NICE will shortly be publishing information from audits relevant to its recommendations. This is a complex array of platforms and health service managers, clinicians, academics and patients report finding it confusing. The HSCIC, which might be regarded as the primary platform for accessing NHS data, has a dense website that is more of a catalogue than an easily navigable source of information. There is scope to consolidate and simplify how health care quality and performance data is published therefore. The approach taken by the Canadian Institute of Health Information, that prioritises the clarity and attractiveness of health system performance data as well as its validity, should be considered (see Box 1.7). Sweden's *Quality and Efficiency* publication (Box 1.1) is another good example of complex health system data being made relevant and accessible. It takes the format of a book, and twins graphical representations with clear textual explanations of each performance indicator. The publication has gone through seven editions using a consistent format which increases its usability.

Box 1.7. Dissemination of health system performance data in Canada

The Canadian Institute for Health Information consolidates and publishes health system performance data on the yourhealthsystem.cihi.ca website. Simple definitions of technical terms (such as "Getting needed care at the right time, without financial, organisational or geographical barriers" for access) and questions (such as "Are Canadians actually getting healthier?") are the predominant tools used to guide users around the website.

The *In Brief* section of the website focuses on five themes that prior research revealed were of most interest to Canadians: access, quality, spending, prevention and outcomes. The *In Depth* section uses 37 indicators to go into more detail, as well as providing descriptive data of health service resources and activity. The indicators in this section cover all dimensions of health system performance, including quality (such as readmission rates or restraint use in long-term care), efficiency (such as the cost of a standard hospital stay), access (such as waiting times for emergency physician assessment) and prevention (such as smoking and obesity rates). Results are available by province, territory, region, city or hospital and infographics are used to convey statistical information, including benchmarking against regional and national averages.

More needs to be done to measure quality in community services

In common with the majority of OECD health systems, most of England's quality indicators relate to acute, hospital-based services. This is typically because the processes and outcomes of hospital-based activity are relatively easily observed. In contrast, primary and community care services are less procedural. The aspects of quality that are valued in these domains – continuity, comprehensiveness and co-ordination – are less amenable to minimum standards and guidelines, and less visible to data systems. Whilst true that England's Quality and Outcomes Framework is a better primary care quality monitoring system than is seen in the majority of OECD health systems, performance monitoring in primary and community services still relies on one-off, summative approaches of minimum standards and performance. The QOF demonstrates this.

The situation in community services (such district nurses, health visitors, community mental health services, community paediatric services, physiotherapy or occupational therapy) is worse. A recent study by the King's Fund found that, while some community health care providers had quality measurement systems in place, there were very few robustly comparable national indicators of quality in this sector. Lack of valid measures was compounded by a lack of technology and data systems to support quality measurement. Yet, risks were significant. The report concluded that high caseloads and staff shortages jeopardise the quality of care, particularly given the increasingly complex needs of many community care. Development of a standardised individual-level data on needs and outcomes, more measures of the quality of care, and better support for community service workers to engage in continuous quality improvement were recommended (King's Fund, 2014).

More needs to be done to develop appropriate quality standards, guidelines and metrics for the community care sector, with a consistent monitoring regime to enable quality gains to be assessed. As stated in Section 1.2, relevant indicators should be brought into the NHS Outcomes Framework as soon as they are identified. Efforts should also be made to move toward a more continuous and proactive model of quality monitoring and improvement in community services. The extension of the Friends and Family Test to GPs (described in Section 1.9) and community services should be closely evaluated, to ensure that these services find the Test useful in knowing where and how to make improvements. Recently established Quality Surveillance Groups are another means to monitor and take action to improve quality in a richer, more continuous way. Currently, however, there is a very variable approach across QSGs in how they approach these tasks. Some have developed Quality Dashboards (as described earlier in this section) capturing referral rates, complaints, prescribing patterns and other “live” data, others have not. Work is needed to encourage proactive monitoring across all QSGs and ensure that the most promising approaches are widely taken up. Work on national Quality Dashboards for primary and community care services should also accelerate. MyNHS has made a start in this area, but data remains unavailable for many indicators in the primary care domain.

Renewed focus on quality at the interfaces of care is also needed

Important interfaces of care exist between primary care and secondary care, between health care and social care, between mental health care and other health care services and between public health activities and clinical care. These interfaces represent critical points in a patient’s pathway, where effectiveness, safety and patient-centredness may lapse, and they are under-addressed in England’s current quality architecture.

Plans to apply an assurance framework to CCGs may partially fill this gap. This will be underpinned by a set of delivery metrics focussed on aspects such as digital record keeping and transfers of care, with particular attention to five population groups: the generally well, people with long term conditions, people with mental health problems or learning disabilities, children and young people, and the frail elderly. Promoting integration is one of the broad objectives of Commissioning for Quality and Innovation (CQUIN). The 2015/16 scheme is structured so that the national goals reward transformation across care pathways that cut across different providers.

Initiatives such as Strategic Clinical Networks and the Better Care Fund are also very promising avenues to better integrate care. Local reconfigurations around the co-ordination and integration of services should not be just about joining organisations, however. A patient-centred, outcome-based view is essential; hence local initiatives must also prioritise effective patient involvement, better multidisciplinary team-work and wider use of individual care plans. Individual budgets, again something that England has pioneered amongst OECD countries, are a powerful idea to drive better co-ordination and integration from the bottom-up. Continued experience with their use should be encouraged, ensuring close evaluation (particularly with respect to whether local choice and competition helps or hinders the co-ordination of care). Making sure that patients and carers have the right support to make use of them effectively will also be necessary.

One approach to better integrating care, around which England has innovated less, concerns the creation of new professional roles and service configurations in primary care. Innovations in GP roles are well-established in Scandinavian health systems, for example, and have been found to promote co-operation and better communication between primary and secondary care (see Box 1.8). England, as signalled in the recently published NHS Five Year Forward View, should look to international experience to innovate more extensively in this area than in has in the past.

Box 1.8. New roles to support better integration of care in Denmark and Norway

Praksiskonsulenterordningerne (PKO), sometimes referred to in English as "General practitioner advisors in hospitals", began on the Danish island of Fyn in 1991. Broadly, these are GPs who are employed part-time (between 5% and 40% full-time equivalent) by a hospital, to support the co-ordinated management of patients with multiple health care needs, at the same time as developing local reforms to support co-ordination across pathways involving primary and secondary care more generally (by improving communications and information flows, for example). An evaluation of the PKO scheme in Denmark reported positive impacts found on co-operation and communication between primary and secondary care. Efforts to achieve greater integration between health and social care have also focussed on attaching GPs to municipality social services departments. As for PKO, a bimodal pattern of work managing individual cases whilst pursuing broader organisational integration is typical.

PKOs have existed in Norway for a similar length of time. In addition, Norwegian GPs (who are nearly all independent contractors) are required to spend 7.5 hours/week on municipality activities, such as school health and nursing homes. This brings them into regular contact with the broader health economy.

Source: OECD (2013), *OECD Reviews of Health Care Quality: Denmark 2013 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264191136-en; OECD (2014), *OECD Reviews of Health Care Quality: Norway 2014 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264208605-en.

The CQC's intention to undertake cross-cutting reviews of care for particular patient groups (such as the elderly) also offer a promising avenue to address quality in community services and across transitions of care. Lessons from these reviews (regarding both quality monitoring and quality improvement) should be distilled and disseminated as a priority.

1.8. Public reporting of quality and performance

Linked to the relative richness of data that England has available for monitoring performance of many parts of its health system, the public reporting of quality and performance is also extensive. Open reporting has long been an important part of the English approach to quality improvement and England has gone further than many OECD health systems in terms of the volume and detail of the data that it makes available. Benchmarking outcomes, particularly at very granular levels of analysis (such as individual surgeons) must be undertaken with care, however, particularly if contextual factors are poorly understood. Similarly, performance indicators should be viewed as signals of potential excellence or concern that merit further scrutiny, rather than employed as absolute verdicts of good or bad quality.

Transparency and public reporting is a extensively implemented across the English NHS

Few, if any OECD health systems can match the volume and detail of openly published health system performance data that exists in England. England was one of the first OECD countries, for example, to publish individual surgeons' mortality rates. The *NHS Choices* website now publishes data on the outcomes of surgeons' care for 12 surgical specialities, with plans to extend this to other surgical and medical specialities, including cancer care. Currently, data shows how many times a consultant has performed a particular procedure and, in many instances, includes other quality measures such as length of hospital stay, re-admission rate, complication rate, adverse events and mortality rates. Importantly, the data is published in conjunction with surgeons' professional/academic societies (see http://www.nhs.uk/service-search/performance/Consultants). In a similar vein, the primary care performance data for individual general practices collected through the QOF have always been publically available.

The volume and variety of performance data and quality assessments made publically available is extensive. All NHS providers (including those in the independent sector), for example, are required to publish a *Quality Account*. This gives an assessment of the provider's quality of service and capacity for continuous quality improvement, as well as describing processes for internal quality monitoring and for responding to checks made by regulators such as the CQC. Statements from local patient representative groups and wider stakeholders, such as Health and Wellbeing Boards, may also be included. In addition, Foundation Trusts may publish a *Quality Report* to satisfy additional reporting requirements imposed by Monitor, the economic and competition regulator. Beyond these documents, the NHS Outcomes Framework, referred to earlier, publishes the indicators used to demonstrate improvements in health outcomes and the Summary Hospital-level Mortality Indicator (SHMI) reports mortality at trust level. Finally, the CQC also publishes data from its on-going surveillance of acute and specialist NHS Trusts and primary care providers, as described in Section 1.4. At national level, the CQC also publishes an annual *State of Health Care and Adult Social Care in England* report which summarises findings from its work inspecting and rating care services. *NHS Atlases of Variation in Healthcare* illustrate regional differences in indicators of quality and value, including for specific clinical areas such as kidney disease or children's services.

Open comparison of performance, however, should be undertaken advisedly and sensitively

England has already implemented public reporting and transparency more extensively than most OECD health systems. As discussed earlier, the challenge will be to make sure that such information is used as a positive incentive to encourage ever better performance, rather than being perceived as a mechanism to punish apparently bad performers. Even well-intentioned policy initiatives can risk coming across as heavy-handed and judgmental. For example, a recent initiative marks out GPs with low reported rates of cancer referrals in "red" categories. The intention of this is to serve as a signal of good performance or cause for concern, and there is a good case for being as transparent as possible about the performance of all health service providers. However, the use of a "red" category, for only one particular aspect of performance, risks being seen as "punishing" GPs. Benchmarking schemes should not need to seek to categorise professionals in this way, recognising that a single metric such as referral rate has multiple determinants (including local epidemiology or patients' health care seeking behaviour) and that virtually no professional willfully sets out to perform worse than peers. The reasons that underlie poorer performance require understanding and remediation as part of a culture that emphasises learning rather than blame.

Similarly, given the significant limits to any performance indicator's validity and comparability across reporting units, indicators should be viewed as *signals* of potential excellence or concern. Such signals invite further scrutiny, to understand the extent to which they reflect the true level of performance, and/or reflect chance, bias or confounding. The impression that quality indicators can serve as failsafe, final verdicts of good or bad quality should be avoided.

The set of actors involved in performance reporting, and in England's quality architecture more broadly, appears both congested and fragmented

The range of actors responsible for monitoring, reporting and improving the quality of care in England is unusually large, and some parts of the institutional landscape appear particularly congested. As described in Sections 1.2, 1.3, 1.4 and 1.7, this is particularly true of the inspection regime and performance monitoring frameworks. At a population level, organisations with cross-sectoral objectives and activities are held accountable to multiple, disconnected performance frameworks. Similarly, health care providers, who must optimise performance against multiple clinical, financial and governance objectives, are regulated by CQC and either Monitor or the Trust Development Authority on distinct parts of their work. Professionals working together within an institution are regulated by several different authorities, reducing the possibilities for sharing intelligence and observing patterns of practice within a provider or local area. Quality reporting appears particularly fragmented, with relevant data published by the HSCIC, NHS Choices, NHS England, the CQC, HQIP, NICE and professionally-led national audit studies.

Fragmentation is also apparent in planning at local level. CCGs are supported by Commissioning Support Units, Strategic Clinical Networks, and Clinical Senates. Commissioning Support Units offer strategic decision making around, for example, service redesign. Strategic Clinical Networks focus on priority service areas – for example cardiovascular, mental health, cancer – and also advise local commissioners. SCNs are meant to take an integrated, whole-system approach, but given that their focus is on particular disease areas, this may be incompatible. At the same time, Clinical Senates, led by clinicians, also help strategic commissioning and decision making. There are also incongruities in how quality agencies map out their activities at local level. The (current) 27 Quality Surveillance Groups do not map onto the 211 Clinical Commissioning Groups, for example. And whilst CCGs' primary lens for thinking about the quality of care is population-based, the CQC applies an institution-based lens to quality assessment. A review of NHS England's improvement and change capability, including gaps and duplication in the current architecture, is currently underway.

There is scope to consolidate the institutions and policies responsible for assuring, monitoring and improving quality of care

Partly as a result of England's long-established commitment to demonstrating and improving health care quality, the number of agencies, policies, reviews and recommendations which aim to assure, monitor and improve the health care quality is now very large. There have been attempts to consolidate the approach. The Fundamental Standards of Care, for example, are easily understood, relatively few in number and universally applicable. Likewise, the domains addressed in the NHS Outcomes Framework have the virtues of being simple and clear, whilst being applicable at every level of the NHS.

Nevertheless, England's quality architecture remains complex. It also seems unlikely that most local service managers or ward sisters, for example, would be fully cognisant of the objectives of HQIP, NHSIQ, the National Quality Board and other national and local quality bodies, or of the main recommendations in, for example, the Francis Report, Keogh Review, Berwick Review, Cavendish Review, Winterbourne Review, Whistleblowing Review or the government's responses to them. This is a shame since local service managers, ward sisters and their colleagues are *exactly* the people who should be entirely clear about the system's quality improvement priorities and means to achieve them.

There is scope, therefore, to simplify and align England's quality architecture, to ensure that it is as simple, clear and coherent as possible. England should consider how it could move towards having one body more clearly identified with each stage of the *plan-do-study-act* cycle of quality improvement, at national as well as local level. In terms of "planning", it would be worth examining whether Commissioning Support Units, Strategic Clinical Networks, and Clinical Senates each make separate and substantive contributions to the work of CCG and Health and Wellbeing Boards. In terms of "doing", the operational frameworks which guide clinicians and managers should be consolidated. Greater alignment should be sought between the NHS, Adult Social Care and Public Health Outcomes Frameworks, with the eventual ambition, perhaps, of merging them into one unified health and social care outcomes framework. More fundamentally, the five domains addressed in the NHS Outcomes Framework (Figure 1.2), underpinned by the Fundamental Standards of Care should form the nucleus of a conceptual framework for quality that is communicated consistently; understood by all managers, clinicians and patients; and implemented in a sustained manner across all services.

In terms of "studying", a simpler and more user-friendly interface for health and social care information should be developed, mirroring what has been achieved in Canada and Sweden. In terms of "acting", England has already taken steps to simplify the regulatory framework by announcing the bringing together of Monitor and the Trust Development Authority under a single leadership. Further consolidation and alignment would be welcome. For example, closer integration with the GMC, NMC and other professional regulators should be sought because professionals' practice cannot be separated from their organisation. Evidence of poor professional training or performance may in fact be a signal of a struggling organisation. An example of a more consolidated approach comes from the Netherlands. There, the *Inspectie voor de Gezondheidszorg (*IGZ or "health care inspectorate") was formed in 1995 by bringing together three separated fields of inspection relating to health care, pharmaceutical care, and mental health care. The IGZ is also authorised to bring proceedings to disciplinary courts against individual practitioners and may make referrals to the Medical Supervision Board to assess whether practitioners are fit to practice. The quality architecture in Norway exhibits a more streamlined approach, as well as a lighter-touch governance model (Box 1.2).

In particular, when a quality concern is identified, an aligned and joined-up response from the relevant local and national authorities is required. Clinicians and managers have reported that these agencies are "quick to react, but not always in a co-ordinated manner".[2] As national authorities in England take steps to streamline its regulatory framework (by more clearly defining the roles of the CQC and Monitor, for example) it will be important to ensure that the perspective of the frontline users and providers of care is put first.

1.9. Patient and public involvement in improving health care quality

There are multiple avenues through which the NHS has sought to better involve patients in their care and contribute to the health care quality agenda. A wide-ranging set of patient surveys allows patients to give feedback on the services they have received, alongside more innovative measures such as Patient Reported Outcome Measures and the Friends and Family Test. Opportunities to influence policy making are also built into the system, nationally and locally. Most recently the National Quality Board (NQB) published a report *Improving experiences of care: Our shared understanding and ambition*, which sets out a common way for the national health and care organisations to talk about people's experiences of care and their roles in improving them (http://www.england.nhs.uk/ourwork/part-rel/nqb/). Wide-spread implementation of choice and competition as a tool to drive quality improvement is a particularly distinctive feature of the English NHS. Innovation continues in this area although concerns that choice and competition may fragment services will need to be addressed.

English patients are explicitly encouraged to give regular feedback on NHS services

Few if any other OECD health systems are able to replicate the opportunities that English patients have to give feedback on their care. England has perhaps the most extensive set of regular, national patient surveys of any OECD health system. These include the GP Patient Survey, which collects feedback from over 900 000 individuals every year, the annual Inpatient Survey, the Outpatient Survey, the Maternity Services Survey, the Community Mental Health Survey, the Accident and Emergency Survey, the Cancer Patient Experience Survey and the National Survey of Bereaved People About End of Life Care.

The *Friends and Family Test* (FFT) was introduced in 2013. This asks patients in acute in-patient, Accident & Emergency and maternity settings if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the

FFT provides a mechanism to highlight both good and poor patient experience. The Test is believed to be useful since it provides real-time, service-level feedback. A recent review concluded that the test was performing well as a service improvement tool, with 85% of trusts reporting that it is being used to improve patient experience, and 78% saying that it had increased the emphasis placed on patient experience (NHS England, 2014b). The main finding from the review was that it was often the qualitative feedback (from the free text option) that was the driver of improvement. Use of the Friends & Family Test will be expanded to other services, such as general practice, mental health and community services in 2015. Another innovation concerns the *Patient-led Assessments of the Care Environmen*t (PLACE) test. This takes place each year, and applies to hospitals, hospices and day treatment centres. The test looks at how the environment supports patient’s privacy and dignity, food, cleanliness and general building maintenance.

Complaints from patients and carers are seen as a valuable source of learning and opportunity for service improvement, and a number of steps have been taken recently to improve the speed, effectiveness and consistency with which complaints are resolved across the NHS. All providers of NHS-funded care must have a designated officer responsible for handling complaints. It is expected that most complaints will be resolved at this local level, within six months. General assistance to complainants is offered by *Patient Advice and Liaison Services* (available in most hospitals) or, specifically, by Independent NHS Complaints Advocacy Services (commissioned by local councils). The quality of complaints handling has been included in CQC inspections since 2014, and quarterly publication of hospital complaints data is expected to start this year. The more recent initiatives have been spurred in part by a Complaints Programme Board set up by the Department of Health in response to the Francis Report, comprising partners from across the care system, and used to support the drive to improve NHS and adult social care complaints handling across England.

England, along with Sweden and some health systems in the United States, has also pioneered the use of patient experience measures, and patient reported outcomes measures (PROMs). These measure health status or health-related quality of life before and after hip replacements, knee replacements, groin hernia and varicose vein repair. PROMs are mandatory for these four procedures, and support both individual clinical care as well as quality assessment of local services. They are intended to calculate health gain, as measured from the patient’s point of view, as distinct from an assessment of the health care experience. PROMs are included in the NHS

Outcomes Framework; few other OECD health systems use patient reported outcomes in this systematic fashion.

More broadly, English patients have an unusually rich set of means to give feedback to service providers. A number of different types of online feedback mechanisms are available to patients, including on-line ratings sites such as NHS Choices (and *MyNHS* pages within NHS Choices), *Care Connect, Patient Opinion* and *iWantGreatCare*; on-line patient story sites, such as *HealthTalkOnline* and *Patient Voices*; and general social media platforms, such as *Patients Like Me*.

Patients' also have opportunities to influence policy making

The patient and service-user voice is well-organised in England. *Healthwatch England* is the statutory organisation which represents users of health and social care. It is a large organisation with 650 employees and 7 000 volunteers that, through national and local branches, identifies communities' concerns and priorities. It is formally represented on Health and Wellbeing Boards, so is able to scrutinise local commissioning plans. At national level, the organisation is entitled to scrutinise the work of NHS England, the CQC, Monitor and other key actors. Legislation protects its right to express concerns, responses to which have to be placed on the public record.

National Voices is a coalition of health and social care charities that represents patients, service users, carers, their families and voluntary organisations. It works directly with national decision makers and participates in most high-level policy forums. A particular priority is to develop more effective integration of health and social care services, particularly at local level. To that end, it has developed a set of narratives that describe person-centred, co-ordinated care from the patient's point of view ("I could decide the kind of support I needed and how to receive it" is an example). These are intended to help local areas set their visions and outcomes for integration. National Voices has also brought together evidence on effective ways of implement person-centred care, drawn from 779 systematic reviews (www.nationalvoices.org.uk).

NHS Citizen is a project that aims to answer a simple question: what is the best way for NHS England to take into account the views of all the public when it makes decisions? The project aims to encourage the public to be actively involved at the very heart of the organisation to help solve long-term problems, deal with ongoing issues and take part in its decision making. NHS England wants everyone in England to have the opportunity to participate in the open design process for this new collaborative model, which commenced with design workshops in July 2013 and January 2015 (see http://www.nhscitizen.org.uk/)

Other examples of how patients and the public are well integrated into national policy include the Public Involvement Programme at NICE, which supports lay people's involvement in developing and implementing specific guidance or quality standard topics and the development of the lay versions of NICE guidance. The CQC always uses lay members of the public in its inspections ("Experts by Experience"), and seeks public views to steer its overall strategy and work. Likewise, the GMC, whose Council was previously constituted by 106 members elected by the profession, now has a much reduced Council of 12. All are appointed through an independent appointments process, and half are lay members.

Patient choice is widely applied, but care is needed to ensure that competition does not lead to fragmentation of care

Patient choice and competition have long been seen as key drivers for quality improvement in the English NHS, since at least the NHS Plan in 2000. More recently, the Choice Framework brings together information about patients' rights to choice about their health care, where to get more information to help make a choice, and how they can complain if they have not been offered choice. Patients are entitled to choose GP, specialist out-patient and in-patient services, maternity care and community services. Patients defined as receiving "continuing care" are also entitled to request a personal health budget. With the support of clinical professionals, this allows them to specify the health outcomes they want and the services they need to help them achieve those outcomes.

The quality related data provided on the NHS Choices website (*MyNHS*) is taken from existing publications and is presented in a way that is meaningful to patients and the public. For example, the data on safety covers ward staffing levels, infection and cleanliness information and CQC ratings, amongst other indicators. This information is intended to be used by patients to choose high performing services and to hold services to account, thereby driving continuous quality improvement. The same information is also used by Parliament, the media and other organisations engaged in health service scrutiny.

Choice and competition is an increasingly used tool across OECD health systems. Typically, however, reforms are directed at fostering competition between hospitals and less often amongst primary care providers. England's adoption of the choice and competition agenda across all health services thus reflects one of the broader and more ambitious approaches being seen in OECD health systems. Some evidence supports the view that choice and competition can lead to quality gains (Gaynor et al., 2013; Pike, 2010). The risk has also been pointed out, however, that a market place of providers offering disparate individual services may threaten geographic equity of care or could discourage the co-ordination and integration of care (OECD, 2013c). A recent study evaluating extended choice and competition in Swedish primary care by the National Audit Office found greater availability, but apart from that mainly negative impacts. Costs were not contained, service innovation was not apparent and the greater accessibility of care was mainly enjoyed by patients with minor care needs and a higher socioeconomic status, disadvantaging those with greater needs (Swedish National Audit Office, 2014).

The lack of quality and outcomes indicators in community care, as discussed in Section 1.7, means that monitoring impacts from increased choice and competition will be particularly difficult in this sector. As the choice and competition agenda continues to be developed, therefore, parallel work will be needed to develop appropriate quality standards, guidelines and metrics (particularly in the community care sector), with a consistent monitoring regime to enable quality gains to be assessed.

Patients and professionals must work together to drive quality improvement from the bottom-up

Together, the set of initiatives to strengthen the patient's voice and user choice seek to make patients equal partners with clinicians in how health care is delivered in the English NHS. This is important because providing a positive experience of care is probably the most challenging dimension of quality to achieve – achieve it, and the other dimensions of quality will follow.

England has led the way on many initiatives to empower patients and involve the more closely in their care. More could be done though. In terms of planning, a limited number of patient-decision aids are available through the) *Right Care Programme*, and NICE has recently published two and endorsed several others. These should be extended, better publicised and better integrated into the websites and software used by clinicians and patients to encourage their use. Individual care plans, currently underutilised, should also be encouraged. Training, for both clinicians and patients, on how patient decision-aids and individual care plans can improve care should be easily accessible. In terms of monitoring care, continually greater emphasis should be placed on measuring outcomes, including the experience of care. England already does well on this front – the challenge is to make sure that collecting these measures reflects patients' active rather than passive involvement in care. Patients and their carers could also be made more active partners in efforts to improve health care safety, as described in Section 1.10.

1.10. Use of financial incentives to improve quality

The application of financial incentives to drive quality improvement is a good example of how the NHS has not been afraid to innovate and experiment with new approaches to quality improvement. England applies financial incentives targeted on quality gains relatively extensively and in a sophisticated manner. As innovation continues in this field, however, the impacts of less familiar scheme designs will need to be closely evaluated.

Financial incentives are a widely deployed tool to drive quality improvement

Widespread use of financial incentives (and sanctions) is another distinctive feature of the English policy landscape. Several financial incentive schemes exist, targeted to multiple actors at different levels of the system, each aiming to drive up quality. At area level, the *Quality Premium* (worth GBP 270 million) is directed to Clinical Commissioning Groups and the *Better Care Fund* (worth GBP 3.8 billion) is directed to Clinical Commissioning Groups and Local Authorities (and are described in more detail below). In secondary care, the *Commissioning for Quality and Innovation* (CQUIN) Fund is worth GBP 1.75 billion and seeks to identify improvements in a mixture of nationally and locally determined clinical priorities. Contract sanctions may also be applied to secondary care providers, if national standards (around waiting times, health care acquired infections or the duty of candour, for example) are breached. In primary care, the Quality and Outcomes Framework (worth GBP 1.1 billion) is an internationally well-known scheme to improve processes and outcomes in general practice.

The Quality Premium and Better Care Fund both illustrate the degree of sophistication that characterises the application of financial incentives in the English NHS. The Quality Premium is voluntary, but all CCG participate in practice. The scheme is developed by NHS England but requires cross-government approval. The Treasury, for example, is particularly engaged and requested that a wider range of mental health measures be included for 2015/16. The national measures are demanding, high-level objectives and currently specify a reduction in potential years of life lost, improved access to psychological therapies, a reduction in avoidable emergency admissions, improved reporting of medication-safety errors and improvements in patients' experience of care (se e http://www.england.nhs.uk/ccg-ois/qual-prem/).

The Better Care Fund aims to promote integration across health and social care services and, in particular, prevent unnecessary hospital admissions. Requirements include better data sharing across agencies, provision of 7-day a week social services to support discharges and prevent admissions at weekends, designation of accountable lead professionals in integrated care packages and measures of patient/service-user experience. Operationalisation of these plans, however, must be locally determined and agreed between the CCG, Health and Well Being Board and local authority. The Better Care Fund thus closely resembles area-based financial incentives seen in other OECD countries that aim to drive better integrated care, such as Sweden's Elderly Care Fund (OECD, 2013c) or Norway's Co-ordination Reform (OECD, 2014a).

The application of financial incentives to drive quality improvement is a good example of how the NHS has not been afraid to innovate and experiment with new approaches. The Quality and Outcomes Framework, for example, was one of the earliest international schemes to apply pay-for-performance in primary care, at system-wide level. From its inception, the scheme was detailed and ambitious, and it now covers a range of clinical areas (focussing on long-term conditions and associated risk factors). Target outcomes were specified for particular clinical groups, such as achieving blood pressures of 145/85 or less in at least 85% of diabetics. Evidence of the impact of QOF and similar pay-for-performance schemes remains mixed (see Box 1.9). Partly because of this, as well as simply a preference for other approaches, several OECD countries with strong primary care systems (such as Israel and Norway) have decided against using financial incentives in this way. Nevertheless, England ought to be commended for its willingness to innovate, evaluate and add to the international community's experience of less familiar policy tools.

Box 1.9. International experience with pay-for-performance schemes in primary care

Since their inception in the United States, United Kingdom and Australia in the late 1990s and early 2000s, pay-for-performance schemes have become increasingly popular payment mechanisms for primary care across the OECD. Pay-for-performance is, in fact, more widely used in primary care than in secondary care. Primary care schemes operate in around half of countries, focusing mainly on preventive care and care for chronic disease. Design varies widely, ranging from relatively simple schemes in New Zealand (10 indicators) or France (16 indicators) to the complexity of the United Kingdom's Quality and Outcomes Framework (QOF) – the largest scheme currently in operation. QOF covers over 100 indicators in 22 clinical areas and is implemented across the whole country.

Box 1.9. International experience with pay-for-performance schemes in primary care *(cont.)*

Given its scale, and the fact that it was a system-wide reform, much research has focused on the impacts of QOF. Gillam et al. (2012), in a systematic review covering 124 published studies, note that evaluation is complicated by lack of a control group and the difficulty of ascribing changes in clinical practice or outcomes (each with manifold determinants) to a complex intervention such as the QOF. Nevertheless, against a background of improving care generally, they report that quality of care for incentivised conditions during the first year of implementation improved at a faster rate than prior to QOF, although subsequently returned to prior rates of improvement. Given the cost of QOF (around GBP 1 billion per year), much debate has focused on its cost-effectiveness. Gillam et al. reported evidence of modest cost-effective reductions in mortality and hospital admissions in some areas, such as epilepsy. Of note, however, work by Walker et al. finds no relationship between the size of payments in a clinical domain (ranging from GBP 0.63 to GBP 40.61 per patient), suggesting substantial efficiency gains by reducing the upper spread of these figures.

In a review of 22 systematic reviews looking at pay-for-performance schemes internationally (not confined to primary care), Eijkenaar et al. (2013) find that P4P seems to have led to a 5% improvement in performance of incentivised aspects of care. Effects were generally stronger in primary care than in secondary care although, given the extent of variation in findings and the paucity of rigorous study designs, the authors conclude that there is insufficient evidence to support or not support the use of pay-for-performance.

Beyond clinical effectiveness and efficiency measures, pay-for-performance schemes have been associated with narrowing of the quality gap between deprived and non-deprived areas (Doran et al., 2008); systems strengthening by expanding use of practice-based IT, patient registers, call-recall procedures and audit; and expansion of nursing roles and competencies, including better team working. They may also support better dialogue between purchasers and providers, promote broader public debate and thereby clarify the objectives of primary care services (Cashin et al., 2014). Some evidence of negative effects, such as deprioritisation of non-incentivised activities or a fragmentation of the continuity of care, have also been noted.

Pay-for-performance in primary care should not be seen as the ideal or only payment system, but a potentially useful tool in a blended payment system, particularly where it might spur other activities such as development of quality indicators and better monitoring. As stated in a recent editorial cautioning against over-enthusiastic adoption of the schemes, “the choice should not be P4P or no P4P, but rather which type of P4P should be used and with which other quality improvement interventions” (Roland, 2012). Fundamentally, pay-for-performance should be seen as part of the means to move toward better purchasing (including, in this case, GPs’ time), in which quality plays a more prominent role.

Source: OECD (2014), *OECD Reviews of Health Care Quality: Norway 2014 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264208605-en.

Recent innovations have incited some controversy and will benefit from close scrutiny of both intended and unintended outcomes

NHS England has recently implemented a time-limited scheme to reward GPs for identifying patients with dementia. Implementation of local plans to improve diagnosis rates over the longer term is a necessary condition to benefit from the incentive. The scheme was designed in response to an estimated shortfall of 90 000 patients (around 12 per practice) on the national dementia register, who modelling predicted should have been already identified and offered appropriate support. Although this approach has previously featured in the QOF, it is a significant departure from prior schemes, given that it encourages GPs to make a particular diagnosis in a particular patient group. Introduction of the scheme met with some controversy, from both professional and patient groups, however, concerned that the incentive might adversely distort clinical practice and encourage over-diagnosis. NHS England intends to investigate this.

The scheme is primarily directed at practices with fewer than expected cases of dementia, with the intention of bringing their diagnosis rate closer to the national average. As such, the scheme represents an innovation which other OECD health systems will be keen to learn from. As England continues to innovate with the design and application of financial incentive schemes, thorough and transparent evaluation will be needed to ensure that schemes evolve to best meet patient, and population, health care needs. In this particular case, evaluation should assess both intended and unintended effects, including whether the incentive increased diagnosis rates significantly in practices that already had a high case load of patients with dementia.

1.11. Patient safety initiatives

England's drive to improve patient safety benefits from a comprehensive and well-coordinated approach. Broadly, the strategy encompasses three aims: gaining a better understanding of what goes wrong in health care, enhancing NHS capability and capacity to improve patient safety, and tackling key patient safety priorities via specific programmes of work. England could do more, however, to harness the role of patients themselves in improving the safety of health care.

England has one of the most comprehensive databases of patient safety incident reports in the world

Gaining a better understanding of what goes wrong in health care is generally accomplished through the collection and analysis of adverse event reports. Each NHS organisation has its own incident reporting system. Staff are encouraged to report events which have, or may have caused harm to patients. Patients and carers can also report events. Incidents are dealt with within the organisation, which may comprise root cause analysis and changes to local policies and procedures. Reports are then sent electronically to the *National Reporting and Learning System* (NRLS), for further analysis and learning at national level. Submitted data is subject to several quality checks and is anonymised. Analysis at this level comprises tools to search for specific incidents, quantitative analysis of patterns and trends, and detailed review of individual incidents by clinical and patient safety experts. Free text descriptions of "what happened," and the possible cause and contributory factors are a major source of information for local and national learning.

The NRLS was set up in 2003 and now contains over 10 million reported incidents. Results of these analyses are used to identify priorities for NHS England (and other third parties), and lead to range of outputs, including regular Quarterly Data Summaries, which show the trends and patterns in level of reporting, and also patterns in reported incidents with respect to health care setting and incident types; feedback reports for each NHS organisation, which assist with local interpretation of data and provide evidence to back up local action to improve safety; and specific Patient Safety Alerts, tools and guidance. A new *National Patient Safety Alerting System* was launched in 2014 to strengthen and speed up the dissemination of urgent patient safety alerts. The System also includes resources to support implementation of safety and best practice measures and, for the highest level of alert, directs what action must be taken and specifies how organisations will be held accountable for doing so. The NRLS also shares all incident reports with the Care Quality Commission on an on-going basis.

The MHRA (see Section 1.5) also operates a system of post-marketing surveillance of medicines and devices used in England. Its "Yellow Card" scheme encourages reporting of all adverse drug reactions, including over-the-counter, herbal and complementary preparations. Yellow Card reports received on suspected side effects are evaluated by pharmacists and doctors to identify previously unidentified safety issues or adverse drug reactions. Patient Safety Alerts, as described above, may be issued. Reports of suspected defective medicines are sent to the Defective Medicines Reporting Centre (DMRC) who will take appropriate action, including issuing a recall if necessary. The MHRA also issues regular Drug Safety Updates.

Initiatives to improve patient safety are continuously evolving, at all levels of the system

A range of programmes and initiatives have been established which aim to strengthen patient safety work across the NHS. These include a network of 15 *Patient Safety Collaboratives*, which are led by the Academic Health Science Networks described in Section 1.5.They bring together patients and health care staff to work together to identify safety priorities, implement and test solutions. This initiative was launched in response to the Berwick report on patient safety (Department of Health, 2013). In addition, it is intended to appoint 5 000 *Patient Safety Fellows* to act as champions, experts, leaders and motivators to drive patient safety improvement across the NHS.

A *Sign up to Safety Campaign* was launched in March 2014, with the stated aim of making the NHS the safest health care system in the world (http://www.england.nhs.uk/signuptosafety/). Its specific objective is to reduce avoidable harm by 50% and save 6 000 lives over three years. It aims to do this by asking individuals and organisations to sign up to five pledges, namely to put safety first; continually learn; be candid with patients and their families if something goes wrong and transparent about progress in improving things; collaborate; and support people to understand why things go wrong and how to put them right. Organisations able to demonstrate that their Safety Improvement Plan would reduce harm are eligible for partial reimbursement of their subscription to the NHS Litigation Authority's (NHS LA) Clinical Negligence Scheme. The NHS LA (which manages negligence and other claims against the NHS) has also developed a scorecard to help hospitals understand their claims profile.

More broadly, several specific programmes of safety work are also underway in the English NHS through the Patient Safety Collaboratives, including initiatives on pressure ulcers; anti-microbial resistance; mental health; learning disabilities; health care safety in the criminal justice system, handovers of care and discharge. In addition, there are plans to conduct a review of hospital mortality based upon case note reviews. This has potential to be internationally innovative.

More could be done to involve patients themselves in making health care safer

England has a sophisticated and comprehensive approach to identifying and reducing risks to patient safety. In common with much of its quality architecture, however, all the major patient safety initiatives are predominantly top-down and nationally-led. Nationally-led initiatives (such as the NRLS) clearly have an important role, but the bulk of patient safety learning and change work has to occur at local and organisational level. This is because most safety risks occur during the delivery of clinical care to individual patients. Initiatives such as Patient Safety Collaboratives are a step in the right direction and should be continued.

A distinctive feature of the Collaboratives is their active involvement of patients to improve health care safety. Patients themselves do not feature prominently in much of the patient safety work that England currently does. Correspondingly, patient safety rarely features in patient engagement work, or in narratives around patient empowerment. This is an important omission since patients and their carers can be powerful partners in identifying safety risks and developing solutions, both during the individual clinical encounter and more systemically. England needs to do more to harness the role of patients themselves in improving the safety of health care. Denmark's distinctive approach to improving safety offers several ideas worth considering (see Box 1.10).

Box 1.10. Improving patient safety in Denmark

The lead organisation for improving the safety of health care in Denmark is the *Danish Society for Patient Safety*. In contrast to the English approach, it is a third-sector (non-profit) organisation made up health care professionals, patient and research organisations, the pharmaceutical and medical device industry, hospitals and local government. As well as producing tools (such as a Root Cause Analysis Tool Kit) and guidance (such as on how better hospital design can improve safety), it also engages in campaigns and advocacy. Its *Danish Safer Hospital Programme* aims to achieve a 15% reduction in mortality and 30% reduction in harm by reducing the number of cardiac arrests, eliminating hospital infections, reducing pressure ulcers and preventing medication errors and other actions.

A distinctive feature of the Society is its emphasis on patients and carers as key partners in improving health care safety. A number of tools and campaigns have been developed to support this. Amongst the most well-known is the Society's *Patient Handbook*, designed to accompany a hospital admission. The Handbook covers a range of topics, much of which is distilled into the following ten Safety Tips for Patients:

1. Speak up if you have any questions or concerns
2. Let us know about your habits
3. Take notes during your stay
4. More ears listen better
5. You can let somebody else handle your consultation
6. Check your personal data
7. Ask about your operation

Box 1.10. Improving patient safety in Denmark *(cont.)*

8. Tell us if it hurts
9. Before discharge from hospital
10. Know the medication you are taking

Another patient-oriented initiative is called *Hello Healthcare*. This recognises that there are significant barriers for patients to overcome when dealing with the health care system, such as the power gap between doctor and patient or lack of staff time, which pose safety risks. The campaign encourages patients to participate more actively in their health care, and expect to be heard and listened to.

Source: http://www.patientsikkerhed.dk/.

1.12. Conclusions

The English NHS takes health care quality seriously and makes great effort to be a system that learns. The NHS Outcomes Framework is entirely built around quality and patient-centredness is the system's focal point. England has internationally pioneered many initiatives, including clinical guidelines, continuing professional development and use of patient surveys and patient-reported outcomes.

Professionalism was for many years the base upon which quality monitoring and improvement activities rested. Over time, though, the governance model shifted toward a quality management approach, more reliant upon transparency and regulation. There has been a proliferation of national agencies, reviews and policies that address quality, leading to a somewhat congested and fragmented field of actors, particularly in the fields of regulation and performance monitoring. A tension, perhaps more pronounced than in other OECD health systems, has been evident between top-down quality management approaches and bottom-up quality improvement techniques. This has been recognised and national authorities in England are now attempting to build a more balanced approach to quality governance.

This chapter makes three key recommendations for England, so that the NHS can ensure that its quality architecture remains one that is studied and emulated by other OECD health systems. First, greater emphasis on bottom-up approaches, led by patients and clinicians, should be encouraged. As the same time there is scope to simplify the range of institutions and policies regulating health care quality at national and local level. Finally, renewed focus on the quality at the interfaces of care, as well as on community-based services, is needed.

Policy recommendations for England

To ensure high quality health care at every encounter and continuously improving care across the system, the English NHS should:

1. Balance current regulatory approaches of quality management and control with greater emphasis on bottom-up approaches led by patients and professionals, by:

- Prioritising action to implement the recommendations of the Berwick Review, Compassion in Practice and other reviews which reaffirm the importance of professionalism as the bedrock of quality.
- Encouraging the CQC, GMC, NMC and other regulators to identify, promote and celebrate excellence, rather than solely regulate failure.
- Continuing efforts to engage professionals in the revalidation process and better explaining its purpose and potential to improve quality.
- Ensuring that quality indicators and performance monitoring frameworks viewed as signals of potential excellence or concern that merit further scrutiny, rather than employed as absolute verdicts of good or bad quality.
- Applying summary metrics or categorisations implying good or bad quality within an organisation with extreme caution, or avoid altogether.
- Avoiding language in health service documents, directives and announcements that may be perceived signalling failure or blame.

2. At the same time, consolidate and simplify the range of institutions and policies regulating health care quality, by:

- Working towards one national body that can clearly be identified with each stage of the national plan-do-study-act cycle of quality improvement.
- Examining whether Commissioning Support Units, Strategic Clinical Networks, and Clinical Senates each make separate and substantive contributions to the work of CCG and Health and Wellbeing Boards.
- Aiming for greater alignment between the NHS, Adult Social Care and Public Health Outcomes Frameworks, with the eventual ambition of merging them into one unified health and social care outcomes framework.
- Considering merging the GMC, NMC and other professional regulators, to increase possibilities for sharing intelligence and observing patterns of practice within a provider or local area.
- Working toward greater integration between professional and organisational regulators, for the same reason.

Policy recommendations for England *(cont.)*

3. Renew the focus on quality at the interfaces of care, as well as on community-based services, by:

- Developing appropriate quality standards, guidelines and metrics for the community care sector, with a consistent monitoring regime to enable quality gains to be assessed. Relevant indicators should be brought into the NHS Outcomes Framework as soon as they are identified.
- Moving toward more continuous and proactive model of quality monitoring and improvement in community services. Work on national Quality Dashboards for primary and community care services should begin.
- Closely evaluating extension of the Friends and Family Test to GPs and community services, to ensure that these services find the Test useful in knowing where and how to make improvements.
- Considering inclusion of a new standard around the safe handover of care in the NHS Fundamental Standards of Care, similar to that used in other OECD health systems, such as Australia's.
- Encouraging thematic reviews of quality and outcomes of care for particular groups, such as elderly people. All elements of the patient pathway (primary care, acute care and social care) could be looked at, with standards developed around measurable such as timeliness, information exchange and patient involvement in their care.
- Encouraging greater innovation in how primary and community care services are delivered, how they integrate with acute care services, and demonstrate continuous quality improvement. Scandinavian innovations in general practitioner roles could be piloted.
- Ensuring a patient-centred, outcome-based view in discussions around co-ordination and integration of services. Policies should prioritise embedding effective patient involvement, better multidisciplinary team-work and wider use of individual care plans.

4. Take additional specific actions in particular policy areas:

- Including other dimensions of performance in the NHS Outcomes Framework, to allow integrated performance management across all health system objectives in a unified manner.
- Developing a consistent and systemic approach to patient empowerment across the NHS. Continually greater emphasis on measuring outcomes, particularly patient-reported outcomes and the experience of care, will support this.
- Extending, publicising and better integrating the patient decision aids produced or endorsed by QIPP and NICE into the websites and software used by clinicians and patients.

Policy recommendations for England *(cont.)*

- Increasing the use of Individual Care Plans by better informing clinicians and patients of their value, so that patients can specify the goals and outcomes that they want from health care.
- Better harnessing the role of patients and carers in improving the safety of health care, emulating approaches developed in Denmark for example.
- Closely evaluating innovations in financial incentive schemes targeted on better quality, to ensure that schemes evolve to best meet patient, and population, health care needs.

Notes

1. Comprehensive discussions have been written by the Nuffield Trust (such as nhstimeline.nuffieldtrust.org.uk) and the King’s Fund (such as kingsfund.org.uk/topics/nhs-reform) amongst others.
2. Reported during three OECD Study Visits (or follow-up telephone interviews) to the English NHS in September 2014, March 2015 & July 2015.
3. See for example the article in Pulse magasine, widely read by GPs and their staff, on 30 June 2014 “GPs to be ‘named and shamed’ after missing cancer diagnoses”. http://www.pulsetoday.co.uk/clinical/cancer/gps-to-be-named-and-shamed-after-missing-cancer-diagnoses/20007138.article#.VL4w9fnF9ik.
4. In early twentieth century America, Frederick W. Taylor sought to optimise productivity and quality in industrial processes by distinguishing workers from a new class of quality control engineers and inspectors, requiring workers to complywith pre-determined standards and production methods, and treating lapses in quality or productivity as a failing, the source of which should be identified, removed and replaced (see “The Principles of Scientific Management”, F.W. Taylor, New York, 1911).
5. Professor Donabedian was also a poet. The complete citation reads “It is the ethical dimensions of individuals that are essential to a system’s success. Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system.”.

References

British Medical Journal (2014), “A Third of NHS Contracts Have Gone to the Private Sector Since the Reforms”, Vol. 349: g7606.

Cashin, C. et al. (2014), *Paying for Performance in Healthcare: Implications for Health System Performance and Accountability*, Open University Press.

CHRE – Council for Healthcare Regulatory Excellence (2010), “Right-touch Regulation”, CHRE, London, http://www.professionalstandards.org.uk.

Department of Health (2014), “A Mandate from the Government to NHS England: April 2014 to March 2015”, London, www.gov.uk/dh.

Department of Health (2013), “Improving the Safety of Patients in England”, National Advisory Group on the Safety of Patients in England, London.

Department of Health (2012a), *Long Term Conditions Compendium of Information: Third Edition*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf.

Department of Health (2012b), “Compassion in Care”, London, http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf, Department of Health.

Department of Health (2011), “The Operating Framework for the NHS in England”, London, https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13.

Department of Health (2008), “High Quality Care for All: NHS Next Stage Review”, final report, The Stationery Office. Cm 7432, London, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825.

Donabedian, A. (1966), “Evaluating the Quality of Medical Care”, *Milbank Memorial Fund Quarterly*, Vol. 44, pp. 166-206.

Doran, T. et al. (2008), “Effect of Financial Incentives on Inequalities in the Delivery of Primary Clinical Care in England”, *The Lancet*, Vol. 372, No. 9640, pp. 728-736.

Eijkenaar, F. et al. (2013), "Effects of Pay for Performance in Health Care: A Systematic Review of Systematic Reviews", *Health Policy,* in press.

Gaynor, M., R. Moreno-Serra and C. Propper (2013), "Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service", *American Economic Journal: Economic Policy*, Vol. 5, pp. 134-166.

Gillam, S.G. et al. (2012), "Pay-for-performance in the United Kingdom: Impact of the Quality and Outcomes Framework – A Systematic Review", *Annals of Family Medicine*, Vol. 10, pp. 461-468.

The Health Foundation and the Nuffield Trust (2013 and 2014), "Quality Watch Annual Statements", London, www.qualitywatch.org.uk.

The King's Fund (2014a), "Medical Revalidation: From Compliance to Commitment", London, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/medical-validation-vijaya-nath-mar14.pdf.

The King's Fund (2014b), "Managing Quality in Community Health Care Services', London, http://www.kingsfund.org.uk/publications/managing-quality-community-health-care-services.

King's Fund, NHS Reform, www.kingsfund.org.uk/topics/nhs-reform, accessed 20.01.2015.

Pike, A. (2010), "An Empirical Analysis of the Effects of GP Competition", *Working Paper Series*, Vol. 1, No. 2, Competition and Co-operation Panel, Munich Personal RePEc Archive (MPRA), http://mpra.ub.unimuenchen.de/27613/.

Maybin, J. and R. Thorlby (2008), "High Quality Care for All", briefing, The King's Fund, London, http://www.kingsfund.org.uk/sites/files/kf/briefing-high-quality-care-for-all-jo-maybin-ruth-thorlby-kings-fund-july-2008.pdf.

MPS – Medical Protection Society, Press Release 27th November 2013, http://www.medicalprotection.org/Default.aspx?DN=799622fb-c5aa-4612-bc21-a87e5d0674c1.

Merkur, S. et al. (2008), "Physician Revalidation in Europe", *Clinical Medicine*, Vol. 8, No. 4, pp. 371-376.

NHS England (2014a), *Understanding the New NHS*, London, www.england.nhs.uk/nhsguide/.

NHS England (2014b), *NHS Five Year Forward View*, London, http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf.

NHS England (2014c), *NHS England's Business Plan 2014/15-2016/17: Putting Patients First*, London, www.england.nhs.uk.

NHS England (2014d), *NHS England Review of the Friends and Family Test*, London, www.england.nhs.uk.

Nuffield Trust, NHS Timeline, nhstimeline.nuffieldtrust.org.uk, accessed 20.01.2015.

OECD (2013a), *Health at a Glance 2013: OECD Indicators*, OECD Publishing, Paris, http://dx.doi.org/10.1787/health_glance-2013-en.

OECD (2013b), *OECD Reviews of Health Care Quality: Denmark 2013 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264191136-en.

OECD (2013c), *OECD Reviews of Health Care Quality: Sweden 2013 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204799-en.

OECD (2014a), *OECD Reviews of Health Care Quality: Norway 2014 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264208605-en.

ONS – Office for National Statistics (2011), *National Population Projections, 2010-Based Statistical Bulletin*, http://www.ons.gov.uk/ons/dcp171778_235886.pdf.

QualityWatch (2014), "Focus On: Social Care for Older People. Reductions in Adult Social Services for Older People in England", http://www.qualitywatch.org.uk/focus-on/social-care-older-people.

Revalidation Support Team (2014), "The Early Benefits and Impact of Medical Revalidation: Report on Research Findings in Year One", March 2014, www.revalidationsupport.nhs.uk/CubeCore/.uploads/documents/pdf/Early_benefits_impact_medical_revalidation_report_March_2014.pdf.

Roland, M. (2012), "Pay-for-performance: Not a Magic Bullet", *Annals of Internal Medicine*, Vol. 157, No. 12, pp. 912-913.

Scally, G. and L.J. Donaldson (1998), "Clinical Governance and the Drive for Quality Improvement in the New NHS in England", *British Medical Journal*, pp. 61-65

Swedish National Audit Office (2014), "Primary Health Care Governance – Based on Need or Demand?", http://www.riksrevisionen.se/PageFiles/21020/Summary%202014_22.pdf.

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