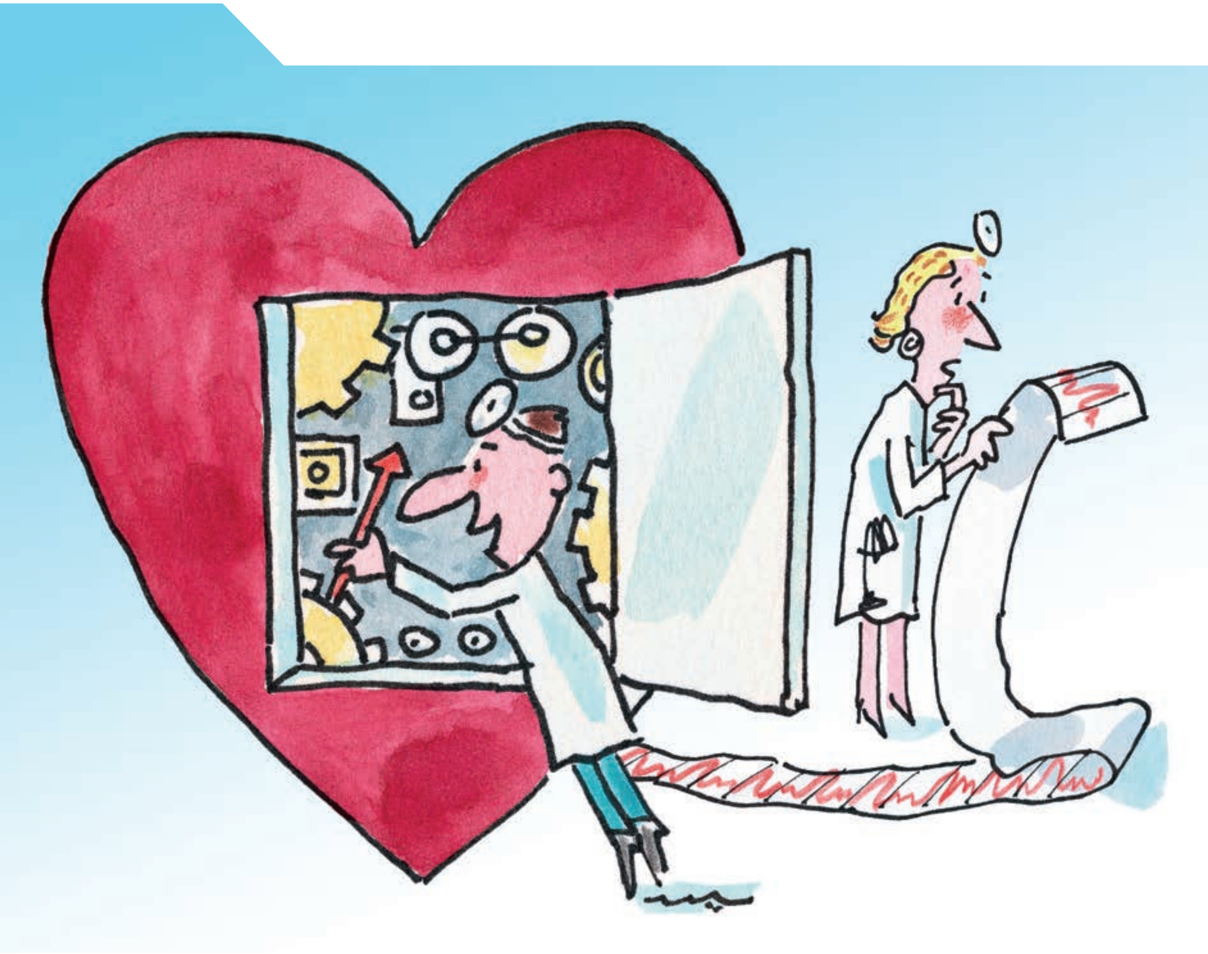
OECD Reviews of Health Care Quality

UNITED KINGDOM

RAISING STANDARDS



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OECD Reviews of Health Care Quality: United Kingdom 2016

RAISING STANDARDS

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BETTER POLICIES FOR BETTER LIVES

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Foreword

This report is part of a series of publications reviewing the quality of health care across selected OECD countries. As health costs continue to climb, policy makers increasingly face the challenge of ensuring that substantial spending on health is delivering value for money. At the same time, concerns about patients occasionally receiving poor quality health care have led to demands for greater transparency and accountability. Despite this, there is still considerable uncertainty over which policies work best in delivering health care that is safe, effective and provides a good patient experience, and which quality-improvement strategies can help deliver the best care at the least cost. *OECD Reviews of Health Care Quality* seek to highlight and support the development of better policies to improve quality in health care, to help ensure that the substantial resources devoted to health are being used effectively in supporting people to live healthier lives.

This report reviews the quality of health care in England, Scotland, Wales and Northern Ireland, seeking to highlight best practices, and provides a series of targeted assessments and recommendations for further quality gains in health care. Health systems in the United Kingdom have, for many years, made the quality of care a highly visible priority, internationally pioneering many tools and policies to assure and improve the quality of care. A key challenge, however, is to understand why, despite being a global leader in quality monitoring and improvement, the United Kingdom does not consistently demonstrate strong performance on international benchmarks of quality. To secure continued quality gains, the four health systems will need to balance top-down approaches to quality management and bottom-up approaches to quality improvement; publish more quality and outcomes data disaggregated by country; and, establish a forum where the key officials and clinical leaders from the four health systems responsible for quality of care can meet on a regular basis to learn from each other's innovations.

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This report has benefited from the expertise and material received from many health officials, health professionals, patient groups and other health experts that the OECD review team interviewed during missions to the United Kingdom in September 2014, March 2015 and July 2015. These included officials and representatives from:

- in **England,** the Department of Health, NHS England, the Care Quality Commission, Monitor, the NHS Trust Development Authority, the General Medical Council, the Nursing and Midwifery Council, the Health and Care Professions Council, the Professional Standards Authority, the Medicines and Healthcare products Regulatory Agency, the Health and Safety Executive, the Health and Social Care Information Centre, the National Institute for Health and Care Excellence, Health Education England, National Voices, Healthwatch, the King's Fund, the Nuffield Trust, the Shelford Group, Airedale NHS Foundation Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust, Birmingham Community Healthcare NHS Trust, Hertfordshire Partnership University NHS Foundation Trust, Northern Lincolnshire and Goole NHS Foundation Trust, Somerset Clinical Commissioning Group, Southend Clinical Commissioning Group;
- in **Scotland,** the Health and Social Care Directorates of the Scottish Government (including the Healthcare Quality and Strategy Directorate; Health Analytical Services; and, Health Workforce and Performance), Healthcare Improvement Scotland, the Scottish Health Council, the Information Services Division of NHS National Services Scotland, the Health and Social Care Alliance Scotland, Audit Scotland, NHS Education for Scotland, NHS Highland, NHS Lothian, NHS Tayside, the

State Hospital, the Scottish branch of UNISON, the Scottish branch of Royal College of Nursing, the Scottish branch of the British Medical Association, Scottish Enterprise, Corri Black from the University of Aberdeen, Bruce Guthrie and Tom McDonald from the University of Dundee, Aziz Sheikh from the University of Edinburgh;

- in **Wales,** the Department of Health and Social Services of the Welsh Government (including Finance; Healthcare Innovation; Healthcare Policy; Patient Experience Framework Oversight; Patient Safety; Social Services and Integration; Strategy, Policy and Planning; Mental Health Services; and, Workforce), NHS Wales, Public Health Wales, the Healthcare Inspectorate Wales, the National Institute for Social Care and Health Research, the Wales Audit Office, the National Clinical Audit Steering Committee, the All Wales Medicines Strategy Group, the Surgical Materials Testing Laboratory, the All Wales Therapeutics and Toxicology Centre, the NICE Liaison Group, the Bevan Commission, the British Medical Association Cymru Wales, the Royal College of Nursing Wales, Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board, Cwm Taf University Health Board, Velindre NHS Trust, the Board of Community Health Councils, Academi Wales, Sharon Mayor from the Institute of Primary Care and Public Health, Cardiff University;
- in **Northern Ireland,** the Department of Health, Social Services and Public Safety of the Northern Ireland Executive, the Health and Social Care Board, the Public Health Agency for Northern Ireland, the Health and Social Care Regulation Quality Improvement Authority, the Northern Ireland Medical and Dental Training Agency, the Patient Client Council, the Belfast Health and Social Care Trust, the Northern Health and Social Care Trust, the South Eastern Health and Social Care Trust, the Southern Health and Social Care Trust, the Western Health and Social Care Trust.

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Acronyms and abbreviations

A&E	Accident and emergency
AMT	Antimicrobial Management Team
ASD	Analytical Services Division
AWMSG	All Wales Medicines Strategy Group
AWPAG	All Wales Prescribing and Advisory Group
AWTTC	All Wales Therapeutics and Toxicology Centre
BMA	British Medical Association
BSA	British Social Attitudes
BSI	British Standards Institution
BSO	Business Service Organisation
CAAS	Care Assurance and Accreditation System
CCG	Clinical Commissioning Group
CHC	Community Health Council
CHI	Community Health Index
CNS	Central nervous system
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
CQC	Care Quality Commission
CPRD	Clinical Practice Research Database
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CYPADM	Children and Young Persons Acute Deterioration Management

DECI	Dignity and Essential Care Inspection
DHSSPS	Department of Health, Social Services and Public Safety
DMRC	Defective Medicines Reporting Centre
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DOH	Department of Health
DRG	Diagnosis related group
ECT	Electroconvulsive Therapy
FHU	Family Health Unit
FFT	Friends and Family Test
FT	Foundation Trust
FTE	Full Time Equivalent
GAIN	Guidelines and Audit Implementation Network
GBP	Great Britain pound
GDP	Gross domestic product
GMC	General Medical Council
GP	General practitioner
GVA	Gross value added
HCAI	Health care acquired infection
HCQI	OECD's Health Care Quality Indicators
HIS	Healthcare Improvement Scotland
HIW	Healthcare Inspectorate Wales
HQIP	Healthcare Quality Improvement Partnership
HSC	Health and social care
HSCB	Health and Social Care Board
HSCDIIP	Health and Social Care Data Integration and Intelligence Project
HSCIC	Health and Social Care Information Centre
HTA	Health technology assessment
ICP	Integrated Care Partnership

IFS	Institute of Fiscal Studies
IHI	Institute for Healthcare Improvement
IMTO	Innovative Medical Technology Overview
IMTP	Integrated Medium Term Plan
ISD	Information Services Division
IVF	In vitro fertilisation
LCG	Local Commissioning Group
LDP	Local Delivery Plan
MHRA	Medicines and Healthcare products Regulatory Agency
MPS	Medical Protection Society
MRI	Magnetic Resonance Imaging
MRSA	Meticillin-resistant staphylococcus aureus
MSSA	Meticillin-sensitive staphylococcus aureus
NACPOP	National Clinical Audit and Patient Outcomes Programme
NCQSG	National Cancer Quality Steering Group
NHS	National Health Service
NHS LA	NHS Litigation Authority
NHSIQ	NHS Improving Quality
NHSOF	NHS Outcomes Framework
NI	Northern Ireland
NIB	National Information Board
NIBSC	National Institute of Biological Standards and Control
NICE	National Institute for Health and Care Excellence
NIMDTA	Northern Ireland Medical and Dental Training Agency
NIPECNM	Northern Ireland Practice and Education Council for Nursing and Midwifery

NMC	Nursing and Midwifery Council
NMG	New Medicines Group
NPF	National Planning Forum
NQB	National Quality Board
NRLS	National Reporting and Learning System
NSUE	National Service User Experience
NWSSPPS	NHS Wales Shared Services Partnership Procurement Services
PASS	Patient Advice and Support Service
PCC	Patient and Client Council
PDSA	Plan-do-study-act
PHA	Public Health Agency
PLACE	Patient-led Assessments of the Care Environment
PROM	Patient reported outcomes measure
QDM	Quality and Delivery Meetings
QOF	Quality and Outcomes Framework
QPI	Quality Performance Indicator
QSG	Quality Steering Group
QuEST	Quality and Efficiency Support Team
QUIP	Healthcare Quality Improvement Plan
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority
SAIL	Secure Anonymised Information Linkage
SAPG	Scottish Antimicrobial Prescribing Group
ScRAP	Scottish Reduction in Antimicrobial Prescribing
SEAN	Scottish ECT Accreditation Network
SHMI	Summary Hospital-level Mortality Indicator
SHTG	Scottish Health Technologies Group
SICSAG	Scottish Intensive Care Society Audit Group

SIGN	Scottish Intercollegiate Guidelines Network
SIMD	Scottish Index of Multiple Deprivation
SMC	Scottish Medicines Consortium
SMTL	Surgical Materials Testing Laboratory
SOAR	Scottish Online Appraisal Resource
SUI	Serious untoward incident
TDA	Trust Development Authority
VLAD	Variable Life-Adjusted Display
WHSSC	Welsh Health Specialised Services Committee

Executive summary

The United Kingdom's four health systems have much in common. They all offer population-wide insurance for the vast majority of health care needs, largely free at the point of use, through tax-funded single national pools. Similar values and service-models (such as a strong primary care sector) stem from a common heritage and evolution over the past 60 years. In addition, continuously improving the quality of care is a deeply established and widely shared commitment in all of the four systems. Each benefits from a bold and clear vision to achieve care that is consistently safe, effective and person-centred. The United Kingdom's drive to continuously strengthen quality assurance, monitoring and improvement means that it has pioneered, or implemented more widely and deeply than elsewhere, several tools and approaches to monitoring and improving health care quality. The United Kingdom has become a point of reference, for example, in the development of evidence-based clinical guidelines; resources to support clinicians to stay up to date and engage in on-going 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.

Despite the clear and consistent commitment to quality of care in all of the United Kingdom's health systems, and the ambitious policies around quality assurance and promotion, data on outcomes for the United Kingdom raise some concerns. Based on international benchmarks of health care quality, notably OECD data, some indicators for the United Kingdom show average or disappointing performance. Survival estimates for breast, cervical and colorectal cancer, for example, are all below the OECD average (of note, though, the rate of improvement in breast cancer survival over the past decade has been faster than the OECD on average; and improvements in survival rates for colorectal and cervical cancer appear to have increased marginally faster as well). Hospital admissions for asthma and COPD, which should be avoided, are also above the OECD average (they have, however, improved faster in the United Kingdom between 2008 and 2013 than the OECD average). A surprisingly limited number of indicators are published separately for the four health systems, making benchmarking within the United Kingdom nations, or indeed against other OECD countries, challenging. From the limited country-specific data available, however, no consistent picture emerges of one of the United Kingdom's four health systems performing better than another.

There is much that is common in the tools, policies and approaches that four health systems have used to respond to the challenges of delivering ever better health care, in the face of increasing demands and tighter finances. There is divergence, however, in the degree to which inspection, regulation and public disclosure of the performance of local services by central authorities is used as a lever to assure quality. Over recent years, England has increasingly emphasised the role of regulation, inspection and transparent publication of performance indicators to drive local quality improvement. In contrast, Scotland, Wales and Northern Ireland have sought to strengthen locally-owned, grass-roots initiatives around quality assurance and improvement, whilst maintaining an emphasis on transparency. Each of the four health systems is pursuing the approach to quality assurance, monitoring and improvement that it feels is best suited to its context and challenges.

To secure continued quality gains, each system must strike the right balance between a centrally-driven, regulatory approach to quality management and locally-driven quality improvement activities. There is scope, for example, to rebalance England's current regulatory approach, focused on quality management, with greater emphasis on bottom-up approaches led by patients and professionals. Likewise, in Scotland, Wales and Northern Ireland, which consciously prioritise a locally-owned and bottom-up approach to quality assurance and improvement, there is scope for a greater degree of steering and oversight from central authorities, to provide consistency, direction and a strong accountability framework that is lacking in places. Taken together, these recommendations demonstrate the need for a responsive and flexible approach to health system governance, which balances central and local roles.

The four health systems should also move towards reporting more quality benchmarks at country or regional level, rather than the United Kingdom aggregates which are currently reported. Whilst it is naive to imagine that any one of the four systems would ever emerge as plainly "better" or "worse" than another, more disaggregated data could shed light on the relative benefits of particular aspects of each national approach. More disaggregated data may also yield some answers to, or at least allow a more nuanced analysis of, the question of why the United Kingdom's performance on some international quality benchmarks is middling, despite the attention and investment given to quality improvement in all four health systems. Regionally-disaggregated data may be even more informative than national disaggregates. Concerns over national comparability could be overcome by comparing, for example, Wales with the north eastern region of England (which shares some demographic and socioeconomic characteristics), as well as England as a whole.

A final recommendation concerns learning and collaboration. At present, there are no standing mechanisms to enable the four health systems to collaborate on monitoring and improving health care quality in a comprehensive or on-going way. Key officials from each system (such as the Chief Medical Officers) meet regularly; relevant aspects of the health care quality agenda (such as revalidation) inevitably feature in these discussions. There is nevertheless substantial scope to develop more regular and comprehensive collaboration on the quality of care agenda across England, Scotland, Wales and Northern Ireland. A forum, meeting regularly and comprising those individuals responsible for steering and implementing the quality agenda in each country, would allow discussion of shared challenges, collaboration around proposed solutions and exchange of successful experiences – potentially being of great benefit to the four health systems, as well as to the OECD as a whole.

Assessment and recommendations

Health systems in the United Kingdom have, for many years, made the quality of care a highly visible priority, internationally pioneering many tools and policies to assure and improve the quality of care. Although each system has pursued distinct policy priorities under the leadership of the devolved administrations over recent years, the four still have much in common in terms of context and challenges. Key amongst these challenges is to understand why, despite being a global leader in quality monitoring and improvement, the United Kingdom does not consistently demonstrate strong performance on international benchmarks of quality.

To make further quality gains, each system needs to find an appropriate balance between top-down regulatory approaches to quality management, and a bottom-up, locally-led model of quality improvement. Additionally, as the four health systems pursue increasingly distinct policy trajectories with respect to quality assurance, quality improvement and providing more integrated, patient-centred care, there is a need for more formal collaboration between the systems – so that experiences, lessons and opportunities can be shared more effectively. Finally, the four health systems should also move towards reporting more quality benchmarks at country or regional level, rather than the United Kingdom aggregates which are currently reported. This again would allow for more effective comparison and learning across them, as well as benefit the wider OECD community.

The chapter opens by summarising the main quality policies in place in each health system, emphasising how the United Kingdom has for many years been an international leader in the health care quality agenda. Health system challenges are set out next, including disappointing performance on some international benchmarks of quality. The four systems' distinctive responses to this challenge are described, paying particular attention to how England has increasingly emphasised the role of regulation, inspection and transparent publication of performance indicators to drive local quality improvement, in contrast to Scotland, Wales and Northern Ireland who have sought to strengthen locally-owned, grass-roots initiatives around quality assurance and improvement (whilst maintaining an emphasis on transparency). Policy recommendations to secure continued quality gains complete the chapter, including the need to balance top-down approaches to quality management and bottom-up approaches to quality improvement; to publish more quality and outcomes data disaggregated by country; and, establish a forum where the key officials and clinical leaders from England, Scotland, Wales and Northern Ireland responsible for quality of care can meet on a regular basis to learn from each other's innovations, and discuss shared concerns and potential solutions.

0.1. Health care quality monitoring and improvement in the United Kingdom

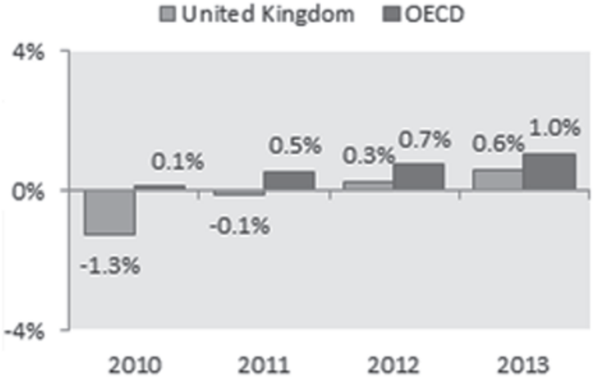
All four of the United Kingdom's health systems place a high premium on the quality of care. This is underpinned by ambitious, regularly updated policy frameworks within each system that commit to ensuring and continuously improving the quality of care. In several policy areas, such as clinical guidelines, continuous professional development and performance monitoring in primary care, the United Kingdom has been an international pioneer.

Although broadly similar, recent years have seen the four health systems develop different models in the planning and delivery of care

The United Kingdom's four health systems have much in common. They all offer population-wide insurance for the vast majority of health care needs, largely free at the point of use, through tax-funded single national pools. Similar values and service-models (such as a strong primary care sector, characterised by patient registration and obligatory referrals to secondary care) stem from a common heritage and evolution over the past 60 years. Collectively, the United Kingdom spends 8.5% of GDP on health services, close to the OECD average of 8.9% (8.7% excluding the United States). Growth in spending was significantly affected by the 2008 global financial crisis, which saw health spending growth fall significantly from 2010, with spending growth still below the OECD average.

In recent years, differences between the four systems have become increasingly apparent. The approaches taken to pressures on government spending as a result of the 2008 crisis, for example, varied between countries. In England, the health system was protected from direct cuts to spending. Spending on social care has fallen, however, which might be expected to have an impact upon health care needs and the health system. In contrast, in Wales a decision was made to balance spending cuts more evenly between health and social care. Estimates from the Health Foundation and the Nuffield Trust (2014) suggest that between 2010/11 and 2012/13 the annual rate of growth of health spending in England and Scotland was 1%, while Wales saw a 1% decline. The Institute of Fiscal Studies (IFS, 2015) estimated that while in England health spending increased by +4.3%, social services spending fell by -11.5%; in Wales the IFS estimates that health spending fell by -2.0%, while social services spending fell by only -0.8%. At 2014/15 prices, the Nuffield Trust estimates that England and Wales spent GBP 2 022 per head on health care services, with spending 6-7% higher in Northern Ireland (GBP 2 151) and Scotland (GBP 2 181; nuffieldtrust.org.uk/data-and-charts/health-spending-head-country).

Figure 0.1. Annual health spending growth,[1] 2010-13



1. Per capita spending in real terms.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Another critical difference relates to how health care services are matched to need. In England, the function of choosing and buying health care services for the population ("commissioning") has been transferred to distinct agencies, specialised in this activity. Providers compete for contracts with these agencies. In addition, providers' funding is increasingly demand-led: that is, patients choose a provider and funding follows. The levers of locally-based commissioning, choice and competition are expected to create more responsive health care services that better meet patients' needs.

In Scotland, the split between purchasers and providers of health care was abolished in 2004. The Chief Executive of the health service is also the Director-General of Health and Social Care for the Scottish Government, illustrating a close functional connection between system governance, service planning and service delivery, which the Scottish authorities seek to replicate at every level of the system. Wales, too, does not have a split between the purchaser and the provider. As in Scotland, the Chief Executive of NHS Wales is also the Director-General of Health and Social Services, again yielding a close functional connection between system governance, service planning and service delivery. NHS Wales is a "planned" system, based on unified decision making and integration of service delivery. The Welsh Government has overall responsibility for planning of the system, while seven local Health Boards and three NHS Trusts (ambulance, public health and non-surgical cancer) combine planning and provision for health services in systematic, medium-term (three year) planning cycles.

A structural characteristic that sets Northern Ireland apart from the others countries of the United Kingdom is the model of integrated governance that has existed for health and social care services for over 40 years. The Department of Health, Social Services and Public Safety (DHSSPS) has strategic oversight of both health and social care. The Health and Social Care Board is responsible for commissioning care, performance management, service improvement and resource management. The Board is assisted by five Local Commissioning Groups that are aligned geographically to the Health and Social Care Trusts that are responsible for providing health and social care.

Continuously improving health care quality is a shared and highly visible commitment across all four systems

Continuously improving the quality of care is a deeply established and widely shared commitment in all of the four systems. Each system benefits from a bold and clear vision to achieve care that is consistently safe, effective and person-centred. In England, 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". *Hard Truths: The Journey to Putting Patients First* published in 2013 provided the government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry including 290 recommendations for system reform. *Culture change in the NHS: Applying the lessons of the Francis Inquiries* sets out the progress that has been made in applying these recommendations. In addition, NHS England's business plan for 2015/16, *Building the NHS of the Five Year Forward View*, includes four priorities to improve health (cancer, mental health, learning disabilities and diabetes) and four priorities to redesign care around patients and what they need most (urgent and emergency care, primary care, elective care, and specialised services).

Scotland's *2020 Vision,* the *Healthcare Quality Strategy for NHSScotland* and accompanying *Route Map* represent an ambitious and detailed agenda to improve health and social care. The *2020 Vision* provides the strategic narrative and context for taking forward the implementation of the *Strategy*. The *Strategy* strives to achieve three main quality ambitions (namely, effective, safe and patient-centred care). The accompanying *Route Map to the 2020 Vision for Health and Social Care* identifies 12 priority areas required to deliver the 2020 ambition across the domains of quality of care, population health, and value and sustainability. Alongside these policy documents is Scotland's vision for the NHS workforce. *Everyone Matters: 2020 Workforce Vision* was launched in 2013 and consists of five priority areas: healthy organisational culture, sustainable workforce, capable workforce, integrated workforce and effective leadership and management.

In Wales, several documents and frameworks addressing quality of care have been published since devolution. These include: *The Health and Social Care (Community Health and Standards) Act 2003* which set out an overarching duty of quality for health bodies; *the Healthcare Standards for Wales Framework 2005,* after which health bodies were to demonstrate progress against the standards through an annual assessment; and the *Healthcare Quality Improvement Plan (QUIP) 2006* which set out to strengthen the focus on quality in the Welsh NHS. Most recently*, Doing Well, Doing Better, Standards for Health Services in Wales* (2010) sets out the core standards for the NHS, revising the Healthcare Standards Framework with the aim of better reflecting the new integrated NHS structures in Wales and the prevention agenda. In 2012, *Achieving Excellence: the Quality Delivery Plan for the NHS in Wales* set the double goal of ensuring continuous quality improvement through inspiring all staff and managers to take responsibility for improving the quality of care they provide. This was supported by the 1000 Lives quality improvement programme. More recently, a suite of condition specific delivery plans with corresponding implementation groups provide extra emphasis for whole pathway improvement.

In Northern Ireland, *Transforming Your Care*, the most significant and broad reaching review of the Northern Ireland health and social care system, was initiated in 2011and emphasised the need to drive up the quality of care, improve outcomes and enhance patient experiences of care. In addition, *Quality 2020*, released in 2011, seeks to provide a strategy and clear directions over the next ten years for the quality and safety of health and social care services in Northern Ireland. The strategy defines three quality dimensions – safety, effectiveness and patient and client focus – and sets out a bold vision for the system, that it "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care”. Particular emphasis is placed on leadership, resources, a learning culture and quality measurement. In 2012 an implementation plan was subsequently developed, along with an outline of the governance structure for the strategy, including the development of a suite of quality and safety performance indicators, and establishment of targets with regular quality review and reporting at the trust and whole of system level.

The United Kingdom is an international leader of the health care quality agenda

The United Kingdom’s drive to continuously strengthen quality assurance, monitoring and improvement means that it has pioneered, or implemented more widely and deeply than elsewhere, several tools and approaches to monitoring and improving health care quality. The United Kingdom has become a point of reference, for example, in the development of evidence-based clinical guidelines; resources to support clinicians to stay up to date and engage in on-going 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. System-wide measurement of activities and outcomes achieved within primary care, through the *Quality and Outcomes Framework*, was particularly groundbreaking and its ongoing evolution continues to be of international interest. 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. Scotland is also taking forward a Sustainability and Seven Day Services work programme, and a national Task Force has been established with responsibility for overseeing work. In Wales, the focus for enhanced 7-day working is broader than just hospital care but designed to improve the quality of and access to community services.

Few if any other OECD health systems are able to replicate the opportunities that patients in the United Kingdom have to give feedback on their care. Patient feedback is collected through surveys, patient-reported outcomes, online feedback portals, and involvement of patient and consumer groups. In Northern Ireland, for instance, there is a legislative basis for personal and public involvement in health and social cares, which requires organisations to develop a consultation scheme setting out how it will involve patients, clients, carers and the Patient and Client Council. In Scotland, NHS Boards are required to involve patients, carers and the public in the planning and design of health services, and in decisions significantly affecting the operation of those services. In Wales, the 2013 *Framework for*

Assuring Service User Experience sets out core patient experience questions, to be used across all care settings to complement local patient feedback methods. 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). Few other OECD health systems use patient reported outcomes in this systematic fashion.

Innovation continues at pace. The *National Institute for Health and Care Excellence* (NICE), for example, is increasingly publishing guidance and advice around appropriate use of established treatments (rather than just new technologies), producing public health and social care guidelines, and endorsing patient-decision aids and other patient-oriented material. The United Kingdom has, in addition, always shown a willingness to engage with and lead the international health care quality agenda. *NICE International* works to build capacity for assessing and interpreting evidence in health systems abroad. The United Kingdom's *Quality and Outcomes Framework* for measuring and incentivising the quality of primary care is also internationally known, and has been adapted to local contexts in each of the four health systems.

0.2. Challenges faced by the United Kingdom's health systems

The challenges faced by the United Kingdom's health systems are, largely, no different to those experienced by OECD health systems more generally: an ageing population with increasing health care demands alongside a tougher financial environment. A particularly striking challenge, however, is the United Kingdom's relatively mediocre performance on some international benchmarks of the quality of care. Reasons for this are unclear and perhaps puzzling, given the United Kingdom's long-standing and extensive investment in health care quality initiatives.

Increasing demand amidst a tougher financial climate is a shared challenge

The United Kingdom's health systems, like many other OECD health systems, is facing the challenges of a shifting set of patient needs and significant financial pressures. An aging population, 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 resources, and traditional health system structures. Care for people with long term conditions accounts for some 70% of the money spent on health and social care in the United Kingdom.

The United Kingdom’s elderly population is projected to rise significantly over the next few decades. Around a quarter of the population will be over 65 by 2050. The number of people aged over 80 will more than double in that time to 10.3% of the population, just above the OECD average of 10.1%. Ageing of the population is not evenly distributed across the United Kingdom, and is most pronounced in Wales. There, the mid-2014 estimated median age was 42.1 years, compared to 38.0 years in Northern Ireland.

Linked to this, as well as to lifestyle factors, the burden of chronic conditions is also rising. In England alone, 15 million people suffer from at least one long-term condition; 3 million people, for example, have been diagnosed with diabetes and 7 million are understood to be at risk of becoming diabetic. Rates are even higher in Wales. The prevalence of chronic kidney disease, hypothyroidism, chronic obstructive pulmonary disease (COPD) and dementia has also been rising across the United Kingdom. Multiple morbidities are also a cause for concern, with the number of people with more than one long term condition projected to rise significantly over the coming years.

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, as outlined earlier. There are also some emergent signs that NHS services may not be adequately resourced to deal with shifting needs for care, and financial pressures may be creating additional strain. Staffing levels in primary and community care, for example, are areas for concern. There has been a trend towards a more specialised medical, nursing and wider workforce, even though need for more holistic care for multiple conditions, closer to the community, is increasing most quickly. A similar trend is seen in nursing, and nursing shortages and recruitment pressures have been reported in all four nations.

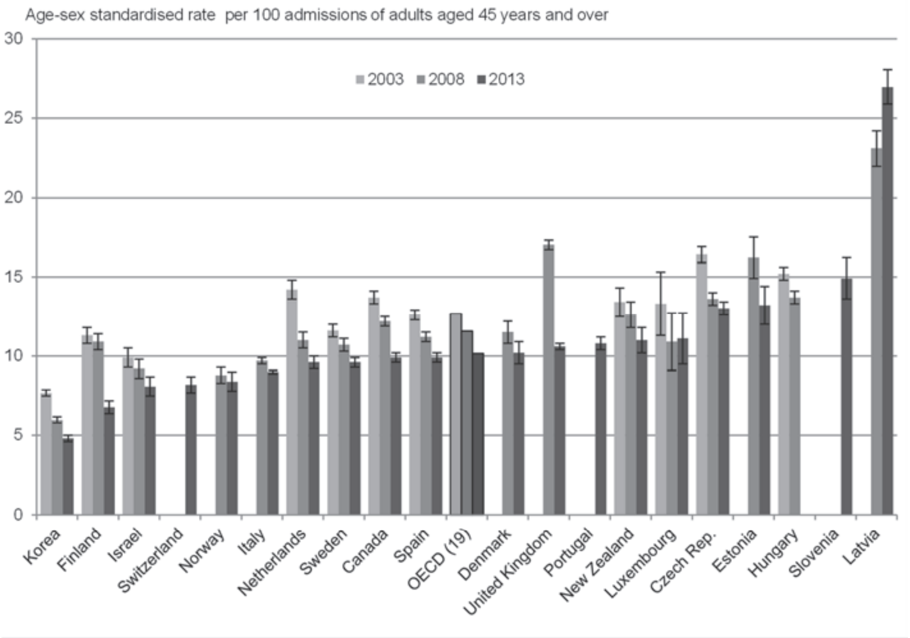
In addition, some systems (notably Scotland, but also Wales to some extent) face the difficulties of providing health care services to geographically remote communities. Northern Ireland and Wales (where gross disposable household incomes per head per year are GBP 13 902 and GBP 14 623 respectively) are considerably poorer regions than Scotland and England (GBP 16 267 and GBP 17 066 respectively). Health services in Wales also face the unique expectation of providing care in Welsh or in English, according to patients’ preference.

Average performance on some international benchmarks of the quality of care is also a cause for concern

Despite the clear and consistent commitment to quality of care in all of the United Kingdom’s health systems, and the ambitious policies around quality assurance and promotion, data on outcomes for the United Kingdom raise some concerns. Based on international benchmarks of health care quality, notably OECD data, some indicators for the United Kingdom show average or disappointing performance.

Regarding indicators of acute care, the United Kingdom's rate of fatality after an ischaemic stroke is worse than the OECD average (Figure 0.2), although better than the OECD average after a heart attack (Figure 0.3). Overall, the United Kingdom compares poorly to OECD countries that should be viewed as peers such as Norway or the Netherlands, which have similarly structured health systems. Declines in fatality rate over the past decade, however, are particularly steep in the United Kingdom, for both stroke and heart attack.

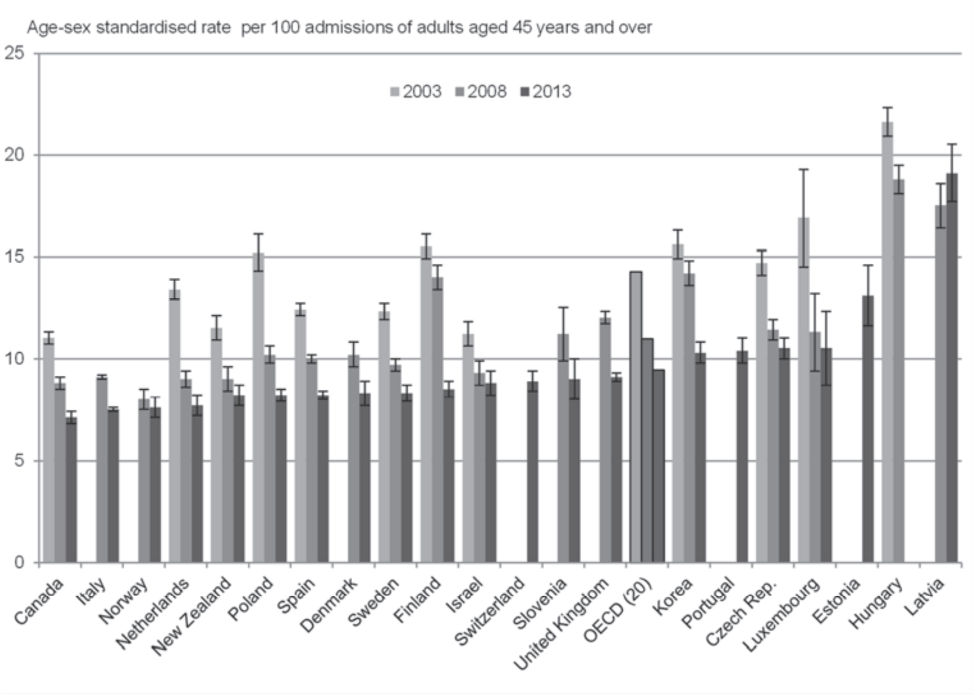
Figure 0.2. Thirty-day fatality after admission to hospital for ischemic stroke based on patient data, 2003 to 2013 (or nearest years)



Note: 95% confidence intervals represented by H. Three-year average for Luxembourg. Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Figure 0.3. Thirty-day fatality after admission to hospital for AMI based on patient data, 2003 to 2013 (or nearest years)

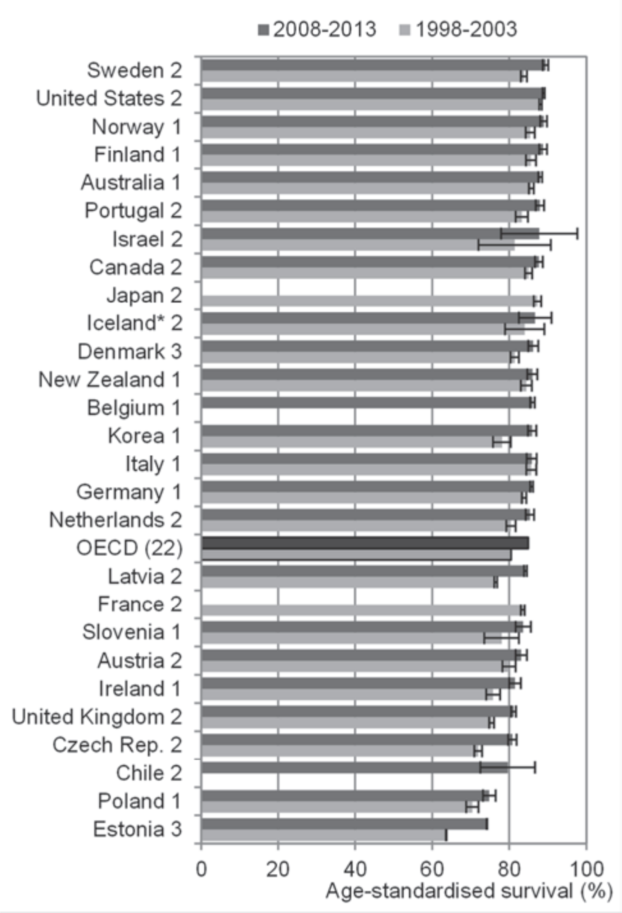


Note: 95% confidence intervals represented by H. Three-year average for Luxembourg. Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Outcomes for cancer in the United Kingdom show a mixed picture. Screening coverage for breast and cervical cancer are well above OECD averages. Survival estimates for breast, cervical and colorectal cancer, however, are all below the OECD average (see Figures 0.4, 0.5 and 0.6). However, the rate of improvement in breast cancer survival over the past decade has been faster in the United Kingdom than the OECD on average; improvements in survival rates for colorectal and cervical cancer appear to have increased marginally faster than the OECD average.

Figure 0.4. Breast cancer five-year relative survival, follow-up until 2003 and 2013 (or nearest years)



1. Period analysis.

2. Cohort analysis.

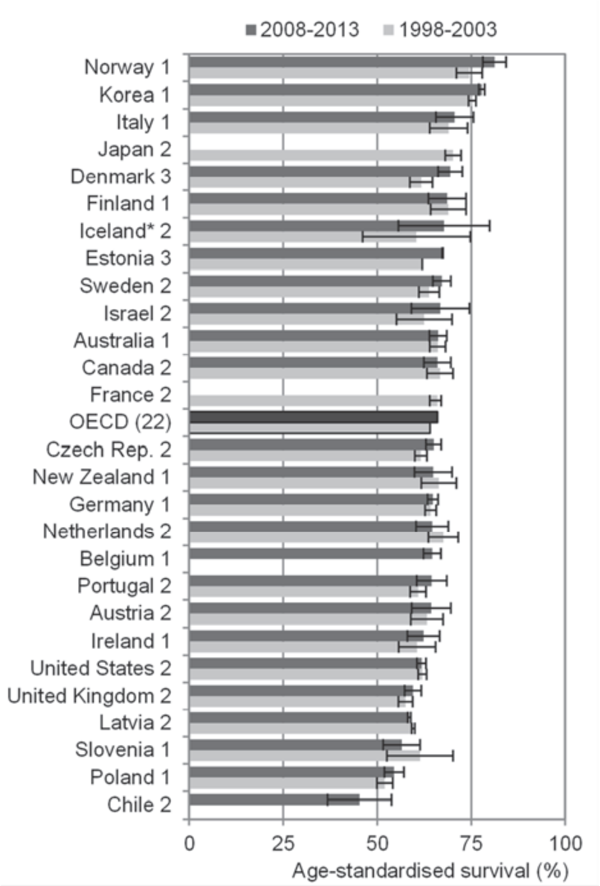
3. Different analysis methods used for different years.

* Three-period average.

Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Figure 0.5. Cervical cancer five-year relative survival, follow-up until 2003 and 2013 (or nearest years)



1. Period analysis.

2. Cohort analysis.

3. Different analysis methods used for different years.

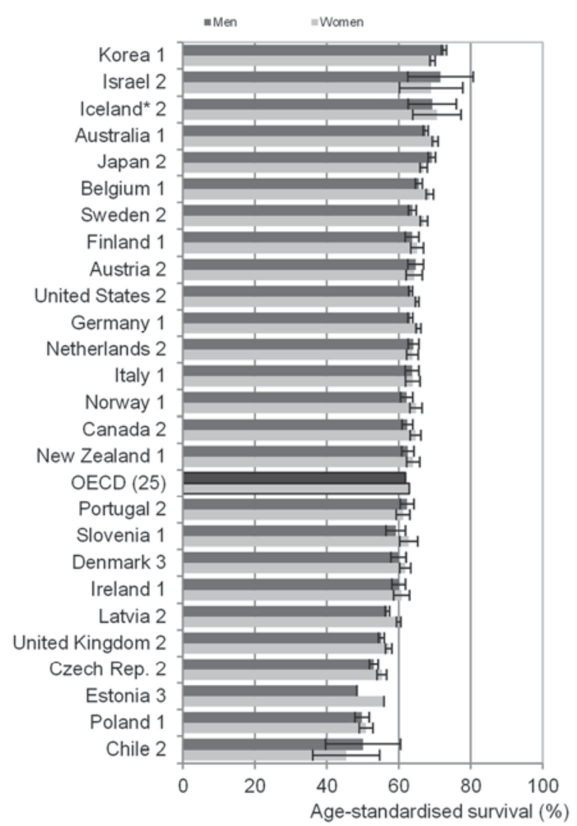
* Three-period average.

Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Indicators of the quality of primary care again show a mixed picture, with room for improvement. Given evidence on the link between the volume of antibiotics prescribed in primary care and the development of antimicrobial resistance, it is recommended that antibiotics only be given when there is an evidence-based need, and that the use of second-line antibiotics (such as cephalosporin and quinolones) be kept low. Regarding the former, the total volume of antibiotics prescribed in the United Kingdom is higher than the OECD average. More promisingly, however, the volume of second-line antibiotics is amongst the lowest observed (0.8 defined daily doses per 1 000 population per year, compared to 3.3 OECD average).

Figure 0.6. Colorectal cancer, five-year relative survival by gender, follow-up until 2013 (or nearest year)



1. Period analysis.

2. Cohort analysis.

3. Different analysis methods used for different years.

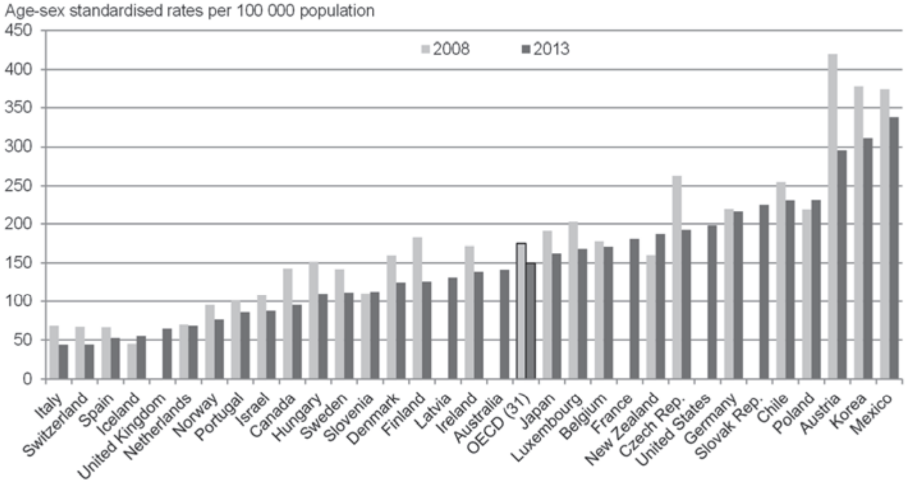
* Three-period average.

Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

When looking at the rate of hospital admissions for conditions that should be managed by primary care, the picture is also mixed. Whilst hospital admissions are amongst the lowest in the OECD for diabetes (Figure 0.7) and heart failure (Figure 0.8), admissions for asthma and COPD are above the OECD average (Figure 0.9). In percentage terms, however, admission rates for asthma and COPD fell faster in the United Kingdom between 2008 and 2013 than the OECD average.

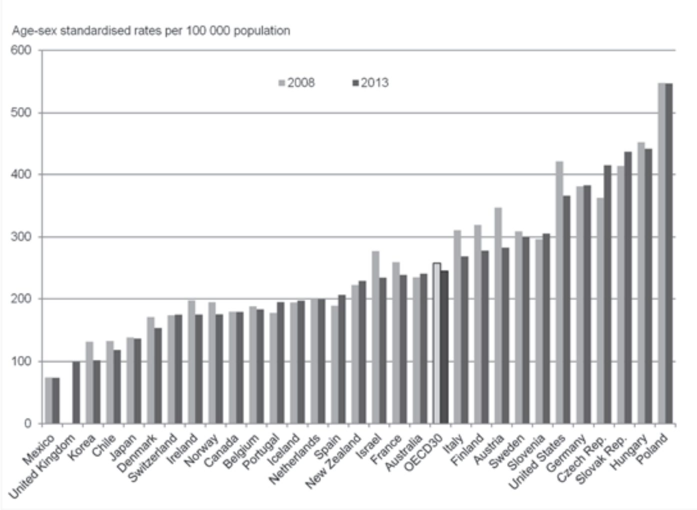
Figure 0.7. Diabetes hospital admission in adults, 2008 and 2013 (or latest year)



Note: Three-year average for Iceland and Luxembourg. Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

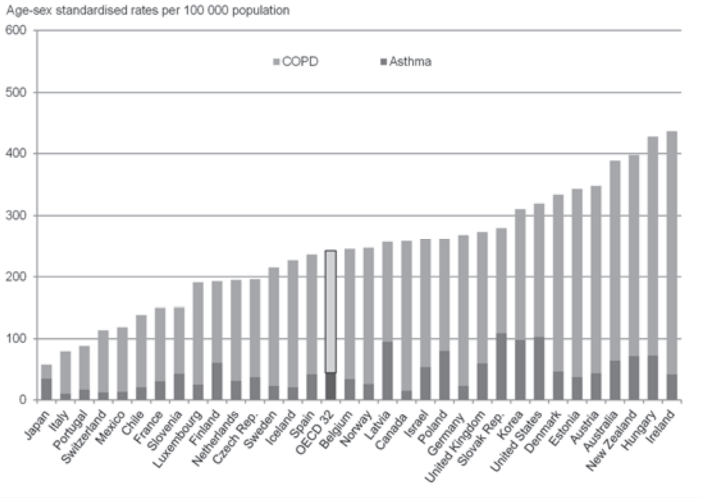
Figure 0.8. Congestive heart failure hospital admission in adults, 2008 and 2013 (or latest year)



Note: Three-year average for Iceland and Luxembourg. Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

Figure 0.9. Asthma and COPD hospital admission in adults, 2013 (or latest year)



Note: Three-year average for Iceland and Luxembourg. Information on data for Israel: http://oe.cd/israel-disclaimer.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

More promisingly, two indicators of a positive patient experience in primary or ambulatory care (regarding opportunities to ask questions or raise concerns and involvement in care and treatment decisions) are well above average in the United Kingdom (at 92% vs 85%, and 88% vs 81% respectively). On two other indicators of patient experience (regarding the doctor spending enough time in the consultation, the doctor providing easy-to-understand explanations), the United Kingdom is only just above the OECD average (at 86% vs 85%, and 90% vs 88% respectively). In contrast, Belgium and Luxembourg score above 95% patient satisfaction for all four indicators.

Other organisations also produce international benchmarks of the quality of care. The Commonwealth Fund's *Mirror, Mirror* publication ranks 11 high-income health systems on indicators of quality, access, efficiency, equity and mortality/life expectancy (Davis et al., 2014). The United Kingdom scores very highly in this framework, coming first out of all indicators except timeliness of care (where it comes 3rd) and mortality/life expectancy (where it comes 10th). Of note, the publication does not use routinely-collected system-wide data, but data from three surveys of 1 000 adults, 1 001 sicker adults and 500 primary care physicians in the United Kingdom (with comparable numbers in the other ten countries). In contrast, in the EuroHealth Consumer Index (which assesses a range of performance indicators including use of electronic patient records, same-day access to Family Physicians, survival rates and access to pharmaceuticals), England is ranked 14th out of 36 countries and Scotland 16th.

On balance, the United Kingdom does not consistently demonstrate strong performance on international benchmarks of health care quality, despite having prioritised quality assurance, monitoring and improvement work for many years. It is not obvious why this might be. It may be because the United Kingdom spends less on health care (as a share of GDP) than peers such as the Netherlands, Sweden, Germany, France, Denmark and Canada, all of whom spend more than 10%. It may be that the quality initiatives in place need more time to yield results. Alternatively, it may be that these quality initiatives are not optimally designed or implemented. This possibility is explored more in Sections 0.3 and 0.4, and examined in detail in each of the country-specific chapters that follow.

Fewer country-specific quality benchmarks are routinely published than they could be

A surprisingly limited number of comparable national quality and outcome indicators are published separately for England, Northern Ireland, Scotland and Wales, making benchmarking within the United Kingdom nations, or indeed against other OECD countries, challenging. Some indicators are published where data and targets are broadly comparable (such as for some mortality measures), or where comparable data has been assembled independently (in reviews by the Health Foundation and Nuffield Trust, for example, discussed in the next section).

The OECD's *Health Care Quality Indicators* are only published at an aggregate UK level. These aggregate data are constructed from separate submissions from each country – but the country-level data are not systematically published nor made externally available. This includes avoidable hospital admission rates; diabetes complications rates; fatality rates after a stroke or heart attack; foreign body left during procedures; hip fracture surgery initiated within two calendar days of hospital admission; and breast, cervical and colorectal cancer survival rates. It is understood that disaggregated information is not routinely published because of concerns that cross-country comparability may be limited by differences in demographics, socioeconomic context and the cost of providing health care.

National clinical audits are another source of cross-country information. For example, the *National Thoracic Surgery Activity & Outcomes Report* includes hospitals in all four countries, as does the Association of Breast Surgery's *Breast Screening Audit*. The National Hip Fracture Database's *Anaesthesia Sprint Audit of Practice* provides hospital-level data against various standards, with hospitals from all over the United Kingdom participating. Many clinical audits, however, do not cover all four countries. For example, the *National Diabetes Audit* measures the effectiveness of diabetes care against NICE clinical guidelines and quality standards, but only in England and Wales. Those two countries also participate in the *National Bowel Cancer Audit*. Three countries participate in the *National Audit of Cardiac Rehabilitation* and *National Joint Registry*, with Scotland not taking part in either. Nor is Scotland included in the Royal College of Physicians' *Sentinel Stroke National Audit Programme*. Scotland has its own stroke audit, providing hospital-level data on a range of indicators showing whether the performance of individual hospitals is improving. Similarly, the *British Social Attitudes* survey assessed levels of satisfaction for various aspects of the health system in 2011, but does not cover Northern Ireland.

The relative lack of published country-specific quality benchmarks in the United Kingdom has been noted by other bodies. The National Audit Office observed that comparable data on the efficiency and quality of health care across the four countries was "patchy". Likewise, the Royal College of Paediatrics and Child Health, in a review of child deaths, noted that differences in access to data limit cross-country comparisons and the ability to inform policy and practice. The authors observed that datasets and access needed to be harmonised.

Given the limited comparable data available across the four health systems, it is difficult to draw sound conclusions about broader quality and performance. This should be a good argument for first, better understanding the drivers behind the limited set of comparable data available, and second, expanding comparable data that allows benchmarking between the United Kingdom's four health systems, and between these and international peers to give a fuller perspective on performance and quality. As the four United Kingdom health systems continue to develop their quality architecture (whilst also pursuing increasingly distinct policy trajectories more generally), publicly reporting health system data, and all HCQI in particular, at country level could help evaluate the impacts of policies, enabling the countries to draw lessons about what works. Given that each of the countries is striving to be patient-centred, it could also be argued that this comes with a responsibility to provide the public with as much information as possible.

As noted, concern exists that the four countries in the United Kingdom are sufficiently different to prevent meaningful comparison of health system outcomes. This does not seem entirely justified. The OECD's *Health Care Quality Indicators* (HCQI) benchmark Korea alongside the Czech Republic, or Canada alongside Hungary and so on. Interpretation, individual learning and shared reflection proceed despite the many differences between these health systems. None of the United Kingdom's economies, benchmarked against OECD economies, is exceptional. Estonia, Luxembourg and Iceland have similar sized or smaller populations than the smallest United Kingdom country (Northern Ireland) and OECD average household per capita income is only marginally above that of the least prosperous United Kingdom economy (Wales). Appearance of English, Scottish, Welsh and Northern Irish data within an OECD panel would be entirely appropriate, therefore. As discussed later, regionally-disaggregated data (comparing, for example, Wales with the north eastern region of England, given their demographic and socioeconomic similarities) may also help overcome concerns around national comparability.

Based on the available information, no one health system appears to consistently outperform the others

From the limited country-specific data available, no consistent picture emerges of one of the United Kingdom's four health systems performing better than another. A recent review by the Nuffield Trust and the Health Foundation (2014) brought together the indicators that are reported separately for the four United Kingdom countries, and used them to compare health system performance and health outcomes. This review found, as the chapters of this report and available OECD data have pointed to, that there have been improvements in population health across all four countries, in areas such amenable mortality and life expectancy. In many areas outcomes are similar – uptake of breast cancer screening between the ages of 50 and 70, for example, was similar for all four countries in 2010-11 (around 70%), and there was little difference between the four countries with regards to one-year rates of survival for patients on renal replacement therapy (around 90%).

Differences in levels of satisfaction with health services emerged from the British Social Attitudes (BSA) 2011 survey for various aspects of health services, but not in a consistent manner. In Wales, 78% of survey respondents were "very satisfied" or "quite satisfied" with how local doctors or GPs were being run compared to 68% in Scotland, for example. In contrast, 68% of respondents in Scotland were "very satisfied" or "quite satisfied" with being in hospital as an inpatient, compared to 53% in Wales. Meanwhile, more recent national surveys have shown different results. In Wales for example in a 2013-14 national survey found that 92% of people were satisfied (68% very satisfied and 24% fairly satisfied) with their GP services, 91% were satisfied (70% very satisfied and 21% fairly satisfied) with the care they received in hospital.

There are also differences in influenza vaccination, important in light of the World Health Assembly goal of attaining vaccination coverage against influenza of 75% of the elderly population by 2010. In 2012-13, Scotland and Northern Ireland attained the target, with about 76% of people aged over 65 vaccinated. In England, it was about 75%, while coverage was lowest in Wales (68%). There was wide variation in vaccination rates for under-65s at risk, from 50% in Wales to 80% in Northern Ireland. Similarly, there were discrepancies in coverage rates among pregnant women, from 40% in England to almost 65% in Northern Ireland. The report also provided disaggregated data for methicillin-resistant staphylococcus aureus (MRSA) mortality rates per one million population for three countries (but not for Scotland). The data indicate MRSA mortality rates for men were about twice those for women. The rates for males in England fell from a peak of 27 in 2006 to 3.7 in 2012; in Wales, from a peak of 28 in 2005 to 7.6 in 2012; and in Northern Ireland, from a peak of 43 in 2008 to 9.7 in 2012.

The report did, however, identify four areas where differences within the United Kingdom were more pronounced: amenable mortality, life expectancy, waiting times, and nurse staffing levels. Importantly, none of these four measures is usually considered as an indicator of the quality of care. In particular, life expectancy and amenable mortality are partially determined by socioeconomic contexts. Nevertheless, to summarise briefly, England has the highest life expectancy for males (78.9 years in 2011) and females (82.9) and Scotland had the lowest life expectancy (76.1 and 80.6), with Wales and Northern Ireland falling in between; a spread that is also reflected in rates of amenable mortality (defined as premature death under age 75 from causes that should not occur in the presence of timely and effective health care). Overall, though, between the four countries the review identified no consistently poor or poorest performer, nor a clear "high achiever" (Box 0.1).

Box 0.1. Waiting times across the United Kingdom

Waiting times can be an indicator of how well a system is able to manage and respond to demand for care, and can be a measure of how easily patients can get timely access to the treatment or service they need. The OECD, which collects internationally comparable waiting times data on elective surgery for cataract surgery, hip and knee replacement, considers that waiting times are an important indicator of access to health care, but does not include waiting times in the core quality indicator set. Based on latest available data (2014), the United Kingdom has below average waiting times for the 14 OECD countries that report waiting times for these elective procedures. OECD data suggests that UK wait times have either remained steady between 2007 and 2014 (cataract surgery), or fallen (hip and knee replacement) (OECD, 2015).

Some waiting time data are collected across the four UK nations, and are broadly comparable, including waiting times for select common procedures (for example cataract surgery, coronary artery bypass grafts surgery, inguinal hernia procedure and hip and knee replacement) and ambulance response times. These data are not available for Northern Ireland after 2009/10 (Nuffield Trust and The Health Foundation, 2014).

Hospital waiting times are also collected in the four countries, but changes over time in targets and standards set, and different standards and targets in place across the four countries. These differences mean that it is not possible to examine past trends in waiting times, or between countries (Nuffield Trust and The Health Foundation, 2014). For example, performance targets for hospital referrals to treatment for elective care differ (Nuffield Trust and The Health Foundation, 2014).

However, while differences in target setting and waiting times standards are likely to remain as devolved administrations pursue different priorities, aiming toward consistently comparable data as a minimum across the four countries is evidently desirable. Comparable waiting time data will help show the impact of different policy changes between and within the four countries. Some information is already collected on a country basis.

0.3. The United Kingdom's responses to health system challenges

There is much that is common in the tools, policies and approaches that four health systems have used to respond to the challenges of delivering ever better health care quality, in the face of increasing demands and tighter finances. Policies around professional training and certification, authorisation of medical devices and pharmaceuticals, development and use of practice guidelines and patient involvement in improving health care quality are very similar, for example.

There is divergence, however, in the degree to which inspection, regulation and public disclosure of the performance of local services by central authorities is used as a lever to assure quality. Over recent years, England has increasingly emphasised the role of regulation, inspection and transparent publication of performance indicators to drive local quality improvement. In contrast, Scotland, Wales and Northern Ireland have sought to strengthen locally-owned, grass-roots initiatives around quality assurance and improvement, whilst maintaining an emphasis on transparency. Whilst none of the systems is entirely characterised by a top-down or bottom-up stance, the existence of distinct approaches is acknowledged by those responsible for leading the quality agendas in each health system.

Distinct approaches to quality assurance of minimum standards are evident

England's quality governance is notably centralised compared to most other OECD health systems and those in other parts of the United Kingdom, particularly with regards to the assurance of minimum standards. National bodies such as *NHS England* and the *Care Quality Commission* have significant reach into how local providers' quality of care is demonstrated and assured. Monitor and the Trust Development Authority (TDA) act as independent regulators. The Department of Health maintains a close interest in the quality and outcomes of local providers, and is proactive in intervening where concerns arise. A number of external, independent reviews of quality have triggered substantial, system-wide reforms in an attempt to prevent future failings in the quality of care, exemplified by the reviews following episodes of unacceptable care at Mid Staffordshire NHS Foundation Trust and the Morecambe Bay Hospital. Wales also has commissioned and published external reviews of service quality after quality concerns have been raised.

In broad terms, England's health care quality governance model has progressively shifted toward a quality management approach, increasingly reliant upon inspection, external supervision (and, at times, externally-imposed management) where minimum standards are not met. In particular, the *Care Quality Commission* demonstrates one of the most comprehensive and sophisticated approaches seen within OECD health systems, and serves as a model for other countries wishing to develop an inspection/accreditation function or develop a more regulatory approach to quality governance.

National regulators and inspectorates, of course, are present and active in the quality agendas of Scottish, Welsh and Northern Irish health systems, and it would not be true to say that central authorities are not involved, or are laissez-faire. Nevertheless, a lighter-touch engagement is consciously pursued – something more easily done, perhaps, in these much smaller organisations. Periodic service accreditation, for example, is not prioritised as much as other tools in Scotland's quality agenda. Likewise, in Wales and Northern Ireland accreditation and inspection have not, historically, been as heavily relied upon as in England, even though these health systems remain highly scrutinised (by the media and civil society groups, for example). In general, it seems that the smaller systems are more able to use geographical proximity and long-standing personal or institutional connections to have a continuous, even if not always formally constructed, dialogue about local services' performance. Where concerns arise, formally constituted escalation frameworks are in place and are used to ensure prompt action and accountability.

Contrasting approaches to quality improvement are also seen

Mirroring the differences in how quality assurance is arranged, the four systems show differences in how quality improvement is delivered. In broad terms, England's emphasis on strengthening central authorities' regulation and inspection of local providers' quality can be contrasted with Scotland, Wales and Northern Ireland's focus on continuous quality improvement through bottom-up, grass-roots initiatives. Small-scale interventions and peer-to-peer learning are firmly embedded in the quality culture of these systems and positively encouraged. Scotland, for example, has worked closely with the Institute for Healthcare Improvement (IHI) in Boston, and applied its *Breakthrough Collaborative* method in numerous services (such as Intensive Care Units, in order to prevent nosocomial infection). Teaching quality improvement techniques is also deeply engrained into education and training (the Scottish *Patient Safety Fellowship* programme being an example). From a quality improvement point of view, Scotland's under- and post-graduate training programmes are amongst the most impressive seen in OECD health systems, and offer a model to emulate.

In a similar vein, Wales' "1000 Lives" and "1000 Lives Plus" campaigns have sought to engage staff in developing evidence-based interventions and spreading good practice, using an adapted version of the *Model for Improvement* developed by Associates in Process Improvement. This also emphasises change and iterative testing at a local level, before becoming systematised. Wales' undergraduate health training curricula also incorporate quality improvement through the *Improving Quality Together* programme, which is being rolled out across the NHS workforce. Wales' system of peer-review of cancer services is another good illustration of a bottom-up quality improvement approach, and will be a model that other OECD health systems looking to develop a collaborative approach to health care improvement will wish to learn from. Again as part of an emphasis on system-learning and improvement, as well as giving families reassurance, every death in hospital in Wales is followed by a case note review, with consistent methodology. In Northern Ireland, the five geographically-aligned Health and Social Care Trusts have each developed quite distinct quality agendas, with different emphases according to local priorities. For example, in one Trust, much emphasis is place on developing hospital-based indicators of quality, while in another Trust improved support for palliative care is being explored.

England, of course, also pursues locally-led quality improvement activities. The *Sign up to Safety* campaign, for example, brings together local safety leads and extends to all care settings, including general practices. This is supported by 15 *Patient Safety Collaboratives* working with their health care communities to tackle the leading causes of harm. Also at a local level, Clinical Commissioning Groups (CCGs) are increasingly working across health, social care, the voluntary and independent sectors and local authorities, to develop tools for quality improvement. Audit cycles of local practice have also been built in to clinicians' training and continuing professional development for many years.

Efforts to build more patient-centred, integrated care also diverge

Across all the four health systems, there is substantial investment directed toward delivery of more patient-centred and better-integrated care. This is expected to lead to both quality and efficiency gains. Approaches to achieving this, however, vary significantly. In England, demand-led commissioning, choice and competition are expected to create more responsive health care services that better meet patients' needs. While the availability of evidence related to this is evolving, available evidence shows that competition at regulated prices can also help with the integration of care (OHE Commission on Competition in the NHS, 2012). Additionally, resources and support from the centre (such as the *Better Care Fund*) are also intended to drive more integrated, person-centred care. Of note, England has been particularly innovative in the payment systems it uses to reimburse providers, again in an effort to drive more patient-centred care (purchasing pre-defined pathways of care for patients with complex needs, for example, rather than reimbursing isolated episodes). Promoting integration is also one of the broad objectives of the *Commissioning for Quality and Innovation* (CQUIN) initiative. The 2015/16 scheme aims to reward transformation across care pathways that cut across different providers. England's experience here again offers substantial learning for other OECD health systems.

In contrast to England, Scotland, Wales and Northern Ireland expect to achieve more integrated, person-centred care through prior planning of providers' activities, with co-ordination and collaboration between them on the ground. A particularly impressive example is seen in Scotland's *Early Years Collaborative*. This programme, which Scotland identifies as a globally pioneering multi-agency, bottom-up quality improvement programme, aims to improve child and family health and reduce inequalities, with health services working in co-operation with sectors such as social services, education and the police. In Wales, a clear example of local collaboration concerns the 64 primary care clusters that have been created. These are expected to deliver service improvements and reduce inequalities by linking elements of individual practices' development plans, whilst working with other partners to improve the co-ordination of care and the integration of health and social care. In Northern Ireland, the *Transforming Your Care* agenda, established in 2012, provides a blueprint for service reform, with the transition to local population based service planning and integrated local service provision. The review places general practice central to this reform, and looks to general practitioners to form geographical networks and assume leadership roles in 17 Integrated Care Partnerships.

One aspect where the four systems have more in common concerns data and information systems. All four countries are making substantial investments to build consolidated health and social care databases (from the multiple disparate ones that currently exist) that will allow a complete picture of individuals' needs, use of services, outcomes and associated costs. The United Kingdom systems' activity in this area is, again, amongst the most advanced in the OECD. England's *care.data* programme is perhaps the best known, but other examples also offer valuable learning for other OECD health systems. Wales' *Secure Anonymised Information Linkage* (SAIL) databank, for example, brings together demographic, public health, secondary care and primary care individual-level data. It is used for epidemiological research and clinical trials, geared to improving service quality. In Scotland, the *Health and Social Care Data Integration and Intelligence Project* will use unique identifiers to link health and social care data at an individual level, with derived activity and costs, to build an understanding of how people use services and underpin local strategic commissioning plans. This work builds upon earlier experience in Scotland around developing an *Integrated Resource Framework* for health and community care, and should enable local systems to quantify health and social care use across populations (rather than organisations) and realign resources accordingly.

No one national approach clearly works better than another and there are signals that each system may need to rebalance its quality architecture

Each of the four health systems is pursuing the approach to quality assurance, monitoring and improvement systems that it feels is best suited to its context and challenges. Whether one national approach works better than another is an open question. As indicated earlier, there is no empirical evidence to suggest that one approach is working better than another. This is partly due to a lack of comparable quality and performance indicators across the four systems and is an argument to move as quickly as possible to a much richer set of disaggregated country- (or region-) specific indicators.

In the absence of such information, health systems should nevertheless be alert to signals of an emerging imbalance between top-down quality management and bottom-up quality improvement tools, upon either approach becoming too dominant in a system's overall quality architecture. An overly centralised, top-heavy system is likely to be characterised by numerous regulations that attempt to standardise processes and outputs; repeated system overhauls in reaction to individual incidents of inadequate care (as opposed to using existing structures to understand and address the reasons for failure); and feelings of disempowerment, distrust or fear amongst those working on the front line. This may manifest as difficulties in recruitment and retention of staff. In contrast, a system too dependent on bottom-up approaches risks slow or patchy progress on key strategic objectives (such as strengthening primary care); inability or unwillingness to standardise information and analysis on critical outcomes (such as patient safety events); and, linked to this, lack of transparency and accountability for health system performance. Broadly, this may mean that central authorities have difficulty in capturing a system-wide snapshot of activities and performance.

There are signals of such imbalances in each system. In England, the shift towards a quality management approach has led to a proliferation of national agencies, reviews and policies, creating a congested and fragmented field of actors, particularly in the fields of regulation and performance monitoring (although this is beginning to be addressed through, for example, the bringing together of TDA and Monitor under a single leadership). In Scotland, adverse event reporting is done locally, not nationally. Although this is a deliberate approach (to foster local ownership), there is nevertheless a need for a national reporting/monitoring system to benchmark local patient safety work, identify emergent safety concerns, and monitor the impacts of national patient safety programmes. In Wales, local Health Boards (established in 2009 to plan and deliver care for the local population) do not appear to have sufficient institutional and technical capacity to drive meaningful innovation and quality gains, and a stronger central guiding hand is now needed to play a more supportive – and prescriptive – role. Similarly, in Northern Ireland, whilst Health and Social Care Trusts exhibit an array of grassroots initiatives to improve quality, there is a lack of system-wide approach to drive effective learning and sharing across services, and scaling up of good practices.

0.4. Strengthening health care quality in the United Kingdom

Taken as a whole, there is no area in the health care quality agenda in which the United Kingdom's health systems are less active than other countries. In many cases, as illustrated earlier, the United Kingdom has led the field internationally. Reflecting on what could be done differently across the four systems is necessary, though, for two reasons. First, to enable the United Kingdom to remain at the forefront of innovation and learning around health care quality, generating global goods in doing so. Second, and more importantly, is to enable the United Kingdom to address disappointing performance on some international benchmarks of health care quality such as survival after a stroke or a diagnosis of cancer, as discussed in Section 0.2.

Top-down regulatory approaches and bottom-up, locally-owned approaches to quality improvement need to be better balanced

There is a balance to be struck between a centrally-driven, regulatory approach to quality management and locally-driven quality improvement activities. Chapter 1 on England's health system, for example, underlines that there are limits to what regulation, inspection and transparency can achieve. External scrutiny, no matter how sophisticated, cannot be a guarantee of quality and safety in a complex, busy and high-risk endeavour such as the NHS. The current regulatory approach focused on quality management needs to be balanced with greater emphasis on bottom-up approaches led by patients and professionals. Implementing the recommendations of the *Berwick Review, Compassion in Practice* and other reviews which reaffirm the importance of professionalism as the bedrock of quality should be priorities, as well as ensuring that 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.

Recommendations in the chapters that follow on Scotland's, Wales' and Northern Ireland's health systems focus on the counter-risk. In these health systems, which consciously prioritise a locally-owned and bottom-up approach to quality assurance and improvement, there is a need for a greater degree of steering and oversight from central authorities, to provide consistency, direction and a strong accountability framework that is lacking in places. In Scotland, one priority to strengthen national quality work is to develop a more systematic approach to national patient registers and quality audits. Currently, these largely depend on the initiative of individual clinicians, meaning that some patient groups are poorly represented. A national reporting and monitoring system for adverse events is also needed. In Wales, more prescriptive demands of Health Boards in terms of performance and quality improvement are needed, with open comparison of results and visible accountability for all Health Boards. Positive steps in this direction have already been started, with the introduction of a new escalation and intervention framework. More could still be done, though, and in particular the *Prudent Healthcare* agenda should be backed up with concrete, measurable, time-bound objectives to bring about tangible results. In Northern Ireland, a more robust role for the Regulation and Quality Improvement Authority is needed. In particular, a core set of quality and clinical and social care standards should be established, with clear expectations regarding compliance and reporting communicated to providers as a matter of priority.

Taken together, these recommendations demonstrate the need for a responsive and flexible approach to health system governance, which balances central and local roles. There is no one system, either in the United Kingdom or in the OECD, that has optimised this balance better than any other. An optimal balance would be hard to define, since there are tradeoffs in prioritising either a centralised or localised governance model. Instead, a system should seek to combine the best elements of both centralised governance (consistency) and local governance (diversity), acknowledging historical context and current challenges, keeping the governance model under constant review to ensure that neither an overly centralised, nor overly localised, model becomes dominant.

The four health systems in the United Kingdom should reflect on how quality governance is applied in their setting. In the smaller, more intimate settings of Wales, Scotland and Northern Ireland, a lighter touch from central authorities might be more feasible than in England's much larger system, but this must not be at the expense of precision and conformity in meeting centrally-determined requirements, where appropriate. In contrast, England's bigger size (which implies that standards and other forms of regulation may need to be applied more overtly than in smaller systems) should not be allowed to suppress flexibility, innovation, professional motivation and a sense of local ownership; and quality improvement should continue to be devolved to a local level.

Both the streamlined, light-touch central governance model of the Nordic countries (OECD, 2013a and 2013b), as well as the fully regionalised governance model of Italy, complemented by clearly specified accountabilities to national agencies (OECD, 2014) will be of interest to United Kingdom authorities seeking to achieve consistency and accountability, whilst encouraging local ownership of service delivery and freedom to innovate.

More indicators of health care quality are needed that benchmark the four health systems separately

As illustrated earlier, there is a surprising lack of quality and outcomes data that is published in disaggregated form across the United Kingdom's different health systems. Very few of the OECD's *Health Care Quality Indicators* (HCQI), for example, are reported separately for the four systems – although the reported aggregate indicator (at UK level) have been compiled from country-level data. This is a clear missed opportunity.

The four health systems should move towards reporting more quality benchmarks at country or regional level, rather than the United Kingdom aggregates which are currently reported. The United Kingdom, and the OECD community more broadly, could learn a great deal from more open comparison of performance, given the different challenges that each system faces, and the different policy trajectories that each is pursuing. Whilst it is naive to imagine that any one of the four systems would ever emerge as plainly "better" or "worse" than another (given the breadth of health care activities), more disaggregated data could shed light on the relative benefits of particular aspects of each national approach. More disaggregated data may also yield some answers to, or at least allow a more nuanced analysis of, the question of why the United Kingdom's performance on some international quality benchmarks is middling, despite the attention and investment given to quality improvement in all four health systems.

Several immediate opportunities present themselves. First and foremost, the four systems should start reporting the OECD's *Health Care Quality Indicators* separately, since these data exist for each health system, are already used internally, and are internationally validated as quality benchmarks. Second, the four health systems should look to extend or harmonise data collection where comparable quality indicators exist for two or three of the four systems. This applies, for example, to some national clinical audits as outlined in Section 0.4. Finally, promising unilateral initiatives should be considered for UK-wide application. Scotland, for example, in a pioneering initiative related to out-of-hours primary care collects indicators on response times, appropriateness of triage for home visits, effective information exchange, implementation of national clinical standards and guidelines, antimicrobial prescribing and patient experience. With the provision of out-of-hours care a challenge for all OECD countries, there would be great value in collecting this information across all four United Kingdom nations to help evaluate the impacts of different models of care.

Regionally-disaggregated data may be even more informative than national disaggregates. Concerns over national comparability could be overcome by comparing, for example, Wales with the north eastern region of England (which shares some demographic and socioeconomic characteristics), as well as England as a whole. This is the approach taken in some recent studies such as the 2014 Health Foundation and the Nuffield Trust report. Data from the *Global Burden of Disease Study* has also been used to compare mortality and preventable ill-health in the English regions against Scotland, Wales, Northern Ireland and other national health systems (Newton et al., 2015). This study came to the important conclusion that if levels of health in the worst performing regions in England matched the best performing ones, England would have one of the lowest burdens of disease of any advanced industrialised country – showing the value of regional benchmarking.

Canada serves as a model to explore in this regard. The Canadian Institute of Health Information's *Your Health System* initiative (http://yourhealthsystem.cihi.ca) allows professionals and the public to benchmark a range of performance indicators at organisational, city, province or territory level. Indicators on access, safety, effectiveness, patient safety and others are reported (in a very user-friendly, interactive format) against national averages. The Canadian Provinces and Territories are extremely heterogeneous in terms of size, population, GDP per capita and other contextual factors – but this has not stood in the way of an ambitious benchmarking initiative whose goals are clearly stated in its strap line "Know, See, Share".

Formal mechanisms to allow the four health systems to collaborate and learn from each other are needed

At present, there are no standing mechanisms to enable the four health systems to collaborate on monitoring and improving health care quality in a comprehensive or on-going way. Key officials from each system (such as the Chief Medical Officers) meet regularly; relevant aspects of the health care quality agenda (such as revalidation) inevitably feature in these discussions. Quality of care also features in less regular, or more informal, contacts between other key officials and clinical leaders in each country. Within specific programme areas, there may also be regular interaction across the four systems.

There is nevertheless substantial scope to develop more regular and comprehensive collaboration on the quality of care agenda across England, Scotland, Wales and Northern Ireland. A forum, meeting regularly and comprising those individuals responsible for steering and implementing the quality agenda in each country, would allow discussion of shared challenges, collaboration around proposed solutions and exchange of successful experiences – potentially being of great benefit.

Key initial topics that the forum might address include achieving an appropriate balance between central and local quality governance of health services that best meets the needs of each country; appropriate reporting and use of quality and outcome metrics, particularly at service or clinician level; ensuring and improving quality at the interfaces between institutions and transitions between phases of care; developing indicator definitions, technology and data systems to support quality improvement in the community care sector. Another priority topic should be country-level reporting of the OECD's *Health Care Quality Indicators.*

The forum would also provide a setting to learn from the innovations being tried in each system. As the four systems continue to develop their distinct identities, such innovations are numerous. Innovations are also remarkably diverse across the four countries – underscoring the value of a forum in which the countries can come together and learn from each other. Examples include Scotland's *Early Years Collaborative*, described earlier; Wales's *Prudent Healthcare* initiative, that seeks to address over-diagnosis and over-treatment, whilst rebalancing the relationship between patients and their health services; Northern Ireland's long experience with the joint commissioning and performance management of health and social care, or England's innovation in using the *Friends and Family Test* to provide rapid, granular feedback on patient satisfaction across an increasing range of NHS services.

0.5. Conclusions

All four of the United Kingdom's health systems place a high premium on the quality of care. In several policy areas, such as clinical guidelines, continuous professional development and performance monitoring in primary care, the United Kingdom has been an international pioneer. Nevertheless, the United Kingdom's performance on some international benchmarks of the quality of care is disappointing. Reasons for this are unclear and perhaps puzzling, given the United Kingdom's long-standing and extensive investment in health care quality initiatives.

Faced with this challenge, there is much that is common in the tool and policies that the four health systems have used to improve the quality of care. Policies around professional training and certification, authorisation of medical devices and pharmaceuticals, development and use of practice guidelines and patient involvement in improving health care quality are very similar, for example. There is divergence, however, in the degree to which inspection, regulation and public disclosure of the performance of local services by central authorities is used as a lever to assure quality. Whether one national approach works better than another is an open question.

To help answer this question, or at least allow a more nuanced analysis of, the question of why the United Kingdom's performance on some international quality benchmarks is middling, the four health systems should move, where appropriate, towards reporting more quality benchmarks at country or regional level, rather than the United Kingdom aggregates which are currently reported.

Additionally, as the four health systems pursue increasingly distinct policy trajectories with respect to quality assurance, quality improvement and providing more integrated, patient-centred care, there is a need for more formal collaboration between the systems – so that experiences, lessons and opportunities can be shared more effectively. This again would allow for more effective comparison and learning across them, as well as benefit the wider OECD community.

Policy recommendations

In addition to the recommendations given in the separate chapters for England, Scotland, Wales and Northern Ireland, health care systems in the United Kingdom can strengthen the assurance, monitoring and improvement of health care quality by:

1. Examining whether the balance between top-down regulatory approaches to quality management and bottom-up, locally-owned approaches to quality improvement are sufficiently even to catalyse flexibility, innovation and professional motivation whilst maintaining accountability. In some cases, a tighter grip from central authorities is needed; in others, this could be relaxed.
2. Publishing more quality and outcomes data disaggregated by country and, in particular, reporting each of the OECD's Health Care Quality Indicators separately, for England, Scotland, Wales and Northern Ireland.
3. Establishing a forum where the key officials and clinical leaders from England, Scotland, Wales and Northern Ireland responsible for quality of care can meet on a regular basis to learn from each other's innovations, and discuss shared concerns and potential solutions.
4. Continuing to look outward to learn from best practice internationally, and continuing to play a leadership role in international efforts to strengthen the measurement and comparison of health system performance.

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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.

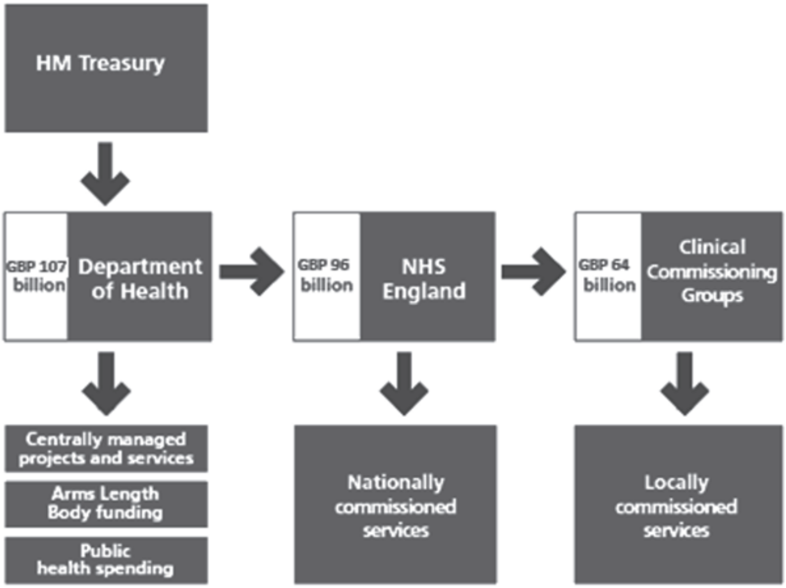
The main areas that the plan covers are prevention and public health; patient-led care; breaking down barriers between levels of care (notably family doctors and hospitals); building systems responsive to local needs; and, sustainable efficiency and funding models. As well as assessing the NHS' challenges 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.

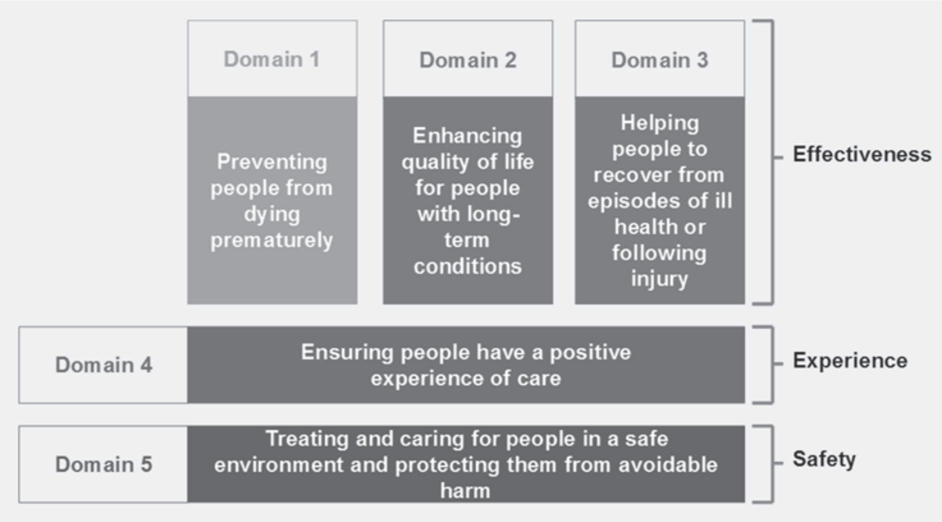
NHS England's business plan for 2015/16, *Building the NHS of the Five Year Forward View*, states that the over-arching ambition of NHS England's business is to improve health and wellbeing, secure high quality care, and put the NHS on the path to a sustainable future. This includes four priorities to 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.”.

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Chapter 2

Health care quality in Scotland

Scotland has set itself an ambitious quality agenda that strives to achieve health care that is consistently safe, effective and person-centred. This is underpinned by a bold public health vision that states that by 2020, everyone will live longer, healthier lives at home. Scotland has demonstrated keenness to play an internationally leading role in promoting health care quality, as evidenced by its innovative patient safety initiatives, world-class training programmes, and a clear desire to learn from patients' experience. Scotland is also taking steps to integrate health, social care and other services for local populations, and has an abundance of data to measure the progress in achieving health system and outcome goals. Paradoxically, health and social care data is not reliably converted into information that can be used by local clinicians and managers, nor oriented towards the public, often enough. This chapter gives a series of recommendations to support Scotland strengthening the health care quality architecture, including around making better use of information systems, facilitating transparency and reporting to the public, supporting bottom-up approaches with stronger national frameworks, and creating a more independent mechanism for assessing health system performance system-wide.

Scotland's *2020 Vision, Quality Strategy* and accompanying *Route Map* represent an ambitious and detailed agenda to improve health and social care in Scotland. At service level, these quality goals are delivered through a well-established approach of small-cycle testing of change and collaborative learning. A move towards integrating health and social care, illustrated by a ground-breaking approach to child health in the most vulnerable early years, demonstrates that Scotland is seeking to develop a whole-of-government approach to improving health outcomes.

There is still, however, much that Scotland can do. Quality improvement programmes should be applied to primary care and community care services more extensively and consistently. Consolidation of some content from the multiple data platforms that currently exist would facilitate transparency and public understanding of the quality of care. The lack of a national system for reporting/counting adverse events is another weakness, despite other innovations in promoting patient safety. Consideration should also be given to the creation of a more independent mechanism for assessing health system performance, since this function currently sits too closely to the agencies responsible for the task of quality improvement itself.

This chapter opens with a brief account of the planning, financing and delivery of health care in Scotland, which is followed by a description of the key policies and strategies in place to drive quality improvement in NHSScotland. The latter part of this chapter then describes and assesses the 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.

2.1. The planning, financing and delivery of health care in Scotland

Scotland has larger rural and remote areas than its neighbours, posing geographical challenges not experienced in other parts of the United Kingdom. Its approach to dealing with these issues is to forge close connections between policy making and implementation, to better respond to population need at a regional level. This section describes the governance and organisation of NHSScotland, and the state of population health.

Population health care needs in Scotland

Scotland has a population of about 5.2 million. Most people live in a central belt taking in the major cities of Glasgow and Edinburgh. Population density is low compared with the rest of the United Kingdom, due to larger rural and remote areas. While the size of the population has remained relatively stable over the past 50 years, the proportion aged 65 years and over has grown significantly and is projected to increase further.

Despite substantial improvements in population health during the past 15 years, life expectancy in Scotland is still lower than in other western European countries. The mean life expectancy in 2013 was 77.1 years for men in Scotland, compared with a mean western European average (not including the United Kingdom) of 78.9 years. Mean life expectancy for Scottish women was 81.1 years, compared with 83.7 for Western Europe more broadly.

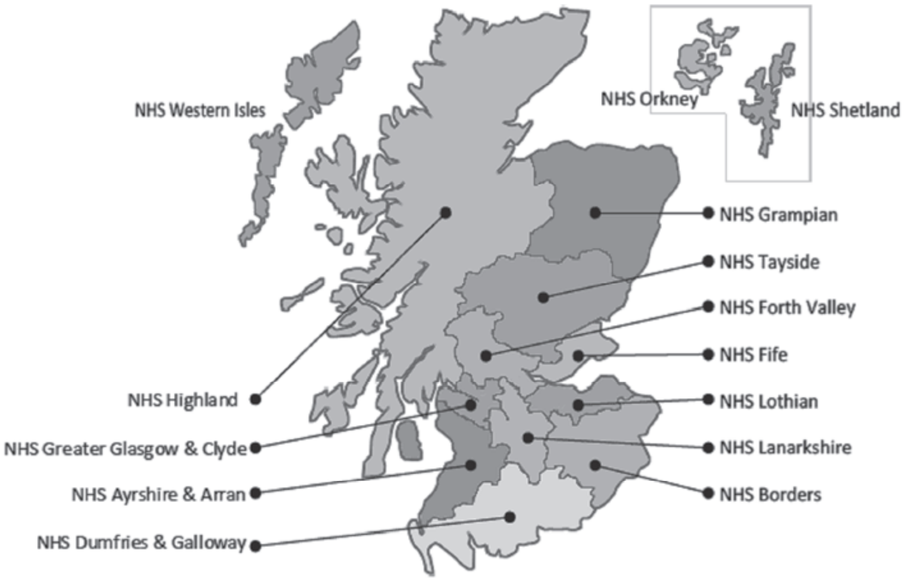
The 2013 Scottish Health Survey suggests Scotland is facing similar health issues to those experienced by other OECD countries. Almost half (44%) of adults and 17% of children aged up to 15 had a long-term health condition. More than 5% of adults reported they had been diagnosed with diabetes, and 8% reported a diagnosis of ischaemic heart disease or stroke. Three-quarters of adults aged 16 and over assessed their health as either “good” or “very good” (Scottish Government, 2014b). The management of complex conditions is recognised by Scottish health authorities as one of the most significant challenges it is facing.

Scotland faces substantial geographical challenges, particularly in the provision of health care in remote areas. About 20% of the Scottish population lives in a rural or remote area, spread across 94% of the landmass defined as rural and remote (MacVicar and Nicoll, 2013). Adding to this challenge is a greater proportion of older people live in these areas, and they inevitably have more complex health care needs. While 17% of the Scottish population is aged 65 and over, the councils with the largest proportion of people aged over 65 are predominantly rural (MacVicar and Nicoll, 2013). Equal access to high-quality health care is a stated goal, with the importance of remote health care cited in the Scottish Quality Strategy. Still, difficulties persist in recruiting health care professionals to live and work in rural areas. Apart from the provision of financial incentives, it is difficult to identify solutions that Scotland has tried to deal with this challenge.

The Scottish health care system

The Scottish Government’s Health and Social Care Directorate is responsible for the development and implementation of health and social care policy. It allocates resources and sets the strategic direction for NHSScotland, the primary provider of health care services. NHSScotland employs more than 140 000 staff and is organised into 14 Regional Boards, seven Special Boards and a Public Health Board (Figure 2.1 and Box 2.1). Each NHS Board is accountable to the Scottish Cabinet Secretary and Ministers for Health.

Figure 2.1. The 14 Regional Health Boards of NHS Scotland



Source: The Scottish Government.

The Chief Executive of NHSScotland is also the Director-General of Health and Social Care for the Scottish Government. This illustrates a close functional connection between policy making and implementation, which the Scottish authorities seek to replicate across the country and at every level of the system. Ministers and a team from the Directorate spend a day each year, for example, in every health authority, meeting health service staff, patients and the public in an effort to better understand priorities and concerns at the service level. Ministers also meet on a monthly basis with NHS Board Chairs to review strategy and performance.

In terms of quality governance, a particularly important body is the Healthcare Quality and Strategy Directorate, led by the National Clinical Director for Healthcare Quality and the Director for Healthcare Strategy. This Directorate, supported by the broader Health and Social Care Management Board, is responsible for delivering NHSScotland’s Quality Strategy, described in more detail in Section 2.1. The Unit meets regularly with the leaders of the Regional and Special NHS Boards to ensure effective and sustained translation of policy intentions into health care delivery. Key stakeholders within these governance arrangements describe a nimble, responsive system characterised by short management lines and consensual decision making, driven by learning from frontline services.[1]

Box 2.1. NHSScotland’s Special Boards

NHS Education for Scotland: NHSScotland’s education and training body.

NHS Health Scotland: Promotes ways to improve population health and reduce health inequalities.

NHS National Waiting Times Centre: Ensures prompt access to first-class treatment.

NHS24: Provides health advice and information.

Scottish Ambulance Service: Responds to almost 600 000 accident and emergency calls and takes 1.6 million patients to and from hospital each year.

The State Hospitals Board for Scotland: Provides assessment, treatment and care in conditions of special security for individuals with a mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting.

NHS National Services Scotland: Supplies essential services including health protection, blood transfusion and information.

Healthcare Improvement Scotland: supports and empowers people to have an informed voice; delivers scrutiny activity; provides quality improvement support; and provides clinical standards, guidelines and advice.

Source: NHS Scotland, http://www.show.scot.nhs.uk/introduction.aspx.

Health services in Scotland are government-funded and almost entirely financed by taxation. Health care is free at the point of care and available to all residents. User charges exist for dental services and some ophthalmic services. Prescription drugs and personal social care for those aged over 65 are free. The private sector is very small and consists of both for-profit and non-profit providers. About 8.5% of people have voluntary private health insurance. Per capita spending on health care in Scotland is slightly higher than in England (GBP 2 151 per head annually versus GBP 1 994 in England (HM Treasury, 2014). Of note, the split between purchasers and providers of health care was abolished in 2004.

2.2. The key policies and governance of health care quality monitoring and improvement in Scotland

Scotland’s ambitious vision to improve population health and quality of care is complemented by real progress toward better integration of health and social care. While presenting many challenges, this inter-sectoral approach strives to reduce health inequalities, starting with the pivotal early years of life. Scotland’s quality approach emphasises grass-roots initiatives and shared learning at local level to achieve patient-centred, safe and effective health care. This section describes and assesses the main policies and institutions tasked with monitoring and improving the quality of health care in Scotland.

Scotland's 2020 Vision, Quality Strategy and Route Map represent an ambitious agenda to improve health and social care in Scotland

Scotland has an ambitious, well-articulated national vision to achieve better population health and improve health care quality, underpinned by a national strategy and route map to get there. The government's *2020 Vision* states that by 2020, everyone will live longer, healthier lives at home, or in a homely setting. It sets out as significant challenges Scotland's public health record, changing demography and the economic environment. The document cites as a key challenge an anticipated 25% rise in the proportion of people aged 75 and over in Scotland in the next ten years. This rise is likely to be accompanied by more chronic disease, and growing numbers of older people with complex needs such as dementia. It estimates over the next 20 years, demography alone could increase expenditure on health and social care by over 70%. The *2020 Vision* reiterates the ambition of integrated health and social care, and a focus on prevention and self-management.

The *2020 Vision* provides the strategic narrative and context for taking forward the implementation of the *Healthcare Quality Strategy for NHSScotland*, and the required actions to improve efficiency and achieve financial sustainability. The *Strategy* goes beyond safety and quality to more broadly encompass effectiveness of care, and variations in medical practice. It strives to achieve three main quality ambitions. The *Strategy* aims for health care to be:

- *Person-centred*: featuring mutually beneficial partnerships between patients, their families and those delivering health care that respect individual needs and values and that demonstrate compassion, continuity, clear communication and shared decision making.
- *Safe*: with no avoidable injury or harm and the delivery of health care in an appropriate, clean and safe environment.
- *Effective*: with the most appropriate treatment provided, and wasteful or harmful variation eradicated.

The *Strategy* acknowledges that measuring quality is fundamental to its improvement. It sets out a *Quality Measurement Framework*, which provides the basis for the use of indicators at three national levels. The framework's highest level sets out long-term quality outcome indicators, which are intended to measure progress towards system-wide priorities. The second level relates to the performance management of NHS Boards, with agreed Local Delivery Plan (LDP) Standards (discussed in Section 2.7). The third level consists of several existing national and local measurement systems that are used to measure and drive improvement.

Finally, an accompanying *Route Map to the 2020 Vision for Health and Social Care* identifies the focus on priority areas. It defines 12 priority areas required to deliver the 2020 ambition across the domains of quality of care, population health, and value and sustainability. The priority areas are: person-centred care; safe care; primary care; unscheduled and emergency care; integrated care; care for multiple and chronic illnesses; early years; health inequalities; prevention; workforce; innovation; and efficiency and productivity. Alongside these policy documents is Scotland’s vision for the NHS workforce. *Everyone Matters: 2020 Workforce Vision* was launched in 2013 and consists of five priority areas: healthy organisational culture, sustainable workforce, capable workforce, integrated workforce and effective leadership and management.

Healthcare Improvement Scotland supports delivery of NHSScotland’s Quality Strategy through provision of standards and guidelines, inspection and other activities

Healthcare Improvement Scotland (HIS) is NHSScotland’s national health care improvement organisation. It was created in 2011, under the Public Services Reform (Scotland) Act 2010. The organisation provides quality improvement support to hospitals, primary care practices, NHS Boards, patients, carers and communities. A particular emphasis is to encourage patient involvement and shared decision making in an effort to improve the effectiveness, safety and patient-centredness of care.

Among HIS’s constituent elements is a Healthcare Environment Inspectorate, which carries out safety and cleanliness inspections across hospitals. A key aim of the Inspectorate is to reduce health care-acquired infections through the promotion of infection prevention and control. Between 1 October 2013 and 31 December 2014, it conducted 51 inspections, of which 41 were unannounced. The inspections resulted in a published report or letter to the relevant NHS Board. Detailed inspection reports documenting the safety and cleanliness of individual hospitals are available on the Healthcare Improvement Scotland website. This is discussed more fully in Section 2.4.

The Scottish Health Technologies Group is another component of HIS and provides advice about the clinical and cost effectiveness of health technologies to NHSScotland Boards. The Scottish Medicines Consortium performs this function for medicines. These are discussed more fully in Section 2.5. Linked to these activities, the Scottish Intercollegiate Guidelines Network (SIGN) develops evidence-based clinical practice guidelines for NHSScotland. SIGN also comes under the umbrella of HIS. Clinical guidelines are discussed further in Section 2.6.

The Scottish Health Council is a committee of HIS, but has its own distinct identity. The Council promotes patient and public involvement in the NHS, as a means of ensuring NHS Boards take into account the public perspective. This is discussed further in Section 2.9. Finally, another key element of Healthcare Improvement Scotland's work is the Scottish Patient Safety Programme, discussed in more detail in Section 2.11.

Implementation of NHSScotland's quality goals at service level is characterised by small-cycle testing of change and collaborative learning

NHSScotland's approach to implementing quality goals at service level has made use of several tools and approaches. In particular, the "Breakthrough Collaborative" method, developed at the Institute for Healthcare Improvement (IHI) in Boston, has been widely applied. This is a 6- to 15-month learning system that brings together clinicians, managers and other individuals within a service to seek improvement in a focused area. An issue for improvement is identified; key individuals with the capacity or accountability to bring about change are brought together; objectives and metrics are agreed; the *plan-do-study-act* (PDSA) cycle of change is started; and repeated as new learning or opportunities emerge.

A number of successful service innovations have become embedded across NHSScotland as a result of this approach. Some examples of improvements include the reliable implementation of care processes that prevent Intensive Care Unit acquired infections. Initiatives to prevent ventilator acquired pneumonia and central venous catheter related infections have been widely implemented, with evidence of improvements in clinical outcomes across Scotland. Implementation of the WHO surgical checklist and pause was supported by Scottish Patient Safety Programme implementation. In Scotland there has been an explicit strategic approach to build frontline and leadership improvement capability and capacity. The Scottish Patient Safety Fellowship is one such example as well training people to develop and utilise improvement advisor competencies. There is now an increasing network of individuals across the country with an understanding of applied quality improvement in their contexts.

Most quality improvement work of this type has taken place in acute hospital settings. A challenge for Scotland will be to replicate an equal, or greater, level of systematised quality improvement work in primary and community care settings. Quality challenges are at least as pressing in these sectors, but relevant metrics for outcomes of interest may be less available, and staff (for example in long-term care settings) may be less used to auditing their work and the PDSA cycle. Scotland has begun to extend the Breakthrough Collaborative approach to primary care, initially focusing on high-risk medications, but additional issues should be identified. Prevention and management of chronic conditions (including co-ordination with other services), mental health, safeguarding vulnerable children and adults would all be priority areas. Scotland has patient safety programmes in some of these areas (notably mental health and child and maternity services, as described in Section 2.11), but these should be built upon to encompass quality improvement work as well.

Scotland's quality agenda has been accompanied by a move towards the integration of health and social care

The 2014 Public Body (Joint Working) (Scotland) Act sets up the integration of health and social care for people using both of these services. It contains nationally agreed outcomes that apply across health and social care, and for which NHS Boards and local authorities are held jointly accountable. Goals for the reform are stated, such as: "people are able to look after and improve their own health and wellbeing and live in good health for longer", and "people who use health and social care services have positive experiences of those services, and have their dignity respected". Health Boards and local authorities will integrate health and social care services from April 2015. Local partnerships are now establishing shadow arrangements, and beginning to produce joint strategic commissioning plans.

NHS Boards and local authorities are required to integrate health and social care budgets, and to establish integrated partnership arrangements to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services. Integration must include, at least, adult social care, adult primary and community health care, and aspects of adult hospital care that offer the best opportunities for service redesign and better outcomes. Other services, including children's health and social care, criminal justice and housing, can also be included in integrated arrangements, if there is local agreement to do so.

One example is the *Early Years Collaborative*, a groundbreaking programme pursuing a particularly far-reaching cross-sectoral approach to child health. The Collaboratives aims to improve child and family health and reduce inequalities, with health services working in co-operation with sectors such as social services, education and the police. The partnership with other sectors is an acknowledgement that broader social determinants can shape health outcomes. Access to a wide range of services beyond health can assist families in obtaining the supports they need. The government has identified key areas for change (Scottish Government, 2015):

- early support for pregnancy and beyond
- attachment and child development
- continuity of care in transitions
- 27-30 month review
- developing parents’ skills
- family engagement to support learning
- addressing child poverty.

All 32 commissioning areas in Scotland are participants of the programme. Launched in 2012, about 700 professionals attend learning sessions, and then take away these learnings to share with their colleagues. There has been a high level of early engagement with the workforce, although several challenges have been identified in the early implementation stages. These include the recruitment of sufficient staff with the right skills to implement the model; training professionals to implement the model along with reporting on results of tests and using data to make planning and resourcing decisions; and challenges in multiple agencies working together (Children and Families Analysis, 2014).

In addition, in March 2015, the government specified an indicator set to monitor progress toward integration (Scottish Government, 2015a). These indicators fall into two groups: those based on surveys (such as the percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated); and, those derived from routine data sources (such as that rate of emergency admissions for adults). These indicators are discussed in more detail in Section 2.7. Given that most OECD health and social care systems are exploring how best to monitor person-centred, integrated care, Scotland’s experience with these indicators will be of international interest.

Scotland’s activity in this domain represents a bolder, and wider-ranging, intended sphere of integration that seen in most OECD systems. It will be important that Scotland publishes successful case studies detailing how integration was achieved, alongside implementation pathways and syntheses of insights, so that other countries can learn from Scotland’s experience.

There are expectations that integration will yield significant improvements in care provision in Scotland. However, there are challenges related to the way this reform has been set up, in that providers are not integrated in terms of budget or management structure. Processes to enable this are underway, including guidance for local authorities on the scope of the health and social care functions to be included in integration.

Another concern is that sufficiently strong mechanisms to leverage general practitioners' contribution to health and social care integration may be lacking. Although GPs are represented in local strategic planning arrangements and are encouraged to take on leadership roles, it is not clear how effective their participation will be given, for example, the fact that they are non-voting NHS Board members. GPs are likely to have a good understanding of local health care needs and service priorities. Scotland should consider, therefore, whether there is scope to deepen GPs' involvement in local care planning, and in the integration of health and social care services in particular.

The integration of health and social care information systems presents another challenge. It is well-recognised across OECD countries that the social care sector generally collects and publishes fewer quality and outcomes data than the health care sector. Care must be taken in Scotland, therefore, to ensure that merging the data from the two sectors does not come at the expense of the less data-developed social care sector. Similarly, there is also a need to ensure that adequate data exist across both health and social sectors not just at a national level, but at a local level.

The Scottish Government is addressing this issue via its *Health and Social Care Data Integration and Intelligence Project* (HSCDIIP). This will use individuals' Community Health Index (CHI) number as the basis for linking health and social care data at an individual level, with derived activity and costs, to build an understanding of how people use services and underpin local strategic commissioning plans. The Project also aims to develop a nationally agreed core dataset and definitions; IT solutions to allow access to these data with appropriate information governance safeguards; a reporting tool that will allow easy analysis and presentation of the data; and, bespoke analytical support and assistance with data interpretation. In addition, since 2011, work has been underway to develop local Integrated Resource Frameworks for health and community care, which enable local systems to quantify resource use across health and social care across populations (rather than organisations) and realign resources accordingly. The aim is to realign resources to deliver better value, and better patient-centred, care.

2.3. Professional training and certification

Scotland's quality drive is supported by professional training programmes that emphasise quality improvement as a core learning objective. There is clear innovation in its use of digital infrastructure to train health professionals so that they are equipped with the skills consistent with the needs of the NHS. The comprehensive suite of tools Scotland uses to train its health workforce makes it a leader among OECD countries.

Regulation of health care workers remains a UK-wide responsibility, while Scotland leads the revalidation process for Scottish doctors and nurses

Professional standards for all doctors and nurses working in the whole of the United Kingdom are set by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), respectively. These UK-wide independent health professional regulatory bodies have statutory responsibility for maintaining registers of all practitioners permitted to practise in the United Kingdom, setting standards for education, behaviour and practice for each of the registered professions. Additional regulatory bodies with statutory responsibility for maintaining the registers of other health practitioners include:

- General Chiropractic Council
- General Dental Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professions Council

These bodies set the standards that health practitioners must attain and maintain, and are responsible for taking action when the standards are not met. Practitioners can face sanctions such as the loss of the right to practise in the United Kingdom. The regulatory bodies are overseen by the Professional Standards Authority for Health and Social Care.

As part of ensuring ongoing professional development and fitness to practise, medical revalidation for physicians has been introduced across the United Kingdom, on a five-yearly basis. Revalidation is linked to demonstration of Continuing Professional Development and quality improvement work, as part of doctors' annual peer-to-peer appraisal. In Scotland, the medical director of each Health Board acts as responsible officer for signing off a doctors' revalidation, on the basis of a successful cycle of appraisals.

The NMC has signalled it will commence revalidation in October 2015, building upon the CPD requirements already in place for nurses and midwives. The NMC's Scotland Stakeholder Group is engaging with stakeholders so that its proposed revalidation system will work effectively within the particular context of NHSScotland (as part of the NMC's work across the United Kingdom to determine how revalidation will work for nurses and midwives more broadly).

NHS Education for Scotland supports an ambitious training agenda, much of it focused on quality improvement

NHS Education for Scotland, a special Health Board, was established 12 years ago and is responsible for supporting NHS services. It develops and delivers education and training for those who work in NHSScotland, working with universities and professional bodies to define or support undergraduate and postgraduate education, as well as CPD activities. *NHS Education for Scotland* is responsible for setting and maintaining high education standards, and making sure that workforce training and curricula are consistent with NHS needs. A number of practical activities have been developed to support workforce development, including clinical skills centres, communities of practice (for peer-to-peer support) and degree-level programmes for primary care Practice Managers.

In particular, the digital infrastructure of *NHS Education for Scotland* is well developed. It offers an e-portfolio to allow recording of CPD activities, available to doctors, nurses, dentists, pharmacists and other health care professionals. Similarly, the Scottish Online Appraisal Resource (SOAR) is an online platform to support doctors working and training in Scotland in the appraisal and revalidation process. The *Flying Start* programme has been created to support newly qualified nurses, midwives and allied health professionals during their first year of practice in Scotland. *NHS Education for Scotland* places particular emphasis on quality improvement, and is seeking to build a common approach to training in quality improvement theory and techniques across professional groups.

The sum of these activities represents a more comprehensive approach – across professional groups, across career stages, and in terms of activities and resources – than seen in most other OECD health systems. *NHS Education for Scotland* is one of the strengths of the Scottish health care system, and effectively reflects workforce ambitions set out in *Everyone Matters*, the workforce strategy for NHSScotland, described in more detail in the following section.

NHSScotland benefits from a clear and impressive workforce strategy

The work of NHS Education for Scotland and other bodies sits within the broader workforce strategy of the 2020 Vision, entitled Everyone Matters. This articulates a core vision for the workforce, developed in conjunction with NHS staff members, that emphasises improved ways of working, collaboration, and embracing technology. Supporting materials, including an Implementation Plan and a Communication Toolkit, have also been developed.

The Implementation Plan sets out detailed objectives and action points, year-by-year. For instance, for 2015-16, as part of the "Sustainable Workforce" objective, the Scottish Government will (as one of three points) "collaborate to make better use of analysis, intelligence and modelling of education and workforce data to inform longer-term planning". Meanwhile, NHS Boards will "use high quality workforce data and contextual information to inform local workforce plans" (Scottish Government, 2014a). The Communication Toolkit offers slides, posters, web banners and other material that may be needed to communicate the *Everyone Matters* agenda to NHS workforce at a local level.

2.4. Inspection and accreditation of health care facilities

Health care services are regularly inspected by Healthcare Improvement Scotland, but the absence of formal accreditation for hospital services is notable. This is an explicit choice taken by the Scottish authorities to encourage continuous quality improvement initiatives, rather than focus on verification of compliance with minimum standards. Given these arrangements, however, Healthcare Improvement Scotland should consider whether its scrutiny and improvement functions should to be more clearly separated. Healthcare Improvement Scotland also needs to be better equipped to respond to quality concerns, a situation which the Scottish authorities is currently looking to address.

Health care services are regularly inspected by Healthcare Improvement Scotland

As mentioned in an earlier section, *Healthcare Improvement Scotland* (HIS) inspects and reviews health care services in Scotland against published quality standards through a programme of announced and unannounced inspections, led by the *Scrutiny and Assurance Directorate*. HIS also regulates and inspects independent sector facilities such as private hospitals, voluntary hospices and private psychiatric hospitals. Assurance, Review and Inspection Reports are published, along with an annual synthesis report and various thematic reviews. This work accounts for about one fifth of HIS' budget.

Underpinning this activity, a scrutiny and inspection plan is produced annually. HIS is working towards a more intelligence-led approach to scrutiny and assurance, to re-align and simplify a range of activities, and to work more closely with other scrutiny bodies and identify opportunities for more joint reviews. As part of Scotland's transition towards integration of health and social care, HIS is already working more closely with the Care Inspectorate, the Scottish social care regulator. As of January 2016, seven joint reports have been published in relation to the care of older adults.

In July 2015, a consultation was launched to consider how HIS could strengthen its assessments of the quality of care.[2] It is proposed to widen the scope service reviews to include leadership, staffing, use of patient and carer feedback and assurance of the sustainability of service provision. In addition, distinctive characteristics of Scotland's locally-rooted approach to service assessments will be strengthened. These include an increased emphasis on local systems of scrutiny and assurance, and stronger focus on scrutiny being a tool for supporting improvement. Systematic linking of scrutiny activities with existing or planned improvement work is intended.

Healthcare Improvement Scotland's inspection role does not appear to be backed up, however, by adequate regulatory power

Despite existence of regular inspections and assessments against published quality standards, there is no formal accreditation system for NHS hospitals in Scotland. This is a conscious choice taken by the Scottish authorities, based on a concern that checking compliance against minimum standards might put a ceiling on improvement, give false assurance or be bureaucratically heavy-handed. Instead, Scotland has chosen to prioritise bottom-up collaboratives that seek continuous quality improvement rather verification of minimum standards, as described in Section 2.2. Providers' statutory duty of quality is believed to provide sufficient assurance, coupled with HIS inspection reports and regular publication of indicators of providers' quality and outcomes.

Whilst recognising Scotland's judicious consideration of the pros and cons of formal accreditation, its absence stands in contrast to most OECD health systems, where mechanisms to regularly and visibly assure the public of providers' quality of care are being strengthened. Some countries, such as Australia (Box 2.2), have gone down the path of mandatory accreditation of health services. The importance of such a function is, in fact, recognised in other parts of the Scottish health care system. Laboratories, for example, may be accredited against the Ionising Radiation (Medical Exposure) Regulations and the Scottish Electroconvulsive Therapy (ECT) Accreditation Network (SEAN) uses evidence-based standards to regularly assure the quality and safety of ECT services, in two-year cycles.

Box 2.2. Health service accreditation in Australia

In 2010, the Australian Government endorsed a national safety and quality framework that placed safety as the central organising theme. This set up the Australian Health Service Safety and Quality Accreditation Scheme. The development of the nationally-consistent accreditation scheme for health services took five years, to ensure stakeholder participation and acceptance.

Since 2013, participation in accreditation has been mandatory for all public and private hospitals. The Australian Commission on Safety and Quality in Health Care, the national regulator charged with leading improvements in safety and quality, developed ten National Safety and Quality Healthcare standards that health services must meet to gain accreditation. These encompass governance, partnering with consumers, preventing and controlling health care-associated infections, medication safety, patient identification and procedure matching, clinical handover, safe use of blood and blood products, preventing and managing pressure injuries, recognising and responding to clinical deterioration in acute health care, and preventing falls and harm from falls.

Discussion continues in Australia around broader system application. Primary care networks, mental health services and long-term care have been identified as domains that would also benefit from a nationally-consistent accreditation scheme.

Source: OECD (2015), *OECD Reviews of Health Care Quality: Australia 2015 – Raising Standards*, OECD Publishing.

Absence of mandatory accreditation makes sense only if two prior conditions are met. First, that sufficiently detailed and timely indicators of providers’ quality and outcomes are available; second, that the body engaged in scrutiny and challenge (as opposed to accreditation) has sufficient levers to respond to quality concerns in a quick and robust manner. Structures are in place to meet each of these conditions in Scotland, but there is scope to strengthen both. Regarding the first, despite an abundance of data in the Scottish NHS, stakeholders report that it is not always packaged into clinically useful information appearing in the right people’s hands. This is discussed further in Section 2.8.

Regarding the second condition, HIS could be better equipped with levers and mechanisms to respond to quality concerns. HIS can escalate concerns to higher authorities (including to the Scottish Ministers) but in the case of serious compromises in patient care, for example, it does not have the power to close a ward or impose special restrictions. These arrangements stand in contrast to the social care sector, where the Care Inspectorate does have powers to close facilities or impose restrictions in relation to regulated services. This would appear to represent a deficit in HIS's "improvement" function and may also pose a problem for fusion of the health and social care sectors in the future. The anomaly has been recognised by the Scottish authorities and is currently being addressed. In line with recommendation 1 of the Vale of Leven Inquiry's recommendations (set up in 2009 to investigate C. difficile infection at the Vale of Leven Hospital that led to 34 deaths), HIS will be given the power to close a ward to new admissions where there is deemed to be a risk to life, health or welling of persons.

Although this strengthening of HIS' competence is welcome, Scotland should reconsider whether the mixing of scrutiny and quality improvement activity within *Healthcare Improvement Scotland* represents a conflict of interest. The mix of these roles means that the system's inspector risks "marking its own homework". The close intertwining of assessment and improvement work is a conscious choice in Scotland, believed to lead to faster improvement and other benefits. Within HIS, efforts are made to keep assessment and improvement work distinct. The two functions (alongside an evidence function) are led by different Directorates, and non-Executive Directors ensure that each function is delivered appropriately. Nevertheless, most OECD health systems are increasingly placing the scrutiny and challenge function at arm's length from the service delivery and improvement function, to ensure the robust independence of the former. Scotland should also consider formally separating out the *Scrutiny and Assurance Directorate* into a distinct and independent entity. One issue for this new body would be to consider publishing a single, comprehensive assessment of the quality of care in NHSScotland.

In Scotland, voluntary accreditation with the capacity to mark out excellence would appear to fit well with its preference for consensual, participatory governance. Following an internationally established accreditation model would give Scottish providers opportunities to connect with, and benchmark themselves against, international peers. Recognising the benefits that a system-wide accreditation system might bring to complement existing arrangements, Scotland is piloting new initiatives in this domain. Following publication of the Vale of Leven Hospital inquiry report, The Scottish Government announced that the Chief Nursing Officer would work with nurse directors to roll out care assurance programmes covering nursing and midwifery in all hospitals and community services. This work will comprise a small set of nationally-agreed indicators of high quality nursing and midwifery; development of local and national data infrastructure (such as a "dashboard" that reports performance "from Ward to Board"); a framework that outlines key principles on development and implementation of local care assurance system/processes; and, a set of NHS

Scotland record keeping standards (including a list of core assessments for all adult inpatient admissions). One example of this work is the *Care Assurance and Accreditation System* (CAAS), currently being piloted in three Health Boards. CAAS is intended to provide public assurance on the delivery of 13 standards of care consistently across the Scottish NHS (including adequate staffing levels), whilst delegating more decision making responsibility to frontline nurses and midwives, and releasing senior staff from office-based functions to spend more time on patient care. If shown to be of value, and welcomed by patients and by staff, Scotland should look to see whether the CAAS model might be more widely applied across the health system, perhaps initially as a voluntary scheme.

2.5. Authorisation of medical devices and pharmaceuticals

Scotland has well-established policies and institutions in place to evaluate new drugs and devices, emphasising a transparent approach to explaining decisions about the accessibility of medicines to the public. The effective use of antibiotics has been a priority in the quality use of medicines, and in this Scotland has achieved significant gains.

Authorisation of medical devices and pharmaceuticals is performed at a UK level

The Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible for regulating all medicines and medical devices in the United Kingdom. It is charged with ensuring medicines, medical devices, advanced therapy medicinal products and blood products are safe and work effectively. It also works to educate the public and health care professionals about the risks and benefits of medicines, medical devices and blood components, leading to safer and more effective use, and promotes international standardisation and harmonisation to assure the effectiveness and safety of biological medicines.

MHRA’s main function is to protect public health and safety by promoting public awareness and assessing the acceptable benefit-risk profiles for medicines and devices. The MHRA balances the need to ensure devices and medicines are acceptably safe, with the need to not stifle innovation. Its other functions are to ensure clinical trials meet robust standards, and to receive and investigate reports of suspected problems with medicines and devices. It also investigates and prosecutes cases of non-compliance, including misleading advertising claims.

Some medicines are reviewed under a European centralised process. The European Medicines Agency evaluates applications for European Union marketing authorisations for medicines. Only certain medicines are eligible for the centralised procedure, which enables a European-wide single evaluation and authorisation. The Agency also monitors the safety of medicines.

The Scottish Medicine Consortium authorises the use of new pharmaceuticals and strives for timely, transparent decisions

The Scottish Medicines Consortium (SMC) is responsible for accepting newly licensed pharmaceuticals for use in Scotland. It assesses their efficacy, health benefits and the appropriateness of the price, based on information shared by pharmaceutical manufacturers. Established in 2001, the SMC is a consortium of NHS Scotland's 14 Health Boards. It is made up of lead clinicians, pharmacists and health economists together with representatives of Health Boards, the pharmaceutical industry and the public. Once a medicine has been appraised by the SMC, NHS Boards consider the introduction of the medicine based on clinical and cost-effectiveness advice. This is done by the Boards' Area and Drug Therapeutic Committees. SMC's remit excludes the assessment of vaccines, branded generics, non-prescription medicines, blood products, plasma substitutes and diagnostic drugs.

Transparency in how decisions are made, particularly in the exclusion of medicines from the Scottish NHS, is particularly important. This is all the more pertinent in cases where medicines are available in England but not in Scotland. An example of how the SMC has engaged the community by explaining its decisions can be seen in a user-friendly presentation, *"Why does SMC say no?",* on the SMC website. All SMC advice is published on an online directory, and members of the public can subscribe to receive a monthly update via email. Real efforts are also made to reflect the views and wishes of patients, their families and carers in the SMC decision-making process. SMC works in partnership with patient groups, and gathers information through patient group submissions.

The SMC has taken on a horizon-scanning role. A key aim is to provide early intelligence on new medicines in development to help NHS Boards improve financial and service planning. The horizon-scanning team, comprising pharmacists and management accountants, gathers intelligence on new medicines by engaging clinical specialists across Scotland, as well as the pharmaceutical industry. A confidential "Forward Look" report is sent to key Health Board personnel annually. It features medicines expected to become available within the following 12-18 months, with potential to have a "moderate to high" net impact on the drug budget, and/or significant implications for service delivery. The budget impact assessment of

"Forward Look", which considers projections for years 1 and 5, takes into account anticipated costs and savings. This can include offsetting the costs of a displaced medicine, or adding associated costs of additional treatment monitoring.

All OECD health systems struggle to balance access to novel therapies, cost containment and incentives for research and innovation. An effective policy response requires careful planning, good governance and budgeting, and effective use of information. With the SMC's well-established horizon-scanning function, Scotland is a step ahead in this respect. A 2008 evaluation of its budget impact estimates concluded that they were valued and used by NHS Boards. However, limitations in budget impact data and information provided to SMC by the pharmaceutical industry meant that meaningful comparisons of estimates with actual expenditure could not be made, nor the reliability of manufacturers' estimates determined (Scottish Medicines Consortium, 2008).

Eight years on, a second evaluation would be timely. An assessment of the utility of information produced for NHS Boards – especially in the context of the post-financial crisis years – and whether information availability has improved, could be a useful learning experience for the SMC. So, too, could an exploration of avenues for strengthening this process. It could also be useful for other OECD countries grappling with similar challenges.

The safe and effective use of pharmaceuticals appears to be improving, particularly for antimicrobials

The safe and effective use of antibiotics has become an important part of the SMC's work. The Scottish Antimicrobial Prescribing Group (SAPG) has existed since 2008, and is hosted by the SMC. It aims to enhance the quality prescribing of antibiotics in hospitals and primary care, through a national framework for antimicrobial stewardship. Strategies include the improved collation, analysis, correlation and reporting of antimicrobial use and resistance data, and improved education programmes for health professionals. The SAPG national prescribing indicators are accessible as standard reports within the Prescribing Information System for Scotland, a web-based application providing information for all prescriptions dispensed in the community in the previous five years.

SAPG's work underpins the Scottish Reduction in Antimicrobial Prescribing (ScRAP) initiative, an educational toolkit that aims to reduce unnecessary antibiotic prescribing. SAPG publishes an annual report on primary care prescribing, and progress reports. They indicate there has been a consistent improvement in prescribing. In 2013-14, there was a 6.5% decrease in the total number of prescriptions in primary care for antibacterials compared with the previous year, and an 11.6% reduction in prescriptions of broad spectrum antibacterials associated with a higher risk of *Clostridium difficile* infection (Scottish Antimicrobial Prescribing Group, 2014).

Health technologies are assessed by the Scottish Health Technologies Group

The Scottish Health Technologies Group (SHTG) is an advisory group that assists NHS Boards to make decisions about health technologies, excluding medicines that are reviewed by the SMC. The group provides advice on clinical evidence and cost-effectiveness, considering new and existing technologies. SHTG considers technical evidence from its Evidence Review Committee alongside the knowledge and experience of its wide membership to reach its decisions. The group also works closely with the Health Innovation Partnership Board to streamline the pathway for new health innovations. Its pilot Innovative Medical Technology Overview (IMTO), for example, takes weeks rather than years to assess a new technology. SHTG has also adopted a horizon-scanning function similar to that of the SMC. It provides early intelligence of the nature, potential budget and service impact of health technologies in development.

The National Planning Forum (NPF) is a mechanism for NHS Boards and the Scottish Government Health and Social Care Directorates to agree on how to address planning issues requiring attention on a national basis. The NFP is represented by all 22 NHS Boards and the Scottish Government, as well as other stakeholders. It meets five times a year, and is chaired by the Healthcare Quality and Strategy Directorate. Agreements are expected to be acted on by NHS Boards. Among the issues that have previously been on the agenda are laparoscopic prostatectomies (surgery for prostate cancer), the treatment of endometriosis, and the status of adult intensive care treatment. The fundamental aim is to ensure equal access to quality care across Scotland. Several decisions made by NPF have resulted in greater centralisation of procedures and treatments, as well as the strategic localisation of new technical equipment such as surgical robots. The minutes and reports of meetings are published on the NPF website.

Scotland also takes part in the collaboration facilitated by the British Standards Institution (BSI), which brings together industry and government stakeholders to develop standards promoting safe and effective health care. Standards are developed across areas such as eHealth, nanotechnology and regenerative medicine.

2.6. Development and use of standards and guidelines

The Scottish Intercollegiate Guidelines Network is an internationally-recognised authority in the production of evidence-based clinical guidelines, which supports Scotland's key challenges around chronic disease and other conditions. Ensuring that these guidelines remain up-to-date and relevant, however, appears to be an ongoing challenge. Several activities help build awareness to support the implementation of clinical guidelines.

The Scottish Intercollegiate Guidelines Network is an internationally-recognised source of high-quality clinical guidelines

The Scottish Intercollegiate Guidelines Network (SIGN), part of Healthcare Improvement Scotland since 2011, develops evidence-based clinical practice guidelines for NHSScotland (Healthcare Improvement Scotland, 2014b). SIGN guidelines are derived from a systematic review of the scientific literature and cover health issues including those relating to NHS Scotland priority areas, such as cancer, cardiovascular disease and mental health. They are designed to draw on current evidence to assist in meeting the aims of reducing variations in practice, and improving patient outcomes. Guidelines are disseminated to health care professionals and organisations in Scotland and patient versions are available. A reported challenge for SIGN is ensuring that its guidelines remain up to date.

A number of clinical standards also exist, covering particular patient groups (such as older people in hospital), services (such as asthma services for children and young people) or particular clinical conditions (such as pressure ulcers). As with SIGN Guidelines, there is a challenge to keep these standards up to date (several are a decade or more old), whilst expanding their number. HIS is currently reviewing these standards to identify any standards and indicators which are no longer fit for purpose. As part of this review the Scottish Government has asked HIS to articulate how the work on standards will inform scrutiny and improvement.

Targeted support to aid guideline use by both clinicians and patients is available

SIGN offers support in the form of customised resources for the implementation of every guideline. These include awareness-raising activities, announcements of implementation meetings and resources such as audit tools, algorithms and pathways, and adjusted implementation support for each guideline. On-line training modules or CPD sessions are linked to some SIGN Guidelines, such as those available for SIGN Guideline 98 (which covers the assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders) and Guideline 95 (which addresses the management of chronic heart failure).

Apps have also been developed, such as one designed to encourage health professionals in training to undertake audits based on the guidelines appropriate to the specialty in which they are training. A number of audits are in place, assessing whether the guidelines have been implemented and are being followed.

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

Scotland has a well-developed performance framework, and uses quality indicators to measure progress towards the stated outcomes it wants to achieve. Notably, Scotland is a rare example of an OECD country that applies indicators to the quality of out-of-hours primary care – an initiative that other countries should emulate. Efforts should be made, however, to develop a more systematic approach to national quality audits and disease registers, which are currently developed in a somewhat *ad hoc* manner by individual centres of excellence.

The Scottish Government's National Performance Framework contains several health-related indicators

The Scottish Government's National Performance Framework covers government activity directed toward achieving 16 outcomes, such as "*we live longer, healthier lives*" and "*our people are able to maintain their independence as they get older and are able to access appropriate support when they need it*". Seven "purpose targets" (economic growth, productivity, participation, population, solidarity, cohesion and sustainability) and 50 indicators are used to measure progress towards achieving these high-level outcomes. Several indicators relate to the performance of the health system, and include:

- improve children's dental health
- increase the proportion of babies with a healthy birth weight
- increase the proportion of healthy weight children
- increase physical activity
- improve self-assessed general health
- improve mental wellbeing
- reduce premature mortality

- improve end-of-life care
- improve support for people with care needs
- reduce emergency admissions to hospital
- improve the quality of health care experience
- reduce the percentage of adults who smoke
- reduce alcohol-related hospital admissions
- reduce the number of individuals with problem drug use.

The Scotland Performs website uses a progress arrow to signal whether performance against each indicator is improving, worsening or the same, as shown in Figure 2.2. The website also provides more detailed information about how targets are measured, and about performance. For example, collecting data on tooth decay in children is important because dental decay is highly preventable, but is the most common reason children are admitted to hospital in Scotland. Good dental health is also an indicator of a child's health more broadly, as it reflects good parental care in the early years of a child's life.

Figure 2.2. Examples of progress of national indicators

Source: Scotland Performs, http://www.gov.scot/About/Performance/scotPerforms/indicator.

NHSScotland has a well-developed infrastructure to collect and analyse health system metrics, including quality-related data

NHSScotland established the *Information Services Division* (ISD) to provide information on activities, costs and outcomes within the health system, and inform policy and quality improvement in health care. In terms of quality governance, a key element of ISD's work is the *Quality Measurement Framework*, consisting of three levels, as described earlier in Section 2.2. The third level of the framework consists of 12 Quality Outcome Indicators linked to the goals set out in the *Healthcare Quality Strategy*. Three of the 12 indicators are still under development (employee engagement, resource use, and safe care). Data are available for nine indicators, and information on their progress is provided (Table 2.1).

Table 2.1. Progress on the Quality Outcome Indicators

Indicator	Progress
Care experience	The latest value of the indicator is 80.3 which is a statistically significant increase of 0.9 compared to 2012. This implies that overall people's quality of experience has improved (the indicator is a score between 0 and 100, with higher scores representing a better experience. The score is based on survey questions and does not represent a percentage).
Emergency admissions	In 2013/14 the rate of emergency admissions was a provisional 10 188 emergency admissions per 100 000 population. Since 2008/09, this rate has remained level at around 10 000 emergency admissions per 100 000 population, with very slight increases in each of the last three years. In 2013/14 the emergency admission bed day rate was 71 895 emergency bed days per 100 000 population. Since 2008/09 the rate has shown a steady reduction. Note that the 2013/14 figures are provisional and likely to be slightly lower than the final figure.
End of life care	The proportion of the last six months of life spent at home or in a community setting was 90.8% in the year ending March 2014. This figure has remained at just over 90% for the five years to 2013/14.
Healthcare Associated Infection (HAI)	In 2011 the prevalence of HAT was 4.9% in acute hospitals, a significant reduction since the last survey, at 9.5% in 2005/06.
Health birthweight	The percentage of babies born at a healthy birthweight in the year ending March 2013 was 90.1%. This figure has remained relatively stable over the last ten years.
Hospital Standardised Mortality Ratios (HSMR)	HSMR at Scotland level has decreased by 15.7% between the quarter October to December 2007 and the latest quarter (January to March 2015) with the latest figure at 0.90 for January to March 2015.
Personal outcomes	The 2013/14 value for the indicator is 75.2. This shows no change from the previous data point, 2011/12, when the indicator was introduced (the indicator is a score between 0 and 100, but not a percentage value, with higher score representing better outcomes).
Premature mortality	In 2014, the European age-standardised mortality rate (using the 2013 European Standard Population) among those aged under 75 in Scotland was 123.2 per 100 000, a decrease of 3.3% over the last year and by 22.5% over the last ten years.
Self-assessed general health	In 2014, 74% of adults described their health in general as either "good" or "very good". Since 2008, this level has fuctuated betwen 74% and 77%.

Source: ISD Scotland, Quality Measurement Framework, www.isdscotland.org/Health-Topics/Quality-Measurement-Framework/Summary-of-Progress/, accessed 01.10.2015.

Accompanying the indicators is an explanation of what work is being done to improve progress. For example, in the case of health care-acquired infections, the website explains that improvements can be achieved through measures including hand hygiene, hospital cleanliness, equipment decontamination and optimal antimicrobial prescribing. The data for this indicator, however, relate to 2011, and some of the other indicators are also based on old data, making them less useful. Efforts are being made to improve the timeliness and accuracy of data. Weekly hospital-level reporting of emergency department waiting times began early in 2015, for example. Nevertheless, there is still significant scope to provide more timely information on other aspects of hospital performance. A new website, *NHS Performs* (http://www.nhsperforms.scot/), aims to improve the accessibility, frequency and range of information on hospital performance. This is discussed further in Section 2.8.

As discussed in Section 2.1, a core suite of indicators has been recently developed, with broad stakeholder consultation, for the integration of health and social care. The indicators have still to be tested in practice, and it is anticipated that they will be refined over time. Each Integration Authority is required to publish an annual performance report, including information about the indicators, supported by local measures and contextualising data to provide a broader picture of local performance. Some of the indicators still require data development. The indicators are grouped into two types of complementary measures (Box 2.3). Scotland's experience with these indicators will be of international interest, most OECD health and social care systems are exploring how best to monitor integrated care,

Box 2.3. Health and Social Care Integration: Core suite of indicators

Outcome indicators based on survey feedback

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.

Box 2.3. Health and Social Care Integration: Core suite of indicators *(cont.)*

8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.*

Indicators derived from organisational/system data primarily collected for other reasons

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last six months of life spent at home or in community setting.
16. Falls rate per 1 000 population in over 65s.*
17. Proportion of care services graded “good” (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*
23. Expenditure on end of life care.*

* Indicator under development.

Source: The Scottish Government, http://www.gov.scot/Publications/2015/04/3012/2, accessed 11 August, 2015.

Performance is monitored through the reporting of health indicators linked to Local Delivery Plan Standards

Each of the NHS Boards are expected to produce Local Delivery Plans, as part of the performance framework. The plans outline their activities in six improvement priority areas:

1. health inequalities and prevention
2. antenatal and early years
3. person-centred care
4. safe care
5. primary care
6. integration.

Additionally, the plans set out standards set and agreed between the Scottish Government and the NHS Boards. The standards, which the boards are expected to report on, focus mostly on indicators concerning access and the process of care, as listed below:

- Increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%.
- 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.
- People newly diagnosed with dementia will have a minimum of one year post-diagnostic support.
- 100% of patients to wait no longer than 12 weeks from the patient agreeing to treatment with the hospital to treatment for inpatient or day case treatment (Treatment Time Guarantee).
- 95% of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100%.
- 90% of planned/elective patients to commence treatment within 18 weeks of referral.
- At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation.
- 90% of eligible patients to commence IVF treatment within 12 months of referral.
- 90% of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.
- 90% of patients to commence psychological therapy based treatment within 18 weeks of referral.

- NHS Boards’ rate of staphylococcus aureus bacteraemia (including MRSA) to be 0.24 cases or less per 1 000 acute occupied bed days.
- NHS Boards’ rate of Clostridium difficile in patients aged 15 and over to be 0.32 cases or less per 1 000 occupied bed days.
- 90% of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.
- NHS Boards to sustain and embed alcohol brief interventions in the three priority settings of primary care, A&E and antenatal and to broaden delivery in wider settings.
- NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards).
- GPs to provide 48-hour access or advance booking to an appropriate member of the GP team for at least 90% of patients.
- NHS Boards to achieve a staff sickness absence rate of 4%.
- 95% of patients to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. Boards to work towards 98%.
- NHS Boards are required to operate within their Revenue Resource Limit (RRL), their Capital Resource Limit (CRL) and meet their Cash Requirement.

Indicators relating to clinical outcomes are limited to staphylococcus aureus bacteraemia and Clostridium difficile infection rates. Notably, none of the standards relate to patient experience or patient-reported outcome measures. This would appear to be a weakness in the standards as currently agreed, and Scotland should consider whether patient-reported measures (including patient satisfaction and experience) should be included. Several OECD health systems (in the Nordic countries and in Canada, for example) are increasingly using patient-reported measures in accountability and contracting frameworks (OECD, 2015) in an effort to make services more responsive to patient needs and preferences.

The second level of the *Quality Measurement Framework* is made up of a suite of national NHS performance targets that NHSScotland and the Scottish Government agree to each year. They are known as Local Delivery Plan (LDP) Standards and cover traditional performance targets such as emergency department attendances and smoking cessation, alongside more innovative measures such as sickness absence of NHS staff (believed to be important because of the impact on cancelled appointments and procedures, leading to increased pressure on staff and patients, increased costs of employing bank and agency staff, and reduced efficiency). The inclusion of this target helps underline the need to see a whole-system approach to targets and system performance relative to targets, considering the inputs and drivers behind successfully, or unsuccessfully, met targets.

As for the indicators linked to the National Performance Framework, performance against the LDP Standards is reported online. Importantly, an explanation of why a particular target is used aims to help staff and patient understanding, and is provided alongside the LDP Standard results on the NHSScotland website. The latest data shows that some LDP Standards are being met (such as 90% of eligible patients to commence IVF treatment within 12 months of referral; 90% of individuals needing drug or alcohol treatment will wait no longer than three weeks from referral received to appropriate treatment; or all NHS Boards required to operate within their Revenue Resource Limit, their Capital Resource Limit and meet their Cash Requirement). Others, however, remain challenging and strong incentives to Health Boards to secure continued improvement. Examples of these more challenging standards include for 90% of young people to start treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral (in the quarter ending June 2015, 76.6% of children and young people were seen within 18 weeks); for rates of Staphylococcus aureus bacteraemia (including MRSA) cases to be 0.24 or less per 1 000 acute occupied bed days (in the year ending March 2015, the rate was 0.31 per 1 000 acute occupied bed days); and, for NHS Boards to achieve a sickness absence rate of 4% or less (in 2014/15, the rate was 5.04%).

The current relatively succinct number of LDP Standards (just under 20) is a significant reduction on the previous 180 targets. The smaller number is thought to be more focused and effective at driving core improvements. NHS Boards state how they will commit to meeting their targets as outlined in their annual Local Delivery Plans. The targets are being followed up through reviews, and if targets are not met, the NHS Boards may be offered help from the government improvement team. National results are published on the *Scotland Performs* website, broken down by NHS Board, as well as in an annual report (Scottish Government, 2014c).

The importance of setting well-considered targets, which promote system-wide quality improvement as well as focusing on areas of identified weakness, has become clear across all OECD health systems. While targets can effectively direct attention and resources towards areas of weakness, or areas of particular importance, they can also encourage too narrow a vision of care quality achievements, and sometimes "gaming" effects. Reflecting these concerns, the performance reporting approach of the Scottish NHS is strongly influenced by an ongoing discussion around the degree to which nationally-set targets, and benchmarking, support quality improvement. Scotland appears to have achieved a good balance, though, between targets specified by national authorities which are sufficiently ambitious and more bottom-up approaches, such as the Breakthrough Collaboratives described earlier. Additionally, including mental health (psychological therapies and child and adolescent services) in waiting times targets sets Scotland apart from most other OECD countries, very few of which record waiting times for mental health services, or set associated targets and standards. The reduction in target numbers to 18 is a reassuring signal of this healthy balance.

Waiting time targets are also widely applied across the health sector

To support the "access" dimension of the LDP Standards, the Information Services Division (ISD) collects a range of waiting time data. A new approach to measuring and understanding waiting times came into effect at the beginning of 2008, called the "New Ways of Defining and Measuring Waiting Lists" (known as "*New Ways*") (ISD Scotland, 2007). *New Ways* sets out new guidance on how NHS Boards should manage patients' waits and how to measure and report waiting times consistently. It aims to set out fair and appropriate procedures for patients who do not or cannot attend an appointment, and ensure that patients' waiting time guarantees are maintained wherever possible. Notably, this is a change to the system in which patients lost their guarantee if they were unavailable for medical or social reasons. Weekly statistics on A&E performance are now being published, including the four-hour core performance target for A&E departments in Scotland.

There has also been a shift to make waiting times a shared responsibility of GPs, hospital services, and patients. An evaluation in 2010 (Auditor General for Scotland, 2010) found that *New Ways* had been fairly successful, and seemed to have improved patient experiences. Notably, *New Ways* was found to have stopped patients remaining on waiting lists indefinitely, and helped with the fair and consistent management of patients. Areas highlighted for further work included communications with patients regarding the timing and planning of their appointment, and filling in gaps in some recorded data.

A 2013 audit was less positive (Auditor General for Scotland, 2013a), and found that there were areas where information was incomplete. For instance, information contained in patient records was limited, making it not possible to trace all the amendments that may have been made. Of greater concern was the use of "unavailability codes", which were introduced with *New Ways* to give patients more flexibility over when they would be available for appointments, giving more room to the way that waits are recorded. The audit raised concerns about the increasing use of social unavailability codes. The proportion of people waiting for inpatient treatment who were given a social unavailability code rose from 11% in 2008 to just over 30% at the end of June 2011. It also raised concerns about the higher use of these codes in some specialities, such as orthopaedics and ophthalmology, and instances of inappropriate use. Both the initial report by the Auditor General for Scotland (2013a), and a follow-up report from later that year (Auditor General for Scotland, 2013b), do importantly note that the use of unavailability codes began to reduce in late 2011, a trend which continued into 2012 and 2013.

Scotland has engaged in specific work to improve patient flows, reduce the need for unscheduled care, as well as reduce unnecessary attendances or hospital stays for patients with planned care. Much of this work is the Quality and Efficiency Support Team (QuEST) and is described further in Section 2.9. The Scottish Government, ISD Scotland, and Health Boards also put in place processes to produce additional information about the management of waiting lists, for example identifying when patients are recorded as unavailable for patient choice reasons, which has helped add transparency to the process.

Scotland is a rare example of an OECD country that collects information on the quality of out-of-hours primary care services

Scottish primary care physicians participate in the UK-wide Quality and Outcomes Framework, under which physicians can earn financial incentives for meeting a wide range of quality indicators (see Section 2.10 for more on financial incentives). In addition to this programme, a series of primary care indicators have been developed to identify issues around avoidable variation and health system waste. These indicators include referrals, hospital admissions, prescribing and patient experience.

Notably, *Healthcare Improvement Scotland* has developed quality indicators for out-of-hours primary care (Box 2.4). These indicators apply to all territorial NHS Boards in Scotland, NHS 24, and all providers of out-of-hours primary care services either provided directly by, or secured on behalf of, NHS Boards. The indicators are intended to identify good practice and potential problems, so that NHS Boards may be benchmarked against their peers. The indicators are accompanied by standards for the provision of out-of-hours primary care. All providers are required to complete an annual review of quality indicators and develop improvement plans.

Box 2.4. Quality indicators for out-of-hours primary care services

Indicator 1: Response times

- Proportion of calls to NHS 24 answered within 30 seconds by an NHS 24 call handler.
- Proportion of home visit cases where a clinician arrives at the destination of care within the timescale recommended by triage.
- Volume and proportion of one-, two- and four-hour home visit referrals.

Indicator 2: Appropriateness of triage for home visits

- Proportion of clinically appropriate one-, two- and four-hour home visit referrals.

Indicator 3: Effective information exchange

- Proportion of primary care out-of-hours consultations during which the patient's electronic care summary is accessed by a clinician.
- Proportion of primary care out-of-hours consultations with patients registered with a GP within the same NHS Board for which consultation information is provided to their GP by 8.30 am the following working day.
- Proportion of primary care out-of-hours consultations resulting in admission to acute care for which referral information is provided at the time of referral.

Indicator 4: Implementing national clinical standards and guidelines

- Proportion of patients with a suspected or confirmed diagnosis of asthma assessed in line with current national standards and guidelines.

Indicator 5: Antimicrobial prescribing

- Proportion of prescriptions of antimicrobial medications that are for high-risk antimicrobial medications (cephalosporins, quinolones, co-amoxiclav and clindamycin).

Indicator 6: Patient experience

- Proportion of primary care out-of-hours service patients who report a positive experience.
- Proportion of primary care out-of-hours service patients who say they got the outcome (or care/support) they expected and needed.
- Proportion of complaints received from primary care out-of-hours service patients.

Source: Healthcare Improvement Scotland (2014), Quality Indicators for Primary Care Out-of-Hours Services, http://www.healthcareimprovementscotland.org/our_work/primary_care/out-of-hours_services/ooh_quality_indicators.aspx.

All OECD health systems are struggling to provide out-of-hours primary care in an accessible, safe and sustainable way. A targeted initiative focused on performance in this area is rare, and represents a promising innovation that other health systems will be keen to learn from. It will be essential to ensure that learning from these performance metrics translates into better policy and better services. Currently, little of this information is made publicly available, although Scotland's Public Health and Intelligence services are undertaking work is underway to create an Out of Hours Data set to inform policy development and to provide some limited publicly accessible information. This work should be prioritised, so that these metrics, and the learning and services improvements that result from them, are properly shared.

In another initiative that is uncommon in OECD health systems, Scotland has developed quality performance indicators specific to the care of several types of cancers, including breast, prostate, leukemia and endometrial cancer. The Scottish Cancer Taskforce established the National Cancer Quality Steering Group (NCQSG), which includes responsibility for developing small sets of about 10-15 tumour-specific national quality performance indicators.

For example, in the case of brain and central nervous system (CNS) cancer, indicators include:

- Proportion of newly-diagnosed patients with brain/CNS cancer who have a documented WHO performance status at the time of multidisciplinary team discussion.
- Proportion of patients with brain/CNS cancer who are discussed at multidisciplinary team discussion meetings before definitive management.
- Proportion of patients with biopsied or resected gliomas who undergo relevant molecular analysis of tumour tissue within 21 days of surgery.
- Proportion of patients with brain/CNS cancer where the pathology report contains a full set of data items (as defined by the Royal College of Pathologists).
- Proportion of patients with brain/CNS cancer undergoing surgical resection and/or radical radiotherapy or chemotherapy, who have a MRI prior to treatment.

- Proportion of patients with high grade malignant glioma who undergo maximal surgical resection (>90%), provided it is considered consistent with safe outcome.
- Proportion of patients with malignant glioma WHO grades II, III and IV, who receive early post-operative imaging with Magnetic Resonance Imaging (MRI) within three days (72 hours) of surgical resection.
- Proportion of patients with brain/CNS cancer undergoing oncological treatment (chemotherapy or radiotherapy) who are managed by a specialist neuro-oncologist.
- Proportion of patients with high grade glioma (WHO grades III and IV) undergoing surgical resection who commence their oncological treatment (chemotherapy or radiotherapy) within six weeks of surgical resection.
- Proportion of patients with brain/CNS cancer undergoing radical radiotherapy for whom the radiotherapy planning process includes MRI fusion.
- Proportion of patients with brain/CNS cancer presenting with seizures at diagnosis who are seen by a neurologist or a nurse with expertise in epilepsy management.

While NHS Boards will be required to report against the indicators, there are reports to date only on four cancers: breast, upper gastrointestinal, lung and colorectal. Some of the information is quite old. For example, in the case of breast cancer, the report concerns patients diagnosed in 2012.

The indicators mostly relate to the process of care. While this information is useful, there could be an opportunity to include indicators on the experience of patients undergoing cancer treatment, and their outcomes. This could include, for example, whether patients felt they had the opportunity to make decisions about their care, and whether they understood information given to them by clinicians. It could also extend to indicators measuring their quality of life, such as the extent to which they are in pain.

Healthcare Improvement Scotland has also developed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) indicator. The indicator focuses on four areas of improvement:

- All resuscitation attempts are carried out in line with national resuscitation guidelines.

- All recognised expected deaths have a DNACPR/Children and Young Persons Acute Deterioration Management (CYPADM) decision documented in line with national policy.
- The NHSScotland DNACPR or CYPADM form is completed correctly for every DNACPR decision.
- All advance/anticipatory care plan templates must include a field about resuscitation status and DNACPR/CYPADM decision.

The development of this indicator, as with the cancer indicators, provides a useful mechanism to ensure that health professionals are complying with guidelines in the clinical management of patients. It is intended that health providers will use clinical governance and quality improvement forums to collect and analyse the data, and develop improvement plans where necessary.

A more systematic approach to national quality registers and clinical audits would benefit Scottish health care

National quality registers and clinical audits, both essential to monitor quality and outcomes for particular patient groups, have emerged as bottom-up, clinical-led processes in Scotland, often led by pioneering clinicians. This is a typical pattern seen in countries with long histories of quality improvement work, such as Denmark or Sweden. In addition, Scotland participates in the UK-wide programme of national clinical audits run by the Healthcare Quality Improvement Programme (HQIP).

Good use, by clinicians and managers, is reportedly made of the findings of clinical audits in Scotland. They are used in clinical governance discussions at all levels of the Scottish health care system. At a national level, some of the clinical audits that have been published include:

- Musculoskeletal Access Audit (MSK Audit) (2014)
- Scottish ECT Accreditation Network (SEAN) (2014)
- Scottish Intensive Care Society Audit Group (SICSAG) framework for quality indicators (2012; Critical care report 2014)
- Scottish Multiple Sclerosis Register (2014)
- Scottish Stroke Care Audit (2014)
- Scottish Renal Registry (2014)
- Scottish Arthroplasty project (2014)

- Scottish Trauma Audit Group (2013)
- Scottish Audit of Intracranial Vascular Malformations (latest report 2011)
- Scottish Audit of Surgical Mortality (latest report 2009).

While there would be clear value in maintaining the audits as a bottom-up, clinician-led activity, there may be weaknesses in the current approach. Strategic oversight appears to be lacking. Comparability across audits, possibilities for data linkage across registers and systematic appraisal of quality of care system-wide can be limited. The publication and dissemination strategy of Scotland's national audits is also uneven. Some regularly publish their findings, while others (such as the Scottish Audit of Intracranial Vascular Malformations) have their last publication dating back several years. The Scottish Audit of Surgical Mortality intended to evolve into a structured morbidity and mortality review process for all hospital deaths, but the current status of this project is unclear.

The *Clinical Outcomes Measures for Quality Improvement* group has started to taken on the strategic management of national audits. Work is also now underway to develop a system for auditing the effectiveness of audits. As this work continues in Scotland, a more systematic national approach to quality registers and clinical audits should be considered. This would probably be best co-ordinated by NHSScotland, and seek to encourage an appropriate level of consistency in the objectives, format and use of quality registers and clinical audits, whilst allowing sufficient freedom to develop distinct clinical priorities or research agendas. Findings from national audits need to be translated, as far as possible, to local contexts. National authorities rightly recognise this to be particularly important in Scottish context, given the emphasis placed on local collaboratives and learning cycles in Scotland. If such links are not made from national studies, there is a risk that important findings will not be acted upon. Denmark has been pursuing this approach in recent years, and offers a model to consider (Box 2.5).

There also appears to be scope for better linkage of data across databases, such as linking episodes of care across different specialties to outcomes. This is essential to build a full picture of the activities, costs and outcomes of care across complete patient journeys. As earlier mentioned in this chapter, the Integrated Resources Framework is an example of data linkage across health and social care to provide information on resource use along patient pathways. This work is being taken forward in the Health and Social Care Data Integration and Intelligence Project, which will provide cross-sector intelligence for partnerships to underpin their strategic commissioning plans.

Box 2.5. Building an information infrastructure for measuring quality in Denmark

Denmark is advanced in measuring quality of care through clinical registries, although this is more developed in the hospital sector. The databases were originally created in single departments by physicians, but quickly spread to include surgical specialties or treatments. Initial databases focused on outcomes and additional information on co-morbidities to allow risk-adjustment. The first national database was set up in 1976 for breast cancer treatment. In 1999, the Danish National Indicator Project (NIP) was established as a mandatory disease-specific quality system for all hospitals.

In 2000, quality standards, indicators and prognostic factors were developed in ten domains: acute abdominal surgery, birth, chronic obstructive pulmonary disease, depression, diabetes, heart failure, hip fracture, lung cancer, schizophrenia, and stroke. At the time, the number of national clinical databases was as high as 60.

A need for standardisation was identified to secure the efficiency of data collection and the rational use of data to provide a basis for improving the quality of care. A national Quality Improvement Programme was established in 2010 to provide a framework for strengthening the infrastructure around the clinical quality databases, with the planned standardisation of the conditions for the operation of the 60 national clinical databases.

All registries include data at the patient level, using the patients' unique patient identifier. The national clinical registries are increasingly based on data from national administrative registers, which increasingly supplement the use of dedicated collection systems in the older registries. Data collection in the primary sector is done exclusively via the electronic health record. In the secondary sector, experiments with data collection to the clinical registers directly via the electronic health record are ongoing, as are projects trying to include laboratory data and prescription data. Seven registries at present include patient outcome measures based on data collected from patients using either online or paper-based surveys.

All national clinical databases publish an annual report. In addition, several methods are applied systematically to ensure that the data collected in the clinical registries are used actively for quality improvement. Among them are an annual clinical audit at national level, annual qualitative audits at regional and local level, ad hoc in-depth national clinical audits on specific items (such as reports on regional variation in survival on lung cancer), and the feedback of results to decision makers and public reporting.

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

In Sweden, quality of care for the elderly has been improved by linking together databases on healthy ageing (prevention), dementia (long-term illness), behavioural and psychotic symptoms (acute exacerbations) and falls (adverse events). In Scotland, the community health index (CHI) is a unique number that identifies patients across any health service in NHSScotland. The use of such a number aims to improve the co-ordination of patient care by making health information about patients accessible to all health professionals involved in the patient's care, at any service, and provides the basis of linkage of individual-level data.

At the same time, additional investment in a fuller set of disease registers is needed, to cover patient groups that are poorly represented in Scotland's suite of national quality audits. Children's services and mental health care are examples, with dementia care being a particular priority. Of note, Scotland is has a number of projects underway around mental health. Collection of a suite of indicators relating to the quality of dementia care should be piloted later this year. HQIP have commissioned a national confidential inquiry into suicides and homicides in those with a history of mental illness, and work is being undertaken to review Scottish Mental Health performance indicators, with a focus on more robust collection of effectiveness and patient experience data.

2.8. Public reporting of quality and performance

Despite the existence of copious amounts of information on health and social care, there is a need to improve its utility. The analysis and dissemination of data is not always designed with the clinicians, service managers and the public in mind. Likewise, opportunities to benchmark the performance of health services in Scotland are not as fully developed as they could be.

Efforts are made to encourage effective use and dissemination of health system data

An abundance of information on health and social care is available in Scotland. The Scottish Public Health Observatory added Scottish data to a European download of the World Health Organization's European Health for All Database in 2006. This led to the creation of the first Scotland and European Health for All Database. There have since been further updates, with the most recent one in 2012. Scottish data are available for 501 (84%) of 600 indicators (Scottish Public Health Observatory, 2012). Most of the information in the database, however, relates to the epidemiology of health care needs, health service inputs and cost and utilisation data. There is relatively little quality and outcomes data (apart from mortality rates and some infection rates).

The government initiative *Scotland Performs*, discussed earlier in this chapter, measures and reports on progress in achieving the outcomes in the National Performance Framework (and NHSScotland was the first partner organisation to report results under this framework). The ISD produces more than 100 statistical publications and clinical audits each year, all of which are available on its website. The NHSScotland Chief Executive's Annual Report also presents an assessment of the performance of NHSScotland, with key achievements and outcomes.

In a new initiative, ISD is working with Health Protection Scotland (the division of NHS Scotland responsible for infectious diseases and environmental health) and the Scottish Government to develop a new website, *NHS Performs* (http://www.nhsperforms.scot/). This pulls together performance information to provide information including emergency department waiting times, surgery cancellations and health care-associated infections. For example, information is published on the performance of accident and emergency departments, including the proportion of patients seen within four hours. Results are presented at hospital level and benchmarked against averages for Scotland the local NHS Board as well, in some cases, against historical figures. Currently, however, nearly all the indicators relate to inputs and activities (such as staff numbers or waiting times), and very few relate to outcomes (with the exception of standardised mortality ratios and infection rates). Patient experiences are not included either. As the *NHS Performs* website is developed further, it should publish more outcomes, including patient reported measures, as a priority.

The development of "whole system indicators" (through an initiative named *Discovery*) is another major project that ISD is taking forward. Its aim is to bring together indicators from various sources on a dynamic system that will be organised around the dimensions of quality and the *2020 Vision* priorities. It should allow peer-to-peer comparison of key quality metrics, such as unplanned readmission rates. In addition, *Healthcare Improvement Scotland,* the main body charged with scrutinising the Scottish health system, publishes inspection reports of health services, as mentioned in Section 2.4. It works with NHS Boards to review their services and provide feedback and support to achieve quality improvements. NHS Boards must also publish annual reports containing information on a range of performance and financial measures.

Complementing these efforts, the Health and Social Care Directorate's *Analytical Services Division* (Health ASD) brings together economists, statisticians and social and health system researchers to provide an analytical support and briefings to health ministers and senior officials. Situated within government, the ASD also provides policy advice, around measurement frameworks and indicator specifications, for example. Health ASD largely engages in secondary data analysis, using data collected by ISD, local authorities and other sources. It is, however, also responsible for some primary data collections such as the Scottish Health Survey and patient experience surveys.

To some extent, Health ASD and ISD have broadly similar functions (of data collection, analysis and reporting) which may reflect historical arrangements rather than optimal configuration. Some consolidation across Health ASD and ISD is occurring (with the transfer of some surveys to ISD, for example). It would nevertheless seem wise to consider the benefit of two parallel institutions with similar roles, and whether greater impact and value-for-money might be obtained by consolidating all collection, analysis and dissemination of health system data into a single institution. Care would need to be taken to ensure that the particular advantages of individual bodies (such as ASD's diverse professional backgrounds and embedded relation to government) are not lost. Scotland is currently engaged in a strategic overview of institutions and activity related to health data, where the benefits or otherwise of such consolidation should become clear.

Nevertheless, stakeholders report that more could be done to convert data into useful information

Despite this abundance of data, stakeholders report that it is not always packaged into clinically useful information appearing in the right people's hands. ISD's website has been referred to as "an electronic filing cabinet", that is, tidy and well-organised but essentially just a collection of reports, without much interactive potential (see endnote 1 to this chapter). Trying to find regional comparisons of cancer survival estimates within Scotland (a fairly basic indicator that is of interest to a wide sector of society) is a case in point. National survival estimates and local incidence or mortality benchmarks can be found, but local survival estimates are difficult to access. ISD holds a large array of Cancer Quality Performance Indicators and publishes various reports for specific tumour sites, but the overall presentation of the information is much more oriented to specialists than to service users.

It seems that health system information in Scotland is rarely oriented towards the public. Benchmarking and open comparisons (formats which are generally easily understood by the public) also appear under-used. Scotland currently has, for example, limited atlases of variation, satisfaction or outcomes. The Scottish Public Health Observatory, in partnership with other bodies such as ISD, produces local *Health and Well-being Profiles* that highlight variation in health between areas and help identify priorities for health improvement (https://scotpho.nhsnss.scot.nhs.uk/). Most of the information in the profiles, however, relates to the epidemiology of health care needs. There are some quality and outcome measures (such as premature mortality rates, or quality of care for diabetes) but these are currently limited and relate largely to public health and primary care sectors. There is no obvious integration between these indicators or benchmarking efforts and the hospital-based benchmarking efforts of the *NHS Performs* website referred to earlier.

In a political system where open deliberation and involvement of the public in decision making is so prominent, such data should be available to the public in a user-friendly format that enables comparisons between health services. The existence of multiple websites to access information can also be confusing. Providing one main online entry point for the public would be a simpler approach. Sweden, for example, has a robust information infrastructure that is used as the basis for regular performance reports on quality and efficiency; Canada publishes consolidated health system performance data, along with user-friendly definitions, display and high-level analysis, on their *Your Health System* website (Box 2.6). Most information on health care quality is available in a searchable database on the Internet. This enables the user to make individual selections based on what level of presentation is of interest. All registers include unique patient identified data, making it possible to match data from different registers to obtain additional information about the care given (OECD, 2013b).

Box 2.6. 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.

Scotland is taking steps to move toward more open and usable data, through NHS Performs, Health and Well-being Profiles and, in the case of cancer Quality Performance Indicators referred to earlier, development of more user-friendly QPI dashboards. As these continue to develop, it will be important that they focus on quality and outcomes as much as possible (rather than inputs and activities) and that patient-reported outcomes and experiences are increasingly brought into these frameworks. The consultation launched by HIS on improving the scrutiny and assessment of services (described in Section 2.4) makes clear that a greater focus on patient-reported measures is needed. Scotland also needs to ensure strategic oversight so that performance reporting tools evolve in a co-ordinated and consolidated manner, rather than being scattered around different websites in disparate and incompatible formats.

2.9. Patient and public involvement in improving health care quality

Scotland is active in promoting the role of patients as participants in decisions about their care. It seeks patient feedback to drive improvement and promotes a robust culture of transparency. The country encourages patients to share their experiences on a website, and publicly demonstrates how negative feedback has prompted health services to make changes to improve the quality of care. It is a rare initiative that other countries could emulate to demonstrate they are responsive to patients. Scotland's desire to strengthen the patient voice is grounded in a recently developed framework that empowers patients as equal partners in their care.

Listening and learning from patients is a well-embedded tool to drive quality improvement

Engaging patients and the public in making improvements to health care is a stated priority for NHSScotland and the Scottish Government. Patient and public involvement is promoted through a commitment to transparency about the direction and performance of the NHS, and through a commitment to using feedback as a tool for improvement. For example, the results of a national survey on maternity care were used to identify areas where there was a need for improvement, and to inform future maternity policy.

Under the National Health Service Reform (Scotland) Act 2004, NHS Boards are required to involve patients, carers and the public in the planning and design of health services, and in decisions significantly affecting the operation of those services. The Patients' Rights (Scotland) Act 2011 sets out patient rights and principles for the delivery of health care. It notes that people have the right to complain, raise concerns, make comments and give feedback about the NHS services they have received. The Act also charges the NHS with the duty to encourage, monitor, take action and share learning from the feedback it receives.

The *Patient Advice and Support Service* (PASS) was established under the Act, and operates independently of NHSScotland. It supports patients and their carers and families in their dealings with the NHS and in other matters affecting their health and health care. PASS can assist patients in providing feedback about their health care. It can direct patients to other types of support, such as independent advocacy, mediation or communication support services.

Scotland is also promoting better engagement with patients and the public with the *Our Voice* framework (Figure 2.3). It aims to better respond to the views of patients and their families, with a clear focus on improvement. The vision of the initiative is: people who use health and care services, carers and the public will be enabled to engage purposefully with health and social care providers to continuously improve and transform services. People will be provided with feedback on the impact of their engagement, or a demonstration of how their views have been considered.

Figure 2.3. The *Our Voice* framework

Source: Scottish Health Council, http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice_framework.aspx#.Vcm2CPmqpHw.

The framework contains initiatives at an individual, local, national and leadership level to drive health care quality improvement. Examples include, at an individual level, "integration stakeholders" that will develop systems for responding to feedback in a way that is accessible, manageable for staff, and capable of being transferred across settings. At a local level, peer networks will be developed to support people to participate in local engagement and planning processes. At a national level, citizens' panels will create opportunities for people to engage in national policy debate. Notably, a leadership coalition of health and social care service users, carers and leaders in the NHS, local authorities and the third sector will guide the development of the framework and will be chaired by a member of the public. The framework will continue to be developed until the end of 2017.

Transparency of information and a robust feedback system help day-to-day engagement with patient experiences, and patient feedback is used to inform quality initiatives

There are a number of ways that patients and the public can make complaints and give feedback on the quality of care they receive in Scotland. *Patient Opinion*, an online portal, enables people to post their experiences of NHS services anonymously. People who wish to give feedback on a service can leave a comment and can expect a reply from a member of NHS staff, often from the institution concerned. In a recent example, a patient wrote on the online forum about a negative experience with a rheumatology service. A few days later, the chief executive of the relevant health service responded, apologising and providing information on future plans to improve the service. People can see online which organisations the feedback has been sent to, such as the Scottish Health Council and Scottish Public Services Ombudsman. They can also track online whether a change has been made since the feedback, or a change is planned. Such an initiative facilitates dialogue between patients and health providers, and provides evidence that health services are listening to patients and acting on their feedback to drive improvement. It also facilitates feedback to NHS staff, and can promote learning. Other OECD health systems could look to this example as a way of improving responsiveness to patients.

The ISD also gathers official statistics on complaints, as a key quality indicator. An annual complaints report is compiled and published, and accessible on the ISD website. The data are broken down by individual NHS Board. The complaints data for Scotland are not directly comparable with other parts of the United Kingdom. Health Boards are required to publicise their feedback and complaints processes. They must also produce an annual report demonstrating the learning and improvement achieved from the feedback they have received from patients and independent contractors. These reports also provide information on how Boards are using feedback to improve the quality of services.

There are various systems and methods in place across NHSScotland capturing "real time" information relating to people's experiences of local systems. *The Person-Centred Health and Care Collaborative, launched in November 2012,* aims to take a "human rights-based approach" to health and care by empowering people to participate in making decisions about their own care and encouraging person-centredness and self-management. Evidence-based interventions are trialled to assess the best approaches to improve patient-centred care. Since its launch, it has provided support to teams across NHS Scotland, including a measurement framework focused on five "*must do with me*" elements of care: personal goals, the important people in one's life, the information necessary to make decisions, the opportunity to be involved in discussions about one's own care, and the use of services that are flexible to meet individual need. The *must do with me* approach is an innovative way to underline the importance of patient involvement, that other countries will be interested to learn from.

Other support it has delivered includes a measurement framework to support work to develop new methods of gathering regular, real-time feedback from people who use services. There have also been five national learning events, which have brought over 2 000 NHS staff together to hear from world experts in improvement science and person-centred care, to share practical examples of what works well, and work in teams to plan how they would apply, test and refine these interventions in their own organisations. Other initiatives are a a series of WebEx events where boards present their work and learn from each other, and improvement support to NHS Boards, delivered through team visits and improvement skills development courses.

HIS is now refocusing national quality improvement support for person-centred care to build on progress since 2012. The new model will incorporate three main strands:

- Supporting NHS Boards to further develop real-time feedback systems and methods to capture care experience. It is anticipated that this approach will evolve in line with the developing "our voice" framework, and will include qualitative data measurement and the use of that feedback to drive improvement.
- Ensuring person-centred care is integral to other national quality improvement programmes.
- Sharing best practice examples and person-centred evidence across NHS Scotland through a variety of "social movement" methods, including networking, social media, WebEx and video streaming technologies.

Box 2.7. A person-centred approach to electronic health in Sweden

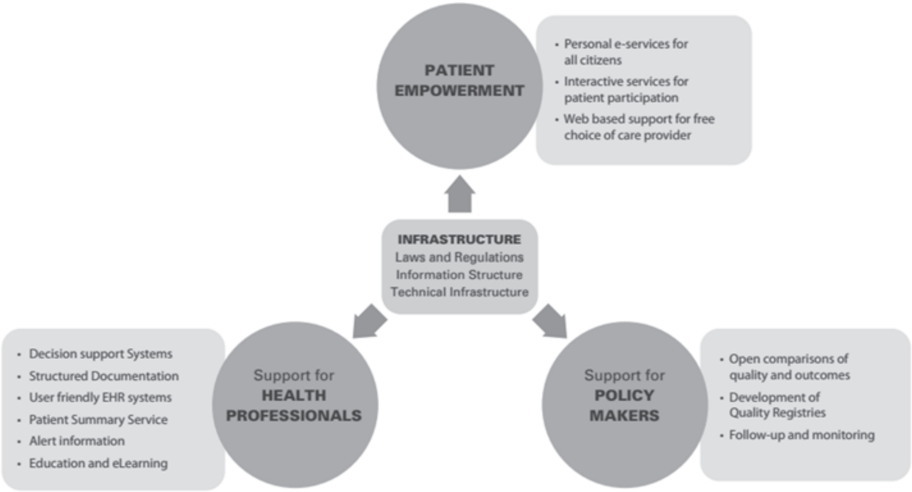
Sweden's national strategy for eHealth sets the patient's desire for information at the centre. Notably, it extends to social care, to promote the integration of care as people move between the two sectors. The change in this way of thinking has resulted in the *National eHealth strategy for accessible and secure information in health and social care*.

The strategy names the individual "citizen" as the most important beneficiary, with easy access to quality-assured information on health and social care, as well as access to documentation on previous treatment. The intent is to offer the patient a customised and interactive service so that they may actively participate in their own care, based on their own prerequisites. There are benefits, too, for health professionals and policy makers, as shown in the figure below.

The strategy cites as a prerequisite putting the needs of the individual first. Another stated priority is the efficient exchange of information and co-operation between all purchasers and practitioners. The information is then intended to follow the citizen through the health and social care sectors.

Personal eServices give patients the opportunity to document information about their own health and obtain advice about care. The Swedish Government's vision is that it shall be easy for everyone to access information about themselves, be able to interact with health and social services, make informed choices and have contact with their practitioner.

Electronic health strategy in Sweden



Source: Swedish Ministry of Health and Social Affairs (2010), "National eHealth – The Strategy for Accessible and Secure Information in Health and Social Care", http://www.isfteh.org/files/media/sweden_national_ehealth_strategy.pdf.

Clinicians currently have good access to a core set of patient information across the various levels of health care. Patients, however, do not yet have access to this information, which could support them to participate more actively in decisions about their care. Work is underway to develop an electronic health record accessible to patients, and discussions on a national patient portal facility for access to digital personal health records and services in Scotland are ongoing. However, Scotland is further behind other OECD health systems in this regard. Additional investment to accelerate this initiative should be considered. The example set by Sweden, particularly with its integration of health and social care in eHealth, could be one to follow (Box 2.7).

Public and patient opinions are routinely used in planning activities

The Scottish Health Council was established in 2005 to promote patient focus and public involvement in the NHS. It is a committee of Healthcare Improvement Scotland. Its role is to ensure that NHS Boards take into account the patient perspective to achieve a “mutual NHS”. In so doing, patients become partners in decision making concerning their own health care, and can also influence how NHS services are delivered.

The Council seeks to ensure that NHS Boards listen and take account of people's views, and support NHS Boards in fulfilling their legal responsibility to engage with patients and the public. The Council supports patients, carers and the public in influencing the planning and delivery of NHS services by, for instance, developing and maintaining the Participation Toolkit, supporting local Public Partnership Forums, encouraging volunteering in the NHS and, through the Participation Standard for NHS Scotland, measuring how well NHS Boards are involving people. Public Partnership Forums are networks of patients, carers, community groups, voluntary organisations and individuals interested in the development and design of local health and social care services. Each NHS Board has a designated director with responsibility for public involvement. The boards are expected to take a proactive and positive approach to public involvement in possible service changes.

The Scottish Health Council’s 2013 *“Listening and Learning”,* report, commissioned by the government, sought to identify good practice and barriers in listening to feedback and complaints. The report found that all NHS Boards had made some progress in responding to the aspirations of the Patient Rights (Scotland) Act 2011. Many were able to demonstrate innovative thinking and techniques in their handling of feedback and complaints. Feedback is also sought in the form of surveys of patient experiences. These are conducted in the domains of primary care, inpatient care and maternity services, on an annual, or close to annual, basis.

2.10. Use of financial incentives to improve quality

Direct financial incentives are seldom used to promote quality in the Scottish health care system. General practitioners' participation in the UK-wide primary care pay-for-performance scheme is the exception to this.

Financial incentives do not feature prominently in Scotland's quality architecture

Scotland has adopted the approach of assuring and improving high-quality care by seeking promoting quality and efficiency initiatives, rather than through rewarding quality with financial incentives. NHSScotland does not seek to promote competition between health services, but instead seeks to instil co-operation and collaboration both across NHSScotland and between NHSScotland and its partners.

NHS Boards receive baseline funding for services based on target shares calculated using a resource allocation formula. This calculation takes into account local need for health care due to the population's age and sex profile, morbidity and life circumstances. Geographical considerations, particularly the cost of delivering health care in more remote areas, are also taken into account. Financial incentives are not a consideration.

Primary care provides the only Scottish example of linking quality to financial incentives. The UK-wide Quality and Outcomes Framework (QOF) is one of the main sources of potential income for general practices. As in other parts of the United Kingdom, participation by Scottish primary care physicians is voluntary. For those who choose to participate, the QOF measures achievement against a range of evidence-based quality indicators, with points and payments awarded according to the level of achievement. Public scrutiny provides an additional incentive, with the performance of individual practices published on a website. Physicians benefit by having the capacity to compare their performance against that of their peers.

However, in late 2015 Scotland's Health, Well-being and Sport Secretary announced that the QOF in Scotland would be removed by the end of 2017 in preparation for a new GP contract. This is a move consistent with Scotland's bottom-up approach to quality improvement and reluctance to use financial incentives to promote health care quality.

There is little evidence of other direct financial incentives to improve health care quality in Scotland. NHS Boards undertake an annual process where they may award discretionary point payments to eligible hospital consultants who have demonstrated that they have made an outstanding contribution in improving quality of care.

Savings and reinvestment from quality and efficiency gains, however, act as an indirect financial incentive to improve quality

Scotland's NHS Boards are required to deliver an annual efficiency saving of 3% of baseline funding, to be reinvested in frontline services. Special NHS Boards that do not provide direct patient care return their savings in order that they are recycled into the overall funding available to support patient care. Much of these savings are expected to be found by through improvements in the quality of care – by reducing unnecessary hospital stays, unplanned readmissions and adverse events for example.

Providers are subject to an indirect financial incentive via this mechanism, therefore, to improve quality. Over the past five years, NHSScotland has successfully saved over GBP 1.5 billion. Savings have been reinvested in improving the quality of services, signaling a virtuous circle. Hospitals and boards are supported to identify quality and efficiency gains through the work of the Quality and Efficiency Support Team (QuEST) described in Box 2.8.

Box 2.8. Scotland's Quality and Efficiency Support Team (QuEST)

The Quality and Efficiency Support Team (QuEST) commissions, supports and leads a number of national programmes to support improvement in the quality, efficiency and value of health care within NHSScotland (qihub.scot.nhs.uk/quality-and-efficiency.aspx). The approaches supported by QuEST are set out in NHSScotland's *2020 Framework for Quality, Efficiency and Value.*

In particular, QuEST delivers ten specialist, focused programmes across a range of clinical and non-clinical areas including procurement, prescribing, dementia and cancer. Between them, these programmes have supported NHS Boards to test, spread and embed their own innovative good practice as evidenced by almost 200 examples collected to date. Examples include redesign of the patient pathway after a fracture to reduce unnecessary clinic visits, development of national therapeutics indicators to improve prescribing practices, or intensive home (rather than in-patient) treatment for mental illnesses.

Additionally, Scottish Government funds the production and dissemination of a range of benchmarking products covering business critical areas such as surgical operating theatres utilisation, procurement and estates management. A dashboard containing a range of Efficiency and Productivity indicators that enable NHS Boards to benchmark themselves against each other and NHS England, where appropriate, is centrally produced and a new product bringing together all data sets that allow benchmarking is intended to be launched later in 2015.

2.11. Patient safety initiatives

Scotland's proactive approach to patient safety provides lessons other OECD countries can learn from. The emphasis is on the exchange of knowledge and shared learning, rather than assigning blame. Scotland launched the world's first national Patient Safety Programme in 2008, with an emphasis on preventing avoidable mortality and harm in acute adult hospitals. Its approach is to apply quality improvement methodology to the business of improving safety of care focusing on five work streams. The scale and ambition has grown and the scope of the patient safety work in Scotland now extends to primary care, mental health and maternal and child health.

Scotland plays a leading role in patient safety initiatives in Europe

Scotland was among the first places in Europe to commence systematic patient safety work. It has been a leader in the organisation of patient safety programmes, in education around safety, and in launching new initiatives. As described earlier, NHSScotland's close collaboration with the Institute for Healthcare Improvement (IHI) has been instrumental in helping Scotland become a leader in quality improvement and patient safety in Europe.

An example of one initiative is the NHS Scotland Confidential Alert Line, which enables staff to make a confidential phone call to receive advice from legally-trained staff about how to report a patient safety or malpractice matter. The Scottish Government is also exploring the possibility of introducing a no-fault compensation scheme for injuries caused by clinical treatment, although this seems to be in its infancy. Scotland has also adopted a duty of candour, with a new requirement from 2017 that all patients be informed in writing of incidents of harm affecting them. This is based on the premise that patients should be involved in enhancing the learning of health professionals. The requirement will apply to NHS Boards, GPs and care homes.

National patient safety initiatives are spearheaded by Healthcare Improvement Scotland. The Patient Safety Programme has moved from the traditional somatic hospital setting, to extend to maternity and child health, primary health care and psychiatric care (Box 2.9). The programme is based on the IHI's Breakthrough Series Collaborative Model, which comprises a series of learning sessions enabling NHS Boards to exchange knowledge and learn from each other. Discussions are underway about how these patient safety programmes can be more closely linked and integrated with a wider set of quality improvement initiatives in these sectors.

Box 2.9. The Scottish Patient Safety Programme Priority Areas

Scotland's Patient Safety Programme identifies a series of priority areas, across a broad number of domains – acute care, maternity and child care, mental health care etc. Below are some select examples of priorities identified within this programme, by care domain.

Acute adult care

- reduce mortality and harm from sepsis
- reduce cardiac arrests in general wards by improving the response to, and review of, deteriorating patients
- prevent surgical site infections
- safer use of medicines
- reduce harm and mortality from Venous Thromboembolism (VTE)
- reduce harm from falls while promoting recovery, independence and rehabilitation
- reduce harm from pressure ulcers
- reduce harm from Catheter-Associated Urinary Tract Infections
- improve outcomes for patients with heart failure

Maternity and children collaborative

- maternity care
- neonatal and paediatric care

Mental health

- risk assessment and safety planning
- restraint and seclusion
- safer medicines management
- safe and effective person-centred communication at key transition points

Primary care

- promoting a safety culture through the use of trigger tools (structured case note reviews) and safety climate surveys
- promoting safer use of medicines including the prescribing and monitoring of high-risk medications and developing reliable systems for medication reconciliation in the community
- promoting safety across the interface by developing reliable systems for handling written and electronic communication and implementing measures to ensure reliable care for patients.

Source: Scottish Patient Safety Programme, http://www.scottishpatientsafetyprogramme.scot.nhs.uk/.

The Patient Safety Programme initiatives were designed in recognition of common adverse events, such as sepsis and mental health-related harm. The programme includes performance measurement at both a local and national level. Most results from the safety work are reported locally, and national data are not published in a systematic manner. However, according to highlights provided during a 2014 conference, there has been much progress since the programme's 2008 launch (Scottish Patient Safety Programme, 2014). Among the results cited are:

- 25.5% reduction in surgical mortality
- 15.9% reduction in the hospital standardised mortality ratio
- 80% reduction in clostridium difficile rates in people aged 65 and over
- 89% reduction in MRSA cases
- 300 000 surgical pauses have been recorded, and 10 000 pauses are taking place each month. A surgical pause, or "time out", refers to a brief pause in an operating room before incision, at which time all members of the operating team verbally confirm the patient's identity, operative site and procedure to be performed. It is a means of avoiding errors concerning the wrong site or patient, and is mandatory in the United States and a few other countries (World Health Organization, 2008).

A sound communication strategy has been key to the success of the Scottish Patient Safety Programme. Its success story has been told in published articles, and in the presentation of results at national and international meetings. This is driving motivation and further work in the area (Haraden and Leitch, 2011). The early good results have been broadcast to promote the sentiment of team effort, and this has contributed to the programme's enthusiasm, energy and international recognition.

Although national learning systems related to adverse events are in place, a national reporting system is not

Adverse event reporting in Scotland is done locally, not nationally. This is a deliberate approach, to foster local ownership and response. All Health Boards have an obligation to have systems for internal control, and thus a system for identifying and working with adverse events. Most hospitals have electronic systems for reporting, but the situation in primary care is more variable with regards to electronic reporting systems. There are a number of regulations on the reporting of some types of adverse events to national agencies, such as technical errors in equipment and serious medication side effects. Additionally, the previously mentioned duty of candour procedure, when it comes into effect, will emphasise the need for learning and improvement actions after harm. The legislative provisions include the requirement for reporting at a national level, in the form of an annual report, on all incidents that come within the scope of the duty of candour procedure. This will include learning, change and improvements that have occurred.

Despite lack of a national reporting system, systems to share lessons and service improvements at national level do exist, as described above. In addition, Healthcare Improvement Scotland undertook an extensive consultation exercise with NHS Boards, clinicians, patients and other stakeholders in 2013, to understand how these systems could be improved. This feedback, along with existing evidence and good practice from Scotland and internationally, was used to develop *Learning from adverse events through reporting and review: A national framework for NHS Scotland.* The adverse events framework allows local boards to identify areas for change and improvement. There have been visits to all NHS Boards, and reports identifying locally-owned change and improvements that are being made.

All NHS Boards providing services directly to patients have had their processes for managing adverse events reviewed, to help them learn and improve their services. The reviews aim to reduce the risk of these events happening again, and to provide public assurance that NHS Boards are effectively managing adverse events. This led to the following national recommendations for areas of improvement:

- Patients, families and carers should be involved in the adverse event review process, and their involvement should be documented.
- Staff members should be given feedback about the review in a timely manner.
- Information from all stages of the adverse event review process, from initial report through to monitoring of actions, should be consistently and reliably recorded.
- Learning should be consistently shared and improvements demonstrated.

A set of good clinical practices were identified and presented in the national report. A managed community of practice was established to support learning from adverse events nationally. Such communities comprise people with the same profession or area of interest, whose main purpose is to share knowledge. A website with educational resources about the handling of adverse events is under development (NHS Education for Scotland, 2014). There is a challenge, however, to incorporate this initiative with other programmes and initiatives promoting safe care.

Nevertheless, while it is commendable that local reporting programmes and national learning systems exist, there is still a need for a nationally consistent reporting system (or other counting system, based on clinical and administrative records). A national reporting/counting system is needed to benchmark local patient safety work, identify emergent safety concerns, and monitor the impacts of national patient safety programmes. A national system provides a bigger pool from which health services can share knowledge on these incidents and learn from one another. Technical issues, such as harmonisation of definitions and reporting mechanisms across regions can be complex, but have been successfully overcome in many OECD health systems (EC, 2014).

As an additional mechanism for commissioning learning and improvement, Scotland should consider introducing a national reporting/counting system for adverse events. National systems need not do away with local reporting, and should not undermine local empowerment, ownership or learning. A well-designed national reporting system, that remains closely linked to local and frontline services, should add to continuous learning. National reporting already occurs for adverse reactions to medications (through the Yellow Card scheme) and Health Protection Scotland already produces reports on infections regularly, such as Staphylococcus aureus bacteraemia infection (which is then analysed and reported back at NHS Board level), so precedents exist. A country Scotland could follow in promoting a national adverse events reporting system is Denmark (Box 2.10).

Box 2.10. Reporting adverse events in Denmark

Denmark introduced a national reporting system for adverse events in 2004 to improve patient safety. Notably, six years later, the system was expanded to include adverse events occurring in primary care, including in general practice and pharmacy. Information on patient safety in primary care is sparsely reported across OECD countries, making Denmark a leader in this sphere.

In 2011, the system was expanded again to give patients and their relatives the opportunity to report adverse events, emphasising the active participation of patients in the health care system. The reporting system aims to collect, analyse and communicate knowledge of adverse events, to reduce their number.

Box 2.10. Reporting adverse events in Denmark *(cont.)*

The sanction-free and no-blame reporting scheme makes it mandatory for Danish health professionals to report any adverse events they become aware of in connect with patients' treatment. The system is designed as a bottom-up process, where the majority of the work is locally rooted. This is based on the idea that adverse events that occur locally should be analysed and corrected locally. This is also thought to have a positive impact on the development of a safety culture. Therefore, the responsible authorities – the regions or the municipalities – are obliged to receive and analyse reports of adverse events. The information is later sent to the National Agency for Patients' Rights and Complaints.

On the basis of the information provided by the local authorities, the Agency advises other stakeholders in the health care system concerning patient safety, thus supporting the development of learning from adverse events nationally. To encourage reporting, health care professionals reporting an adverse event are not subjected to disciplinary investigations or other measures by their employer, supervisory reaction by the Danish Health and Medicines Authority, or criminal sanction by the courts.

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

2.12. Conclusions

Scotland has a comprehensive and ambitious quality strategy, with clear goals to provide person-centred, safe and effective care. The strategy is underscored by a quality measurement framework providing the basis for the use of indicators to measure progress towards desired outcomes. The quality strategy sits alongside the Scottish Government's *2020 Vision* and *Route Map,* which set out aspirations for longer, healthier lives. Taking these national initiatives as a foundation, Scotland's quality improvement efforts are primarily driven from the bottom-up and characterised by local-learning collaboratives, small cycles of innovation and testing, and communities of practice. At the same time, Scotland is pursuing the integration of health, social and other care for individuals with complex needs.

There is still, however, much that Scotland can do. To help inform its quality improvement efforts, a key priority will be for Scotland to make better use of its information systems to allow a clearer understanding of whether quality initiatives have improved population health. Consolidation of some content from the multiple data platforms that currently exist would help in this regard, to facilitate transparency and public understanding of the quality of care. Although there is much to praise in Scotland's local, or bottom-up, approach to quality monitoring and improvement, these initiatives could at times be supported by stronger national frameworks. The lack of a national system for reporting/counting adverse events is one weakness for example, that should be addressed. Consideration should also be given to the creation of a more independent mechanism for assessing health system performance (separate from the improvement function), and ensuring that primary and community care services are subject to the same level of scrutiny as hospital services.

Policy recommendations for Scotland

To ensure high-quality health care, and continuously improve care across the system, Scotland should:

1. Capitalise on and extend the gains it has made in improving quality of health care by:

- Applying the breakthrough collaborative model and other quality improvement programmes across primary care and community care services more extensively and consistently. Priority concerns would be to improve the prevention and management of chronic conditions, mental health, and the safeguarding of vulnerable children and adults, building upon the patient safety work already undertaken in these areas.
- Introducing a national system for reporting/counting adverse events, to improve health care safety in both hospital and primary care settings, to underpin the local reporting systems and national learning systems already in place.
- Considering formally separating the Scrutiny and Assurance Directorate into a distinct and independent entity. Producing annual, comprehensive and independent assessments of the quality of care provided by NHSScotland as a whole would be the priority.
- Once piloting of the *Care Assurance and Accreditation System* (CAAS) is completed, considering whether the CAAS model might be more widely applied across the health system.

2. Improve how health system information is used to drive quality improvement by:

- Orienting health system information towards clinicians, managers and the public in more user-friendly formats that promote interactivity, with one main online entry point for ease of access. Consolidation of some content from the multiple data platforms that currently exist (such as *NHS Performs,* Health and Well-being Profiles, cancer quality performance indicators etc.) would be valuable.
- Benchmarking local health service performance with atlases of quality, outcomes and satisfaction and outcomes, beyond those currently produced by the Scottish Public Health Observatory.
- Developing a more systematic approach to quality registers in particular seeking to cover patient groups that are poorly represented in Scotland's suite of national quality audits. This would include dementia, as well as mental health more broadly. Possibilities for linking of data across databases, whilst assuring individual anonymity, should be maximised.
- Drawing upon experience in other OECD health systems to include patient-reported measures (including patient satisfaction and experience) in Local Development Plan standards, the *NHSPerforms* data set, the cancer quality performance indicators and other monitoring frameworks.

Policy recommendations for Scotland *(cont.)*

- Considering whether greater impact and value-for-money might be obtained by consolidating all collection, analysis and dissemination of health system data into a single institution. Care would need to be taken to ensure that the particular advantages of individual bodies (such as ASD's diverse professional backgrounds and embedded relation to government) are not lost.
- Investing in electronic health to provide patients with a means of accessing their own health records and enabling them to become more active participants in decisions about their care.
- Sharing the information collected about the quality of out-of-hours primary care services in a publicly-accessible format, and using the information to inform policy developments.

3. Support increased integration of health, social care and other services by:

- Ensuring study and publication of successful examples of integration, implementation pathways and syntheses of lessons and insights, so that other countries can learn from Scotland's experience.
- Considering whether there is scope to deepen GPs' involvement in local care planning, and in the integration of health and social care services in particular.
- Focusing on collecting more data on activities, costs and outcomes from the social care sector as the Health and Social Care Data Integration and Intelligence Project (HSCDIIP) is further developed, at both local and national levels.
- Better aligning the health service inspectorate's regulatory competencies with those of the social care inspectorate.

Notes

1. Reported during the OECD Study Visit to Scotland in September 2014.
2. Relevant documents can be found at http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews/qoc_reviews_consultation.aspx.

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Chapter 3

Health care quality in Wales

Less than two decades after devolution, the Welsh health system remains a relatively young one; many of the institutions and mechanisms needed to promote high quality care are in place, but now a further push is needed to move towards a more mature, robust quality architecture. In many respects, "quality" is at the heart of the Welsh health system; this chapter describes Wales' already-rich health care quality architecture. The ambition for an excellent, patient-centred health system, promoting quality, access and equity is clearly there in Wales, but now tangible practical steps are needed to make the necessary changes. This chapter makes a series of recommendations to support Wales in strengthening quality assurance and quality improvement. Assessment and recommendations are made across health system domains – from the role of accreditation and standards, to patient voice and professional training. Cutting across these domains, the priority should now be for Wales should be looking to increase accountability for delivering good quality and improving quality, and trying to establish some more concrete levers for positive system change.

Continuously improving the quality of care is a deeply established and widely shared commitment in the Welsh health system, NHS Wales. This report assesses the governance model, institutions and policies in place to assure, monitor and improve health care quality in Wales. Comparisons with quality monitoring and improvement activities in other OECD health systems are drawn and, based upon these, the strengths and weaknesses in Wales' quality architecture are identified. Where weaknesses are identified, recommendations for strengthening arrangements in Wales are proposed, drawing on successful examples from other OECD countries.

Analyses that quantify quality and outcomes in the Welsh NHS are available elsewhere (for example the Health Foundation and the Nuffield Trust, 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 Wales' quality architecture evolve to deliver ever better health care"? The chapter opens with a brief description of how health care in Wales is planned, financed and delivered, focusing on the role of Health Boards, and the Prudent Healthcare agenda. Section 3.2 then examines separate elements of the quality architecture (such as use of inspection or professional licensing, authorisation of medical devices and pharmaceuticals, audits and peer review, etc.) in detail, in a format that follows other volumes in the OECD's Health Care Quality Review series. An assessment of how the system is meeting the challenges it faces, and a series of recommendations to help Wales improve, are made throughout, and brought together in a conclusion and recommendations box at the end of the chapter.

3.1. The planning, financing and delivery of health care in Wales

The Welsh National Health System provides publically funded health care for Wales' 3 million population. While also a relatively young system – a devolved health system was established in Wales in 1999 – most of the core functions of the health system are devolved as part of NHS Wales, with only some more limited functions remaining at a UK level. Wales has chosen to abolish the purchaser-provider split and does not accept that competition is the best driver for quality improvement. NHS Wales is therefore referred to as a "planned" system, based on unified decision making and integration of service delivery, and a systematic planning cycle. The Welsh Government has overall responsibility for planning of the system, while local Health Boards, trusts and local authorities also have established management and planning mechanisms. Recent health policy in Wales has emphasised the importance of "Prudent Healthcare"; the Prudent Healthcare agenda now needs to be backed up by a detailed roadmap – an Implementation Action Plan – containing a clearer vision for what services will look like.

Population characteristics in Wales

Located on the Western Coast of Great Britain, Wales has a population of just over 3 million people, mostly concentrated in the south of the country and along the northern coast, with a largely rural centre. Some 19% of the population is Welsh speaking, with some communities particularly in the north and west of Wales speaking Welsh as a first language. NHS Wales is the only system in the United Kingdom which endeavors to provide services in two languages, England and Welsh, in line with the patient's wishes.

Wales is the most economically disadvantaged of the four UK nations, with a Gross Value Added in 2012 of GBP 15 696, compared to England GBP 21 349, Scotland GBP 20 571, and Northern Ireland GBP 16 531 (Office of National Statistics, 2012). The lower income per head in Wales likely impacts upon population health and wellbeing, and demand for health services. Wales has a higher dependency ratio than the other UK nations – with more children and retired persons –, and also has a greater number of adults under retirement age with a disability (National Audit Office, 2012). Based on these indicators, as well as other determinants such as rate of drinking, smoking and obesity, a review of the UK nations by the National Audit Office (2012) estimated that relative health need per person in Wales is higher than in England and Scotland (1.07 compared to 0.91 and 0.98 respectively), and slightly lower than in Northern Ireland (1.11).

A devolved health system in Wales was established in 1999 with primary legislative powers passed to the Welsh National Assembly in 2006

The Welsh National Health System (NHS) provides publically funded health care for all of Wales' population of 3 million, which is around 5% of the total population of the United Kingdom. Originally part of the health system for England and Wales, with the National Health Service Act 1946, powers over NHS Wales were passed to the Secretary of State for Wales in 1969. Devolution of responsibility for NHS Wales followed in 1999, following a national referendum, some 50 years after the establishment of the devolved systems in Scotland and Northern Ireland. This Act established the National Assembly for Wales as a corporate body with an executive government and a legislating body, and passed the governance of the NHS in Wales from the UK Parliament to the Welsh Government and the Welsh Minister for Health and Social Services. A subsequent Government of Wales Act 2006 provided the Welsh National Assembly with primary legislative powers in a number of areas including health. The National Assembly for Wales is a democratically elected body that represents the interests of Wales and its people, makes laws for Wales, and holds the

Welsh Government to account, and is responsible for areas such as health, education, language and culture, and public services. The UK Government retains responsibility for UK-wide areas such as tax, defence, foreign policy, social security and welfare benefits. Wales' voice in the UK Government is represented by the Secretary of State for Wales in the Wales Office. There are also certain situations in which the Welsh Government works collaboratively with the UK Government on legislation that affects Wales but which is passed by the Westminster Parliament.

While most of the core functions of the health system are devolved as part of NHS Wales, some areas of health and health services are not devolved, including the following: abortion; human genetics, human fertilisation, human embryology, surrogacy arrangements; xenotransplantation; regulation of health professionals (including persons dispensing hearing aids); poisons; misuse of and dealing in drugs; human medicines and medicinal products, including authorisations for use and regulation of prices; standards for, and testing of, biological substances (that is, substances the purity or potency of which cannot be adequately tested by chemical means); vaccine damage payments; and welfare foods. International mattes, such as relationships with the WHO and the OECD, are also a non-devolved matter. Wales also principally draws on the clinical guidelines developed by the National Institute for Health and Care Excellence (NICE), with some established collaboration around pharmaceuticals and medical devices (see Chapter 1 on England).

The bulk of funding for the NHS Wales comes as part of a block grant from Treasury in the United Kingdom

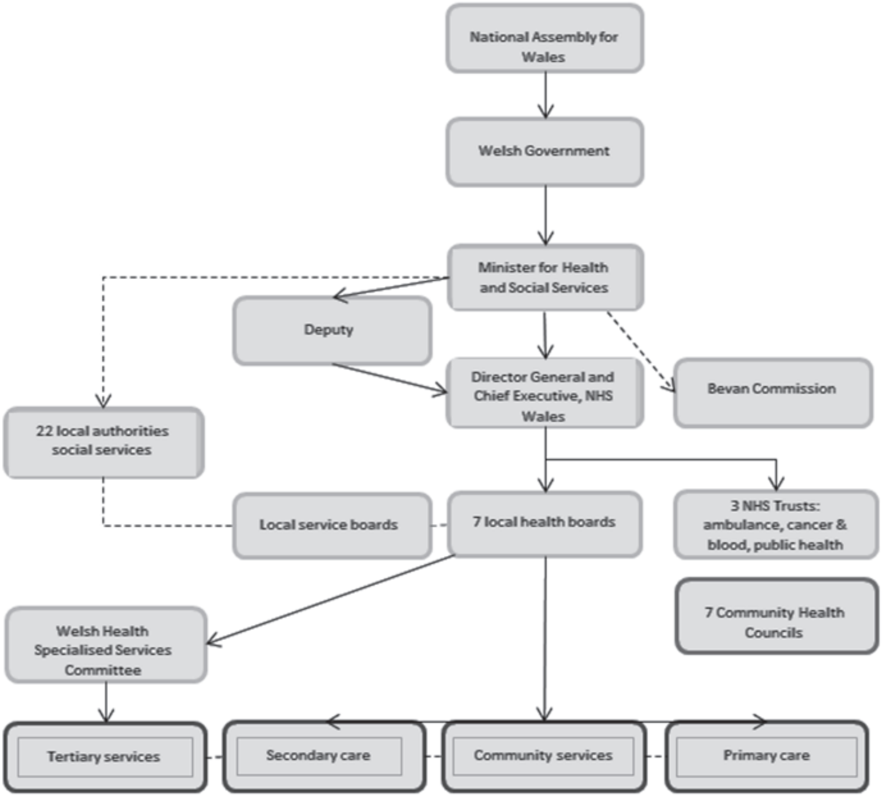
Funding for NHS Wales comes as part of a block grant for the Welsh Government from the Treasury in the United Kingdom. In 2014-15 a grant of GBP 15.1 billion was made to the Welsh Government, of which GBP 6.4 billion was allocated to Health and Social Services, representing 42% of the expenditure of the devolved responsibilities of the Welsh Government (Welsh Government, 2014a). The block grant from the UK Government to Wales is made based on the population allocations covered by the Barnett formula (which is also used to calculate grants to the other devolved nations). The adequacy of this funding calculation has been called into question, notably in the 2010 report "Fairness and accountability: a new funding settlement for Wales" (Welsh Government, 2010). This report suggested that Wales is at present underfunded relative to its needs, and that the funding of devolved activities in Wales has fallen below what Wales would receive if funding was allocated based on the same formulae used to allocate resources to comparable functions in England. The block grant allocation made based on the Barnett Formula to Wales makes up between 50-60% of public spending in Wales, with the remaining per cent of public spending made up in the most part from social security benefits and tax credits (The Health Foundation and Nuffield Trust, 2014).

Wales has chosen to abolish the purchaser-provider split and focuses on careful planning mechanisms

Wales has chosen to abolish the purchaser-provider split and does not accept that competition is the best driver for quality improvement. NHS Wales is therefore referred to as a "planned" system, based on unified decision making and integration of service delivery, and a systematic medium term (three year) planning cycle, set out in the NHS Wales Planning Framework (Welsh Government, 2013), and the NHS Wales (Finance) Act 2014. The system focusses on clearly defined planning roles and responsibilities and clear and integrated national priority setting, while allowing sufficient freedom within arrangements for organisations to respond to local health needs. There is a high level of scrutiny around plans, from government, management, clinical staff, patients and the public, and strong relationship between the planning system and quality, delivery, and performance monitoring arrangements. The Welsh Government has overall responsibility for planning of the system, while local Health Boards, trusts and local authorities also have established mechanisms for setting out how resources (financial, workforce and infrastructure) will be deployed to yield maximum benefit in order to address areas of population health need and improve health outcomes, improve the quality of care, and ensure best value from resources.

NHS Wales is led by the Minister for Health and Social Services in the Welsh National Assembly, and the Director General for Health and Social Services and NHS Wales Chief Executive, and organised and governed through seven local Health Boards and three NHS Trusts (Welsh Ambulance Services NHS Trust, Public Health Wales, and the Velindre NHS Trust for non-surgical cancer care and the blood service). Health Boards in Wales are responsible for assessing the needs of their population as a whole, and for ensuring services are provided that meet those needs. Wales' 22 local authorities, with locally elected politicians, are responsible for local government including social services. They are statutorily required to work with the NHS and non-statutory partners using a variety of joint arrangements such as local strategic partnerships. Groups of local authorities have coterminous boundaries with Health Board (Figure 3.1).

Figure 3.1. Structure of health services in Wales



Source: Adapted from Longley, M. et al. (2012), *United Kingdom (Wales): Health System Review. Health Systems in Transition*, Vol. 14, No. 11, pp. 1-–84, and based on submission from the Welsh Government.

Five years after their establishment Health Boards are showing less local innovation and fewer radical approaches to system change and quality improvements than would be expected

Health Boards, which were created in 2009, plan and commission all services for their local area, with the exception of some of the more highly specialised services covered by the NHS Trusts and the Welsh Specialist Services Committee. Understanding of the role that Health Boards should play has been improving in Wales, and they have moved from an amalgamation of hospitals and commissioners to more cohesive organisations, better connected with local authorities and the needs of the population. Efforts have been made to push the Health Boards towards assuming a planning approach more closely attuned to demand for health services, and anticipating demand ahead of time.

A central part of this has been the expectation that all Health Boards complete Integrated Medium Term Plans, which set out projected Health Board activities for the following three years. The intention of the Integrated Medium Term Plans is that Health Boards, once their plans are approved by the Minister, are given more year-on-year flexibility in their activities, whilst being held to account on the basis of the plans they have put forward. Only a few Health Board plans have to-date been approved by the Minister, and the Health Boards that have not had Integrated Medium Term Plans approved work toward a one year plan and have less flexibility and closer supervision going forward. The Minister and NHS Wales provide a Planning Framework which gives guidance on what Health Board plans will be assessed against.

The introduction of a three-year systematic planning cycle with the IMTPs, as a step forward from yearly budget cycles and a focus on annual targets, seems like a positive one. A move to give Health Boards greater flexibility and independence could also be expected to foster better connectivity with local needs, as well as innovative local approaches to planning and delivering care. Having been established in 2009, Health Boards have now had five years in which to mature, and begin to demonstrate their central importance to the Welsh NHS. Given their close proximity to local population needs, and the apparent desire that they be driving local change, a far greater degree of local innovation and more radical approaches to system change and quality improvements could well be expected from Health Boards by now.

However, there are signs that Health Boards are not at this point fulfilling their full potential, and it may be now be appropriate for the partnership between the Welsh Government and Health Boards to be revisited. While central governing authorities in Wales have taken a deliberate step back to encourage some more local autonomy, it may be that at present Health Boards do not have sufficient institutional and technical capabilities and capacities to drive meaningful change, and a stronger central guiding hand may be needed. To maximise the potential of Health Boards as local planners, purchasers and providers the centre may have to step back in and play a more supportive – and prescriptive – role.

There are some signs of evolving relationships between the Health Boards and the Welsh Government and other central authorities. With the introduction of the Integrated Medium Term Plans Wales has taken a step in the right direction, but more work is needed to get the balance between local freedom, innovation and sensitivity to population needs, and core standards that should be centrally driven, right. Similarly, the introduction of an Escalation and Integration Framework in 2014 seems to be an appropriate development. The framework is used as a tool for greater co-ordinated action between the Welsh Government, Healthcare

Inspectorate Wales, and the Auditor General for Wales, and as a robust tool for quality assurance and intervention by the Welsh Government in case of crisis or serious concerns about quality.

In Wales, though, work is still needed at both ends of the spectrum – in terms of setting expectations of Health Boards, and supporting Health Boards to meet and exceed expectations, and foster local innovation. More can be done to set, and publicise, core minimum expectations of all local Health Boards. While the NHS Wales Planning Framework seems a useful step towards clarifying planning expectations, there still seems to be scope for the government to be more prescriptive about exactly what is expected – in terms of financing and budget allocation, performance and efficiency, and quality achievement and improvement – from Health Boards and the providers they oversee. The Welsh Government is already beginning to explore some of these issues for the health system as a whole, and for Health Boards, in the consultation document (Green Paper) "Our Health, Our Health Service" (Welsh Government, 2015a), and with the Integrated Medium Term Plans. More also needs to be done to support Health Boards as they try to deliver meaningful, and more significant, system change, with a focus on good collaboration between the Welsh Government and the Health Boards, building technical, managerial and leadership capacity in Health Boards, and sharing of experiences and expertise across Health Boards and system-wide. Other OECD countries also struggle with the balance between national standards (and control), and local freedom and innovation, and some offer lessons that Wales could learn from (Box 3.1).

Box 3.1. Getting the balance between local freedom and central standards right: Examples from Denmark, Italy and Norway

In **Italy,** 21 regions and autonomous provinces are responsible for the planning and delivery of health services, and the main way in which the government's steering role and regional government's delivery role is expressed in the Patto per la salute (Pact for health), a three-year plan that is agreed jointly between central and regional governments. Backing up this central direction-setting, which is not dissimilar to Wales Integrated Medium Term Plans for Health Boards, is AGENAS, the *Agenzia Nazionale per i Servizi Sanitari Regionali* (National Agency for Regional Health Services) which is supports regions in developing knowledge and capacity, and also oversees the National Outcomes Programme (*Programma Nazionale Esiti* – PNE). This Programme is a national initiative that monitors129 health care indicators (input, process and outcomes) across hospitals and municipalities in Italy. Results across the indicators, which are at present mostly covering hospital settings, are (depending on the indicator) published at a national, regional, and hospital level. The OECD (2014) has recommended that Italy look to expand further the responsibilities and capacities of the national authorities whose role is to support the R&AP, notably AGENAS, but this supportive institution, and national indicator platform, are already interesting ways of pushing both local performance and quality standards, and fostering innovation.

Box 3.1. Getting the balance between local freedom and central standards right: Examples from Denmark, Italy and Norway *(cont.)*

Denmark also offers a model of considerable interest, with the *Danske Regioner*, or association of Danish regions. In Denmark national legislation increasingly sets out requirements on topics such as waiting times, safety of pharmaceuticals and adverse event reporting, and then more detailed regulation is carried out through the agreement between the national level, the regions, and the municipalities. Quality targets are an increasing feature of these agreements. The agreement on the regional budget for 2013, for example, stipulates a 10% decrease in hospital standardised mortality rate and a 20% decrease in adverse events for the next three years. Although these agreements are not legally binding, they are considered to be an important mechanism to govern the Danish health care system, whilst leaving sufficient room for regional and local adaptations according to needs.

In **Norway** the *Kommunesektorens organisasjon*, the Norwegian Association of Local and Regional Authorities, is a national interest association for all 428 Norwegian municipalities, 19 counties, and public enterprises KS have regular contacts with central authorities to advocate for the interest of its members, and negotiate agreements with the government. The 2012-15 agreement, for example, aims at promoting quality initiatives in the primary health care services. The agreement puts great emphasis on patient participation, prevention, rehabilitation and the use of new technologies. KS actively communicates with the members, disseminates information and facilitates the exchange of experience. The regular consultations between the central government and the Norwegian Association of Local and Regional Authorities also focus on financial issues depending on the duties and responsibilities of local authorities.

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, OECD (2014), *OECD Reviews of Health Care Quality: Italy 2014: Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264225428-en.

What is clear in these international examples is how important collaboration between local authorities is, and how effective support for local bodies – from the centre, from each other, from a third organisation, or a mix – is key. More also needs to be done to support Health Boards as they try to deliver meaningful, and more significant, system change, with a focus on good collaboration between the Welsh Government and the Health Boards, building technical, managerial and leadership capacity in Health Boards, and sharing of experiences and expertise across Health Boards and system-wide. Some ways of doing this in Wales might include:

- Mentoring partnerships between Health Boards, where more successful and experienced Boards can support those that may be struggling.

- Mentoring partnerships and experience exchanges between top managers across boards, the Welsh Government, and organisations from across the United Kingdom.
- Learning trips and exchanges with other countries where local innovation and leadership is well established.
- Staff exchanges and secondments between Health Boards, and between Health Boards and the Welsh Government.

The Prudent Healthcare agenda should now be backed-up by an Implementation Action Plan

Recent health policy in Wales has emphasised the importance of "Prudent Healthcare", with 2014 announced by the Minister for Health and Social Services as the "Year of Prudent Healthcare". Prudent Healthcare is described as being "healthcare that fits the needs and circumstances of patients and actively avoids wasteful care that is not to the patients benefit", a vision outlined in a written statement on 14 July 2014 to the Welsh Government. The Prudent Healthcare agenda focuses on harm reduction, appropriateness of care – notably the minimum appropriate intervention and care setting, and that for instance no patient should be seen routinely by a consultant when their needs could be appropriately dealt with by an advanced nurse practitioner –, a push for professional excellence, promotion of equity and criteria of clinical need, and a remodeling of the relationship between user and provider on the basis of co-production, including the encouragement of a "prudent patient", using NHS resources wisely. Prudent Healthcare can be seen as a way of balancing quality, and the constraints of austerity – it is the bargain of co-production at an individual and population level where patients and the NHS each make a contribution to improve health and wellbeing. All these principles are underlined by a commitment to rebalance the health care system by strengthening primary and community-based care.

The Prudent Healthcare agenda now needs to be backed up by a detailed roadmap – an Implementation Action Plan – containing a clearer vision for what services will look like, and should look like, in Wales in the next decade. This Implementation Action Plan should be a blueprint for the transformations that are expected in NHS Wales in the next 5-10 years, and should be made up of measurable, time-bound and deliverable changes. As a starting point, this chapter gives a series of recommendations that could well be reflected in such an Action Plan.

Health Boards could be pushed to align funding with the goals of Prudent Healthcare

Financial flows in Wales, including to Health Boards, could be better leveraged. Considering the central importance given to shifting care away from hospital settings and towards primary and community care, more could be done both in terms of incentives and levers for this shift, designing and fostering innovative service and organisational models. Though far from the only lever, funding flows have a significant influence on the shape of health systems and services, and could be exploited more in Wales. Some targeted funding has been put in place for 2015-16: GBP 30 million of hypothecated funding to develop primary care services across Wales, and GBP 20 million to take forward projects funded by the Intermediate Care Fund this year that have proven to be effective across community and acute environments, linking out-of-hospital care and social care to strengthen the resilience of the unscheduled care system. Pushing beyond this, Wales could consider commitments or concrete ambitions such as setting an expectation that a certain percentage of Health Board spending be shifted out of hospitals and secondary care and towards primary care in the next 5-10 years, or pushing for minimum investment levels from Health Board financial planning in primary and community care.

Other OECD countries are also grappling with the particular challenge of shifting care away from hospital and specialist settings and towards primary and community care, and many have developed strategies and objectives around making this happen. Fewer countries have backed such strategies with concrete action and effective levers. In Norway, though, the 2012 “Coordination Reform” has the overriding aim of directing more investment towards primary care in order to curb the growth of expenditure in hospitals and strengthening integration between care levels, introduced a vision for change but also substantial economic and organisational changes that went alongside (OECD, 2014a). In particular, the reform relies on a percentage of co-financing of hospital care by municipalities (which has since been repealed), and a financial penalty for municipalities for any delay in discharge for a patient in the event that the municipality is unable to provide appropriate community care. At the same time, Norway started building up a network of intermediate care facilities (“Distriktsmedisinsk senter” or “Sykestue” in Norwegian), which have a key responsibility for caring for patients upon discharge from hospital. These units are service models for integrated care, financed jointly by hospitals and municipalities, for patients who no longer need acute hospital care but are not yet well enough to return home. The careful way in which Norway backed up strategic vision with incentives, financial levers, and organisational and service change is surely very interesting for Wales, even if the detail of the mechanisms to encourage change in Wales will inevitably differ.

Wales could be more ambitious in fostering new models of care delivery and organisation

A central objective of the Prudent Healthcare agenda is to shift more care away from hospitals and towards primary and community settings. Wales is, like many other OECD countries, trying to get the bulk of care and patient contacts taking place away from acute care settings. Given significant challenges of aging populations and a growing burden of chronic disease, a robust and high quality primary care sector is needed to effectively manage patients in the community. The Prudent Healthcare website identifies a number of more concrete ways that Prudent Healthcare could be implemented in primary care, including a greater focus on prevention, "prudent prescribing", and better engagement with patients and encouraging self-care and shared decision making (Lewis, Focusing primary care services on people by applying Prudent Healthcare).

Wales could, though, be more ambitious in fostering new models of care delivery and organisation, particularly given that innovation is identified as a driving force for Prudent Healthcare. This need not be a case of totally transforming governance structures, or system-wide reform, but rather supporting experimentation with care models, and matching a strategic ambition for system change, with system change on the ground. The Primary Care clusters that have been established in Wales seem to be a good move towards developing a more effective and more engaged primary care sector (see Box 3.2).

The Primary Care Clusters have potential to be an important resource in Wales, especially if the balance between cluster autonomy and incentives for innovation and action is got right. The extra funding that is being made available for the Primary Care Clusters could, for instance, be used to incentivise innovation and new ways of working. primary care clusters could be given the opportunity to bid for small grants to fund pilot projects – perhaps in collaboration with other institutions in Wales, or working across clusters – which they have identified as having potentially positive impact for their patients. Successful experiences could then be scaled-up with leadership from the Welsh Government, and/or collaboration with other Primary Care Clusters.

Box 3.2. Primary Care Clusters in Wales

In Wales and in the UK general practitioners (GPs) operate through local practices, providing general medical services as independent practitioners who then contract with the NHS. To promote collaboration between general practices at the level of 25 000 to 50 000 populations, Health Boards have also established a total of 64 primary care "clusters", initially of GP practices, which cover all the localities in Wales. As part of these clusters GPs meet regularly, under a "cluster lead", to discuss and reflect on local health needs and priorities using health records from their surgeries, to identify general practice service improvement by linking elements of the individual practice development plans, to work with other partners to improve the co-ordination of care and the integration of health and social care and to reduce inequalities.

Primary Care Clusters can be a way for GPs to reflect on their own quality of care, particularly given the requirement that practices review all of their case notes, and audit all of their patient deaths. Primary Care Clusters can also take forward recommendations to Health Boards and other service partners, and change approaches within practices. For instance, in Monmouthshire South a complaint from a family member regarding the behaviour of practice staff towards a patient with dementia, that was discussed as part of the cluster, led to the establishment of a "dementia champion" in that practice. The next step is for Health Boards to use cluster action plans as a vehicle for making more rapid and wide scale progress. Cluster action plans will highlight priority areas, such as the rising prevalence of diabetes, and focus on developing solutions e.g. nurse specialist support in the community. Cluster leads are also encouraged to engage voluntary sector organisations to inform proposals for service redesign. It is anticipated that locally agreed dashboards will be used to ensure accountability through professionally led governance arrangements.

The Welsh Government is using the national GP contract and Quality and Outcomes Framework to further strengthen collaboration within clusters, tasked with producing cluster action plans by the end of September 2014 (British Medical Association, 2014). These plans informed the round of Health Board three year Integrated Medium Terms Plans in January 2015.

The Minister for Health and Social services has recently made GBP 6 million available to the 64 Primary Care Clusters across Wales, to enable them to build infrastructure and put leadership and governance arrangements in place. These resources are directed to the clusters through the parent Health Board. This is part of GBP 40 million new funding for primary care announced by the Minister in 2015, of which GBP 30 million will be informed by the three-year Integrated Medium Term Plans established by Health Boards. GBP 4 million will be used to fund new innovative models of working within a primary care programme. It is expected that primary care clusters will inform the use of this new funding.

All Health Boards should have a primary care professional on their board

Health Boards are reported as actively engaging with GPs and primary care staff, and the development of primary care clusters is another avenue for primary care views to feed back into governance structures, but more could be done to promote the voice of primary care. Given the expectation that NHS Wales should gradually re-orientate towards the primary care sector, it is surprising that Health Boards are not expected to always have a primary care professional on the board. At present, officer members of Health Boards consist of the following: a chief officer; a medical officer; a finance officer; a nurse officer; and an officer who has responsibility for the provision of primary, community and mental health services.

Wales has begun grappling with this issue, especially through a recently published consultation document (Green Paper) entitled "Our Health, Our Health Service" (Welsh Government, 2015a) which asks whether the right governance arrangements are in place on Health Boards, including whether the Health Board size and membership are correct. As part of this exercise, and also as part of considering the role of Health Boards more generally, the Welsh Government should seriously consider introducing a requirement that Health Boards have a primary care professional (for instance, a GP or primary care nurse) on their general board.

The value of high level, consistent primary care practitioner involvement is important for at least two reasons. First, primary care practitioners, for example GPs, will have a clear idea of local health needs and weaknesses in service delivery, and as such are well placed to inform Health Board planning. Having a GP or equivalent on the Health Board is a further lever to ensure that these perspectives are heard, and most importantly reflected in planning and action. Second, primary care practitioners will feel the impact of decisions made by Health Boards, for instance with regards to changing hospital services or processes around referral, admission and discharge, or unscheduled care. Given that Health Board decisions can have a potentially significant impact on primary care practice, it is right that they be well represented from the beginning of discussions around service change.

3.2. Governance of health care quality monitoring and improvement

Wales has a rich quality monitoring and improvement architecture, including a range of key health care policies and legislation, the successful 1000 Lives campaign, and periodic external reviews. Some common quality improvement levers are either unrealistic in Wales – notably meaningful patient choice of provider is more difficult in a small system like Wales – or Wales has chosen a different path, notably the abolition the purchaser-provider split. In light of this, robust measurement of performance, open comparison of results, and visible accountability for Health Boards should be ensured.

Much of the legal framework for quality was set out previously on an "England and Wales" basis but Wales is now articulating its own quality strategies and action plans

A range of key health care policies, as encapsulated in policy documents and recent and future legislation, underpin the Welsh approach to the quality of care. Just prior to devolution, Quality Care and Clinical Excellence was published by the Welsh Office in 1998 (Welsh Office, 1998), which introduced clinical governance for all NHS organisations in Wales and provided a framework quality and standards. The key components of the clinical governance framework included clinical audit, evidence-based practice and processes for monitoring clinical care using information and record keeping systems, as well as policies for managing risk and lines of responsibility and accountability for the overall quality of clinical care. The Health Act 1999 (Department of Health, The Health Act, 1999) introduced a statutory duty of quality within NHS trusts, with Chief Executives being held responsible, on behalf of their boards, for assuring the quality of their services.

Since devolution, a number of documents and frameworks addressing quality of care have been published. These include: the Health and Social Care (Community Health and Standards) Act 2003 which set out an overarching duty of quality for health bodies; the Healthcare Standards for Wales Framework 2005, after which health bodies were to demonstrate progress against the standards through an annual assessment; and the Healthcare Quality Improvement Plan (QUIP) 2006 which set out to strengthen the focus on quality in the Welsh NHS.

Most recently, "Doing Well, Doing Better, Standards for Health Services in Wales" (2010) sets out the core standards for the NHS, revising the Healthcare Standards Framework with the aim of better reflecting the new integrated NHS structures in Wales and the prevention agenda. A further update to this framework was issued in April 2015. In 2011 the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 set out the statutory basis for the handling of concerns and complaints in the NHS, and was later complemented by the Framework for Assuring Service User Experience. The Putting Things Right system of "do it once, do it well" was then launched with a view to dealing with complaints effectively and being able to demonstrate clearly that lessons had been learned. In 2012, Achieving Excellence: the Quality Delivery Plan for the NHS in Wales set the double goal of ensuring continuous quality improvement through inspiring all staff and managers to take responsibility for improving the quality of care they provide. This was supported by the 1000 Lives quality improvement programme.

Future legislation is planned in terms of a Public Health Bill (Welsh Government, 2013a) and a Well-being of Future Generations Act (Welsh Government, 2014a), which will impact on the quality of efforts to improve health in the widest sense. The Well-being of Future Generations Act is particularly interesting, and unique, in its approach to strengthening governance arrangements for improving the well-being of Wales and ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. The Act aims to improve well-being in line with the principle of sustainable development. Wales has also introduced new social services legislation which will help drive integrated and preventative services (Social Services and Wellbeing Act, 2014).

The 1000 Lives campaign has been a successful way of fostering a culture of quality improvement

Between 2008 and 2010 NHS Wales Health Boards and trusts took part in the 1000 Lives campaign, a two-year quality improvement initiative which sought to save 1 000 lives, and prevent 50 000 episodes of harm in the NHS. The initiative was adapted from a successful campaign run in America by the Institute for Healthcare Improvement. At the end of the campaign in 2010 these goals were deemed to have been reached, with an End of Campaign Report (NHS Wales, 2010) estimating that 1 199 additional lives had been saved by NHS staff in Wales between April 2008 and April 2010. Given this success, and the momentum the campaign built, 1000 Lives was extended into the 1000 Lives Plus national programme to further improve the quality of Welsh health care and embed the methodology used by the campaign into new areas.

One of the dimensions judged to be a strength of the 1000 Lives campaigns has been the focus on patient experience and putting the patient at the centre of care. In June 2013, the 1000 Lives improvement team published a White paper on "The Listening Organisation – Ensuring care is patient centred in NHS Wales". The paper explains how listening to patients and understanding what it feels like to experience care is a key way for NHS Wales can improve its services. Patient stories have been promoted by the team as an effective and powerful way of making sure that the patient's voice is heard and that improvement of services is centred on the needs of the patient. A number of patient-driven care resources have been developed. Patient stories are now regularly shared at board level and have had a significant impact at a senior executive and non-executive level as they make an abstract problem "real".

External reviews are a common part of the Welsh quality architecture

Wales has seen a number of high profile investigations and reviews of the health system, in England and in Wales, which have had an impact on the quality of care architecture and – often – been a source of external pressure and scrutiny for the health system. One of the most significant policy statements has been "Delivering Safe Care, Compassionate Care" (Welsh Government, 2013b) which was published in 2013 as the response of the Welsh Government to the Francis Report in England, which followed the Mid Staffordshire NHS Foundation Trust Public Inquiry (for further details see also Chapter 1 on England). Amongst the changes following this report were the introduction of an all-Wales Quality Statement from 2014, a revision of the NHS Wales Fundamentals of Care Standards (aligning them within the new Health and Care Standards framework from April 2015), and a commitment to improve the complaints procedures (for discussion of complaints, see Section 3.8). A Green paper on quality and governance, *Our Health, Our Health Service*, was published on 6 July 2015.

A number of other reviews in Wales have been undertaken at the request of the Welsh Government. Amongst them, the 2014 Andrews Report "Trusted to Care" (Andrews and Butler, 2014), an independent review of two hospitals within one Health Board, which was prompted by complaints to the Minister about care standards in one of the hospitals. The report made a series of recommendations on quality and patient safety, and identified areas for concern – for instance medicine management and storage, and concern about care for frail older people. Some changes have followed the report, for instance the introduction of ministerially commissioned "spot checks" in acute hospitals. Another external review, assessing the work of Healthcare Inspectorate Wales (HIW) (Marks, 2014) was published in late 2014. The commissioning of this report, again by the Minister, followed a report by the Health and Social Care Committee of the National Assembly for Wales (HSCC) which highlighted a number of shortcomings of HIW.

While there is a clear value to external scrutiny of the health system, and careful reflection on broad areas of delivery is sometimes called for, there is danger of over-reliance on ad-hoc reports in response to moments of crisis or concern. The main focus of quality improvement strategies and architecture should be, first, on ensuring that appropriate mechanisms for identifying shortcomings early are in place and fit for purpose. These include comprehensive data systems and quality indicators which are regularly reviewed, public reporting of performance, benchmarking of providers, an effective inspection and assurance function for services, and a robust patient feedback and complaints system. Second, systematic quality improvement initiatives need to be in place throughout the system, including shared learning and best practice dissemination, incentives for innovation, public and patient involvement, and professional development. This chapter covers most of these areas in further detail.

Robust measurement of performance and visible accountability for Health Boards must be ensured

Wales has chosen to abolish the purchaser-provider split, and also does not accept that competition is the best driver for quality improvement. The Welsh model is more one of unified planning and integration of service delivery at local level, based on a responsibility for Health Boards to assess and meet the needs of their local population. In addition, Wales has not followed other OECD countries – including England – in prioritising patient choice of provider. While a patient may request to be seen at a particular hospital, Welsh patients do not have a statutory right to choice (unlike in England). Patients are offered care based on their constituency, and based on the organisation judged best placed to provide the care needed.

In a small country such as Wales, where there are limited numbers of specialist services and acute hospitals, a statutory guarantee of patient choice may well be too difficult to deliver. Similarly, in a small system such as Wales abolition of the provider-purchaser split may well be more efficient and possibly save transaction costs, and the Welsh Government should be able to maintain a close working relationship with all provider-purchasers. Nonetheless, patient choice and the provider-purchaser split are in many countries important levers for quality assurance and quality improvement. For instance, where competition for patients exists, and prices are fixed, providers have to compete on parameters other than prices, including on quality (Kumar et al., 2014).

Given that Wales cannot use patient choice or the provider-purchaser split to drive quality improvement, efforts must be made to ensure that all other quality levers are working effectively. In the absence of patient choice, the patient voice must be well represented (see Section 3.8). In the absence of the provider-purchaser split, robust measurement of performance, open comparison of results, and visible accountability for Health Boards must be ensured, and open comparison of results, and visible accountability for Health Boards must be ensured. The Quality Statements are a step towards this, but a core data portal which brings together all Health Board data from across Wales, in as close to real-time as possible, is a further step to consider.

3.3. Professional training and certification

Professional regulation and licensing of all health professionals is currently not a devolved matter, and is dealt with on a UK basis. Meanwhile, Wales takes the lead for continuing professional development and revalidation processes. Wales has already started to use health workforce contracts to align staff expectations with health care goals. Scope remains for Wales to develop a more ambitious and forward looking workforce plan.

Professional certification is on a UK basis while Wales assumes responsibility for medical appraisal for revalidation

Professional regulation and licensing of all health professionals is currently not a devolved matter, and is dealt with on a UK basis (see Chapter 1 on England). The relevant bodies for Medicine, Nursing, Dentistry, Pharmacists, Allied Health Professions, Biomedical and Clinical Scientists, all recognise the importance of close collaborative working with Welsh Government, with regular communication and recognition of the implications of UK level regulation for devolved administrations. While regulation of health professionals is a non-devolved area, education and training is devolved to Wales. The interdependence between these two areas of policy brings some challenges for Wales. The increasing divergence of the health systems across the United Kingdom will inevitably result in different approaches being adopted in these areas and arrangements which provide Wales with the greatest degree of flexibility will be required to address issues that arise in Wales across the full range of professions.

There have been a number of reviews into the education and training of specific professional groups, including the Shape of Training Review and the English Trusted to Care Review. These all have implications for both the professional regulatory and educational frameworks across the United Kingdom as well as in Wales.

In Wales the Health Professional Education Investment Review has recently been concluded, and the report was published on 14th April 2015 for a six-week period of stakeholder engagement which ended on 25th May 2015. The main focus of the report was to consider whether the arrangements currently in place to support the GBP 350 million investment made in health professional education and training each year in Wales represent the best arrangements for Wales. In particular, the review has considered whether Welsh Government obtains value for money and a secure supply of staff for the NHS and wider care settings.

Wales has responsibility for organising processes for annual medical appraisals, linked to five-yearly revalidation (see also Chapter 1 on

England). Wales has commissioned a single web based software platform – the MARS platform – which is available for use by all doctors in Wales (Wales Deanery and Welsh Government, 2014). The MARS platform can also be accessed by the responsible officer for each organisation, who in turn recommends revalidation to the General Medical Council.

The Wales Deanery has a School of Postgraduate Medical and Dental Education, which plays an important role in continual professional development. The General Medical Council undertakes a National Training Survey each year and produces a summary report for Wales. This provides important, if indirect, feedback on services and patients safety. The Welsh Government also has a range of policies and supporting guidance to improve the performance of already registered nurses and midwives, and non-registered Healthcare Support Workers. This includes the Framework for Advance Nursing, Midwifery, and Allied Healthcare Professional Practice in Wales, which is seen as a core standard-setting document for this growing group of professionals, and the only one in the United Kingdom.

The development of a skills and development framework for health care support workers, currently a non-regulated staff group, is under development, and an increasingly modular approach is being taken towards nurse education and development. A focus on extended skills sets for professional staff groups is also a key feature of the "Prudent Healthcare" approach adopted in Wales.

Adequate, effective and innovative staffing aligned with strategic objectives for NHS Wales should be a priority

Wales does have slightly different contracts for the four independent contractor professions who provide General Medical Services, General Dental Services, Community Pharmacy and Community Optometry. These contracts give Welsh authorities more traction in encouraging engagement of professionals with particular population needs in Wales. The Welsh Government and Health Boards should be attentive to using these levers to align professional activities and competencies with the direction of travel for NHS Wales. Notably, given the strategic direction set by the Welsh Government, the role of GPs (under the General Medical Services contract) and community pharmacy would be expected to be central important. Encouragingly, Wales has already started to use the GPs' contract to push for quality improvement, for example as part of the Primary Care Clusters (see Section 3.1).

Aligning staffing for NHS Wales with the Prudent Healthcare agenda – which focuses on the most appropriate care provided by the most appropriate professional, and a shift of services towards primary and community care – will be central to the success of the strategy. This is already recognised by the Welsh Government, who state as part of reflection on "Making prudent healthcare happen", that "the NHS Wales workforce is both a key enabler and driver for change and must be integral to all planning and investment decisions if the opportunities to improve care are to be realized" (Griffith and Middlemiss, Shaping a workforce to serve the people of Wales). This paper identifies a number of possible routes for helping align NHS workforce planning with Prudent Healthcare, for instance 24-hour GP practices in emergency hospital departments; new roles, such as community link workers supporting people experiencing poverty or hard-to-reach groups; and consultants working beyond traditional boundaries in delivering care outside of hospitals. A primary care workforce plan was published in July 2015 (Welsh Government, 2015d). This plan considers the developments that are needed within the primary care workforce, including to align the workforce with the Prudent Healthcare agenda, going forward to 2018. This plan seems to be a step in the right direction, including action points such as the need to put into place more robust workforce planning mechanisms, involving stakeholders including GP clusters, Health Boards and the Welsh Government.

Responsibility for workforce planning is at the level of Health Boards, which means that the expiration of the Welsh workforce strategy – Delivering a Five-Year Service, Workforce and Financial Strategic framework for NHS Wales – in 2016 should present further opportunity for careful and ambitious central planning around workforce development in Wales. To help deliver a more ambitious and forward-looking approach to workforce planning Wales needs to develop more empirical capacity for workforce modelling, based on anticipated population and health needs, and based on the way that the system is expected to change. Then, based on insights from the empirical workforce modelling, Wales could start to experiment with new ways of organising the health workforce in Wales. The focus should be on piloting innovative staffing models, and new care pathways, which then have the potential to be scaled-up if they are found to be successful. The OECD paper "Health Workforce Planning in OECD Countries: A Review of 26 Projection Models from 18 Countries" (Ono, Lafortune and Schoenstein, 2013) should offer a wealth of examples of approaches from other OECD countries, which Wales could draw on. This process could help move the Prudent Healthcare agenda on from strategy setting, to establishing practical consequences for staffing numbers, staff training, and staffing models and organisation.

3.4. Inspection and accreditation of health care facilities

Inspections by Health Inspectorate Wales and accountability against the Health and Care Standards framework are the main tools Wales has to assure quality in health care facilities. To strengthen these approaches, and/or to add to them, Wales could look to international trends in inspection and accreditation.

Healthcare Inspectorate Wales reviews all health services

Health services are reviewed against a range of published standards, policies, guidance and regulations by Healthcare Inspectorate Wales. Healthcare Inspectorate Wales core role is to "review and inspect NHS and independent health care organisations in Wales and provide independent assurance for patients, the public, the Welsh Government and health care providers, that services are safe and of good quality". HIW operates as an "arm's length body" (i.e. it is operationally independent) which carries out its functions on behalf of Welsh Ministers. Although part of the Welsh Government, protocols have been established which safeguard its operational autonomy. Health Boards self-assess against the standards framework for health services in Wales, which HIW is responsible for reviewing. HIW also produces, amongst other types of inspections and reviews, Healthcare Inspectorate Wales Dignity and Essential Care Inspection (DECI) reports as a result of inspections.

The Welsh Government recently commissioned an independent review of HIW, which was published in late 2014 (Marks, 2014). This review suggested that HIW's scope to date has been too narrow – focusing on standards at individual wards and health bodies – and too reactive – undertaking special reviews of services only in response to particular concerns or incidents. The review recommended that HIW take a broader scope to contribute to achieving system-wide improvements, settings its own programme of peer and thematic reviews.

Traditionally, HIW has not looked at the primary care sector, although a review of GP services is to be undertaken in 2015, and a limited programme of primary care inspections and thematic review to commence from 2016. This expansion of coverage seems a welcome development. Healthcare Inspectorate Wales is also undertaking inspections of dental practices.

A standards framework underpins Wales' quality of care architecture

Wales' Health and Care Standards framework was introduced in April 2015, bringing together the two previous sets of standards, the "Fundamentals of Care", Guidance for Health and Social Care Staff, and the

Healthcare Standards for Health Services in Wales (Welsh Government, 2015b). The Health and Care Standards framework underpins the quality of care architecture, and it is against this framework that providers and staff are held to account. The standards fall across seven themes – staff and resources, individual care, staying healthy, safe care, effective care, dignified care, timely care – under which one or more standards are set out (see Box 3.3 for a number of examples).

International trends in accreditation may offer lessons for Wales

Approaches to accreditation in OECD countries show significant diversity, with significant differences in terms of coverage, methods (application of criteria, whether accreditation is mandatory or voluntary), objectives (minimum standards or improvement) and frequency. A few trends do stand out. First, there has been a move towards increasingly consistent methods, for example with national authorities increasingly developing a single, consistent method for system-wide application. The second trend is toward a greater reach of facilities; accreditation is increasingly applied to the private hospitals, to primary care, to laboratory and diagnostic facilities and other organisations involved in providing health care. The third is toward a greater sophistication, including a much broader set of dimensions including customer focus and organisational factors such as managerial competence. The latter two of these trends are worth keeping in mind for Wales, especially given the ongoing evolutions in both the role of HIW and the development of core standards.

Another trend for Wales to look at is the way that a few organisations within OECD health systems are looking to overcome traditional organisational boundaries and better reflect the patient pathway in accreditation and inspection activities (Box 3.4). For HIW to follow some of these approaches as part of their expanded approach to thematic reviews, for example, could be of great interest. Such an approach would consider all elements of the patient pathway (primary care, acute care and social care), and might eventually lead to standards – or guidance – developed around measurable dimensions such as timeliness, information exchange and patient involvement in their care.

Box 3.3. Health and Care Standards framework

Under the Health and Care Standards framework there are seven themes, all of which are turned towards delivering person-centred care. The framework also explicitly acknowledges “the principles of co-production and Prudent Healthcare”. In terms of this focus, co-production of care is seen as a key part of the Prudent Healthcare agenda, wherein patients both take action to protect and promote their own health, and work alongside health professionals in establishing the most appropriate care. For instance, one theme is “Staying Healthy” and is directed in significant part towards patients’ responsibilities. Other standards, for example around Safe Care, are more squarely directed at health care professionals.

Each standard is also set out in terms of what it should mean – when the standard is met – for individuals using the NHS in Wales, for example for the standard of “Timely Care”, this should mean that:

- (I) have easy and timely access to primary care services.
- To ensure the best possible outcome, (my) condition is diagnosed early and treated in accordance with clinical need.

Health and care standards framework, selected examples

Staying healthy	
Standard 1.1. Health promotion, protection and improvement	People are empowered and supported to take responsibility for their own health and wellbeing and carers of individuals who are unable to manage their own health and wellbeing are supported. Health services work in partnership with others to protect and improve the health and wellbeing of people and reduce health inequalities.
Criteria	
	People know and understand what care, support and opportunities are available, locally, regionally and nationally, including community support and support for people from protected groups.
	People are supported to engage, participate and feel valued in society.
	People are supported to be healthy, safe, and happy, and to lead an active life.
	Children have a good, healthy, safe and nurturing start in life.
	Carers of individuals who are unable to manage their own health and wellbeing are supported.
	People are supported to make decisions about their health behaviour and wellbeing which impact on their health and the health and wellbeing of their children.
	Breast feeding is promoted and supported.
	Smoking cessation and smoke free environments are promoted and supported.
	People are supported to avoid harm to their health and wellbeing by making healthy choices and accepting opportunities to prevent ill health.
	There is active promotion of healthy and safe workplaces and communities.
	There is active promotion of the health and well-being of staff.
	Systems, resources and plans are in place to identify and act upon significant public health issues so as to prevent and control communicable diseases and provide immunization programmes; with effective programmes to screen and detect disease.
	Needs assessment and public health advice informs service planning, policies and practices.
	Health services have systems and processes in place that play their part in reducing inequalities and protect and improve the health and wellbeing of their local population.
	Relationships and allocations of responsibilities between the various organisations with public health responsibilities are clear and acted upon.

Box 3.3. Health and Care Standards framework *(cont.)*

Health and care standards framework, selected examples *(cont.)*

Safe care

Standard 2.2. Preventing pressure and tissue damage	People are helped to look after their skin and every effort is made to prevent people from developing pressure and tissue damage.

Criteria

- People are assessed for risk of pressure and tissue damage and if considered at risk, they receive further assessment and a plan of care is developed and implemented.
- People are made aware of the risks of pressure and tissue damage and shown ways of preventing them. They and those caring for them are encouraged and advised on appropriate care procedures, including nutritional advice.
- Appropriate beds, chairs and other equipment are made available to reduce the risks of pressure and tissue damage and specialist preventative equipment such as special mattresses and cushions are also available if necessary. All equipment is clean and properly maintained.
- Correct moving techniques are encouraged, including regular turning and appropriate self-care, helping people to avoid pressure and tissue damage, increasing their well-being, independence and dignity.
- Risk assessments are in place to identify if a person is at risk, their skin is checked at least once daily, and preferably when their personal hygiene is attended to.

Timely care

Standard 5.1. Timely access	All aspects of care are provided in a timely way ensuring that people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Criteria

- People’s health outcomes are monitored in order to ensure they receive care in a timely way.
- All aspects of care are provided, including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with national timescales, pathways and best practice.
- Conditions are diagnosed early and treated in accordance with clinical need.
- Accessible information and support is given to ensure people are actively involved in decisions about their care.
- There is compliance with the NHS Outcomes and Delivery framework relating to timely care outcomes.

Source: Welsh Government (2015), *Health and Care Standards*, http://www.gov.wales.

Box 3.4. 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; Van Doorn, A. et al. (2014), "Effect of Accreditation on the Quality of Chronic Disease Management: A Comparative Observational Study", *BMC Family Practice* 2014, Vol. 15, No. 179, http://dx.doi.org/10.1186/s12875-014-0179-4.

3.5. Authorisation of medical devices and pharmaceuticals

UK level regulations derived from EU Directives on medical devices and pharmaceuticals provide the first layer of authorisation in Wales. In addition, the All Wales Medicines Strategy Group works with NICE around assuring timely and cost-effective provision of medicines. The Surgical Materials Testing Laboratory (SMTL) at Princess of Wales Hospital, Bridgend works to quality assure medical devices for the Welsh NHS and to provide technical advice, and helps to provide a quality and cost control dimension to surgical materials procurement.

Much of the basic regulation of medical devices and pharmaceuticals is based on EU and UK regulation and legislation, while Welsh initiatives add a further layer of quality assurance

The current legislative basis for the quality and assurance of medical devices derives from EU Directives, which have been into four sets of UK regulations which apply across the United Kingdom. In 2003, the

UK Government established the Medicines and Healthcare Products Regulatory Agency (MHRA) as an executive agency of the Department of Health (DOH) to enforce the regulations relating to the safety of medicines and medical devices in the United Kingdom. The Welsh Government works closely with the MHRA, and MHRA's alerts to NHS Wales through the Welsh Government's Public Health Alert System. The Welsh Government's serious incident reporting process acts as an assurance that issues relating to devices are reported promptly to the agency by the NHS organisations. The MHRA also provides the Welsh Government periodically with advice on specific questions and issues about medical devices raised by members of the public and the Welsh Government responds to MHRA's medical device related consultations. Pharmaceutical hazard alerts produced by the MHRA are disseminated electronically to appropriate professional groups across Wales both within and outside normal working hours.

The All Wales Medicines Strategy Group (AWMSG) works with the National Institute for Health and Care Excellence (NICE) (see Chapter 1 on England), to ensure timely and safe access to new, cost effective, medicines and treatment. AWMSG brings together NHS clinicians, pharmacists, health care professionals, academics, health economists, industry representatives and patient advocates. AWMSG, acting in a strategic and advisory capacity, is an authoritative and expert channel through which consensus can be reached on the use of medicines within both primary and secondary care. Established in 2002 AWMSG has always undertaken appraisals in public to improve transparency. Many other bodies, including NICE, have subsequently studied the AWMSG process and moved towards adopting this approach.

Two advisory subgroups report to AWMSG and provide expert advice; the New Medicines Group (NMG) and the All Wales Prescribing and Advisory Group (AWPAG). AWMSG and its subgroups are supported by the All Wales Therapeutics and Toxicology Centre (AWTTC) which provides the secretariat, pharmaceutical assessment and health economics resources. The work of AWTTC consists of health technology appraisals, medicines management prescribing, medicines safety, education, toxicology and prescribing analysis. The All Wales Prescribing Advisory Group (AWPAG) address a range of issues relating to the cost, quality and safety of prescribing and each year review and determines the national prescriber indicators. Performance against these indicators is monitored at national, Health Board and cluster level. To stimulate understanding and awareness of adverse drug reactions and the reporting of these events on Yellow Cards to the MHRA, the number of reports submitted at Health Board and cluster level is being monitored as a national indicator to address a ten-year decline in reporting.

The Welsh Government currently works with NICE under an agreement covered by Section 83 of the Government of Wales Act 2006. In May 2012, a memorandum of understanding was agreed which formally sets out a collaboration between NICE and AWMSG. The aim is to join up the strategic planning, development and delivery of advice in Wales, avoiding duplication or conflict of work, yet complementing and supporting the work of AWMSG. Welsh Government mandates the implementation of both AWSMG and NICE technology appraisals by NHS Wales bodies. NICE advice supersedes advice from AWMSG when this becomes available. Processes to adopt advice from NICE on highly specialised technologies are in place, and similarly, technologies fast tracked through the MHRA early access scheme, will be adopted.

Wales' Surgical Materials Testing Laboratory is an interesting model for other OECD countries

Comparable to the work of NICE and the AWMSG, except applied to surgical materials, the Surgical Materials Testing Laboratory (SMTL) at Princess of Wales Hospital, Bridgend works to quality assure medical devices for the Welsh NHS and to provide technical advice. Funded by the Welsh Government, through the Welsh Health Specialised Services Committee (WHSSC), the laboratory gives advice on appropriate selection of standards and application of test methods, assesses data submissions from manufacturers to support all Wales contracts, including product testing to European and international standards, and clinicians' requirements, and investigates defects and incidents on behalf of NHS Wales, and with liaison with the MHRA.

What is particularly interesting about the work of the SMTL is how it feeds into procurement in Wales (led by the Welsh procurement service, NHS Wales Shared Services Partnership Procurement Services (NWSSPPS). Findings by the SMTL help make evidence-based decisions about which medical devices are fit for purpose, and which are most cost-effective. For example, SMTL will test gloves to ensure that they are fit for purpose, and that they comply with the European Standard (EN 455) specified during procurement. Defect and incident investigations enable NWSSPPS and SMTL to focus their efforts on medical devices which have a track record of causing clinical incidents within Wales. Then, if multiple gloves from different manufacturers are found to be fit for purpose, the final choice can be based on cost, in the knowledge that a shortlist of effective and safe products has already established based on careful testing and evidence review.

SMTL are also starting a Usability (Human Factors) assessment service for medical devices to ensure clinical acceptability, appropriate product handling, and patient safety. An example of this is the contract for single use tonsillectomy instruments. Single use devices from a UK-wide contract had led to an increase in post-operative bleeding rates from 0.6% with reusable instruments to 1.6% with single use (Tompkinson et al., 2005a). SMTL, Procurement and Clinicians were tasked by the Welsh Government to audit suppliers and test instruments (Tompkinson et al., 2005b), and the subsequent highly specified devices led to a drop in post-operative bleeds down to 0.6%. In addition to the testing programme, the Welsh Government funded a surveillance programme to monitor clinician, instrument and patient incidents related to tonsillectomy. This effectively demonstrated that the quality of instruments procured by Wales has resulted in better health outcomes for patients undergoing tonsillectomy than with the original single-use instruments.

3.6. Audits, peer review and performance reporting

Wales has been using audits and peer review processes in an interesting and quite sophisticated way to drive quality improvement in some areas of health care delivery. A large number of national audits and eight outcome reviews are co-ordinated by Welsh Government and contribute to an overarching view of performance and benchmarking with other UK organisations. Peer Review processes in cancer have led to micro-level attention to clinical processes and broader learning for the system, and could be extended. Backing up these improvement tools, Wales has a core performance framework – the NHS Outcomes and Delivery Framework – which is used to hold Health Boards and NHS Trusts to account.

Wales has a core performance framework against which NHS organisations are held to account

The NHS Outcomes and Delivery Framework (Welsh Government, 2014b; Welsh Government, 2015c) is used to hold NHS organisations – essentially Health Boards and NHS Trusts – to account against a set of measures, last revised for the 2013/14 framework, and still in use into 2015/16. Developed following a series of feedback events with stakeholder organisations, citizens and clinicians, the framework has seven identified quality "domains", which are the same as those used in the new standards framework (Staying healthy, Safe care, Effective care, Dignified care, Timely care, Individual care, Our staff and resources). At present, the standards used for previous frameworks have been kept, and these are still being used to measure performance. For example, for the need and prevention domain, there are three standards, covering influenza vaccines, vaccines for children under 4, and smoking cessation, which are checked weekly, quarterly, and quarterly respectively. For experience and access, one of the three standards covers scheduled care acute access times (assessed monthly), under which: 95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks; percentage of procedures cancelled on more than one occasion by the hospital with less than 8-days notice that are subsequently carried out within 14 days or at the patient's earliest convenience. Alongside the new NHS Outcomes and Delivery Framework a new set of clinically focused outcomes indicators are being developed, which will replace the current standards in due course. Reflecting the direction suggested during stakeholder interaction, clinical outcomes measures will focus in particular on the following areas: the ambulance service and A&E; total emergency pathways for fractured neck or femur, stroke and cardiac (heart attack); ophthalmology outpatient waiting times for both new cases and follow-ups based on clinical need and; cancer pathway (Welsh Government, 2015c).

Accountability against the NHS Outcomes and Delivery Framework is through Quality and Delivery Meetings (QDM) between the Welsh Government and all NHS Health Boards and Trusts, covering achievement of standards and delivery requirements. QDMs are informed by the outputs of the quality and safety assurance group, a regular meeting of Welsh Government officials, which considers a wide range of data and "soft" intelligence on organisations. These outputs are in turn matched with performance data at the integrated delivery board, and this determines the content of QDM discussions. Additionally, these meetings will periodically review other key areas, highlighted through other external bodies' reports such as Community Health Council, HIW and outstanding Welsh Audit Office national audit recommendations. The frequency of these meetings is determined by the status of the organisations' Integrated Medium Term Plan (IMTP). For Health Boards where a three year plan has been approved, accountability meetings will be held on a three-monthly basis. For Health Boards where three year plans are yet to be approved, bi-monthly meetings will be held. Frequency will also be determined by the escalation level of delivery determined through the Welsh Government's internal review process, which may point to a need for higher levels of scrutiny on certain aspects of quality, even where a plan has been agreed. Periodic themed meetings may also take place to explore progress against each theme throughout the year.

Following a poor outcome from a QDM – where there is a failure to deliver on one or more of the targets – an escalation plan for action is in place. The response is centred upon increased monitoring by and support from the Welsh Government and relevant agencies. In extreme cases – Continued failure to improve performance or failure to engage with the national process – the issue is elevated to regular reporting established between CEO NHS Wales and Health Board Chief Executives, and the possible introduction of "special measure" arrangements, a review of executive and board effectiveness, and potentially removal of appropriate funding schemes. This process is supported tripartite Escalation and Intervention arrangements bringing together Welsh Government, HIW and the WAO. This enhanced and transparent approach to escalation and intervention was introduced in April 2014, when the framework was published. This process is intended to give a more rounded and fully informed assessment of all potential issues and concerns from across all regulators (Welsh Government, 2014c).

The Escalation and Intervention framework has four levels: routine arrangements (normal business), enhanced monitoring, targeted intervention and special measures. Following the publication of the framework, the Betsi Cadwaladr University Health Board was placed at the second level of escalation – enhanced monitoring – in November 2014. In June 2015, serious concerns about quality and performance within the Health Board led to a decision by the Minister for Health and Social Care, on the basis of advice from the three regulators (Welsh Government, HIW and Wales Audit Office), to move the Health Board into special measures. Special measures may entail the suspension or removal of powers and duties from individual members or all members of the Health Board's board, and also means that Welsh Ministers can also direct a Health Board to undertake certain steps with regards to its functions. Neither of the external review bodies – HIW or the Wales Audit Office – undertakes intervention actions themselves. The Special Measures intervention, as part of the Escalation and Intervention Framework, seems an important quality assurance measure in instances of real quality failings. Clearly a difficult process for patients and staff using and working in a Trust or hospital, the Special Measures intervention demands sensitive handling, with upmost priority given to patient safety, and quality improvement.

Audits are used to benchmark quality and inform planning

Audits of NHS Wales and its organisations and clinical domains are used to give surveillance over quality of care, and inform planning. A total of 33 national audits and eight outcome reviews are co-ordinated by Welsh Government and contribute to an overarching view of performance and benchmarking with other UK organisations (some national audit data are comparable across the UK nations).

The national clinical audit programme began across England and Wales in 1996, were reviewed in 2006, and have been overseen by Healthcare Quality Improvement Partnership (HQIP) since 2008 on behalf of England and Wales. HQIP is led by a consortium of the Academy of Royal Colleges, the Royal College of Nursing and National Voices, and the outputs of audits should feedback to clinical staff, as well as informing policy, strategy and service planning, with audits based on widely agreed standards. For Wales, part of the benefit of HQIP lies in the comparison across a larger pool of hospitals, given the inclusion of England also. Wales has set up a National Clinical Audit & Outcome Review Advisory Committee to improve participation and performance in agreed national audits. The committee is seeking to ensure that there is a Welsh representative on the steering Committee of all the national audits to ensure that a Welsh perspective is taken into account in the ongoing development of each audit. Wales is also moving to a position where there is a local champion for every audit in every Health Board. The Committee sends out regular e-bulletins to develop awareness and encourage participation. The audits are published on the Welsh Government e-governance website and are being gradually put onto the "My Local Health Service" website in a form easily accessible by the public. There are aims to publish the participation rates for each Health Board/hospital as a mechanism for further driving up engagement.

In Wales, the audit findings have been very influential in developing National strategies for improving services and linked to the National improvement process developed by 1000 Lives who are working with individual organisations to encourage and support change and service improvement (see Section 3.2), and for each of the National Implementation Groups working on Delivery Plans. Wales also has "Mortality Case Note Reviews", which are undertaken for all deaths in hospital in Wales. The review is a two-step process, starting with a general (universal) assessment, and followed by a full root cause analysis as a second stage.

Encouragingly, some broad lessons for NHS Wales have been emerging from the various audit processes, and there are some reports of these lessons being fed back into organisation and delivery. For instance, examples of early themes for learning coming out of the Mortality Case Note Reviews are around end of life care, recognition of sepsis, medical record keeping and anticoagulation practice. Welsh Government has appointed a National Clinical Lead for this process to consider how variations in the process can be reduced and a consistent approach taken across the country. A standardised approach to the categorisation of harm is now being applied to this process so quantitative data can be presented in addition to the local learning for improvement. This process will facilitate the implementation of the independent medical examiners role in due course. In terms of lessons from the national audits and outcome studies, findings should be being fed into Clinical Delivery Plans. For instance, clinical audit for diabetes care observed high levels of admissions, and insulin management errors, which fed back into shaping the Clinical Delivery Plan. The audit process should then be able to track whether there have been improvements in care and outcomes.

Some focused peer review processes have been successful ways of identifying weaknesses and improving quality, and could be extended

A number of peer review processes focusing on clinical practice have been started in Wales, notably for cancer, and appear to be effectively identifying weaknesses and in some cases changing practice. Peer Review was launched in Wales in 2012, following a 2011 recommendation by the Welsh Government that a Peer Review process for cancer services be started, to be led by Healthcare Inspectorate Wales (HIW), working in partnership with the Cancer Networks in North and South Wales. The Peer Review processes – reviews for cancer have been carried out or are ongoing for lung, upper gastro intestinal, urology, lower gastro intestinal, head and neck and gynecology, as well as for palliative and end of life care – focuses on the measures required to improve both the quality and safety, and demonstrate and share of cancer services within the revised structures of NHS Wales. The networks leading the Peer Review (South Wales Cancer Network, North Wales Cancer Network, and the Palliative Care Implementation Board) plan each Peer Review, co-ordinate self-assessment, training and documentation within each Health Board, and then report on the Peer Review visit and process within each Health Board.

Completed peer reviews have led to a report, and an action plan, corresponding to the review domain which are published on the Health Inspectorate Wales website. The Peer Review process appears to have been very effective at identifying concrete concerns in clinical practice, and appears well-received by clinicians. For instance, for the lung cancer Peer Review identified specific shortcomings and challenges related to particular wards and units – such as staffing shortages, too low treatment capacity, non-attainment of treatment pathways – along with concrete recommended action, resource implications, responsible person(s) and a target achievement date. Such activities have a clear focus on supporting and improving quality delivered by each team, and each clinician, for each patient.

This micro-level attention to clinical processes and learning from them should be praised, and Wales might look at the feasibility first of making such peer review processes more widespread, and second, trying to find effective ways of integrating lessons from peer review into standard clinical practice. A new wave of peer reviews could, for example, make recommendations on the application of the principles and tools of Prudent Healthcare in organisations across NHS Wales. An approach like this would help generate concrete ideas for implementation, and also make action around Prudent Healthcare more "real" and everybody's concern.

3.7. Development, use and reporting of quality indicators

A good range of health system information, including on quality, is systematically collected in Wales. This information feeds into a number of reports are published or produced for internal use. A particularly promising initiative is the Secure Anonymised Information Linkage Databank (SAIL), which brings together a wide array of routinely collected data on health, well-being and services, which can then be used for research and evaluation. There is still space for wales to strengthen the collection, use and reporting of quality indicators, including through reporting health system data in a more user-friendly format, and participating in UK-wide benchmarking of indicators.

Wales is ahead on securely linking individuals' health and social care data, and is actively using some quality indicators

Wales has some good ways in which data is made easily accessible, which should help its usability for the health system. Amongst the information that is collected systematically in Wales is the following:

- NHS waiting times
- NHS beds and their use
- Delayed transfers of care
- Ambulance service
- NHS complaints
- Quality and Outcomes Framework Statistics on primary care (see Chapter 1 on England)
- All Wales perinatal survey
- Welsh Healthcare Associated Infection Programme
- Antimicrobial resistance programme
- Specialist heart surgery in the United Kingdom.

Much of this data is pulled together and available on the website of the Welsh Government, gov.wales/statistics-and-research/, often in the form of regular summary reports. The datasets for a number of indicators, mostly process indicators with some performance indicators (waiting times, transfer of care delays) are available on the Welsh statistics website, statswales.wales.gov.uk.

In terms of quality indicators specifically, a number of reports are published or produced for internal use. One of these is the Welsh Government Quality Dashboard, which is based on qualitative and quantitative data, and is used internally within the Welsh Government Produced monthly for each Health Board and Trust in Wales, the dashboard presents an overview of priorities and pressure points on a single A3 page. Data include serious untoward incidents (SUIs), never events, patient safety alerts compliance, health care acquired infection (HCAI), pressure ulcer incidence, mortality, timeliness /access indicators as well as narrative on and all-Wales or organisation specific quality issues, notably commentary on serious incidents such as never events or avoidable deaths (for instance suicide, death from HCAI).

Quality Statements are another way that quality indicators are drawn together, and are produced by Health Boards and Trusts to report to their boards on quality and quality indicators in line with health care standards prescribed by the Welsh Government. The Health Board/Trust Annual Quality Reports are summarised by the Welsh Government in a National Annual Quality Statement. This Statement, first published for the year 2014, is focused on patients and consumers, and offers easily understandable information on the implementation of programmes (for instance weight-loss short courses, “Eating For Life”), and efforts being undertaken to improve quality within the NHS (e.g. Health Board and Trust involvement in tackling sepsis; figures on reductions of deaths from MRSA). As well as serving as a summary of quality and quality improvement activities, the Statement has a clear focus on patient education about health service activities and, indirectly, has a value in encouraging better self-care (e.g. awareness of prevention of infection by good hand hygiene, information about smoking, obesity and lifestyle change).

National Delivery Plans for particular clinical areas, for instance diabetes or cancer, use a number of indicators as assurance measures for the plan, for example hospital stays for diabetic patients, or percentage of people with a diabetes related limb amputation. A range of information, including on indicators related to quality for instance “never events”, hospital mortality, and mortality post-surgery, are published by Health Board on the My Local Health and Social Care website.

For emergency care a dashboard of indicators has been created by the Unscheduled Care Board, in conjunction with the Welsh Government. The "Integrated Unscheduled Care Dashboard" contains a large number of indicators that are updated with a frequency ranging from every ten minutes to every day. Information shown includes ambulance activity, any bottlenecks from admission to discharge, or patients over 85 using accident and emergency (A&E) department care. In Wales, this tool has been reported as useful in supporting national discussions regarding the management of Unscheduled Care.

SAIL should be seen as a highly valuable resource, and an example for other countries to follow

A particularly promising initiative is the Secure Anonymised Information Linkage Databank (SAIL), which brings together a wide array of routinely collected data on health, well-being and services, which can then be used for research and evaluation. Using anonymised data, SAIL enables detailed research studies considering broad dimensions of health care, including the impact of health policy on population health and outcome, cost-benefit assessments of new treatments, the impact of changing service design on different populations, socio-determinants of health, and the consequences of demographic change, amongst others. SAIL appears to be an international leader in overcoming the technical and political obstacles and successfully allowing individuals' data to be brought together and studied as a composite picture of health service needs, activities and outcomes.

A large number of the reports and studies that have come out of using the SAIL database are published online (www.saildatabank.com). SAIL should be seen as a highly valuable resource, and an example for other countries, but also for Wales in showing the great value of linking and exploiting available data and using it to reflect on health system performance and quality. Recognising the value of SAIL, the Welsh Government should look for ways to fully exploit the technical resources and insights that SAIL offers; the valuable intelligence that SAIL can offer should be central to NHS Wales' strategy planning and policy impact assessment.

Wales should bring together available data into a more user-friendly format

While Wales is already using some health system data, and quality information, to help system management and quality improvement, more could be done. One further step that Wales could take is to bring together available data into a more user-friendly format. The Integrated Unscheduled Care Dashboard is a positive step towards more proactive use of data – making information available in real time, and promoting a usable format for

NHS Wales professionals – and a good base to build on. Other OECD countries, such as Portugal, Denmark (see Chapter 3 on Scotland) and Sweden (see Chapter 1 on England) have developed more extensive information dashboards, and have managed to promote more information and knowledge based planning across their health systems (Box 3.5).

Box 3.5. A comprehensive health information infrastructure: Lessons from Portugal

Portugal has a very extensive information infrastructure which – relatively exceptionally – spans almost all levels of care. Data sources include setting-specific information structures, and disease-specific registers and data sources. Furthermore, this data is also regularly used to drive quality improvements. Part of the utility of Portugal's data is thanks to its accessibility; three main Portals bring together a significant bulk of available health data.

Much of Portugal's rich data infrastructure is thanks to the use of electronic patient records and unique patient identifiers. These records go towards creating the Portuguese Health Data Platform (PDS), which consists of a Patient Portal (Portal Do Utente, launched May 2012), a Professional Portal (Portal Do Professional, launched June 2012), an Institutional Portal (Portal Institucional, under testing) and an International Portal (Portal Internacional, piloted June 2013). The different portals hold different information, to be used in different ways. For instance, the Professional Portal provides health professionals with patient clinical data and records stored from different institutions and central repositories. The Institutional Portal, when operational, should provide statistics from anonymised clinical data to central institutions.

Eventually, PDS is intended to be a platform linking together data from across the health system. Already good progress has been made in making several data sets available in one place. Prescriptions, a chronic kidney disease register, a surgical safety checklist, and birth reports are all, for example, included in PDS. Long-term care, an oft-neglected area of data collection, is also included in PDS using the RNCCI database

The PDS database consists of several application modules that allow the recording of: medical, nursing, and social service evaluations; assessment by other professionals (rehabilitation medicine, physiotherapy, psychology, occupational therapy, etc.); IAI, a bio-psychosocial evaluation method; pressure ulcer risk evaluation and recording; falls risk evaluation; health care associated infections; pain evaluation; discharge abstracts; diabetes assessment; adverse drug reaction notification; and acute exacerbations.

There are also some mandatory minimal datasets:

- For hospital discharge teams (EGA) and primary care referral teams (CS): medical, nursing and social evaluations; evaluation of physical autonomy; pressure ulcers; pain evaluation.
- For integrated home care teams (ECCI), and for inpatient facilities: the same for hospital discharge teams upon admission, during care and on discharge. In addition the recording of falls, diabetes, pressure ulcers risk, and an individual intervention plan.

Source: OECD (2015), *OECD Reviews of Health Care Quality: Portugal 2015 – Raising Standards*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264225985-en.

As Wales builds its eHealth Strategy, work on which is underway, citizen access to health information should be a priority. Welsh citizens access their own health information, which should eventually be portable across the health system, in a usable, intuitive and straightforward format. For this priority area Portugal's experiences their Patient Portal (Portal Do Utente) may hold lessons for Wales.

While comparability issues will always exist, the four UK nations have much to gain from benchmarking across a core set of agreed common indicators

National and international benchmarking against indicators of quality of care, and outcome indicators, can be an effective way of identifying issues, promoting reflection, and driving improvement. The OECD has been collecting internationally comparable information on health care quality since 2001, and now nearly 15 years later collects over 30 indicators, many of which are reported on by most if not all OECD countries. Internationally comparable indicators such as these help countries benchmark their performance across a range of domains, and OECD includes collection on primary and acute care, mental health care, cancer care, patient safety, responsiveness and patient experiences, and cardiovascular disease and diabetes. Internationally comparable indicators can point to areas in which countries are falling short, as well as areas where they're having particular success. In both cases further reflection with regard to the drivers of the indicators reported is called for – the OECD Health Care Quality Review series seeks to do just that – to understand where improvements and changes need to be made, or to secure and potentially share successful approaches. In some cases, differences in performance can be explained in part by differences in measurement by countries, or comparability problems. Often, though, variations in performance on indicators can be the start of fruitful reflection over the strengths and weaknesses in various areas of the system, quality of care, and outcomes.

In the United Kingdom, the four countries are in a fairly unique position of having, relatively speaking, similar populations, health system structures, and delivery models. Benchmarking of indicators between the four countries should be a valuable way for each country to gain insights into what is going well and less well in each nation. Particularly if benchmarking exercises are backed up with discussions and sharing of experiences and best practice, a core set of comparable indicators collected across all four countries could be a very valuable learning resource. Comparison across countries in the United Kingdom, and benchmarking, is undertaken and possible to a certain extent. A recent report by the Health Foundation and the Nuffield Trust (2014) was able to make some important comparisons across the four nations, pulling together comparable data across areas such as life expectancy, expenditure, some indicators of staffing, some indicators of rates of procedures, waiting times, a limited number of outcome and quality measures (for instance Survival after renal replacement therapy), rates of screening, vaccination and immunisation, and patient satisfaction. This data wasn't systematically available in a comparable way, or systematically benchmarked, but was rather put together by the Health Foundation and the Nuffield Trust. Some benchmarking between regions, or hospital trusts, across the UK countries also takes place.

Nonetheless, political tensions and technical challenges mean that there is a much more limited set of useful comparable data available for the UK nations than would be expected. Indeed, the Health Foundation and the Nuffield Trust (2014) four nations report states that despite the indicators that they were able to put together "there is an increasingly limited set of comparable data on the four health systems of the UK". This same report makes a strong recommendation that a more comparable and wider range of comparative performance data be collected to both enable cross-border learning and for the impacts of divergent policies to be assessed, pointing to a minimal set of data that is currently collected and should be collected with a definition that renders it is comparable across the four countries covering expenditure, staff, hospital activity, hospital waiting times, ambulance services, and satisfaction.

3.8. Patient and public involvement in improving health care quality

Patient and public involvement in improving Welsh health care quality is promoted through regular consultation on the direction and planning of the health system, through prioritising user experience, and through a number of established routes for patient complaints. There is potential for Community Health Councils to play a valuable role in reflecting the patient voice, but some attention to the scope of their activities and remit is needed.

There are a number of avenues through which Welsh patients and public engage with NHS Wales

Regular consultation with the Welsh public on the direction and planning of the Welsh health system is seen as a priority, and there are a number of avenues through which this happens. Consultation can happen through Welsh Ministers. Health Boards and NHS Trusts also hold annual general meetings in public, and consultations around changes to services. Efforts are made to share information about health system performance, for instance Health Board and NHS Trust Quality Statements are made public via the "My Local Health Service" website. The My Local Health Service website gives a large amount of information broken down by Health Board, by hospital, and by GP practice. For example, information on "Safe Care" includes mortality from common medical emergencies, health care acquired infection, mortality following surgery, and serious incident reporting. The National Service User Experience Group (NSUE) works with the Welsh Government to provide advice and recommendations on ensuring that robust and valid service user feedback is sought and used.

Service user experience is also a stated priority in Wales. The 2013 Framework for Assuring Service User Experience is based on three domains of patient experience: first and lasting impressions; receiving care in a safe, supportive, healing environment; and understanding and involvement in care. Particular attention is given to collecting patient experience feedback. Following the publication of the framework, a set of core patient experience questions, to be used across all care settings, were issued to NHS Wales. The questions use the framework's three domains to ensure a consistent approach to determining patient experience across Wales. All NHS organisations are expected to use the core questions to complement their patient feedback method, and regular monitoring suggests an overall improvement in the quality of the data provided.

Established routes for patient complaints exist in Wales

There are established routes for patient complaints and feedback in Wales, notably through the Public Service Ombudsman, to whom patients can direct complaints if they are not satisfied with the response from the Health Board. The Ombudsman publishes an annual report summarising the cases considered and any lessons that should be learned by health or social services. Complaints can also be directed through the advocacy service provided through Community Health Councils.

A clear effort has been made in Wales to use patient concerns and complaints to help improve quality of care. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 [Welsh Government, The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations, 2011] drew on powers in the NHS (Wales) Redress Measure 2008. The regulations set out the statutory basis for the handling of concerns and complaints in the NHS. The Putting Things Right system of "do it once, do it well" was then launched with a view to dealing with complaints effectively and being able to demonstrate clearly that lessons had been learned. In 2014 a report, "Using the Gift of Complaints – A Review of Concerns (Complaints) Handling in NHS Wales", was published (Evans, 2014). The review examines how concerns are handled in NHS Wales and made over

100 recommendations, and following the review a number of reflection groups have been established – supported by a public engagement reference group – which will report to the National Quality and Safety Forum in due course.

Community Health Councils should focus their activities on reflecting the patient voice

Community Health Councils (CHCs) are a key feature in the architecture of Wales, with a clear role to engage with and ensure that the patient voice is heard. Community Health Councils, which are made up of members of the public and have a role representing patients and collecting patient's views, and scrutinising NHS services. There is a CHC for each of the seven Health Boards, which are brought together under a Board of Community Health Councils (CHC Board). The Welsh Government has recently made changes to the Regulations which govern Community Health Councils in Wales, principally to strengthen the leadership role of the CHC Board to allow them to set standards for the way in which CHCs carry out their functions. This includes how they interact with other bodies such as Healthcare Inspectorate Wales and the provision of an effective and responsive advocacy service.

The potential for Community Health Councils to engage with the local community, and advocate for patients around their concerns seems clear. The value added of some of the other CHC functions, notably inspections and on-site scrutiny of health care, is less clear. It would seem more effective for the CHCs to focus their activities on reflecting the patient voice, and engaging with other scrutiny bodies in Wales – notably Healthcare Inspectorate Wales – to make sure that patient concerns are heard and followed through. With comprehensive representation and advocacy of patient views, for which the CHCs have an important role to play, public scrutiny of NHS Wales can still be appropriately maintained.

3.9. Use of financial incentives to improve quality

Wales has introduced some financial incentives to improve quality, including by using the pay-for-performance scheme the Quality and Outcomes Framework to establish a three-year cluster network development programme in primary care. Additionally Wales has given Health Boards more management and financial responsibility, and more freedom to manage their own resources, under certain conditions.

Financing of the health system is mostly centrally planned, although Health Boards now have more management responsibility

The NHS in Wales is funded almost entirely through direct financial allocations from the Welsh Government. In addition to Welsh Government funding, NHS organisations receive a relatively small amount of income for treating patients from outside Wales, private patients, and for non-clinical services such as catering. Approximately 85% of the Welsh Government's health budget flows as a single funding stream to the seven health boards. Funding is allocated to boards, in part calculated on a per-head population basis, to enable them to provide and commission services to meet the health needs of their population. Per capita funding is weighted to reflect relative health needs, and in 2014-15 ranged from GBP 1 621 per head for Cardiff and Vale University Health Board to GBP 1 926 per head for Cwm Taf University Health Board, reflecting differences in the demography and socio-economic structures of the populations.

The recently introduced (2014-15) Integrated Medium Term Planning approach for Health Boards and NHS Trusts is underpinned by a new financial duty on Health Boards, as set out in the NHS Finance (Wales) Act 2014, which enables them to manage their resources over the three-year planning period, rather than the previous requirement to break even each and every year. The Act requires each Health Board and NHS Trust to prepare a plan which sets out its strategy for complying with the financial duty while improving the health of the people for whom it is responsible, and the provision of health care to such people.

The Welsh Government's planning framework sets out the detailed requirements for Health Boards to undertake an assessment of their population's health needs and then develop service responses to meet those needs. The plans are expected to include service, quality, workforce, revenue and capital investment plans that are fully aligned. The additional financial flexibility to manage resources over a three-year period should provide boards with an opportunity to better invest in new service models, particularly enhancing primary and community care services, with the expectation of resource savings in the latter years of the plan, for example through a reduced burden on expensive hospital care. The three year financial flexibility is also intended to avoid the unplanned, and often clinically ineffective, increased expenditure to utilise surplus funds or cuts just to balance the books at end of the year.

Health Boards and NHS Trusts are still in a process of adapting to the new planning framework and its revised financial duty. As part of the IMTPs maturing, attention should be given to how well Health Boards are assuming their new financial responsibilities, and how fully they are taking advantage of the increased flexibility they are given, for example by investing in new service models. It may be that Health Boards need – at least initially – more intensive guidance and support. This may be a balance between more direction over investments and financial flows – for instance a push towards a certain percentage of investment in primary and community care – and support and sharing of best practice, for instance sharing of successful investment models from Wales, as well as from elsewhere in the United Kingdom.

Financial incentives have been directed towards primary care

Financial incentives to promote quality are also in place for general practitioners, throughout the Quality and Outcomes Framework, as they are in England and Scotland. Wales has made some changes to the use of the QOF, notably reducing the scale of points in the clinical domain, and finally removing clinical points in the QOF for 2015/16. This decision was taken because it was felt that indicators either had consistently high levels of performance achieved (for example heart disease area), and/or quality improvement work was ongoing or continuing through National Audit processes (e.g. chronic kidney disease). This step was also part of a desire to emphasise professional clinical judgment, and the use of best practice guidelines, and move away from more prescriptive approaches to clinical management.

Since 2013/14, Wales has used QOF to develop a three-year cluster network development programme. This domain, which is unique to Wales, has a strong focus on strengthening GP-led multi-disciplinary team working and strengthening collaborative with working with both community and social services. In addition, the cluster network development programme delivers quality improvement through work in three general practice national priority areas; the prevention and early diagnosis of cancer; improving end of life care; and minimising the harms of polypharmacy (see also Section 3.1).

3.10. Patient safety initiatives

Wales has a comprehensive approach to patient safety, combining reporting and monitoring, incident follow-up, targeted programmes, and strategic planning to address and prevent areas for concern. Reporting and monitoring of adverse events is well established, with incidents collected centrally, and learning opportunities promoted. Government strategy and guidance has been used to shape action around health care associated infection, complemented by the 1000 Lives programme. Wales is also taking several steps to monitor and tackle antimicrobial resistance.

Mechanisms are in place to promote adverse event reporting and follow-up

Each Health Board and NHS Trust in Wales has a system of collecting adverse events using an electronic DATIX system. This allows central analysis of patterns of adverse events. Patient safety incident reports are submitted to the National Reporting and Learning System (NRLS) and the data is used to develop guidance and tools to help improve patient safety at a local level. A number of practical toolkits and guidance documents are available to help NHS managers and health care staff to implement patient safety initiatives. Guidelines have been developed that support staff learning from patient safety incidents and support approaches to preventing such incidents happening again. This information is provided on a Patient Safety Wales website (NHS Wales, 2014). The Welsh Government monitors adverse events on a regular basis, including Never Events, which are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. An updated list of 25 core Never Events was produced in 2013/14and annually the Welsh Government publishes a report on the never events that have been reported Work is also under way to strengthen reporting of adverse events by primary care.

Some complaints and patient safety incidents are reportable to the Welsh Government, with intelligence gained from investigation of such incidents shared with NHS through the issues of notices and alerts as appropriate. Work is underway to review the Welsh patient safety incident system, and review what is reportable, as well as the internal Welsh Government process to monitor and share incidents and learning with policy leads. Healthcare Inspectorate for Wales is also sighted on all patient safety incidents as part of their intelligence arrangements to monitor NHS organisations. The Coroner and the Public Services Ombudsman for Wales also share their reports with Welsh Government, and the Welsh Government shares these reports with the relevant policy lead for the area. The Coroner has a legal power and duty to write a report following an inquest if it appears that there is a risk of other deaths occurring in similar circumstances. This is known as a “report under regulation 28”, as the power is derived from regulation 28 of the Coroners (Inquests) Regulations 2013. The reports are sent to individuals and organisations that are in a position to take action to reduce any risks that have been identified. They then must reply within 56 days to say what action they plan to take.

The Welsh Government has an agreement with NHS England to ensure continued reporting to the NRLS by Welsh Organisations. Learning from this process results in the development of safety solutions/alerts which is regularly issued to the NHS. Alerts cover a wide range of topics, from vaccines to patient identification. An internal Welsh Government process has been produced to issue such advice to NHS Wales, working with colleagues responsible for this function in NHS England alerts. The various alerts are considered in conjunction with Welsh data and any other available information and where necessary an alert or notice will be issued to the NHS in Wales. The aim of the advice is to help ensure the safety of patients and is issued directly to NHS organisations in Wales. The National Reporting and Learning System collate and summarise incidents that are reported via a national online reporting mechanism. The information gathered is provided on their website. An example of summary data from this source is provided below. In addition the Welsh Government has recently started to publish data specifically on Serious Incidents reported to Welsh Government on My Local Health Service website (Table 3.1).

Table 3.1. Reported patient safety incidents for the financial year 2013-14 by Health Board

Health Board	Number of incidents occurring	Rate per 10 000 population	Degree of harm				
			None	Low	Moderate	Severe	Death
BETSI CADWALADR	6 238	92.44	4 501	1 178	513	37	9
HYWEL DDA	3 564	94.96	2 401	698	464	1	0
ABERTAWE BRO MORGANNWG	5 278	103.48	4 901	289	86	0	2
CARDIFF AND VALE	6 946	150.97	4 594	2 105	155	92	0
CWM TAF	4 224	146.46	2 765	1 044	412	2	1
ANEURIN BEVAN	6 259	110.98	3 873	1 547	828	10	1
POWYS	736	54.74	304	236	182	12	2
Welsh Health Boards	33 245		23 339	7 097	2 640	154	15

Source: Organisation Patient Safety Incident Reports – data workbooks April 2014, available at: www.nrls.npsa.nhs.uk/resources/?entryid45=135255, accessed 1 Sept 2014.

Reducing health care associated infections is an important target

Health care-associated infections (HCAIs) are defined as infections that occur as a result of contact with the health care system in its widest sense – from care provided in the home, to general practice, nursing home care and care in acute hospitals. Wales has a strategy for dealing with these infections – *Healthcare Associated Infections – A strategy for hospitals in Wales* (Welsh Government, 2004) published in 2004 and subsequently *Healthcare Associated Infections – A community strategy for Wales* (Welsh Government, 2007). The latter strategy highlighted the need for: "all staff to understand the impact of infection and infection control practices to enable them to discharge their personal responsibilities to patients, other staff, visitors and themselves". Later, in 2011, a framework of action for health care organisations in Wales – *Commitment to Purpose: Eliminating* *preventable Healthcare Associated Infections* – was issued, which sets out expectations of all health care organisations in Wales as regards HCAIs.

Health Boards and Trusts are responsible for delivering safe and effective care and for taking all steps to avoid preventable HCAIs and to minimise the risk of antimicrobial resistance developing or increasing. National evidence-based guidelines for preventing HCAIs are set out in the June 2014 *Code of Practice for infection prevention and control*. This sets out the minimum necessary IPC arrangements and standards that NHS organisations are expected to meet to ensure that patients are cared for in an environment in which the risk of HCAIs is kept as low as possible. It reinforces and codifies existing expectations of NHS organisations.

Since July 2013, as part of the Welsh Government's commitment to openness, the results from the mandatory national surveillance programme for *C.difficile*, *Meticillin-resistant Staphylococcus aureus* (MRSA) and *Meticillin-sensitive Staphylococcus aureus* (MSSA) have been presented in a more transparent and meaningful way for the public. Every Health Board/Trust publishes information about these infections monthly on their websites. They are also published nationally by the Welsh Government on the *My Local Health Service* website. The information provided includes the number and rates of the three HCAIs per 100 000 population, and per 1 000 District General Hospital admissions. Better access to information is both informing the public and helping to drive up standards across the NHS in Wales. Wales has a national Outbreak Plan that provides a framework for the management of outbreak situations. This has a specific section for dealing with outbreaks of infections in hospital settings.

Public Health Wales provides information, targeted data analysis and advice to Welsh Government, and surveillance of HCAIs. A range of national surveillance programmes are managed by Public Health Wales to ensure the independent provision of accurate indicators related to infection control. The mandatory national surveillance programme includes surveillance of *C.difficile infections*, *Staphylococcus aureus* (Meticillin resistant and sensitive) bacteraemias; Top Ten bacteraemias; Caesarean section surgical site infections; orthopaedic surgical site infections; ventilator associated pneumonia; and central venous catheter infections in critical care. The data is made publically available and is monitored closely by Welsh Government. A new national target was introduced in June 2014, requiring NHS Wales to collectively reduce the rate of *C.difficile* infections and MRSA bacteraemias by at least 50% between 1 April 2014 and 30 September 2015 (18-month period) compared to the 2012-13 rates. To achieve the national target, each of the six major Health Boards are required to reduce the rates to no more than: 31 per 100 000 population for *C.difficile* cases (compared to the 2012-13 rate of 63 per 100 000 population), and 2.6

per 100 000 population for MRSA bacteraemias (compared to the 2012-13 rate of 5 per 100 000 population). Based on estimated associated costs (including treatment and increased length of stay) a reduction of 100 cases would equate to approximate savings for NHS Wales in the order of GBP 1 million for *C.difficile* (GBP 10 000 per case) and GBP 0.70 million for MRSA bacteraemias (GBP 7 000 per case).

The *1000 Lives Improvement Programme* also engages with the challenge of reducing recognises the complex and diverse challenges involved in tackling HCAIs, and has chosen most recently to focus specifically on infections related to invasive devices, notably urinary catheters and peripheral vascular cannulae. Best practice relating to invasive devices is being highlighted in the STOP Campaign. The campaign uses a wide range of communication methods and resources to encourage every member of staff to consider the way in which they use invasive devices, change their practice and stop infection.

Wales is taking steps to monitor and tackle antimicrobial resistance

The Welsh Government supports the UK Five Year Antimicrobial Resistance Strategy, 2013-2018, published in September 2013. This Strategy was developed collaboratively with the UK health departments and the bodies that will be responsible for delivering the work. Public Health Wales is developing a draft Antimicrobal Resistance Delivery Plan which outlines the proposed Welsh response to this call for action, and which will be published in Spring 2015.

Health Boards and trusts have worked closely with Public Health Wales, the All Wales Medicines Strategy Group, professional bodies and higher education providers on a range of AM stewardship activities. Activities include monitoring prescribing patterns and usage, development of audit tools, and provision of educational material for health professionals and the public. Health Boards and Trusts actively promote antimicrobial stewardship by supporting and empowering an Antimicrobial Management Team (AMT). At least twice a year Public Health Wales hosts an all Wales Antimicrobial Stewardship Forum in the interests of shared learning and promoting best practice. Public Health Wales has recently developed a series of Health Check reports designed to support individual Health Boards. They will be repeated every six months summarising local prescribing and resistance data, drawing comparisons with national data and presenting the surveillance data in a format that can be used by Health Boards to support local and focused action.

3.11. Conclusions

Less than two decades after devolution, the Welsh health system remains a relatively young one; many of the institutions and mechanisms needed to promote high quality care are in place, but now a further push is needed to move towards a more mature, robust quality architecture. In many respects, “quality” is at the heart of the Welsh health system: the importance of high quality and patient-centred care is given a high-level priority; strategy documents are ambitious and appropriately orientated; commitment by staff and the public to the values of NHS Wales seems strong. Concrete action across a number of domains is now needed.

Wales should be looking to increase accountability for delivering good quality and improving quality, and trying to establish some more concrete levers for positive system change. This is a process that has already been started, with the introduction of the Integrated Medium Term Plans, and the Escalation and Intervention Framework, both of which add a layer of accountability and assurance overseen by the Welsh Government. There is still room for further progress, though. To do this the Welsh Government will likely have to become more prescriptive about what is expected from some bodies and organisations – notably Health Boards – while encouraging and incentivising innovation – for example from primary care clusters. This may mean, for example, setting out clearer roadmaps for acting on the Prudent Healthcare agenda, and/or a stronger push to support shifting care towards primary care settings. In the absence of patient choice, patient voice also needs to be amplified as an important quality assurance check. A richer, better exploited information infrastructure would also function as a quality assurance check, especially if confidence in the indicators could be fostered, and a driver for positive change. Well-used data – by policy makers, managers, medical staff, patients and the public – can bring a wealth of information about what is and isn’t working in a system, and can support effective decision making at all system levels.

The ambition for an excellent, patient-centred health system, promoting quality, access and equity is there in Wales, but now tangible practical steps are needed to make the necessary changes. One next step may be that the Welsh Government, in consultation with key stakeholders, establish a menu of precise, measurable actions, to be applied in a time-bound way, to create momentum in NHS Wales. Further reflection would be needed do decide what steps are needed to deliver change that is right for Wales, but an action plan for improvement is now what is needed to back up Wales’ strategic ambition for the health system.

Policy recommendations for Wales

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

1. Secure accountability, drive standards, and promote innovation

- Continue developing the partnership between Health Boards and the Welsh Government:
  - to drive meaningful improvement a stronger central guiding hand may be needed, with more prescriptive demands made of Health Boards – in terms of financing and budget allocation, performance and efficiency, and quality achievement and improvement – and how they are expected to contribute towards the growth of NHS Wales;
  - Health Boards, alongside rigorous standards and expectations, should be given sufficient technical, managerial and leadership support, and efforts undertaken to build capacity and knowledge, for example through sharing of experiences and expertise across Health Boards and system-wide, learning trips and exchanges, mentorship systems, and education and development opportunities;
- Ensure open comparison of results, and visible accountability for all Health Board;
- Back up the Prudent Healthcare agenda with an Implementation Action Plan: a menu concrete, measurable, time-bound set of changes to bring tangible results to the Prudent Healthcare objectives;
- Develop an ambitious workforce strategy, which includes planning, piloting and evaluating innovative staffing models.

2. Put primary care front and centre as a force for dynamic system change

- Consider way of supporting and growing Primary Care Clusters and their activities, encouraging the primary care sector to reflect on their own performance and contribution to NHS Wales;
- Foster new models of care delivery and organisation for primary care, incentivising innovation and new ways of working, using small grants for Primary Care Clusters to back pilot programmes;
- Create a formal role for a primary health care professional on all Health Boards – a board seat reserved for a GP on every Board;

3. Make Wales a data-driven system

- Much more could be made of available information to help inform clinical decision making, and pulling together all available information on a single platform or portal – as has been done in Denmark, Portugal and Sweden – would be a good starting point;

Policy recommendations for Wales *(cont.)*

- Work to establish a set of key health data and quality indicators for all UK health systems, collected using agreed common definitions, to facilitate quality and performance benchmarking;
- Capitalise on the state-of-the-art SAIL programme exploiting available linked data and using it to reflect on health system performance and quality.

4. Do more to promote the patient voice

- In the absence of patient choice, patient voice is key: more can be done in Wales to collect patient experiences and views;
- Promote platforms for patient feedback, notably through re-focusing activities of Community Health Councils, and improving avenues for feedback and complaints online;
- Prioritise making electronic patient records accessible, and usable, by patients.

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Chapter 4

Health care quality in Northern Ireland

Northern Ireland has established a robust strategic agenda for quality of care, but faces a difficult challenge in maintaining public confidence amidst sustained economic pressures and ongoing concerns over access. While the small scale of the system promotes a culture of trust, it is over-burdened by a governance structure that may benefit from further consolidation. Amidst an array of grassroots initiatives there exists a need to further promote effective learning and sharing across services and scaling-up of good practices. More metrics to drive benchmarking across services along with a strengthened role for the regulator are indicated. The integration of health and social care governance has been poorly exploited to date, with funding and service arrangements still in silos and a lack of incentives to encourage change. Further integration and development of general practice as a principal agent for co-ordinating community responses to health and wellbeing needs will help drive reform.

Northern Ireland has the smallest population of the four countries in the United Kingdom. Political power was devolved from Westminster to the Northern Ireland Assembly in 1998, although it was suspended during the period between 2002 and 2007. The Assembly is responsible for a range of devolved powers, including the administration of the health and social services system in Northern Ireland. This chapter provides an overview of the key institutions, policies and arrangements in place in Northern Ireland to ensure the provision of high quality health care and promote ongoing improvement.

Section 4.1 of this chapter provides an overview of the structure of the health and social care system in Northern Ireland and sets out the key contextual factors for considering the quality and safety system, including the centrality of primary care policy and reform. Section 4.2 considers quality governance issues and sets out the role of key governance bodies. Sections 4.3 to 4.10 cover specific components of the quality and safety system including professional training and certification, authorisation of medical devices and pharmaceuticals, use of standards and guidelines, regulation and inspection of health care facilities, patient and public involvement in health care quality, use and public reporting of quality indicators and use of financial incentives. Section 4.11 identifies and considers key patient safety initiatives. Finally, Section 4.12 provides some concluding comments along with the key messages and recommendations from the OECD on the review.

4.1. The planning, financing and delivery of health care in Northern Ireland

Since devolution some 17 years ago, the Northern Ireland health and social care system has maintained a number of distinctive features throughout this period of evolution and reform. The system remains organised around a formal functional split between service commissioning or purchasing and provider functions. While the number and configuration of commissioning bodies and provider based trusts has been rationalised over time, the structural framework to promote choice and competition between providers remain. An enduring and unique feature of the system is the integration of health and social care governance, which has been in place for over 40 years. The health and social care portfolio is the largest service sector in Northern Ireland and accounts for more than 45% of total government expenditure.

The system currently faces a difficult challenge in maintaining public confidence in the quality and safety of the care provided, amidst sustained economic pressures and ongoing concerns over adequate access to acute hospital care. A central theme for health and social care reform in Northern Ireland over the past decade has been to rebalance the provisions of services away from hospitals and towards care and support in the community. The

Transforming Your Care strategy underpins the policy and planning agenda for reform in this respect.

Organisation and financing of health care in Northern Ireland

Northern Ireland has a population of approximately 1.8 million people with two-thirds of these people located in and around Belfast the capital. It has the smallest population of the four countries in the United Kingdom, representing only 3% of the total population (see Table 4.1).

Table 4.1. Population Estimates for the United Kingdom by Country, 2012

	Millions	%
England	53.5	84
Scotland	5.3	8
Wales	3.1	5
Northern Ireland	1.8	3
United Kingdom	63.7	100

Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency.

Health and social care services are largely government funded and almost entirely free at the point of care, including hospital, primary and community care and prescription pharmaceuticals. While statutory user charges exist for dental care, these are capped and exemptions exist for young, low income and other groups (O’Neill et al., 2012).

Most health services are provided by public entities. There are only two small private hospitals and private health insurance uptake is low. Aged care and other care home places are largely privately provided and over half of domiciliary care services are provided by the independent sector (Northern Ireland Statistics and Research Agency, 2012). General Medical Practitioners and general dental practitioners (GDPs) are generally self-employed.

General Medical Practitioners play a key role in the primary care system in Northern Ireland. They operate as independent contractors and are funded by the department through a combination of capitation and fee for service payments. The Department for Health, Social Services and Public Safety is responsible for agreeing the contract with general practitioners while the Health and Social Care Board oversees the management of the contract including additional services. General practice is generally organised around single practices though Practices have recently started to form themselves into Federations of around 20 practices with a geographic population focus.

Dentists are generally self-employed, although some are employed by private organisations providing services funded by the department and others in the provision of services, for example, for children through the community dental service. Unlike nearly all other health and social care services provided in Northern Ireland, out of pocket expenses exist for some dental services.

A structural characteristic that sets Northern Ireland apart from the others countries of the United Kingdom is the model of integrated governance that has existed for health and social care services for over 40 years. While in Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPS) has strategic oversight of both health and social care, in England, Scotland and Wales the provision of social care still remains the responsibility of local authorities.

The DHSSPS is by far the largest government department in Northern Ireland, with an estimated budget in 2014-15 of over GBP 4.7 billion (EUR 6.3 billion) – the second largest being Education with just under GBP 1.9 billion (EUR 2.6 billion). Health and social care currently accounts for over 45% of total estimated recurrent expenditure (see Figure 4.1) by government in Northern Ireland (Northern Ireland Executive Budget, 2014).

Figure 4.1. Northern Ireland Public Services Budget,[1] 2015-16

1. Equates with the Non Ring-Fenced Resource specified in NI budget papers which covers the total ongoing costs of providing services.

Source: Northern Ireland Executive (2014), *Budget 2015-16,* available at http://www.northernireland.gov.uk/budget-2015-16.pdf, accessed on 4 February 2015, p. 40.

The Northern Ireland Executive launched the Review of Public Administration (RPA) in June 2002 with the final outcome announced by the Secretary of State in November 2005. Its purpose was to review Northern Ireland's system of public administration with a view to putting in place modern, accountable and effective arrangements for public service delivery in Northern Ireland. A major restructure to the system was introduced following the Review of Public Administration and was aimed at maximising economies of scale and improving outcomes (Ham et al., 2013).

The Health and Social Care (Reform) Act (Northern Ireland) 2009 provided a statutory basis for the restructuring of the administration of health and social care, resulting in the consolidation of the number of organisations involved in the administration, commissioning and delivery of care, including:

- *Commissioning*: from four health and social service boards to one regional board and five local commissioning groups, which act as committees of the board.
- *Provision*: from nineteen trusts (eleven community and social services, seven hospitals and one ambulance) to six trusts (five health and social care and one ambulance).
- *Public involvement*: one patient and client council replaced four health and social services councils (Ham et al., 2013). The Reform Act also placed a statutory obligation on health and social care (HSC) organisations and the department to involve the public and consult with them in relation to their health and social care.

The geographic boundaries of Local Commissioning Groups and Trusts are aligned (see Figure 4.2.)

Figure 4.2. Geographic boundaries of Health and Social Care Local Commissioning Groups and Trusts in Northern Ireland

Source: Northern Ireland Statistics and Research Agency (2013), *NIRA Geography Fact Sheet*, available at: http://www.ninis2.nisra.gov.uk/public/documents/NISRA%20Geography%20Fact%20Sheet.pdf, accessed on 4 February 2015.

Key policy developments aimed at improving quality of care in Northern Ireland

Late in 2005 the DHSSPS released *Caring for People Beyond Tomorrow* a strategic framework for primary health and social care which sought to establish the vision for primary care service policy and development in Northern Ireland. The Minister's foreword amplified the central objective of the strategic framework:

> *"Too much reliance is placed on the hospital sector: a more responsive and dynamic primary care sector could provide the necessary care close to home. Therefore, we need to develop a much more responsive system which is fully integrated and joined up with the wider health and social care network", "Foreword" in Department for Health, Social Services and Public Safety (2005)* Caring For People Beyond Tomorrow: A Strategic Framework for the development of Primary Health and Social Care for Individuals, families and Communities in Northern Ireland.

The framework identified a vision for primary care and a set of high level goals to be achieved in the first five years of the 20 year strategic horizon, including improved access to a wider range of primary care services, more effective and integrated team work, greater community involvement in service planning and infrastructure development for integrated services. A steering committee was established to oversee the implementation of strategies to meet the goals, with an emphasis on reducing reliance on hospital services, improving discharge arrangements and achieving service efficiencies. In June 2006 an improvement programme was announced for commissioners to take forward with providers, including integrated working, nurse-led discharge, intermediate care, case management and non-medical prescribing.

Transforming Your Care, a wide ranging review of the Northern Ireland health and social care system, was initiated in 2011. In announcing the review, the Minister emphasised the overriding need to drive up the quality of care, improve outcomes and enhance patient experiences of care. The focus of the review echoed the central objective of the strategic vision for primary care six years earlier, to see a shift in care currently carried out in hospitals into the community.

The review was undertaken by the Health and Social Care Board Review Team. The Team undertook research, consultation, analysis, drafting of reports and recommendations. An expert panel provided challenge on the progress of the review; the methodology used; the quality of information assembled and analysis undertaken, and finally the robustness and appropriateness of the findings, proposals and recommendations. The expert panel was led by the Chief Executive of the Health and Social Care Board in an ex officio capacity supported by independent experts, including the Chief Executive Officer of The King's Fund, the Executive Chair of SSE Ireland, a general practitioner, academic and retired civil servant. The review covered all health and social services, involved significant stakeholder consultation and provided recommendations and implementation plans for future configuration and delivery of services. It explicitly excluded changes to the existing governance structures, namely the configuration of the Health and Social Care Board and Trusts and the level of the budget resources available.

The key principles and model for reform put forward by the review team focuses on creating greater involvement and control for individuals in care decision making and the provision of services closer to home. The model was applied to a variety of population groups, including those with chronic conditions and the elderly to illustrate how it might work in practice. Around 100 proposals flowed from this work, with many picking up similar themes to the 2005 strategic framework for primary care, including population based multi-service teams with a central role for GP leadership (to be known as Integrated Care Partnerships) and workforce reform. The review understandably went further and made proposals around consolidation of acute services, continuation of the closure of institutional disability and mental health facilities (as recommended in the Bamford Review in 2007) and shifting resources from acute care back into the community.

Quality 2020 is the principal policy document on quality and safety for the Northern Ireland system of health and social care services. The document was launched in November 2011 by the DHSSPS to provide a strategy and clear directions over the subsequent ten years for the quality and safety of health and social care services in Northern Ireland. The strategy was released at a time when the system, while still grappling with the financial challenges resulting from the global financial crisis and in response to recognition that longer term strategies are needed to meet ongoing challenges and maintain high quality services (DHSSPS, 2011).

The strategy aligns with the conceptual framework for quality adopted by the OECD, defining three quality dimensions – safety, effectiveness and patient and client focus. The document sets out a bold vision for the system, that it "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care" (DHSSPS, 2011). In considering how to achieve the vision emphasis is placed on leadership, resources, a learning culture and quality measurement.

Five strategic goals with related key actions are identified for the ten-year period:

1. Transforming the culture
2. Strengthening the workforce
3. Measuring the improvement
4. Raising the standards
5. Integrating the care

In 2012 an implementation plan was subsequently developed. Together the strategy and implementation documents provide a sound blueprint for a robust and comprehensive approach to building a quality and safety focus across the health and social care services in Northern Ireland. A number of the key initiatives set out in the implementation plan are identified in this report and highlighted for priority action by the DHSSPS as it proceeds with the implementation plan for the strategy, including:

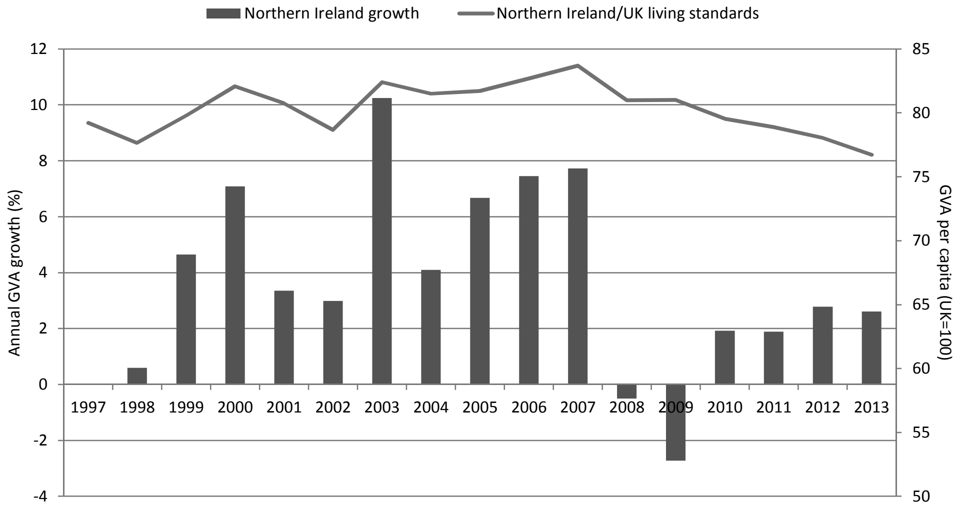
- The promotion of a culture of learning and innovation through strengthened opportunities for benchmarking across trusts and services.
- The clarification of responsibilities and strengthening of accountabilities for quality improvement at all levels in the system.
- The adoption of clinical care standards to promote delivery of appropriate care and reduce unwarranted variation.
- The development of a robust suite of quality and safety performance indicators, including clinical indicators.
- The establishment of targets with regular quality review and reporting at the trust and whole of system level.

The economic context for the health and social care system in Northern Ireland was relatively robust in the years leading up to the global financial crisis. In 2005 Professor John Appleby undertook a review of the provision of Health and Social Services in Northern Ireland to consider scope for resources devoted to health and social care to be used more effectively, particularly in relation to improving service waiting times. While much of the review was taken up with budget considerations, the main conclusion from the review was that the issues for the NI system relate more to the use of resources than the amount of resources available. Appleby pointed strongly towards the need for more robust performance management arrangements with long term targets coupled with rewards and sanctions to encourage service improvements by providers.

The onset of the global financial crisis from 2008 significantly changed the operating environment for the health and social care system in Northern Ireland. The impact of the crisis is clearly evident in the official economic figures of the Northern Ireland Executive (see Figure 4.3), with negative economic growth recorded in both 2008 and 2009.

While there has been positive growth in recent years, it lags behind the UK average. Provisional results for 2013 indicated that the Northern Ireland economy grew by 1.2%, below the UK average of 3.3%. Although more recent data show signs of further limited growth, living standards in Northern Ireland remain below the UK average. In 2013 the living standards index indicated NI was at 76% of the UK level (Northern Ireland Executive).

Figure 4.3. Northern Ireland economic growth and living standards

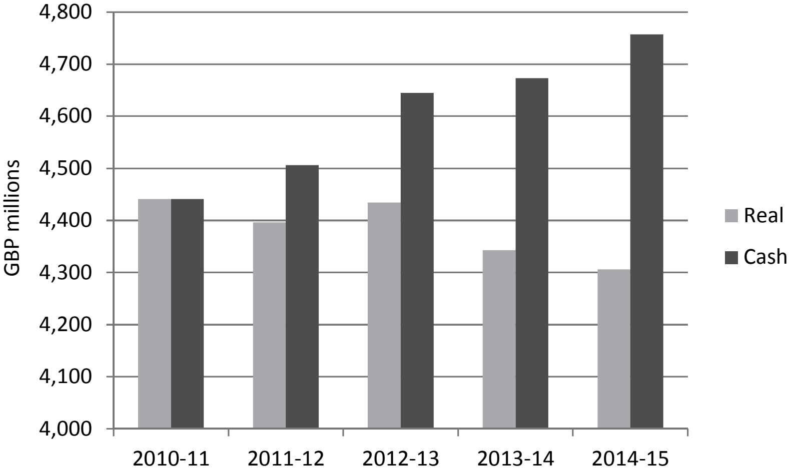


Source: Northern Ireland Executive (2011) *Budget 2011-15*, available at http://www.northernireland.gov.uk/revised_budget_-_website_version.pdf, accessed on 4 February 2015.

In 2011 Professor John Appleby completed an update review on resource needs and opportunities for improved productivity, in light of the implications of the global financial crisis. In his report, Appleby clearly identifies that the need to manage down national debt and to realign government income and expenditure will have significant impact on public spending. Whilst acknowledging that Northern Ireland's proposed budget settlement was relatively favourable and health and social care were relatively better off than other sectors, he identified projected real reduction in spending over the five years to 2014-15 (see Figure 4.4).

Figure 4.4. Northern Ireland Health & Social Care Budget: Projected cash and real change 2010-11 to 2014-15

GBP millions



Source: Appleby, J. (2011), "Rapid Review of Northern Ireland Health and Social Care Funding Needs and the Productivity Challenge; 2011/12-2012/15", Belfast, DHSSPS.

The official budget outcome for the portfolio from 2011-12 to 2014-15 confirm real reductions in total planned spending, estimating reductions of over 5% per annum (Northern Ireland Executive Budget 2011-15). There are indications that these budget pressures are significantly impacting on the portfolio's spending plans and ability to respond to service demands. In late 2014 in an address to the Assembly the Minister stated that his:

> *"Department has been experiencing significant financial pressures, most notably since autumn 2013, and that these have yet to be recurrently resolved. These pressures are in a wide range of areas including children's' services, quality and safety of services, elective care and unscheduled care and they reflect the ever increasing demands on health and social care and the technological and treatment advances that can now be provided" (Oral Statement to the Assembly by Health Minister Jim Wells MLA – 14 October 2014 – Outcome of October Monitoring Round and Paediatric Congential Cardiac Services, available at:* http://www.dhsspsni.gov.uk/print/index/statements-minister/statements-minister-2014/oralstatement141014.htm, accessed 2 October 2015).

The budget position and economic outlook for Northern Ireland provides a challenging policy landscape for the country. The flow-on implications for population health, service demand and health system sustainability are significant.

The quality of care in Northern Ireland has been repeatedly questioned in recent years

In recent years, the health and social care system has been subject to repeated scrutiny in relation to concerns over the standard of care. Separate reports on an inquiry into deaths from Clostridium difficile in hospitals of the Northern Trust and the recall of over 100 dental patients by Belfast Trust after a review of the clinical performance of a senior doctor were released in early 2011. Later that year, a report by the RQIA examining delays in the reporting of x-rays in the system was also released. During 2012, the system also began responding to the 32 recommendations related to the findings of an investigation into an outbreak of Pseudomonas aeruginosa infections in neonatal units which had resulted in five neonatal deaths. More recently, a review of unscheduled care was undertaken by the RQIA, in response to concerns about access to hospital care in the Belfast Trust and media reporting on extended waits in emergency departments.

While strategies to address these issues may have brought improved care quality through better co-ordination of acute and primary and community care, there is a risk the intensity and urgency of the responses required by such reviews detract from longer term strategies for quality and safety improvement and the pursuit of system reforms, such as those under the *Transforming Your Care* agenda. Senior officials consulted during the review repeatedly reflected on the disproportionately high level of scrutiny the media places on health and social services provision in Northern Ireland and expressed concern over the level of resources and attention required to manage public expectations.

Other commentators have noted the “high, perhaps unrivalled, level of media coverage” in Northern Ireland and the impact of the shocks to the system that have been brought about by various reports from the recent raft of formal reviews. They observe “it often paralyses the organisation under scrutiny” with opportunities for learning lost through the organisation being overwhelmed by the burden of recommendations (Donaldson, 2014).

Priorities for health service reform in Northern Ireland are well established but progress with system change has been slow

A central theme for health and social care reform in Northern Ireland over the past decade has been to rebalance the provisions of services away from hospitals and towards care and support in the community.

In 2005, amidst recommendations to sharpen the incentives in the system to improve health resources use, the Appleby review recommended greater attention be given to practical involvement of GPs in the purchasing of care as a way of both strengthening the involvement of general practitioners in the system and as part of a devolution strategy for commissioning secondary care services.

Later in 2005 the DHSSPS released *Caring for People Beyond Tomorrow* a strategic framework for primary health and social care which sought to establish the vision for primary care service policy and development in Northern Ireland.

The most fundamental aspect of this change agenda lay in the notion of integrated care, namely the establishment of a central role for GPs in the development of population based primary care teams. A central recommendation, reflective of the Appleby review, was to develop a managerial partnership between Trust and GP practice leadership. The planning and successful integration of other key elements of the reforms, including better community based-case management, non-medical prescribing, changes in skill-mix, information system and capital infrastructure development and intermediate care are identified as being pivotal on the establishment and leadership of the new primary care teams or bodies.

While GP leadership was evident on the boards of governance of trusts and the planning for clinically led pilot projects (known as Primary Care Partnerships) to promote new and innovative approaches to commissioning care was initiated in 2010, evidence of progress on concrete reform to the service system in the early years after the change agenda was established was limited. The Primary Care Partnerships consisted of voluntary alliances of health and care professionals and voluntary and community sector bodies working together to inform the Local Commissioning Groups of agreed areas in which services could be provided more effectively and efficiently around the needs of patients (Northern Ireland Assembly, 2012). While the achievements of the partnerships would seem modest, they appear to have provided a basis for future service developments under the *Transforming Your Care* reform agenda established in 2011-12.

The *Transforming Your Care* review echoed the central objective of the strategic vision for primary care six years earlier, to see a shift in care currently carried out in hospitals into the community. The review was undertaken at a time when a number of incidents and inquiries into the standards of care were causing public concern over care quality and safety (e.g. inquiry into deaths from Clostridium difficile in hospitals of the Northern Trust). It would also appear that the reform agenda for primary care had lost momentum in the preceding years, most likely as a consequence of the greater policy attention to system sustainability required during the early aftermath of the global financial crisis.

The review provides a robust blueprint for service reform, with the transition to local population based service planning and integrated local service provision at the heart of the new system model. The review sensibly places general practice central to this reform looking for general practitioners to form geographical networks (referred to as federations of practices) and assume critical leadership roles in Integrated Care Partnerships (ICPs), the successors to PCPs. The 17 ICPs are collaborative networks of health care providers, statutory, community & voluntary and independent, who seek to ensure the co-ordination and effectiveness of care for local service users across acute and community based health and social care services.

The *Transforming Your Care* review identifies the need for a transition period for the system in building the new partnership model, before the anticipated dividends to better patient outcomes and economies in the system enabled financial sustainability. To this end, the review identified transitional or “hump” funding over the first three year of GBP 70 million. Although challenging to achieve, given the current budgetary context for health and social care portfolio, the allocation of such funding recognised the significant upfront investment required to provide well targeted incentives to providers, build information systems to enable care and performance monitoring and establish operational capacity of any new organisations. For example, the review identified the potential for Integrated Care Partnerships to form the basis for a multidisciplinary mutual organisation or to have social firm status. In addition, there is planned development of federations of general practice (DHSSPS, 2011). This form of investment would appear consistent with plans in Scotland to make available additional resources of up to GBP 100 million in 2015-16 to support government plans to further integrate health and social care.

Progress with the transition to this new system since the release of the *Transforming Your Care* review would appear modest, particularly given the long lead-time for the preliminary development with Primary Care Partnerships in the five years prior to the review. While 17 Integrated Care

Partnerships have been established, they are still in early stages of service planning and development. At a workshop for the members of the committees for the Integrated Care Partnerships in mid-2014, while participants reported improvements in communication between services, relationship building and a clearer vision for improving services there were frustrations raised over the pace of change, the adequacy of transitional funding and the lack of clarity over the longer term commitment to change (Integrated Care Partnership, 2014).

The partnership models vary across the region and in many instances are initially of relatively small scale and address different aspects of care for specific population groups or care issues rather than take a broader-based systematic service approach to addressing the needs of the local community. For example, in one Local Commissioning Group (LCG) area a falls clinic for the elderly is being piloted, while in another LCG area improved support for palliative care is being explored and in another a specialist clinic for respiratory conditions is being tested. Mechanisms have been established to disseminate lessons learnt from each project. While a number of these initiatives may prove after evaluation to be valuable innovations, plans for diffusion and system-wide application of best practice models are required for large-scale system reform. With a view to addressing this issue, DHSSPS entered into an agreement with the Institute for Healthcare Improvement (IHI) in October 2014. This sought to utilise IHI's "Triple Aim" methodology, initially in two prototype sites with a view to scaling up throughout Northern Ireland.

Clarification of the role of general practice in the Integrated Partnerships now and as they evolve in the future is critical. General practitioners would appear to have robust opportunities for input into deliberations on changes to service provision in the community through their membership on the Partnership Committees of the Integrated Care Partnerships (ICPs) and LCGs. However, the central role of general practice in the design and delivery of the new models of care has not been fully exploited at this point. Liam Donaldson goes further in asserting that the "frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations" (2014).

The BMA Northern Ireland's GP Committee is co-ordinating the establishment of a Federation of GP practices. Each Federation comprises of around 20 general practices and delivers services to local populations of around 100 000, aligned with the population coverage of the ICPs. The plan was for all GP practices in Northern Ireland to be incorporated into not-for-profit Federations during 2015 (BMA, 2015). While these Federations may provide potential for a greater focus on population health and enable a scale of service that could support further service integration, careful integration will be required to ensure that these non-government bodies align with ICPs and the ongoing evolution of organisation and governance of community care and support services.

There are indications that insufficient funding support has been dedicated to this endeavor. The current financial pressures and urgent service access issues facing the portfolio are likely have impacted on this situation. In a recent oral presentation to the Northern Ireland Assembly regarding the budget, it is noted that GBP 8 million in additional funding was being earmarked for progressing the Transforming Your Care agenda in 2015-16, which falls well short of the level of funding originally identified to effectively enable service system transition.

Further, clearer specification of the operational model of service integration to apply across Northern Ireland through the 17 partnerships is warranted. This work could involve greater encouragement of GP leadership, through well targeted incentives and alignment of performance expectations, for example through the Quality Outcome Framework, and the identification of the core elements of a primary care model that should be evident across each region, to enable consistent coverage and access by the community. This could be informed by consideration of the characteristics and implementation strategies for models being pursued in other countries including Medical Homes and Accountable Care Organisations in the US and the transition to Family Health Units in Portugal (see Box 4.1) and to Primary Health Networks in Australia.

While the key elements for reform in the health and social services system in Northern Ireland have been specified and the case for change has been established, bold and sustained political and clinical leadership is required, along with progressive funding transitions, to generate system-wide change of the scale required to bring the vision to full fruition.

Box 4.1. Primary Care Reform in Portugal

The primary health care reform agenda in Portugal led to the development of a new organisational model for primary health care known as Family Health Units (FHUs) in 2006. FHUs are self-organising multi-professional teams that are formed by general practitioners, nurses, managers and other professionals to deliver primary care together. The average FHU has around 12 000 patients, with 7 doctors and 20 professionals in total. These teams have functional and technical autonomy enabling them to define their own working processes and to negotiate goals with their local authorities (Fialho et al., 2011) and a payment system sensitive to performance that is designed to reward productivity, accessibility and quality. A comprehensive performance indicator set is tied to the payment system.

The 350 Primary Health Care Centres that existed in Portugal during 2006 have been rapidly transitioning into the new FHU model. By 2010, about 300 FHUs were in place and by 2014 the growth in this model of care had reached coverage of around half of the Portuguese population, noting the FHU model had evolved somewhat since 2005.

The funding of FHUs can vary according to different models. One model, known as Model B, supplements a small salary component with capacitation payments, payment for negotiated additional services, a premium for negotiated goals and a fee-for-service for house calls. The possibility to negotiate with the purchasing/commissioning agency the achievement of certain goals that can lead to further institutional incentives is a distinctive feature of this model.

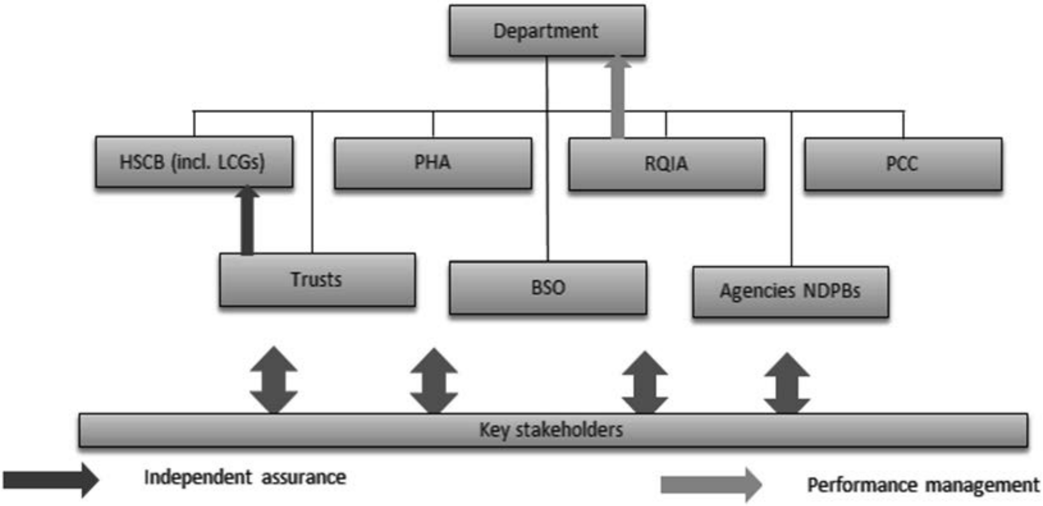
4.2. Governance of health care quality monitoring and improvement

This section sets out the key organisations and bodies in the structure of the health and social care system in Northern Ireland, along with the lines of accountability and reporting (see Figure 4.5). Each has an integral role to play in the overall governance of the system and the overall assurance and improvement of the quality and safety of services. However while integration of health and social care is a structural strength of the system, this has not been well exploited to achieve service reform.

The key agencies and stakeholders involved in quality of care in Northern Ireland

Responsibility for the administration and management of health-related matters in Northern Ireland lies with the Minister of Health, Social Services and Public Safety who is part of an eleven person executive led by a First Minister and a Deputy First Minister (O’Neill et al., 2012). The Programme of Government sets out the Executive’s budget and investment across departments.

Figure 4.5. Structure of Health and Social Care System in Northern Ireland



BSO = Business Service Organisation; HSCB = Health and Social Care Board; NDPB = Non-departmental public body; PCC = Patient and Client Council; PHA = Public Health Agency; RQIA = Regulation and Quality Improvement Authority

Source: Department for Health, Social Services and Public Safety (2011) *Framework Document,* DHSSPS available at http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf, accessed on 11 June 2015.

The Department of Health, Social Services and Public Safety leads on the Programme of Government commitments relevant to the portfolio. The department has strategic control of care and issues to the Social Care Board each year:

- A Commissioning Plan Direction (CPD), which sets out the Minister’s priorities and details specific standards and targets that should be delivered by health and social care.
- An Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance (see Section 4.8).

The department is responsible for Policy on Safety and Quality, including standards and guidelines, professional regulation and adverse incident reporting and learning.

The Health and Social Care Board is responsible for commissioning care, performance management, service improvement and resource management. The Health and Social Care Board consults with the PHA to produce an annual Commissioning Plan that responds to the higher level Commissioning Plan Direction and Indicators of Performance Direction. The Commissioning Plan and its associated service and budget agreements are agreed between the Public Health Agency and Health and Social Care Board. The board is assisted by five Local Commissioning Groups that are aligned geographically to the Health and Social Care Trusts. The Groups assess the needs of their local populations, identify priorities and secure the delivery of services to meet those needs within the overall remit of the board to undertake the commissioning of care for the region.

The six Health and Social Care Trusts (five geographic and one regional ambulance) are the key bodies responsible for providing health and social care in Northern Ireland. They may also commission some aspects of social care, including domiciliary care services. Although the quality and safety of health and social care services have been the responsibility of the Health and Social Care Boards and Trusts in Northern Ireland for some time, the Health and Personal Social Services Order 2003 placed a statutory duty of quality on these bodies. The Order requires that these bodies establish and maintain arrangements for the purpose of monitoring and improving the quality of the health and personal social services they provide and the environment in which they are provided.

The primary operational responsibility for public health in Northern Ireland rests with the Public Health Agency. Activities undertaken by the Agency include the promotion of health and well-being by working with other agencies on particular initiatives aimed, for example, at promoting healthy lifestyles, supporting commissioning activities with public health advice, responding to threats posed by infectious diseases and supporting research and development on new interventions. The Agency also maintains a register of professionals across the range of specified allied health professions such as dietetics, radiography, speech and language therapy, and physiotherapy and podiatry. The intention is to help maintain standards and protect the public (O’Neill et al., 2012). The PHA has a central role in the promotion of patient and client involvement in health and social care.

The Quality, Improvement and Regulation (NI) Order (2003) established the role and functions of the Regulation and Quality Improvement Authority (RQIA) which plays a central regulatory role in the health and social services sector in assuring and improving quality of care in Northern Ireland. The Authority has a broad range of powers in relation to conducting reviews and carrying out inspections and investigations and reporting on arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and personal social services for which they have responsibility.

Under the order, the Department of Health, Social Services and Public Safety is able to prepare and publish statements of minimum standards, which are required to be taken into account by the Regulation and Quality Improvement Authority in determining extent of compliance. Statements of minimum standards of care have been published for the following bodies:

- Nursing homes
- Residential care homes
- Nursing agencies
- Domiciliary care agencies
- Residential family centres
- Day care settings
- Child-minding and day care for children
- Children's homes
- Independent healthcare establishments.

The RQIA may serve an Improvement Notice to a person or organisation that the Authority believes is failing to comply with any statement of minimum standards. A notice is required to specify in what respect there is a failure to comply with a statement of minimum standards and what improvements the Authority considers necessary.

The Order also provides for the regulation of health and social care services by the Authority, including registration and inspection of nursing homes, domiciliary care agencies, children's homes and private hospitals. Although Health and Social Care Trusts (including public hospitals and general practices) lie outside of the RQIA regulatory powers, the Order places no limit on what standards the DHSSPS may issue and the frequency by which the RQIA can inspect Trusts.

The department publishes overarching standards to support good governance and practice in the health and social care services sector, which the RQIA use to assess the quality of services when conducting clinical and social care governance reviews. The Quality Standards for Health and Social Care, published in 2006, reflect five themes:

1. Corporate leadership and accountability of organisations
2. Safe and effective care
3. Accessible, flexible and responsive services
4. Promoting, protecting and improving health and social well-being
5. Effective communication and information.

Integration of health and social care is a structural strength of the system that has not been well exploited to achieve service reform

Northern Ireland has an enviable structural advantage over many OECD countries, with a well-established system of integrated governance for health and social care services. Despite this structural advantage, Northern Ireland does not appear to have vigorously pursued and realised significant advances in integrated models of care and achieved shifts in resources from the acute sector to strengthen care in community settings. While pockets of innovation were identified, and recent initiatives such as the Integrated Care Partnerships show promise, Northern Ireland has not fully capitalised on this structural strength to its system with some commentators asserting that "Northern Ireland represents a missed opportunity to demonstrate on a system-wide basis what can be achieved when the organisational barriers to integration of health and social care are removed" (The King's Fund, 2013).

It would appear that the funding and purchasing of acute care, general practice and social care remains largely in silos, with little real exploration of innovative funding models to promote new service delivery arrangements or incentive programmes to promote quality improvement. While stakeholder concerns to safeguard social care funding allocations from redistribution to acute care are appreciated, the existing integration of health and social care governance provides a basis for funds pooling and explicit redistributions, at least at the margins, to help drive more integrated and primary care oriented models of care. For example, in relation to general practice, a review of the alignment and effectiveness of the Quality Outcomes Framework settings and incentives with overall policy objectives and priorities for team-based primary care and changes in skill-mix may generate opportunities for development of mixed payments models that underpin sound business models for the promotion of planned integrated care models.

Quality governance requires simplification and further clarification of responsibilities to improve coherency

Stakeholders consulted during the review expressed concerns over the current arrangements for improving quality and safety in the health and social system, with Trusts communicating a sense of being "swamped by directives" with no clear communication of priorities by the DHSSPS. Notwithstanding DHSSPS documentation on the roles and functions of key bodies (DHSSPS, 2011), they expressed that they experienced confusion at times over the respective roles of central bodies in setting the quality and safety agenda, particularly in relation to DHSSPS, HSCB, PHA and RQIA. For example, stakeholder comment suggested there is ambiguity over system expectations for adhering to NICE standards and who in the system is responsible for co-ordination, priority setting and how compliance is resourced and monitored. The authority of the RQIA in Trust matters is also considered unclear, particularly in relation to the outcome of reviews and further DHSSPS related advice.

The Appleby review in 2005 concluded that more robust performance management arrangements were required in the health and social services system in Northern Ireland. Clear lines of accountability to the department and the Minister for expenditure, quality and performance were seen as prerequisites for further building the commissioning capacity of the system.

As previously mentioned, the Health and Social Care (Reform) Act (Northern Ireland) 2009 provided a statutory basis for the restructuring of the administration of health and social care. It is clear that Northern Ireland has invested in reforming its structure to improve economies and effectiveness in managing the performance of the health and social care system. The number of previous bodies have been rationalised (19 trusts to 6), commissioning processes have been consolidated (four boards to one) and new regulatory and consumer bodies established. The responsibilities of each are either established in the legislation or codified in a variety of standards, policies and guidelines. A great deal of effort has been made to build a better structure and create a well-functioning system. However, while it would appear many of the right ingredients are in place, there is a need to consider rationalisation of the "top to bottom" chain of governance in quality and more clearly identify, and build the capacity, of central leadership and authority on the direction and priority for quality improvements. There are signs that through the establishment of the Health and Social Care Board and the Regulation and Quality Improvement Authority the lines of authority and accountability for quality and safety in the system have become more blurred and complicated.

There are concerns that the current governance structure of the Northern Ireland health and social care system may be over-engineered and burdensome. As noted later in this report, little action has been taken to lever off the commissioning function to drive innovations in service funding and service design, through the application of innovations and structural incentives. Further, given the nature and scale of the system, reconsideration of the value of maintaining a clear split between "commissioning" and "provision" functions is highlighted.

Countries maintaining a formal separation between providers and purchasers of services seek to benefit from the creation of "market forces" and through sharpened incentives improve quality and value. The private hospital sector in Northern Ireland is very limited and the scope for public hospital competition and choice is both geographically and structurally limited.

4.3. Professional training and certification

The regulation of health professionals working in Northern Ireland is largely undertaken on a UK-wide basis through national regulatory bodies. The UK regulator for doctors, along with more recent consideration by the UK regulator for nurses, is overseeing an agenda for revalidation where practitioners are required to participate in an annual appraisal. Agencies within Northern Ireland are responsible for managing and supporting post graduate education and ongoing professional development and training for doctors, nurses and allied health professionals.

Regulation and education of health professionals is largely UK-wide

Jurisdiction for bodies involved in health professional regulation are largely UK-wide. There are nine principal regulators of health and social care professionals in Northern Ireland, seven are national health regulators and two are regional regulators, covering:

- Chiropractic
- Dental
- Medical
- Optical
- Osteopathic
- Nursing and midwifery

- Allied health (e.g. physiotherapy, speech therapists, dieticians, podiatrists)
- Pharmaceutical (Northern Ireland only)
- Social care (including social workers, Northern Ireland only)

The regulators each keep professional registers, set standards for education and practice, and ensure that professionals are fit to practice.

Within this overall approach, the national regulators have significant input from each country. For example, the General Medical Council has offices in Northern Ireland, Scotland and Wales which provides for greater capacity to respond to devolution and works to ensure regulation remains appropriate, in light of the different evolution of health policies and structures across the countries. The Nursing and Midwifery Council has at least one member from each of the countries on its council. The Northern Ireland Public Health Agency also reports having responsibilities in relation to professional regulation, education, workforce planning and development activities for nurses.

It is noted that the Pharmaceutical Society of Northern Ireland and the General Pharmaceutical Council (the regulatory body for pharmacists for the rest of the United Kingdom) have established a memorandum of understanding with the primary purpose of the two organisations working together as efficiently and effectively as possible, "so that the principles of regulation remain consistent and public confidence and safety is maintained in Northern Ireland and Great Britain" (2011).

The regulation of social care professionals falls within the legislative competence of each country. England, Scotland, Wales and Northern Ireland have all now introduced separate arrangements for the regulation of social workers and other social care staff (Law Commission, 2014). The regulator for the social care workforce in Northern Ireland is the Northern Ireland Social Care Council.

Education and Training is undertaken both on a UK-wide basis and by agencies within Northern Ireland

The General Medical Council (GMC) is the regulator for doctors in the United Kingdom. In 2012 regulations were established to allow the GMC to proceed with medical revalidation, which requires all medical practitioners to participate in an annual appraisal that considers all areas of their practice and provide the GMC with supporting information on quality improvement activity, review of significant events and feedback from colleagues and patients for every five-year revalidation cycle.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is responsible for managing and supporting post graduate education for doctors and dentists in foundation, core and specialist training programmes. NIMDTA also delivers Continuing Professional Development courses for general practitioners, both medical and dental, as well as dental care practitioners. The Agency allocates the funding to service providers for the salary and training of newly graduated doctors participating in the foundation programme and partial funding of more experienced doctors participating in specialist training programmes.

The Agency has a role in determining the distribution of specialist training posts commissioned by the DHSSPS and ensuring each post meets standards set by the GMC. There is scope for strengthening and better aligning longer-term workforce planning functions with year on year allocations and distribution of training posts for specialty training in Northern Ireland, particularly in relation to responding to emerging priorities or gaps and accommodating transitions to new models of care.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPECNM) and the Northern Ireland Social Care Council is responsible for managing and supporting post-graduate education and ongoing professional development and training for nurses, midwives and social care workers respectively. In late 2014 the Nursing and Midwifery Council announced it is partnering with Northern Ireland and bodies in the other countries of the United Kingdom to test a system of revalidation, with a view to introduction by the end of 2015.

The NIPECNM undertakes regional co-ordination and commissioning of training with a view to ensuring best-value and a system-wide approach. Concerns exist over differences in required training and capacity to practice across the service system and the NIPECNM is working to reduce training duplication and improve workforce mobility by promoting uniform training programmes across the system.

The NIPECNM is also developing metrics to monitor nursing staffing levels, staff experiences and care outcomes to enable better understanding of the impact of staffing policies on service costs and outcomes.

Workforce and leadership development is orientated towards skills building for quality improvement

There is recognition in Northern Ireland that while excellent arrangements are in place for leadership development across health and social care providers, there is a significant deficient in leadership skills for quality improvement and safety across the system. To help address this situation the *Leadership Attributes Framework* was announced in November 2014.

The purpose of this framework is to:

- Assist individuals in assessing their current attributes (knowledge, skills and attitudes) in relation to leadership for quality improvement and safety and their learning and development needs for their current role or for future roles.
- Help organisations to build the capability and capacity of the workforce to participate in and lead, initiatives which develop quality care and services.

The framework provides a sound basis from which to build distributed leadership capacity across frontline care staff, management, commissioners and policy leaders. Funding commitments to support staff development and provide incentives to acquire further skills and competencies in quality and safety will be required. In the shorter term, incentive programmes to attract and retain skills and expertise in strategic leadership areas of need may be required, including organisational culture, clinical benchmarking and new business development. The *Transforming Your Care* agenda presents an opportunity to establish additional primary care workforce capacity through the development and implementation of safe and effective workforce innovations, including extended roles for nurses and possible expansion of community pharmacy.

4.4. Inspection and accreditation of health care facilities

The regulation and registration of health services in Northern Ireland is undertaken by the Regulation and Quality Improvement Authority (RQIA). While a system of health service accreditation does not exist, the RQIA does undertake routine inspections of services in reference to relevant standards and conduct thematic reviews as part of overall efforts to provide assurance on and improve health care quality. There is scope to strengthen the role of the RQIA in promoting diffusion of innovation and sharing of practices to improve quality across the system, including primary care.

The role of the RQIA should be strengthened and expanded

As previously outlined, the regulation of a wide range of health and social services in Northern Ireland is undertaken by the Regulation and Quality Improvement Authority (RQIA). The Health and Social Care Trusts, including public hospitals services, and general practice are not registered by the RQIA and not subject to the same standard setting and inspection regime applied to the independent sector, including the limited number of private hospitals in Northern Ireland. While Trusts are subject to various accountability processes, there may be justification to review the existing legislative framework for the RQIA to ensure consistent powers and arrangements exist for all health and social care services.

The Health and Social Care Board (HSCB) has principal responsibility for the performance of the Health and Social Care Trusts and Primary Care, including general practice. Services provided by general practitioners are separately contracted by the board through the General Medical Services Contract, with the Quality Outcomes Framework applied as the principal mechanism for performance accountability. The HSCB maintains a register of general practitioners providing services in Northern Ireland; the Primary Medical Performers List. NIMDTA plays a central role in the annual appraisal of general practitioners on behalf of HSCB who provide the Responsible Officer for GP revalidation.

The RQIA has a role in assuring the quality of services provided by the Health and Social Care Trusts. The Authority undertakes ad hoc thematic reviews, either at the request of the Minister or through self-initiation, and it would appear this is the main avenue through which the Authority currently contributes to the improvement in various aspects of the services provided through the Trusts. These reviews are wide ranging and require considerable expertise and understanding on often quite specific and specialised issues, particularly in relation to clinical care in acute hospital settings.

Although the RQIA does not currently undertake regular inspection of public hospitals as part of its programme of inspection of regulated bodies (except in relation to hygiene and mental health services), the Minister recently announced that from 2015 the RQIA will commence a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland (Donaldson, 2014). While this should reduce the call on thematic reviews, this will have implications for the capacity and expertise of the authority in seeking to carry out this role change competently. The RQIA has also had a limited purview of general practice quality, with only a few reviews on such issues as revalidation readiness and after hours care noted.

A ubiquitous role in health and social care regulation for the RQIA should be considered, including public and private hospitals, aged care, mental health and primary and community care and support, that creates a uniform platform for regulation and common standards for quality and safety across government and non-government providers. This would provide coherency to the system of regulation, inspection and assessment and offers up greater opportunities to comment and influence on the system's ability to respond in co-ordinated ways to the health and social care needs of the community.

In addition to the scope of regulation, inspection and assessment functions of the RQIA consideration should be given to the approach taken by the regulator in undertaking an extended assessment role. Significant expertise and capacity development will be required to take on this broader role and an expert review of international inspection methods and processes would enable "best practice" approaches to acute and primary care accreditation and external inspection to be considered and appropriately integrated.

In Australia, the Australian Council on Healthcare Standards (major non-government health care accreditation agency) established the Clinical Indicator Program over 20 years ago. Over time the organisation has developed a robust suite of clinical indicators and a database of member indicator data. The service provides an analysis and reporting service to member health care organisations and facilitates national clinical benchmarking using comparative information on the processes and outcomes of health care. Data are aggregated and analysed twice yearly and results are provided in the form of comparative reports. These reports compare results across all contributing organisations as well as providing a comparison with "peer" organisations based on a number of variables (ACHS, 2013). The Health Roundtable is another non-government organisation in Australia that provides executive opportunities for benchmarking and sharing health care intelligence and innovation.

Greater efforts to create whole of system learning and performance improvement are required

The current governance structure for the health and social services system in Northern Ireland provides for coherency and alignment of population based planning, commissioning and service delivery functions. However, there are signs this structural coherency has fostered the development of five relatively self-sufficient and somewhat separate care systems. Without careful corrective policy action, there is a risk this structure will increasingly work against system-wide consistency in quality performance and the sharing and learning on innovation that is vital for strong quality improvement.

A lack of standardisation of approach to learning and performance improvement across the system was evident, with high levels of performance variability between trusts, lack of standardised reporting and limited opportunities and incentives to move beyond individual trust boundaries and services to compare and improve quality and safety. Sir

Liam Donaldson in considering current service configurations in his recent review of quality governance noted that despite its small size, “there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme” (2014).

While support of local solutions to common challenges is a considered strength of the Northern Ireland system, there are indications that a greater focus on a whole of system framework for quality and safety improvement and more rigorous standardised performance monitoring across the system is required. This issue is picked up in more detail in Section 4.8. This would present opportunities for greater comparison of performance across trusts and facilitate benchmarking of services to better understand what is driving differences in performance and broaden uptake of innovative local practices.

There is significant scope for the RQIA to take a stronger role in quality improvement, and in conjunction with the development of greater quality and safety intelligence function, could provide the basis for a robust benchmarking programme across health and social services for Northern Ireland. Such a programme, would routinely bring trusts together to consider data and other information to identify good performance and then undertake collaborative activities to understand and share underlying success factors and promote the potential for diffusion across the system.

4.5. Authorisation of medical devices and pharmaceuticals

The regulation of medicines and medical devices is UK-wide. As the UK competent authority, the Medicines and Healthcare Products Regulatory Agency co-operates with the devolved administration in Northern Ireland in carrying out its functions. Medical device management policy exists at the trust level to provide a systematic approach to the acquisition, deployment, maintenance, repair and disposal of medical devices. The Medicines Regulatory Group is responsible for medicines control in Northern Ireland.

Well-established legislative and regulatory processes exist to ensure medical device and medication safety in Northern Ireland

The Medicines and Healthcare Products Regulatory Agency (MHRA) regulates medicines and medical devices across the United Kingdom. The agency is responsible for ensuring that medicines and medical devices meet applicable standards of safety, quality and effectiveness and that the supply chain is made safer over time. The Agency supports research and helps educate the public and health professionals about the risk and benefits of medicines and medical devices in efforts to improve safety and effective use.

As the UK competent authority, the Agency ensures manufacturers meet relevant UK legislation by monitoring adverse incidents, approving clinical trials, auditing relevant bodies, registering classes of medical devices and undertaking compliance and enforcement action. Investigation of adverse incidents may result in the issue of safety warnings and the provision of advice and guidance on safety and quality issues. The MHRA co-operates with the devolved administration of Northern Ireland in carrying out its functions. For example, The Northern Ireland Adverse Incident Centre, a functional arm of the DHSSPS, acts as a regional centre for reporting and investigating adverse incidents involving medical devices and non-medical equipment.

Medical device management policy exists for the Health and Social Care Trusts to provide a systematic approach to the acquisition, deployment, maintenance, repair and disposal of medical devices and medical device training. The monitoring of organisational performance on medical device management is important to minimise or eliminate risks to patients and staff. The Northern Ireland DHSSPS has established a suite of 22 standards, known as the Controls Assurance Standards, to support the embedding of organisation-wide risk management in health and social care bodies. In addition to issues relating to environmental management, emergency planning and financial management, the Controls Assurance Standards cover medical devices and equipment and medicines management.

Compliance with the standards is measured by a system of annual self-assessment by health and social care bodies within the parameters issued by the health and social care bodies. Where self-assessment indicates compliance is below the threshold set down by the DHSSPS, action plans indicating how the body plans to improve and attain a sufficient level of compliance are requested.

The Medicines Regulatory Group is responsible, on behalf of the Minister of Health, Social Services and Public Safety, for medicines control in Northern Ireland, including the monitoring of the production, import/export, possession, supply and administration of controlled drugs and other medicinal products. DHSSPS has a statutory obligation to ensure compliance with legislative requirements in all areas of medicines control as applies to health and social care.

DHSSPS, through the Medicines Regulatory Group, has key responsibility under all medicines related legislation in Northern Ireland. The legislative responsibility concerns achieving compliance with national and international legislative requirements including those imposed by the Single Convention on Narcotic Drugs 1961, the Convention on Psychotropic Substances 1971 and EC Marketing Authorisation Medicines directives namely "The Rules Governing Medicinal Products in the European Community".

The principal national medicines legislation under which the department acts is the Medicines Act 1968 and the Misuse of Drugs Act 1971 together with their attendant subordinate legislation. Other legislation includes the Pharmacy (Northern Ireland) Order 1976, the Poisons (Northern Ireland) Order 1976 and the Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009. It also embraces joint responsibility with the Department of Agriculture and Rural Development (DARD) for the Veterinary Medicines Regulations 2011 and with the Medicines Healthcare Products Regulatory Agency (MHRA) in ensuring compliance with codes of practice and works closely with the Police Service of Northern Ireland in enforcing the precursor chemicals legislation.

4.6. Development and use of standards and guidelines

Northern Ireland has a wide range standards and guidelines for the health and social care system that are generated from a variety of sources and intended for a number of purposes. There is scope to strengthen the objectives for clinical and quality standards in the system, including clarification of priorities for implementation and adherence and expected levels of accountability.

Clearer system expectations for adherence to clinical standards and more effective performance monitoring required

The DHSSPS has a wide range of interwoven standards and guidelines that are generated from a variety of sources and intended for a number of purposes, including:

- *Minimum care standards*: focus on safety and quality of care of regulated organisations. They are designed to address unacceptable variations in the standard of care and improve quality. These standards are used by RQIA in carrying out its regulatory functions.
- *Quality standards*: focus on overarching standards of good governance and best practice across health and social care services. These standards are used by RQIA in carrying out clinical and social care governance reviews.
- *Controls assurance standards*: focus on embedding risk management in HPSS bodies, including key areas of risk for patient safety (e.g. infection control, medicines management).

- *Service frameworks*: focus on care standards for broad health priorities (e.g. cardiovascular health, mental health). They reflect the relevant evidence base, together with the view of frontline staff and stakeholders on best practice. These standards are used by RQIA, HSCB and providers to commission care, evaluate performance and monitor care.
- *NICE guidance*: focuses on clinical guidelines for individual conditions developed by National Institute for Health and Care Excellence and adopted by the DHSSPS.
- *GAIN guidance*: focus on regional guidance by the Guidelines and Audit Implementation Network (GAIN) where no clinical best practice guidance is available or planned (see Section 4.7).

Stakeholders expressed confusion over responsibilities and accountabilities for compliance with the existing range of standards in the system. Further, in the face of feeling overburdened with requirements, the need for clearer indications of the priorities for improvement was indicated. Particular clarification was sought over the status and priority of NICE guidance, in relation to other standards in the system.

As indicated elsewhere in this report, Northern Ireland could strengthen the central leadership role of the DHSSPS in quality and safety governance for the system, by identifying stronger central performance accountability for quality policy implementation and outcomes and building capacity to routinely monitor and assess quality and safety performance improvement.

A high priority task for the department is policy development to further clarify and amplify the objectives for clinical and quality standards for NI, the process of adoption of the standards, priority setting for the system and levels of accountability for adherence, for example through routine clinical indicator monitoring, GAIN audit and/or the RQIA review processes. There would appear scope for greater articulation and strategic framing of the current range of standards and guidelines in the system, to facilitate a more co-ordinated approach to overall standard configuration, endorsement and monitoring. A core set of quality and clinical and social care standards should be established, with clear expectations regarding compliance and reporting communicated to providers as a matter of priority.

Sweden has a well-established programme for quality guidelines that links priority setting in the system to the guideline agenda. Implementation and regular evaluation of compliance is an integral part of the programme (see Box 4.2).

Box 4.2. National Guidelines in Sweden

There are a number of evidence based national guidelines produced by the National Board of Health and Welfare. The guidelines are intended to help health care providers to use resources efficiently, allocate resources where they are needed and make systematic and transparent decisions about setting priorities. In Sweden the development of guidelines is not just the activity of single professional disciplines but a system-wide effort to incorporate notions of evidence-based medicine, cost-effectiveness, multi-disciplinary perspectives and priority setting.

The emphasis is on developing guidance rather than issuing standards. In this respect this part of the work of the National Board bears similarities with the guideline and technology assessment programmes of National Institute of Health and Care Excellence (NICE) in England and the Haute Autorité de Santé (HAS) in France. The idea is that these assessments form the basis for the setting of priorities within Swedish health care, acknowledging the local decision-making freedom. There is also a national model for the transparent setting of priorities in health care.

For some activities recommended in guidelines, the government provides grants intended, among other things, to stimulate implementation of the guideline and encourage broader quality development in the particular clinical area addressed. New guidelines on dementia and schizophrenia, for example, were accompanied by such grants, disbursed to local government who were then free to use the additional funds as they best saw fit. The National Board of Health and Welfare conducts regular evaluations of compliance with the national guidelines, repeated after around three to four years and focused on those aspects of care deemed to have major need for improvement. The results of these evaluations are presented in the form of recommendations to the county councils, regions, hospitals and municipalities, and the goal is that the recommendations form the basis for local initiatives to improve the quality of care (OECD, 2013).

4.7. Audits and peer review

The Guidelines and Audit Implementation Network (GAIN) is responsible for clinical audit, some regional guidance and medical device evaluation in Northern Ireland.

The role and status of the GAIN in clinical audit needs to be clarified

Clinical audit is the systematic review and evaluation of current practice against research based standards with a view to improving clinical care for service users. Clinical audit is a multi-disciplinary activity involving clinicians and managers responsible for the care and services being reviewed, with patients, consumers and carers fully involved wherever possible. Clinical audits should follow the patient journey which may require working across sectors, for example within primary, secondary and tertiary health and social care organisations (Healthcare Quality Improvement Partnership, 2009).

The Guidelines and Audit Implementation Network (GAIN) is responsible for clinical audit, some regional guidance and medical device evaluation in Northern Ireland. The organisation was established in 2007. Previously clinical audit had been the remit of a number of disparate bodies in the health and social care system including the Clinical Resource Efficiency Support Team, Northern Ireland Regional Audit Advisory and Regional Multi-professional Audit Group. The GAIN has published a number of clinical audits since its inception and provides clinical audit training to health and social care staff.

Although GAIN is funded by the DHSSPS the outputs of the organisation are not formally endorsed by the department. It is also not clear how the role of the RQIA and audit activities of the GAIN articulate. For example, the recent review of stroke services by the RQIA adopted a methodology that is well aligned with a clinical audit approach, perhaps with the exception of detailed clinical record review, and involved an assessment of services in line with the DHSSPS *Strategy – Improving Stroke Services* in Northern Ireland (RQIA, 2014a). The status and role of GAIN in auditing compliance of their regional guidance requires clarification, noting (for example) the RQIA recent review of the implementation of GAIN guidelines for people with a learning disability (RQIA, 2014b).

From 1st April 2015 GAIN was transferred to the RQIA following an independent review of its functions. This should provide a basis for clarifying the status of the role of the GAIN.

4.8. Public reporting of quality and performance

Northern Ireland has established a process whereby the performance objectives of the government for health and social care services are translated into performance measures and indicators for providers, including quality and safety of care. The development a more robust set of quality and safety indicators for inclusion in the core performance monitoring functions of the system is indicated. While the core set of indicators may require marginal changes to reflect emerging longer term strategic priorities for the portfolio, they should be relatively stable in order that for longer term targets and monitoring to be established at both the system and trust level. A range of reports and data on system and service performance are provided in the public domain, but there is scope for greater coherency in reporting and a stronger focus on quality and outcomes. Development of a dedicated public reporting website with user friendly access to relevant information at system and local provider levels would improve system transparency.

Stable core set of quality and safety indicators needs to be integrated into the performance framework of the department

The Department of Health, Social Services and Public Safety leads on the Programme of Government commitments relevant to the portfolio. The department has strategic control of care and issues to the Health Services and Social Care Board each year:

- A Commissioning Plan Direction (CPD), which sets out the Minister's priorities and details specific standards and taets that should be delivered by health and social care.
- An Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance.

The Health & Social Care Board, including the five Local Commissioning Groups (LCGs), and the Public Health Agency (PHA) are tasked with commissioning the services to improve the health and social wellbeing of local populations, to meet the assessed needs of those populations, and deliver Ministerial Standards and Targets. This is achieved through the Commissioning Plan, which sets out how available resources will be used equitably to meet the relative health and social care needs of local populations and commission services to meet needs and deliver on ministerial priorities. The HSCB, working with Trusts, manages performance and service improvement against ministerial priorities.

The HSCB monitors performance through a series of monthly meetings with the HSC. The DHSSPS, in addition to its on-going sponsorship role, convenes formal accountability and assurance meetings with each of its Arm's Length Bodies twice a year. The extent to which these discussions integrate consideration of quality, budget and access performance and are referenced to an assessment of performance across the Commissioning Plan Standards and Targets and/or Indicators of Performance Direction is not clear. However, together, the indicators and targets do provide a sound basis for developing a stable and robust high-level performance dashboard for the health and social care system and for the DHSSPS to structure a performance review process.

While it is recognised that Commissioning Plan Direction confines itself to key areas of focus for the year in question and the Indicators of Performance represent a wider suite of measures to gauge performance across the full range of domains the department is responsible for, greater articulation and alignment between shorter term priorities and broader performance measures is required. In 2014-15 indicators and targets were included in the Commissioning Plan Direction on areas that were not included in Indicators of Performance Direction (e.g. bowel screening, health care acquired infections) and indicator specifications existed that did not align (e.g. patient and ambulance turnaround times). While Northern Ireland has sought to separate its systems of performance management from quality improvement, it is unclear why key quality and safety indicators reflected in both the Indicators of Performance Direction and the Quality Reports of the Trusts (e.g. Hospital Standardised Mortality Ratio) are not more closely aligned and supported through appropriate performance targets in the annual Commissioning Plan Direction.

A review of the existing indicators and targets is required to ensure they are:

- limited to high priority strategic issues
- manageable in number for regular executive review
- appropriately balanced across key performance domains
- responsive to strategic operational performance, including general practice
- able to be reported regularly and in a timely manner.

While the performance dashboard may require marginal changes to reflect emerging longer term strategic priorities for the portfolio, they should be relatively stable in order that for longer term targets and monitoring to be established at both the system and trust level. DHSSPS should manage the development of standardised suites of indicators that cascade down from the dashboard to assist service level performance monitoring and facilitate more detailed comparisons across trusts and primary care providers.

Priority should be given to developing a more robust set of quality and safety indicators for inclusion in the dashboard, including priority indicators requiring information systems development. Consideration should be given to further clinical indicators to support clinical guideline uptake. Reference could be made to developments internationally. For example, the National Indicator Project in Denmark has developed clinical indicators for nine conditions (including stroke, heart failure, lung cancer, COPD and schizophrenia) and publishes these on an e-portal by hospital and an annual report on each condition is provided in the public domain (RAND, 2011, p. 28). The annual Quality Reports that have recently been published by trusts provide a good initial basis to build quality reporting.

As part of a broader review of the quality governance arrangements, the role of the Quality2020 Steering Group should be strengthened to include consideration of the system-level performance dashboard, identification of opportunities for learning and sharing good practices and receipt of reports on internal reviews and action taken to address systemic issues of concern.

Early developments in public reporting are promising but greater coherency and improved access is required

The public access to data and information on the quality and safety of their health and social care services is principally achieved through the DHSSPS and the Health and Social Care Trust websites, along with some annual reports.

The development of "Health and Social Care Trust Annual Quality Reports" has flowed from the implementation plan of the *Quality 2020* strategy with the initial publications by trusts occurring in 2014. Although the reports vary in presentation, they all provide a range of data and information across a standard set of themes of:

- effective health and social care
- delivering best practice in safe health and social care settings
- protecting people from avoidable harm
- ensuring people have positive experience of service
- staff health and wellbeing.

While these documents mark a significant step in providing public access to quality of care information in Northern Ireland the relative lack of comparisons in performance across the system, the significant lag time in publication and the frequency of reporting detract from the usefulness of the reports at this early stage. Review of these reports by the Patient and Client Council to assess consumer views on the understandability and usefulness of these reports, if not already carried out, would be a worthwhile exercise to guide ongoing development.

A wide range of data and information is also available from the Information and Analysis portal on the DHSSPS website, including social, health inequalities, family health services, hospitals, lifestyle choices and behaviours, the Quality and Outcomes Framework, workforce, mental health and learning disabilities, quality and safety and trust performance.

The data and information on safety and quality is very limited providing some data and reports on negligence, patient satisfaction, complaints and patient experience. More meaningful data is located in the trust performance section of the portal, where an interactive atlas of performance across the trusts enables access to data on approximately 40 performance indicators in five domains that appear to be reflective of the DHSSPS Indicator of Performance Direction, although this was difficult to verify.

Although many of the indicators pertain to access issues and there is a preponderance on waiting times for care, the indicators include some more centrally relevant quality and safety indicators including hip fracture treatment within 48 hours, bowel cancer screening uptake rates, timely commencement of treatment of suspected cancer patients and proportion of stoke patients who receive thrombolysis. For most indicators 2012-13 monthly data is provided by trust, enabling capacity for (albeit limited) system-wide comparisons. Data are not presented by hospital or service and variation data by provider are not available.

While it is difficult to determine whether this data form the basis of stable and central dashboard of indicators, there are indications they are considered in executive performance review meetings at least twice a year. It is noted that the safety and quality indicators in this suite of indicators do not align with the metrics presented in the Quality Reports prepared by the trusts and in this way the collective information provided by the system is both confusing and relatively difficult to appraise.

There is an urgent need for the DHSSPS to develop a robust suite of quality and safety indicators that can be integrated into a stable dashboard of indicators for the system, that at least reflect cost, quality and access issues. These indicators should draw on the key databases available to the DHSSPS including adverse event monitoring, complaints, hospital administrative databases clinical registries (e.g. hip surgery), patient experiences to provide a balance of indicators across effectiveness, safety and patient responsiveness domains.

System performance framework development that articulates with frameworks for each of the services sectors would help guide the establishment of this dashboard, and open up opportunities to monitor performance in relation to quality improvement related to service integration. The inclusion of general practice data will be critical to this process, particularly in regards to management of chronic conditions in the community. Other countries, including Canada (Canadian Institute for Health Information, 2012) have been developing systems-based performance frameworks to guideline indicator data collection and reporting.

Northern Ireland should consider the development of a dedicated public reporting website, providing well organised performance data and reports on a suite of indicators that cover cost, quality and access. In Canada the *Your Health System* (see Box 2.6, Chapter 2), Australian *My Hospital* and the US (see Box 4.3) the *Hospital Compare* websites provide examples of how countries have developed public access to comparative system performance data.

Box 4.3. Public Reporting of Hospital Performance in the United States

The US Hospital Quality Initiative uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The main objective is to distribute easy to understand data on hospital performance, quality information from the consumer perspectives, and payment and volume data. As part of this initiative, Hospital Compare (www.medicare.gov/hospitalcompare/search.html) provides a dedicated user-friendly website to enable the public to directly compare hospitals performance over 80 indicators. The indicators presented on the website are reflective of contemporary dimensions of hospital performance including:

- patient centredness (patient experiences measures based on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey)
- effectiveness (both clinical process and outcome indicators for specific conditions including AMI, heart failure, stroke, surgical care, preventative care)
- appropriateness (medical imaging utilisation rates including MRI, mammography, CT and cardiac imaging)
- safety (postoperative complications including DVT or PE, accidental puncture)
- timeliness (emergency department waiting times)
- continuity or co-ordination of care (readmission rates)
- activity and expenditure (including Medicare payments and discharges for selected DRGs).

4.9. Patient and public involvement in improving health care quality

Northern Ireland has established a legislative basis for personal and public involvement in health and social cares services, which requires services to involve the public and consult with patients in service development and provision. A network of involvement groups exists across the system to help improve service responsiveness and the *10,000 Voices* survey has been conducted to better understand the experiences of patients, carers and families in receiving care. A well-established system for patient complaints exist that could be more effectively used to monitor performance and inform quality and safety improvements. The Patient and Client Council is responsible for ensuring a strong patient and client voice at both regional and local levels and for strengthening public involvement in decisions about care. The further development of patient and public involvement in health and social care is being explored through the *Transforming Your Care* reform agenda, including personalised budgets and self-directed support.

Patients in Northern Ireland have a legislative right to be involved in the care system

Northern Ireland established a legislative basis for personal and public involvement in health and social cares services in 2009 through the Health and Social Care (Reform) Act (Northern Ireland). It places a statutory obligation on health and social care organisations and the DHSSPS to involve the public and consult with them in relation to their care and requires them to develop a consultation scheme that sets out how the organisation involves and consults with patients, clients, carers and the Patient and Client Council. Each organisation has published a consultation scheme. For example, the Belfast Health and Social Care Trust hosts on its website a publication entitled *Involving You* which sets out their framework for community development and user involvement.

The Public Health Agency co-ordinates a network of personal and public involvement groups that have been established in each health and social care organisation with representation from patients, clients, carers and community organisations and senior trust staff. While the potential of this network to improve service responsiveness is evident, it is not clear how the network's activities link with other patient-centred initiatives (e.g. Improving the Patients and Client Experience Standards, Patient and Client Council, 10,000 Voices, PROMS, Friends and Family Test and complaints intelligence) and reports through to the DHSSPS to build a coherent approach to service improvement.

The Public Health Agency has been conducting the *10,000 Voices* survey to better understand the experiences of patients, carers and families of the health and social care services in Northern Ireland. The survey commenced in mid-2013 and provides consumers an avenue to express what they liked and did not like about their service experiences. The insights from this survey, along with the evaluation of similar surveys in other countries, could have significant value for guiding service improvement and developing ongoing consumer feedback mechanisms. The interim results of this survey have not been published to date and it is not clear what feedback is planned for respondents, in terms of being informed of the overall findings from the survey.

The application of patient reported outcomes (PROMS) in Northern Ireland is still at early stages of development, with ongoing work currently focused on initial survey development. PROMS are intended to calculate health outcomes, as measured from the patient's point of view. Countries like Sweden have been pioneering the use of PROMS for specific procedures such as hip and knee replacements and groin hernia and varicose vein repair. Care should be taken to ensure the progression of work on PROMS in Northern Ireland is integrated into the overall quality and safety strategy for the system, given its significant potential to provide an additional perspective on service quality that can be brought together with clinical indicators and measures of patient experience to provide a richer intelligence for service improvements.

Public reporting and systematic use of complaints data could be improved

Northern Ireland has well-established complaints policies and procedures which require health and social services to have effective processes and procedures in place to facilitate the making of a complaint (including their right to complaint to the Northern Ireland Ombudsman), resolve complaints locally where possible, enable organisational learning and provide regular performance reports through the Health and Social Care Board to the DHSSPS.

Quarterly reporting to the DHSSPS includes data on the number of complaints, the nature of the complaint by category, response times and learning outcomes. All health and social care services and the Health and Social Care Board must publish an annual report on complaints and provision is made for copies to be provided to the RQIA and Patient and Client Council. While a regional breakdown of complaints statistics is to be provided via the DHSSPS website (DHSSPS, 2009) on an annual basis the visibility of this information could be improved through greater integration and amplification in overall system performance reporting.

The Health and Social Care Board plays a central role in monitoring trends in complaints and ensuring the proper functioning of the complaints systems within the trusts. In line with other recommendations in this report to strengthen the leadership role of the DHSSP in quality and safety and the development of a central intelligence function, the development of a more robust central complaints database with enhanced capacity to monitor patterns and trends is required. The development of key performance indicators (e.g. outcome and resolution rates, response times, number of complaints by category) and integration into overall system performance safety and quality performance accountabilities could allow greater triangulation for identification of emerging patient safety issues and give greater impetus for improvements in responsiveness of services to patients concerns.

The Patient and Client Council is the main health and social care consumer organisation in Northern Ireland. It is responsible for ensuring a strong patient and client voice at both regional and local levels and for strengthening public involvement in decisions about care. The Council is supported by five local offices that operate within the same geographical areas as the Local Commissioning Groups and Health and Social Care Trusts.

A particular priority for the organisation is to improve the timing and nature of feedback to patients. There are concerns that complaints resolution is too inward looking, catering more to deal with staff issues and organisational learning than being focused on the patient's needs for feedback and the community's needs for information on the quality of services. While significant support exists for DHSSPS efforts to capture patient experiences through initiatives such as 10,000 Voices and the Family and Friends Test, a stronger feedback loop on the results and implications for assessing local services is required back to the community.

The further development of patient and public involvement in health and social care is being explored through the *Transforming Your Care* reform agenda. For example, personalised budgets or self-directed support are being considered to better enable care to be designed to deliver the outcomes patients and their families want. This would extend beyond the existing model for social care clients where the Direct Payments system in Northern Ireland promotes and supports people in managing their own budgets to purchase services or employ support staff (DHSSPS, 2011). This is a particularly interesting development and one that could potentially drive significant changes in service delivery arrangements in segments of the health and social care system.

4.10. Use of financial incentives to improve quality

The commissioning process for health and social care services in Northern Ireland provides the principal avenue for developing and applying financial incentives to improve the quality and outcomes of the services provided through the trusts. Pursuance of Pay for Performance and other value-driven payment approaches have not been extensively explored in Northern Ireland to date. Scope exists to consider funding alignment and incentives to support resource reallocations and service development in primary care to support the *Transforming Your Care* agenda.

Commissioning process needs to explore brave and innovative funding incentives to support primary care reform and hospital quality improvement

The use of financial incentives to improve quality in the Northern Ireland health and social services system are largely framed through the annual commissioning process of the Health and Social Care Board. The HSCB has responsibility for the commissioning arrangements with Health and Social Care Trusts and managing the contract for General Medical Services (which provides funding for general practice) in providing the health and social care services of the system.

The DHSSPS provides strategic direction and identifies priorities for service delivery each year through a Commissioning Plan Direction. This is accompanied by an Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance. The HSCB then translates these directions into an annual Commissioning Plan, which sets out the system-wide programmes and initiatives and financial allocations and performance requirements of the five regional Health and Social Care Trusts.

The Commissioning Plan for 2014-15 is nearly 600 pages long and provides a comprehensive reflection of the demographic, social and economic factors impacting on the system, along with a descriptive account of key government policies and programmes in health and social care. Strategies and actions for the current year are identified along with financial allocations at the system level and for individual Trusts. While this document lays transparent the rationale and details of the current allocations and deliverables expected on the system, it does convey a rather complex and crowded set of priorities and relies on a high degree of programmatic specification rather than accountability for broader outcomes. While the indicators specified in the Indicators of Performance Direction are mentioned there is no apparent articulation with the commissioning outcomes being sought or specification of specific targets in the plan.

Three key observations are made in relation to incentives for improving quality. First, incentives to improve clinical quality data, care processes or outcomes through targeted payment arrangements are not specified. Second, opportunities to shift resources from the acute sector to the community sector are identified and quantified but fall short of firm targets for systemic reallocation and clear system-wide strategies for liberating funding from acute, general practice and community care, including for example, through funds pooling arrangements to support the business model for Integrated Care Partnerships. Thirdly the differing population share of resources across Trusts is identified but strategic incentives to bring resource requirements in line with population targets were not evident, including targeted service developments and acute pricing policy to incentivise convergence of unit costs.

Funding for acute, primary care and social care are largely managed in silos with historical allocations and only marginal consideration of opening up funds for contestability at the margins. Further, primary care funding to general practice is taken up in separate arrangements and while central to the *Transforming Your Care* agenda, reforms to the payment methods and funding arrangements along with other primary and community care providers is not evident. The Commissioning Plan tends to be more descriptive than strategic in configuring the funding and purchasing of services to deliver on the governments priorities.

A number of OECD countries have been exploring innovative payment systems over recent years to harness greater service value from the resources devoted to health and social care, including a wide variety of Pay for Performance, Bundled Payment and Practice Incentive arrangements. For example, in Australia the Western Australian Government provides incentive payments to increase appropriate use of hospital stroke units (see Box 4.4). The existing Quality Outcomes Framework and blended payments system for general practice across the NHS is an example of these arrangements, and one Northern Ireland should review to consider alignment with current policy directions under the Transforming Your Care agenda.

Box 4.4. Australian Pay for Performance Programs

The Western Australian Department of Health introduced the Performance-Based Premium Payment Program in 2012-13 to improve sustainability of clinical practice improvements within the over performance management and funding framework.

The programme has been designed to:

- recognise and reward services which provide a very high level of best evidence-based care
- reimburse service providers for any additional costs and tasks associated with participation in the scheme, including data collection and submission.

Clinical areas are selected for inclusion in the programme using the following criteria:

- A strong evidence base and clinical consensus on the characteristics of best practice
- High impact, i.e. variation in practice, gap between best evidence and current practice, high volumes or significant impact on outcomes
- Availability and quality of data.

The programme is open to hospitals funded by the Department of Health. Participation is not mandatory and hospitals are only eligible for payment if the required data is submitted.

Each year, the performance-based premium payments and incentive models are reviewed and assessed for their effectiveness in creating and maintaining clinical practice improvements in high priority care areas. This review will result in adjustments to existing payments, and the introduction of new payments for priority clinical areas (Department of Health Western Australia, 2013). Key areas that have been targeted to date are hip fracture, stroke and healthcare associated infection.

For example: An AUD 200 payment is awarded to hospitals for each patient admitted into a designated stroke unit and where the unit treats at least 65% of stroke patients at any time during their admission in a quarter.

The aim of this payment is to ensure appropriate admission to a designated stroke unit for patients suffering stroke. The National Stroke Audit in Australia revealed that in Western Australian hospitals with a stroke unit, only 56% of patients were on the stroke unit on the day of survey, compared to a national rate of 71% (Department of Health Western Australia, 2012, p. 19)

Similar quality based payments systems are continuing to being explored in in other parts of Australia. For example, Queensland has trialled the withholding of payments for “never events”, financial penalties for adverse events (i.e. infections, pressure ulcers) and quality improvement payments for improved access to quality care (e.g. stoke care).

4.11. Patient safety initiatives

The Public Health Agency has primary operational responsibility for patient safety. The Health and Social Care Safety Forum was established to support health and social care organisations in providing safe, high quality care. A well-established adverse incident monitoring system exists and in conjunction with the Public Health Agency, the Health and Social Care Board is responsible for management and follow up of serious adverse incidents in accordance with documented guidance. Strategies for improved safety in priority areas also exist, for example, *Changing the Culture 2010* is Northern Ireland's strategy and action plan for the prevention and control of health care-associated infections. There is recognition that a significant deficit in leadership skills for quality improvement and safety exists across the system. To help address this situation the *Leadership Attributes Framework* has been developed.

A more central role for the department would further strengthen Northern Ireland's robust approach to patient safety

The Public Health Agency has primary operational responsibility for patient safety. The Chief Medical Officer established the Health and Social Care Safety Forum in 2007 to support health and social care organisations in providing safe, high quality care. It became part of The PHA on the latter's establishment in 2009. The HSC Safety Forum:

- works collaboratively with stakeholders to assist improvement in safety and quality in health and social care
- helps service providers build and develop their quality improvement capability in line with internationally recognised theory and practice
- facilitates engagement between patients, clients, commissioners and service providers in order to promote safety and quality.

The HSC Safety Forum uses a variety of facilitative approaches, which include:

- enhancement of knowledge on safety, quality and improvement science within the system
- providing exposure to nationally and internationally recognised experts in the field
- acting as a conduit for the sharing of best practice
- hosting collaborative working
- directly supporting improvement initiatives within health and social care organisations.

The responsibility for HSC Safety Forum and the broader safety and quality activities of the PHA, including patient involvement and experiences work, lies with the Director of Nursing, Midwifery and Allied Health Professionals. Notwithstanding the quality and dedication of staff working in the PHA, a clearer integration point is required for quality and safety in the system, where data and intelligence are brought together (including adverse events, complaints, clinical indicators, clinical audit and review and patient experiences) to monitor performance and identify emerging patient safety and quality issues. This needs to be coupled with a strong system of advice and support for health services and frontline staff to assist in learning, diffusion of innovations and improve practice.

As indicated earlier in this report the existing roles and responsibilities across the DHSSPS and other key bodies, including the HSCB, PHA, RQIA and GAIN, are confusing and require review. For example, the respective roles of the Chief Medical Officer, Chief Social Services Officer as professional advisors to the government in the DHSSPS and the responsibility of the Directorate of Nursing and Allied Health Professions within the governance framework on quality and safety in Northern Ireland should be clarified, given the operational role played by the Public Health Agency presently. Further, while effective collaboration between the HSCB and PHA is noted (for example, on Serious Adverse Incidents), current legislative responsibility for service performance lies with the HSCB, which may further confuse responsibility for quality and safety governance for key stakeholders in the system.

Recommendations in this report seek to create greater visibility and capacity to the DHSSPS for quality and safety vis a vis other bodies in the system. The need for clear and strong leadership is vital for improvement and greater involvement and accountability for these functions centrally will reduce existing ambiguity concerns of stakeholders. Further coherency to this direction could also be achieved by clarifying and strengthening the role of the Chief Medical Officer and/or the Chief Nursing Officer in the DHSSPS, including greater visibility over regional leadership on quality and safety.

System-wide aggregation of adverse incident data would improve system surveillance on safety issues

Health and social care bodies have well-established adverse incident monitoring systems and in conjunction with the Public Health Agency, the HSCB is responsible for management and follow up of serious adverse incidents in accordance with documented guidance. The HSCB works to ensure the learning from trends in incidence data and investigations with a regional application are effectively disseminated, including the issuing of safety alerts. Health and social services in each trust have established Mortality and Morbidity Meetings as a basis for bringing people together from different disciplines to consider incidents and complaints and further generate and share system learning.

The use of adverse incidence data for performance reporting purposes is challenging. As with other countries, Northern Ireland is looking to improve overall incident reporting levels whilst being assured that through system learning and the application of safe practices, the quality and safety of care is improving. Accountability systems based on adverse incidents tend to be mandatory and limited to defined serious events (also known as sentinel events) such as unexpected death, transfusion reaction, and surgery on the wrong body part. These systems typically prompt improvements by requiring an investigation and root cause analysis of the event (WHO, 2005, p. 17).

The OECD Health Care Quality Indicators Project has been actively developing and reporting indicators of hospital care safety based on administrative dataset, including adverse events related to surgical complications and obstetric trauma (OECD, 2013, pp. 116-119) and countries are further developing systems to use such data to build system intelligence and integrate into reporting processes on safety issues. For example, the CHADx taxonomy developed by researchers at the University of Queensland in Australia and subsequent developments by the Australian Commission on Safety and Quality in Health Care (see Box 4.5).

Strategies for improved safety in priority areas have been developed for health and social care services in Northern Ireland, and include patient safety. For example, *Changing the Culture* 2010 is Northern Ireland's strategy and action plan for the prevention and control of health care-associated infections and commits the system to action in five key areas:

- making the patient environment safer
- surveillance of health care-associated infections
- tackling antimicrobial resistance
- improving accountability and public engagement
- research.

Since 2007 targets for the system have been set to reduce Clostridium difficile and MRSA and these targets are specified in the annual Commissioning Plan Direction, with each Health and Social Care Trust required to have an action plan in place for reducing health care-associated infections. As mentioned earlier in this report Controls Assurance Standards (as part of organisational risk-management) exist for specific patient safety issues, including infection prevention. Heightened priority to learn from major incidents and improve infection control has been generated as a result of special investigations and public enquiries, including an inquiry into deaths from Clostridium difficile in hospitals of the Northern Trust in 2011.

Box 4.5. Use of Administrative Data to Capture Adverse Events in Australia

CHADx is taxonomy developed by researchers at the University of Queensland in Australia that allows hospitals to classify adverse events captured in administrative datasets, as markers of patient safety. The occurrence of a hospital-acquired complication is identified using the condition onset flag.

The tool was developed for use within hospitals and not as a means for external monitoring of hospital activity and holding hospitals to account (Utz et al., 2012). It is indicated for use at the local level, to provide a broad safety screen to stimulate further investigation, as one component of a more comprehensive hospital safety monitoring programme.

A statistical analysis of the CHADx commissioned by Queensland Health concluded that the tool provides a comprehensive classification of hospital-acquired conditions that facilities can use to keep track of inpatient harm (Utz et al., 2012, p. 11). The reviewers indicated that through further development work the potential use of the tool could be expanded. Key developments include:

1. Risk adjustment to enable valid comparisons over time and across services,
2. Improved quality of Condition Present on Admission to ensure reliable reporting
3. Clinical review of the tool to evaluate the validity of conditions in relation broader application.

Although the clinical utility of the tool has recently been questioned, the CHADx represents a valuable advance in developing hospital-based patient safety information capacity based on routinely collected administrative data.

Further development work, under the auspice of the Australian Comission on Safety and Quality in Health Care and Independent Hospital Pricing Authority in Australia has recently led to the creation of an alternative classification scheme for “high priority hospital complications” that through further validation and development, including reliable risk-adjustment, could potentially enable it to be used in cross-facility and longitudinal comparisons.

4.12. Conclusions

Since devolution some 17 years ago, the Northern Ireland health and social care system has put in place many of the key institutions, policies and arrangements to enable sound assessment, assurance and improvement of quality and safety. To improve its effectiveness, the system now requires greater strategic leadership and a simplification of its governance structures to ensure the priorities for improvement and key strategies are clearly identified and communicated through the system. In line with its population, the system is small and displays an intimacy and trust in personal relationships that seem to prevail despite the intense scrutiny the health and social services provided face from the media and the steady flow of major reviews and investigations. There are indications the system comes together to address key safety and quality issues but more needs to be done to create a system-wide approach to performance. The five Health and Social Care Trusts have developed systems in quite different ways and there are limited opportunities for sharing and scaling up innovations and greater standardisation is needed to enable priorities for attention to be identified and performance monitored.

The Regulation and Quality Improvement Authority is well respected in its provision of a broad range of regulatory functions, including registration, inspection and review of health and social care services. However, there is scope to clarify and strengthen the role of the RQIA in the quality and safety governance landscape in Northern Ireland and build a more consistent regulatory approach across all health services, including those provided by Health and Social Care Trusts (particularly public hospital services) and general practice. It is not sufficient that central leadership capacity for quality and safety standards and improvement be boosted alone. Leadership skills and capabilities need to be distributed through the system from policy, commissioning, service management to frontline care providers. This needs to be well resourced and appropriate incentives for skills identification and acquisition provided. Additionally, clarifying quality and safety governance, creating greater system thinking, strengthening the role for the regulator, placing primary and community care more central to the *Transforming Your Care* agenda and workforce development and reform are key priorities for Northern Ireland to strengthen quality monitoring and improvement.

There is also a need to bring the clinical community, particularly general practitioners, into a more central place in leading primary and community care reform and informing further primary care policy development and service commissioning. It will be necessary to ensure continued development of robust business models and incentive schemes to encourage and sustain new models of primary care in the community that promote joined–up service provision and inter-disciplinary care. Strategic development of information systems needs to be aligned with developments under the *Transforming Your Care* agenda to support the clinical planning and delivery needs of the care team and improve accountability and performance monitoring. Primary care workforce capacity building is also required to enable the significant reforms to the service system envisioned in the *Transforming Your Care* strategy. There are opportunities to further explore innovative workforce models to cost-effectively transition the service system and build care capacity in the community. Care needs to be taken to ensure these models safeguard confidence in the quality of care.

Policy recommendations for Northern Ireland

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

1. Clarify quality and safety governance

- Strengthen the central voice of the DHSSPS on quality by underlining its responsibility for the overall development of health care quality and safety policy and outcomes in the Northern Ireland health and social care system, along with a stronger public face and executive mandate to ensure alignment of policy priorities with operational outcomes through performance accountability mechanisms and enhanced central quality monitoring and intelligence capacity;
- A priority task for the DHSSPS is to ensure clear and unambiguous communication of the objectives for clinical and quality standards for the health and social care system;
- Clarify the responsibilities for performance governance of the DHSSPS and the Health and Social Care Board, and strengthen the accountability of health and social care organizations for delivering the changes and outcomes envisioned in *Quality 2020* and the subsequent development of related implementation priorities and policy outcomes, including a robust suite of quality and safety indicators integrated into an overall system performance dashboard;
- Undertake a review of the governance of quality and safety at commissioning, trust and individual service levels to identify opportunities to simplify existing arrangements, improve their consistency across services and agencies and strengthen channels of communication;
- Establish and publish a simple unambiguous framework for quality and safety governance that clarifies the core roles and responsibilities, improves vertical alignment of accountabilities and promotes sharing and learning across the system. The governance structure for *Quality 2020* could form the basis from which to develop the framework.

2. Strengthen the system-wide approach to quality and safety

- Establish a more robust suite of quality and safety indicators for integration into the overall system performance dashboard, including budget compliance, activity and access indicators;
- Embed the suite of indicators in the performance governance functions of the DHSSPS and the Health and Social Care Board, and in the key accountabilities of health and social care organizations to provide the principal basis to monitor and assess safety and quality performance at the system level;

Policy recommendations for Northern Ireland *(cont.)*

- Specify core standardised indicator sets that support and articulate with the system dashboard and more directly align with operational priorities, including indicators aligned to primary care QOF;
- Mandate routine monitoring and reporting at the trust and regional primary care level through more frequent *Quality Reports*;
- Establish clear system level thresholds that can trigger internal service review and facilitate peer service benchmarking activities across the system. Opportunities for further comparison with other UK countries should be explored;
- Build upon the role of the Quality2020 Steering Group, as part of the reviewed governance arrangements, to strengthen its consideration of the system level performance dashboard, identification of opportunities for learning and sharing good practices, and receipt of reports on internal reviews and action taken to address systemic issues of concern;
- Establish formal reporting expectations between frontline services (for example, through Mortality and Morbidity Meetings) and the Quality and 2020 Steering Group.

3. Develop more robust and improvement-oriented regulation of core health services

- Amend legislation to extend and strengthen the regulatory powers of the RQIA:
  - Bring trusts and primary care into the central scope of the health service inspection and review functions of the RQIA, along with the existing range of health, aged care and social support services;
  - Establish a cycle of regular review and inspection of health services, according to assessed relative risk and impact on quality and safety of services;
  - Provider a stronger orientation to promoting continuous improvement and facilitating information sharing and learning across the system, including establishment of benchmarking forums and diffusion of innovations to improve quality and safety.
- Undertake a comprehensive review of the inspection and assessment framework of the RQIA giving consideration to approaches internationally that give greater emphasis to promoting continuous quality improvement, incorporate robust forms of self-assessment and involve benchmarking of clinical quality and safety metrics;
- Identify resource requirements to extend and strengthen the RQIA role including expanded capacity for inspections, specialised expertise in acute care and general practice and development and broader access to performance related datasets, clinical quality indicators and QOF. Opportunities for partnering arrangements with other regulators in the United Kingdom could be considered as part of this process;

Policy recommendations for Northern Ireland *(cont.)*

- Clarify reporting relationships with the DHSSPS central safety and quality function and clearly communicate the role of the RQIA to service providers and the public, to avoid ambiguity over central governance of safety and quality and align communication of key priorities for service improvement across the system.

4. Pursue greater structural integration in primary care

- Continue to develop a more prominent role for primary care and in particular seeking high-level input from the general practice community in the central policy and planning functions of the portfolio through the expansion of Integrated Care Partnerships and support for Federations of General Practice;

- Explore the potential to liberate funding within acute, primary and social care for use in scaling up innovative funding and service models aligned with the Transforming Your Care agenda, including stronger incentive programmes aimed at targeted patient population outcomes and promoting team based multidisciplinary care;

- Business models should be developed and seed funding made available for the evolution of GP Federations into comprehensive and sustainable multidisciplinary primary care services, leveraging and integrating the QOF into broader primary care priorities along with enhanced blended payment arrangements;

- Strengthen the capacity and focus of the information management functions on data linkage and electronic health record developments to better support the health information needs of clinicians and enable monitoring of service utilisation across acute, primary and community sectors.

5. Strive for greater development and innovation of the health workforce

- Build on the initial work for the Attributes Framework to establish greater distributed leadership capacity for quality and safety and overall system innovation and performance;

- Establish incentive programmes to attract and retain skills and expertise in strategic leadership areas of organisational culture, clinical benchmarking and new business development;

- Progress development of innovative workforce models, particularly extended roles for general practice based nurses and community pharmacists to enhance accessibility and sustainability of developments in integrated care and support services across the community.

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OECD Reviews of Health Care Quality

UNITED KINGDOM

RAISING STANDARDS

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Contents

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