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Best and Safest Care

REPORT ON THE QUALITY AND PATIENT SAFETY NATIONAL WORKSTREAM OF THE NHS NEXT STAGE REVIEW

The Chief Medical Officer and his team.
March 2008

CONTENTS

FOREWORD

Over the last ten years, there have been major improvements in the NHS resulting in better access and more choice for patients, clear management accountability, more freedom for local services to plan and innovate as well as a more transparent financial regime. There have been substantial increases in the resources devoted to the NHS – financial, workforce, information technology and equipment.

The next steps of reform need to place quality and safety of care at the heart of the NHS – its policies, its plans, the ways its services are designed, delivered and funded. A key element of the transformation required is inspiring, motivating and empowering local clinical teams to assure and improve the quality and safety of the services they provide to patients.

Each of the high performing teams we have studied as part of the work for the Next Stage Review has displayed extraordinary clinical leadership, coupled with a hunger to achieve excellence and a curiosity to find out how the team is performing compared to the best. We were told that the NHS currently has 'islands of excellence' in a sea of often mediocre performance.

When this view was reflected to an audience of clinical staff in Somerset, a nurse stood up and told us 'It is true that we have islands of excellence, but help us to build the bridges and ferry routes between them'.

In this report, we distil what we have learned about the state of quality and safety in the NHS. We acknowledge that the NHS quality framework built up over the last 10 years is greatly admired internationally. But we also make clear that quality and safety have not yet broken into the mainstream of the NHS.

We set out key proposals to take the next steps to turn the services the NHS provides from good to great.

Sir Liam Donaldson
Chief Medical Officer
14 March 2008

EXECUTIVE SUMMARY

- This is the report of the national work stream on quality and patient safety, one of the major inputs to the NHS Next Stage Review.

- It is the work of the Chief Medical Officer and his team, drawing on: the former's 25 year experience in the field of healthcare quality and safety; reviews of the present state of quality improvement in the NHS undertaken by three leading North American agencies; and in-depth studies of high performing services in the NHS and elsewhere.

- This report culminates in fourteen interlinked recommendations that in aim to make quality the currency of the NHS.

- Since 1998, the NHS has put in place and developed a framework for healthcare quality comprising: national standards (led by the National Institute for Health and Clinical Excellence and through National Service Frameworks); local clinical governance and a statutory duty of quality; robust mechanisms of inspection (overseen by the Healthcare Commission).

- In addition to this core framework, further action was taken to enhance the NHS approach to quality in the late 1990s and early 2000s. These included the establishment of a patient safety programme (led by the National Patient Safety Agency) and mechanisms to address poor practitioner performance (led by the National Clinical Assessment Service). Measures to identify and spread good practice and evidence of clinical effectiveness have included the work of the Modernisation Agency (later the Institute for Improvement and Innovation), the Collaborative Programme (notably the highly successful Primary Care Collaborative), the National Library for Health, and the NHS Research and Development programme. The Quality and Outcomes Framework linked to payment to general practitioners has also been used to promote high quality in primary care.

- This decade-long programme of work on quality and patient safety has begun to address long-standing problems within the NHS. Awareness has been raised throughout the NHS of the importance of quality and safety. A culture of clinical governance (certainly an intolerance of bad practice) has infused many parts of the NHS. Improvements have taken place as a result of compliance with key standards in particular fields of care (e.g. cancer, heart disease) and in the primary care sector through the Quality and Outcomes Framework. Attention has also been given to reforming traditional policies (e.g. on medical regulation and medical litigation) to orientate them more effectively to patient safety and quality assurance.

- Despite these changes, serious problems of quality and safety remain (many of which are shared by other healthcare systems around the world), for example:
  - extensive variation in standards of care persists around the country
  - avoidable risks and serious safety incidents have not been adequately controlled or eliminated
  - best practice and excellence is evident only in a minority of services
  - many patient complaints reveal ongoing problems such as bad interpersonal care and poor care coordination

- The overall aim of this strand of work is to mainstream quality and patient safety within all aspects of the work of the NHS:

in policy-making, in planning and commissioning, in design and delivery of services. The feedback from the internationally commissioned work showed major barriers that will need to be overcome if this transformation is to take place, for example:
- there are no quality improvement goals at system level
- there is a plethora of standards with confusion about their definition, use and importance
- information on clinical quality is poor, so too are clinical skills in improvement science and performance assessment
- there is a great absence of patients and family members in the planning and commissioning of services
- the commissioning function is not aligned to levering regular and sustained improvements in quality and patient safety

- The studies of high performing services provided a clear and consistent picture of the nature of clinical teams that deliver excellence on a day-to-day basis. The challenge is how to do this throughout the NHS not as described by one member of NHS staff as only in 'islands of excellence'.

- As a result of this context, experience and analysis, 14 proposals for action have been made aimed at:
  - establishing an accountability framework for quality and safety at the system level and applicable in all service settings
  - rationalising, defining and clarifying the standards used to drive higher quality, safer care and placing this in the hands of an independent, expert body
  - Simplifying the quality landscape to clarify roles, responsibilities and relationships of different bodies and agencies
  - Redesigning the funding flows and incentives within the NHS to reward higher quality and penalise poor or unsafe care
  - Laying down a set of duties and responsibilities for clinical teams to lead, deliver and demonstrate quality
  - Creating a patient safety initiative to take life-saving action to reduce catheter-related bloodstream infection nationwide and embed the use of evidence and measurement into patient safety measures in the NHS
  - Establishing within the new proposed system of regulation of health and social care services, a framework to promote higher quality care

- It is intended that the proposals in this report will help NHS Next Stage Review to make quality and safety the currency of the modern NHS in a way and on a scale that has not been possible in the past.

ABOUT THE REPORT

1. This report has been compiled by the Chief Medical Officer and his team at the request of Lord Darzi to assist in the NHS Next Stage Review that he was asked to undertake by the Prime Minister.

2. The report is the output of the national work stream on quality and patient safety, one of the Review's key programmes of work.

3. The inputs to this work have included:

   a. a series of commissioned pieces of work from leading North American health agencies – the Institute for Health Improvement (based in Boston), the Joint Commission (based in Chicago), and the RAND Corporation (based in Santa Monica);

   b. a short study tour of the East Coast of North America conducted by Lord Darzi and the Chief Medical Officer in November 2007;

   c. in-depth visits and analysis of five high performing NHS services in England: the stroke unit of Guy's and St Thomas' NHS Trust; the South Staffordshire mental health assertive outreach team at South Staffordshire and Shropshire NHS Foundation Trust; the cardiothoracic division at James Cook University Hospital, Middlesbrough; the general practice surgery in Puddletown, Dorset Primary Care Trust; and the paediatric oncology and bone marrow transplant service at the Bristol Royal Hospital for Children;

   d. front-line staff engagement events in Somerset and London;

   e. discussion with a national stakeholders group and a national working group.

4. With these inputs we set out in this report:

   a. the NHS quality journey so far;

   b. where we are now, and where will be in 10 years;

   c. the case for further change to the way that quality and safety are dealt with within the NHS;

   d. the cultural and practical barriers to the achievement of a state where quality and safety are mainstream activities of all NHS organisations and staff;

   e. proposals for achieving the transformation required.

Aims of the Work of Quality and Patient Safety Strand of the NHS Next Stage Review

- To make quality and patient safety the common currency of the NHS through which services are planned, designed, managed, assessed and funded
- To ensure that every NHS organisation's business plan and quality plan are one and the same document
- To achieve greater consistency in the delivery of accepted standards of best practice
- To drive sustained reduction in the risks of healthcare

THE CASE FOR QUALITY

THE NHS QUALITY JOURNEY SO FAR

5. The National Health Service (NHS) has been the vehicle through which the majority of Britons have received their health care for 60 years. At its outset, the NHS set no specific agenda for quality improvement aside from developing the infrastructure of care and embracing clinical advances and new technologies as they arose. In the early days, quality assurance was implicit and based on an assumption that highly educated, well-trained staff would service the needs of patients to a high standard.

6. The position remained much the same for 20 or more years when there was a growing interest in concepts and measures of quality in health care. Much of the stimulus to this new thinking was external. Particularly important was the work of the US quality pioneer, Donabedian, and his conceptualisation of the dimensions of healthcare quality as structures, processes and outcomes. However, such influences were largely on British health services researchers and policy analysts and not on those running the service. In the late 1960s and early 1970s, there was little flow through of new quality concepts into practice or health system design. However, throughout the history of the NHS, professionally-led quality initiatives, particularly clinical audit, have been carried out in many centres.

7. During the 1970s, the NHS remained centrally planned, demand-led and administered rather than managed. Quality still remained largely implied in service goals. Implementation was based on a philosophy of ensuring the presence of skilled staff, the provision of good facilities and equipment backed up by procedural guidance (much of it covering non-clinical areas of service).

8. The introduction of general management – replacing the old system of administration – in the mid-1980s followed a damning report by Sir Roy Griffiths pointing to the inadequacies of leadership, accountability and control mechanisms in the health service compared with other sectors and services. Initially, focusing on executive posts, general management eventually was extended to clinical managerial roles with the establishment of clinical directorates holding their own budgets and Medical and Nursing Directors with seats on the Boards of hospitals and other health organisations.

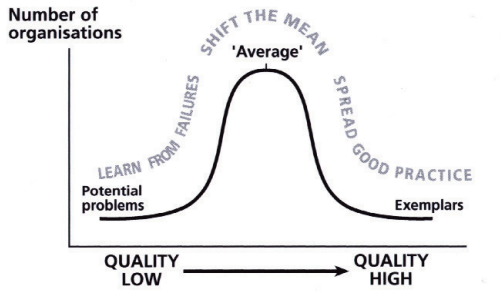
9. The advent of general management introduced more accountability and a stronger notion of health organisations as corporate entities. With this came a tendency for mission statements and planning documents to make explicit their intentions to improve quality. However, this was infrequently backed up by the systems and methods within the organisation to ensure successful delivery of quality goals.

10. In 1990, there was a major redesign of the health care system in Britain with the creation of an internal market splitting purchaser and provider functions with contracts governing the funding and provision of care. This change arose after a period, in the late 1980s, in which a series of well-publicised failures to provide funding for specialist services led to a public outcry. The 1990 changes redesigned the structure and functioning of the NHS with the intention that it should simulate the incentives of the market to achieve greater efficiency and more effective delivery.

11. There was no formal evaluation of the 1990 health system changes but they became increasingly controversial and publicly criticised and were partly dismantled by the incoming Labour government in 1997.

12. Amongst the changes to the NHS introduced by the Labour government was a new duty of quality for all NHS organisations which aimed to address all elements of the quality curve represented in Figure 1.

Figure 1: Variation in the Quality of Health Organisations



Source: *Scally G, Donaldson LJ. BMJ. 1998 Jul 4;317(7150):61-5*

13. Leading up to this was an undoubted shift in public and professional attitudes to poor quality in the NHS. It came through a series of high profile failures in standards of care in a number of services.

14. Serious deficiencies in standards of care were identified in the children's heart surgery service in Bristol, England. Three doctors – two surgeons and the medically qualified Chief Executive Officer – were removed from the Medical Register after the longest running disciplinary hearing in the General Medical Council's history. The fact that the problems were only brought to light by a 'whistleblower' together with the media images of distressed parents picketing the General Medical Council offices carrying cardboard children's coffins, added to the sense that this event was a watershed in public and professional attitudes to quality in the NHS. The Bristol affair was the subject of a public enquiry but many smaller scale incidents helped to form the view that the then mixture of professional self-regulation and employer disciplinary procedures no longer commanded confidence.

15. There were further scandals: the most serious involved the serial killer, general practitioner, Dr Harold Shipman. Serious questions were asked about how his spree of killing could have gone undetected for so long.

16. A key element of the new quality strategy for the NHS introduced in the late 1990s was the concept of clinical governance. It is defined as:

A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

17. It required Boards explicitly to accept responsibility for assuring and improving clinical quality, and to approach this task in a systematic way. All NHS organisations were charged with developing local clinical governance arrangements comprising, as a basic framework:

    - clear accountability arrangements for clinical quality, including regular reporting to the Board and a published annual report

- a programme of quality improvement activity, including participation in clinical audit programmes, application of evidence-based practice and appropriately targeted continuing professional development

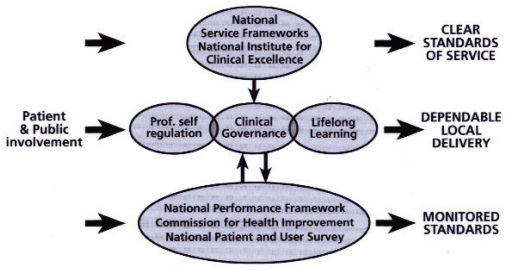
- clear policies for managing risks, including procedures for identifying and remedying poor professional performance

18. Implementation of clinical governance was underpinned by a new statutory duty for quality, established in legislation. The duty required the principal NHS organisations – Health Authorities, NHS Trusts and Primary Care Trusts – to 'put and keep in place arrangements for monitoring and improving the quality of the health care they provide to individuals'.

19. The implementation of clinical governance was a medium to long-term aim, requiring sustained management effort and a fundamental shift in organisational culture. More specific requirements of NHS organisations were set out in management guidance, and the creation of a statutory duty for quality on NHS organisations was intended to ensure that the development of clinical governance arrangements remained a priority.

20. With the centrepiece of the duty of quality and local clinical governance arrangements, a new framework was created (Figure 2) to support the assurance and improvement of quality within the NHS. Clear standards were set by a National Institute of Clinical Excellence (NICE) and through the creation of a series of National Service Frameworks (NSFs) covering major disease or population groups (heart disease, mental health, older people, diabetes, renal disease). An inspectorate, the Commission for Health Improvement (later the Healthcare Commission) was charged with ensuring that local clinical governance arrangements were working effectively and that key standards were in place.

Figure 2: Setting Quality Standards



Source: *A First Class Service: Quality in the new NHS. Department of Health 1998.*

21. With this framework in place, further enhancements to the NHS approach to quality took place from the late 1990s through into the early years of the 21st Century. Investigations into failures in standards of care in particular NHS services had identified various common factors notably a culture of tolerance of poor practitioner performance and a lack of expertise in dealing with it. This led to the establishment of a specialist service to support NHS organisations (the National Clinical Assessment Service) in dealing with poorly performing doctors and also a set of radical proposals to reform the regulation of doctors set out in the Green Paper, *Good Doctors, Safer Patients.*

22. Support mechanisms to assist local NHS organisations to improve quality were also put in place: a Modernisation Agency (later evolved into the National Institute for Improvement and Innovation) and a

series of Collaboratives. These approaches focussed on issues such as leadership, the design of the process of healthcare and ways of galvanising change. They were essentially concerned with identifying and spreading good practice.

23. The other major development was the introduction of a programme of patient safety through the publication of the report, *An organisation with a memory.* This raised awareness of the high level of avoidable errors in health care (700,000 per year) and drew attention to the systems nature of their causation. As a result a National Patient Safety Agency (NPSA) was established and charged with creating a reporting system to identify and analyse adverse events and draw out the lessons for action to reduce risk. The programme was reviewed and reinforced with new measures in a further report published in 2006, *Safety First.*

24. The creation of a national research and development function within the NHS in the early 1990s played its part in the NHS quality journey. It meant that the philosophy of evidence-based medicine which started in North America but rapidly became international in its scope was embraced by the health service in Britain. The difficulties of implementation were formidable, and remain so. The need for professional attitudes and behaviour change, access to valid and appropriate information, the right infrastructure of information technology and training in skills for critical appraisal and clinical practice guideline use, being just some of the developmental challenges.

WHERE WE ARE NOW

25. The NHS quality journey so far shows evidence of progress in developing the culture, methods and accountabilities necessary to sustain high quality health care. The last decade has been a particularly active period. Despite all these positive changes, four major problems stand out:
    - Suboptimal and poor quality care is still endemic within the NHS
    - The quality landscape has become increasingly complex with roles, accountabilities and interrelationships of different organisations lacking clarity
    - Quality and safety is still not the predominant culture of the NHS
    - The system levers, funding flows and incentives of the NHS are not designed to support quality improvement

WHERE WE WILL BE IN 10 YEARS

26. The overall aim of the proposal set out in this report is to create an NHS which has quality and safety of patient care at its heart, by:
    - Refocusing on quality and safety
    - Reclaiming the responsibility for quality of patient care for clinical teams
    - Removing barriers to clinical teams improving their services
    - Providing a framework and help for clinical teams improving their service
    - Rewarding quality of care, not volume

WHY CHANGE?

27. The NHS towards the end of the first decade of the 21st century in the year of its 60th birthday is very different from the one that started as a cornerstone of a new Welfare State in the years after the Second World War.

28. Its infrastructure of buildings, equipment and staff has expanded and modernised.

The range of technologies and drugs available to diagnose and treat illness has burgeoned offering life and hope where it was impossible midway through the 20th century. The range of diseases and the consequent demand for care has increased exponentially as the so-called epidemics of modern living (e.g. cancer, heart disease, diabetes) and an ageing populating have generated pools of need on a much larger scale than when the NHS began. On top of all this, in common with other developed countries, the proportion of the country's budget devoted to health care has expanded dramatically.

29. In the last decade alone, these trends have continued with big extra investments in the NHS producing expansions in the numbers of doctors, nurses and crucial equipment like Magnetic Resonance Imaging (MRI) scanners. In turn, this has helped to reduce access times, treat more people and improve outcomes of care for many patients.

30. As described in the previous section, the development of a quality framework for the NHS over the past 10 years has brought a number of very important and positive changes to the service, in particular:
    - more extensive use of standards to assure and drive improvement in service performance
    - programmes of regular review and inspection of standards of care
    - greater awareness amongst NHS staff that quality and patient safety cannot be improved unless they are explicitly recognised as issues and targeted for action
    - regular reporting and analysis of adverse events and near misses
    - less tolerance of poor practitioner performance when it threatens patient safety or compromises the effective functioning of a clinical team

31. Despite the stronger quality and patient safety ethos that exists in the NHS now compared to 10 years ago, fundamental problems remain, for example:
    - variation in standards of care around the country is extensive
    - some of the basics (notably cleanliness and health care infection) have been neglected
    - best practice (based on research evidence) is adopted too slowly and inconsistently
    - the avoidable risks of health care are still too high
    - incidents of serious failures in standards of care still occur
    - many patient complaints reveal repetition of the same problems: disrespect for patients and their families, bad communication and poor coordination of care

32. All these factors lead to the inevitable conclusion that quality and patient safety are not yet embedded in the planning, design and delivery of NHS services. More sleep is still lost over financial matters than about whether patients are treated with dignity and respect, whether outcomes of care are genuinely world class and whether patients are properly protected from harm when they are being cared for.

33. See Appendix 1 for details of current quality landscape

INTERNATIONAL COMMISSIONS

34. With this background, the internationally commissioned work provided key insights

into the barriers that must be overcome to achieve further transformation. This international work took the form of three separate analyses of quality in the NHS, each looking at a distinct part of the quality improvement process. The RAND Corporation was commissioned to examine standard setting in clinical practice. The Joint Commission, the leading accreditation organisation in the USA, was commissioned to examine inspection of quality in healthcare. The Institute for Healthcare Improvement was asked to examine support for quality improvement. Separate reports are available covering their findings.

35. Each commission carried out a review of current evidence of international best practice and an analysis of the current situation in the UK, meeting with key stakeholders in the UK health system. During this process a total of 160 interviews took place, in 117 meetings involving 116 separate key stakeholders.

36. A number of other key themes emerged from these reviews. These are discussed in the next sections of the report.

Barriers to further transformation identified by the international commissioned reports

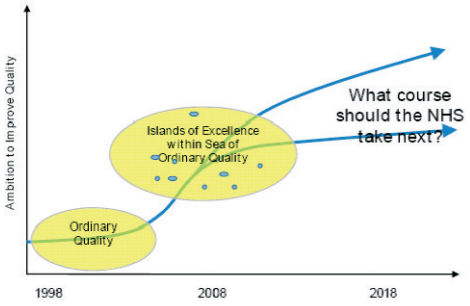
The commissioned work identified that in order to transform itself into a quality improvement organisation the NHS must address:

- The need for **quality improvement goals at system level** into which all activities can be integrated
- Poorly developed **information on clinical quality**
- Confusion about definition, use and importance of **standards**
- Great **absence of patients and family members** in planning, design and delivery of services
- **Clinical skills in improvement science** and performance assessment lacking
- **Commissioning function** aligned to setting tougher contracts rather than focussing on local systems planning to generate faster, consistent quality improvement
- **Culture of fear** too prominent in management hierarchy
- Mechanisms for **oversight of quality** too fragmented and regulation perceived as with overburdening with overlaps of functions

Islands of Excellence

37. Local examples of superb performance at the departmental, service or practice level were found in the NHS, but services performing at this level are relatively rare. The majority of services are functioning at a more moderate level, or simply do not have sufficient data to prove how well they are functioning. This concept, which came from one of the NHS staff interviewed, was expressed as 'Islands of excellence in a sea of mediocrity'.

Figure 3: NHS Quality: where next?



Source: *Achieving the vision of excellence in quality. Institute for Healthcare Improvement. 2008.*

Standards

38. The view reflected to the international reviewers by the NHS stakeholders and staff when they spoke to us was that there are too many standards in the NHS at present. Their heterogeneity is unhelpful. Different organisations set different standards, using different methods and with variable use of evidence. It is not clear which standards must be followed and which are optional as a matter of local discretion. The NHS lacks a clear overarching framework for quality to unite these disparate standards. Table 1 shows a selection of some of the major standards in the NHS, with a range of purposes, users and evidence on which they are based.

Type of Standard	Purpose	Who Uses?	Nature of Evidence
Clinical performance	Improve outcomes of care	Physicians, patients, managers	Scientific, professional consensus
Safety • Patient • Staff	Reduce the likelihood of harm	Managers, clinicians, regulators	Epidemiology (either from literature of from reporting systems)
Access (e.g., waiting times)	Reduce barriers to needed care; improve patient experience	Patients, managers	Patient preference, clinical evidence (delays that affect outcomes)
Service (e.g., patient experience)	Improve patient experience	Patients, managers, clinicians	Patient preferences
Regulatory	Ensure minimal acceptable levels of quality	Regulators, managers	Consensus
Professional	Ensure fitness for practice	Licensing bodies, regulators	Professional consensus
Population health	Motivate action to improve health	Public health professionals	Epidemiology
Financial	Increase value of health care product	Purchasers, regulators	Comparative performance
Data	Enhance utility	Standards setting bodies, vendors	Consensus

Source: *McGlynn EA, Shekelle P, Hussey P, Burgdorf J. Developing, disseminating and assessing standards in the National Health Service: An Assessment of Current Status and Opportunities for Improvement prepared for the NHS Next Stage Review. RAND Corporation 2008.*

39. Some standards are credible and valued by service providers. Others are not. A clear relationship exists between who is responsible for setting standards and their acceptability. Those set by the Department of Health without involvement of outside groups are less acceptable to the NHS. Despite a proliferation of standards in the area of effectiveness, standards are not so well developed in the areas of fairness and personalisation.

40. Publication of standards is insufficient to

promote widespread uptake. A widely used routine mechanism for alerting doctors about new standards or assisting them in putting them into daily practice is needed. Current mechanisms include:
- decision support tools, such as checklists, exist but are not widely used
- a number of organisations assess performance against standards (some are voluntary, others not)
- a number of organisations use standards for accountability (the level of scrutiny varies)

41. Whilst there is a need for terminological clarity in this whole field, there is no need to start from scratch since an extensive academic literature already exists. A number of broad conclusions can be drawn.

42. Two concepts are strongly embedded in the tradition of clinical quality improvement – standards and practice guidelines. Good, formal definitions exist of each and whilst they have different purposes there is a strong relationship between them as processes for improving clinical quality.

43. The field of standards, guidelines and clinical protocols is dogged by different understandings and interpretations. Clinical Pathways is a recent term and has not been subject to so much terminological debate. Ironically, given that the everyday use of these terms is often confused, misunderstood or used synonymously, they are underpinned by an extensive academic literature where good formal definitions do exist. Probably the best were developed by the US Agency for Health Care Policy and Research in the early 1990s and are as follows:
- **Standards** are 'authoritative statements of (satisfactory) levels of performance or results that can range from minimum through acceptable to excellent'
- **Clinical or practice guidelines** are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for particular circumstances'

44. The principal difference, then, is that standards set a particular level of clinical performance that must be attained whilst guidelines aim to promote good clinical performance. The relationship between the two is close since standards will often be derived from guidelines and be a more explicit and measurable form of them. There is further debate in the academic literature about 'levels' at which standards are set and whether the terms 'minimum', 'acceptable', 'excellent' are to be preferred over (say) 'minimum', 'optimal', 'ideal'. Furthermore, researchers have examined methods of constructing and developing guidelines and standards as well as ways of disseminating them and achieving compliance.

45. One concept – clinical pathways – is not so clearly established as a quality improvement tool though it is in widespread use. Essentially, it focuses on the process of care, varying in the extent to which explicit standards are used and the extent to which the aim is more towards efficiency and consumer satisfaction (i.e. 're-engineering' the process).

46. The concept of **clinical pathways** can in fact be traced back to the 1950s when a so-called Critical Path method was used in other industries, but in the USA in the 1980s the technique was first widely used in healthcare. The concept has been taken up more recently in the UK. Again it is a

term that means different things to different people. Essentially though, creating a pathway involves concentrating on the process of care so as to:
- make it more evidence-based
- coordinate more effectively the different stages of care and remove redundant steps
- make it more 'patient friendly'
- allow different practitioner groups to understand how their roles and those of others are contributing to the overall plan of care

47. A more recent concept – the 'care bundle' – has not been formally defined nor widely applied and evaluated but is simple in its construction involving grouping together evidence-based interventions and applying them collectively.

48. This was initially created in a Veterans Health initiative in the USA to improve the quality of care to patients in intensive care units. It drew together the evidence-based measures known to be effective in reducing ventilator-associated pneumonia in such patients. Four practices were chosen:
- elevation of the patient's head to 30 – 45 degrees
- daily sedation vacation and assessment of readiness to extubate
- peptic ulcer disease prophylaxis
- deep vein thrombosis prophylaxis

49. The concept of care bundles has been developed further and widely promoted by the Institute of Health Improvement and others in the USA. So far they have mainly been used in relation to central lines, ventilator-associated pneumonia and sepsis. The care bundle comprises a number of evidence-based practices – no more that three to five – which must all be implemented in the same space of time to achieve clinical improvement.

50. Thus, in the years ahead, four clinical quality assurance and improvement tools: standards, guidelines, clinical pathways, and care bundles, are likely to remain widely used in this country and overseas. To a large extent they can also be used in local clinical audit programmes.

51. There are a number of other issues central to the debate about how these tools are used in the future, the most important of which is the extent to which they are set nationally (and who is involved) or locally (and how this is undertaken). A number of points can be made about this:
- purely 'top-down' standard setting seldom achieves clinical ownership
- local standard-setting exercises that 'take or leave' evidence are wasteful and detrimental to quality improvement
- designing standards into broader pathways of care is particularly challenging task for which there is limited expertise in the clinical world

52. It is probably simplistic to believe that the quality and safety of care can be controlled solely by the setting of national standards or that a watertight distinction can be made between terms such as pathways, guidelines, protocols and standards.

See Appendix 2 *for definitions and taxonomy of the concepts discussed in this section.*

Establishing and agreeing a pathway to achieve consistently high quality can often be a very complex process covering:

- the desired flow of patients through a local or regional health system
- detailed procedural guidance (includingclinical protocols)
- explicit standards
- guidance on the organisation and infrastructure of the service

A good example of this is the pathway of care for patients with acute myocardial infarction (heart attack). Patients who suffer acute myocardial infarctions can be treated in a number of ways depending on the nature and severity of their coronary artery disease, other illnesses they are suffering from, how quickly their heart attack is recognised and where they are in the country at the time.

National 'guidance' sets out the patient 'flow' as pre-hospital and hospital stages of care for people who have had heart attacks. Depending on their symptoms, guidance directs that patients should go into 'pathways' such as for angioplasty, surgery or observation. At some points guidance is expressed in quite specific 'protocol'-style terms for example: 'if the ECG shows ST segment elevation or bundle branch block, then ambulance staff shall make a pre-alert call to the hospital'. At other points the guidance is expressed more as a standard, for example: 'the time from call for professional help to treatment with angioplasty ('call-to-balloon time') should be no more than three hours'. At other points, the guidance directs that more detailed guidance should be followed, for example:

- 'all pre-hospital procedures should be within Joint Royal Colleges Ambulance Liaison Committee and Ambulance Association guidelines'
- 'all in-hospital procedures should meet the latest British Cardiovascular Intervention Society (BCIS) and British Cardiovascular Society guidelines for staffing, surgical cover and procedure numbers'
- 'bare metal stents and drug-eluting stents should be used in accordance with NICE guidelines'

Regulation

53. Notwithstanding confusion about the volume and diversity of current standards, there is also concern amongst front-line NHS staff and local managers about the range of current inspection, regulation and accreditation functions. Too many organisations have the right to visit, to make judgements about services and to call upon the organisation to do something about any shortcomings identified.

54. Most activity is perceived on the front-line as overburdening, producing double jeopardy and sustaining overlapping roles of inspectorial bodies.

Using Data

55. Quality improvement, whether through competition by providers to be selected by informed consumers, or by the effect on reputations of public information, requires good measure of performance that are readily available to those making decisions. This is not currently achieved in the NHS.

56. The quality of much of the data is poor, including significant amounts of both missing and inaccurate data. Some types of data that would be useful are not routinely collected (e.g. procedure-specific mortality, patient outcomes, patient experience). Information is not always presented in ways that can be used by different audiences (e.g. clinicians, managers, patients).

57. Those who produce the data generally do not use it. These data are sent up the line in response to administrative requirements but little data flow back or are used locally. Those who produce the data have little sense of ownership locally, which creates problems with data quality in collecting accurately, correcting errors or flagging problems. Data collection is seen as 'feeding the beast' rather than a path to quality improvement.

58. The need for a national data information infrastructure is recognized. In particular, patient choice and commissioning initiatives require considerably more ability to use data by different audiences than is available today.

59. There is considerable skepticism in the NHS about the possibility of meeting the need for a national data system. Improving data use locally requires culture change and training. Managers do not always respect the importance of clinical information. Doctors do not respect the importance of management information. The skills and capacity to analyze and use data are very limited at local levels.

HIGH PERFORMING SERVICES

60. The visits to high performing services around the country provided insights into how teams within the NHS can demonstrate excellence. These units were identified by a process of triangulation, using objective evidence of clinical outcomes, the opinions of clinical experts, and a measure of patient satisfaction.

Stroke Service at St Thomas' Hospital, London

61. The Stroke Service as St Thomas' Hospital stands out as a leader in the field, pursuing an uncompromising quest for the gold standard. A combination of dynamic clinical leadership, excellent working relationships with management, a highly-skilled multi-disciplinary team and the rigorous use of audit have combined to a produce a service that consistently emerges at the top of the national audit of stroke services. The team demonstrates an enterprising use of service redesign, registries, nurse practitioners and tele-medicine.

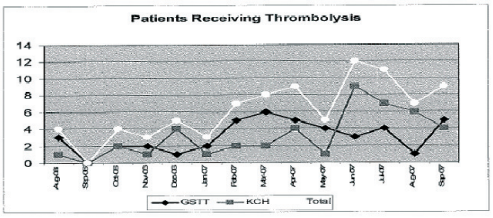
62. This team, in common with all the high performing services visited, uses locally-driven real-time collection of data to great effect. Important clinical indicators, including those identified as needing local improvement, are monitored, with results displayed publicly on the walls of the ward, and used in planning and monitoring improvement strategies.

63. One theme which emerged strongly at this unit was the emphasis placed on role development for all members of staff. For example, the stroke specialist nurse role has been extended to cover many highly skilled tasks; and the stroke specialist nurse, in turn, mentors other nurses

through presenting at conferences and educational opportunities.

64. The Stroke Service at St Thomas' Hospital has also boldly embraced innovation and technology to improve the services it offers to patients. Thrombolysis improves the outcome of a patient who has an ischaemic stroke: but must be delivered within 90 minutes of the stroke. To meet this challenge, the team has set up a telemedicine facility whereby all patients can be assessed by a consultant by videolink, increasing the timeliness of senior assessment and resulting in more patients receiving the best treatment **(Figure 4)**.

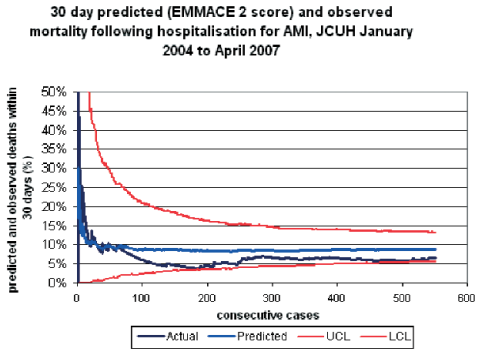
Figure 4: Telemedicine has increased the number of stroke patients receiving thrombolysis at St Thomas' Hospital



Cardiothoracic Service at James Cook University Hospital, Middlesbrough

65. The James Cook University Hospital, Middlesbrough, has built up an exemplary cardiology service in a deprived region of the country. The South Tees Hospital NHS Trust has received national recognition for the high quality of services it delivers. The Cardiothoracic Division is a forward-looking and innovative team, who deliver a service that is now acting to reduce the inequalities compared to the national average. Particularly impressive was the continual search for opportunities to improve all aspects of patient care, from delivering a primary angioplasty service for heart attacks to ensuring continuity of nursing care throughout the patient's journey.

Figure 5: Mortality is lower than expected at the James Cook University Hospital Cardiothoracic Division



66. One theme demonstrated particularly clearly by this team is the value of thorough use of quality management techniques for continual self-evaluation. A dedicated governance team is trained in audit, research, information technology and quality improvement skills. The team makes exceptional use of real-time data to identify problems as soon as they arise.

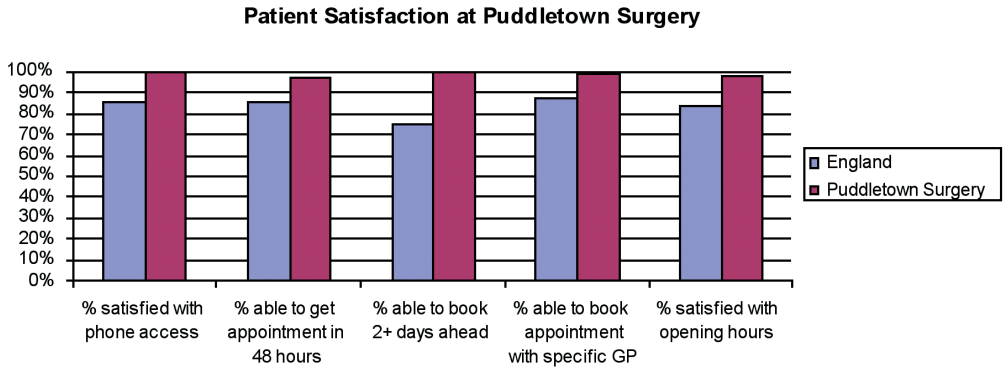
67. Another theme is the value of participation in research. It is well established that academic centres perform well. What was observed in this series of visits was the involvement of the whole multi-disciplinary team. This generates a culture that is receptive to, and aware of, best practice, as well as an eagerness to put research into practice and adopt change to deliver the best possible care to patients.

General Practice in Puddletown Surgery, Dorset

68. Puddletown Surgery, Dorset, is an example of excellent general practice. They have achieved some of the highest patient satisfaction levels in the country, with 98% of their population satisfied with opening hours and only one complaint in the last 10 years **(Figure 6)**. By working closely with a supportive Primary Care Trust and developing exemplary links with the community through a network of volunteers, they have demonstrated an effective and viable model of semi-rural general practice.

69. Continuity of senior staff, clinical and managerial, was a key component of this team's success. Stable relationships had been built between the clinical and managerial staff in the General Practice surgery and in the Primary Care Trust. Mutual trust allowed staff to work as a team across the organisations, and to support each other in their roles in organising and delivering local care; a contrast to the reported management 'culture of fear' in some other parts of the NHS.

Figure 6: Patient Satisfaction at Puddletown Surgery



Paediatric Oncology and Bone Marrow Transplant Service at the Bristol Royal Hospital for Children

70. The Bristol Children's Bone Marrow Transplant Service demonstrated how a culture of excellence can flourish in a previously troubled hospital. The unit is using Toyota Lean methodology to design a service built around maximising efficiency, and improving the experience of all the patients passing through. The team was the first in Europe to start a programme of paediatric unrelated donor bone marrow transplant. Their experience is reflected in the excellent leukaemia-free survival rates of their patients.

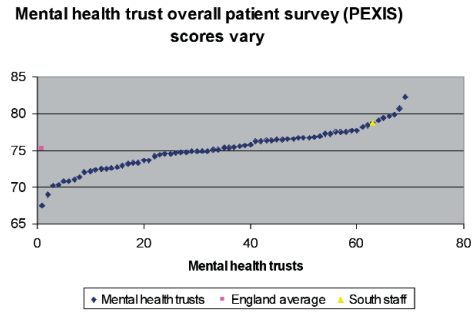
71. The team demonstrates clinical ownership over their service performance. The Toyota Lean methodology was applied by a cross-section of all members of the team, including porters, doctors, domestic workers and nurses. The aims are expressed in a clinically relevant context;

the simplification of the patient journey aims to reduce inefficiencies not just for management reasons, but in order to improve the patient experience by making the patient pathway smoother and with greater continuity of care.

Assertive Outreach Service in South Staffordshire

72. The Staffordshire Mental Health Assertive Outreach Team showed how the often neglected area of mental health can use a patient-centred culture, team-based problem-solving skills, multidisciplinary relationship building and strong leadership to build a service held in high regard by both patients (Figure 7) and where performance stands up to objective assessment. The South Staffordshire and Shropshire NHS Foundation Trust delivers a high quality of service and is rated very positively in patient feedback. The South Staffordshire assertive outreach team is recognised as an excellent unit that exemplifies the values of the Trust.

Figure 7: South Staffordshire, as well as achieving excellent clinical outcomes assessed by other means, is rated positively by its service users



73. The team is committed to putting the service user at the heart of its service. Success has come through working with patients and the wider community to deliver a high-quality service that is led by the needs of its clients. Their highly service user-centred focus has led to strong multi-disciplinary and cross-sectoral relationships, for example with the police, housing association, inpatient services and social services. This has led service users' needs to drive the creation of a joined-up service across health and social care.

International High Performing Teams

74. International examples also demonstrate high quality practice. Peter Pronovost, an intensive care physician at Johns Hopkins Hospital in Baltimore, USA, has shown how a multi-intervention programme to reduce Catheter Related Bloodstream Infections can have a remarkable effect.

75. His team promoted the use of five interventions to reduce infection rates and a check list to make sure each one was done every time. These were in the context of a wider package of measures, including a daily goals sheet for improving communication among clinicians, a unit-based safety programme to generate a culture of patient safety and the coaching of a doctor and nurse to lead local implementation.

76. Using this series of interventions, he and his team have enabled a sustained reduction (up to 66%) in rates of catheter-related blood stream infections across the State of Michigan.

High performing clinical teams: key characteristics

The high-performing teams had many factors in common, including:

- Excellent clinical leadership
- Management goals expressed as clinical benefits understood by the patient and the team
- Clearly understood common culture
- Clinical ownership of service performance
- Strong emphasis on measurement and use of 'real-time' data
- Eagerness to compare with other services
- Continuity of senior staff
- Workload managed to avoid excessive burden on staff
- Quality improvement integral to work with skilled use of performance improvement techniques
- Patient and family involvement strong
- Jobs and individual developed through education, training and role development

RECOMMENDATIONS

THE 14 RECOMMENDATIONS IN SUMMARY FORM

77. In the panel below, the 14 recommendations in our report are summarised. The following sections of the report then discuss the recommendations in greater depth.

Recommendation one: An accountability framework for better, safer care
A set of goals at system level should be established to focus all policies, plans and activities within the NHS on quality and safety.

Recommendation two: Clinical Dashboards
Each clinical team in the country should be required to maintain a clinical dashboard to monitor and benchmark performance against standards agreed nationally and locally designed performance indicators. Clinical dashboards would be statutory requirements, publicly available and presented in a common format that is easily understood.

Recommendation three: Rationalisation of existing standards and guidelines
Existing standards and guidance should be reviewed to produce a set of preferred standards for all clinical areas. This process of rationalising and defining preferred standards would be expected to lead to the generation of outcome indicators for use in clinical team dashboards.

Recommendation four: NHS Preferred Clinical Pathways
Agreed standardised pathways should be designed for a number of key illnesses based on those where variable performance leads to substandard care (e.g. stroke), where heavy resource consumption is associated with waste (e.g. cancer care) or where there are serious risks attached to the process of care.

Recommendation five: An Institute of Medicine
An Institute of Medicine should be created to fulfil an independent role in standard setting, knowledge management and support for quality improvement.

Recommendation six: A regulatory framework
A regulatory framework should be developed to assure quality and penalise poor standards of care. This would require every provider of service within (or for) the NHS to be formally licensed to do so. Licences of this sort could be qualified (or 'endorsed') where there is substandard care. In serious cases, retention of Foundation Trust status could be qualified. A special programme of regulation for the commissioning function itself would be established.

Recomendation seven: Funding higher quality, safer care
Funding flows should be redirected to support higher quality, safer care. Through variations to the tariff (or extra-tariff payments), the funding levels for higher quality and safer care will be made bigger. A proportion of the funding of NHS providers of care would be based on independently conducted surveys of patient experience of the service concerned.

Recommendation eight: Commissioning of services will be linked to clinical dashboards
Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission.

Recommendation nine: Clinical governance duties for every clinical team
All clinical teams should have a specified range of clinical governance duties agreed to ensure the quality and safety of their service.

Recommendation ten: Expanding excellence by making available proven high performing clinical leaders
Clinical leaders in services achieving proven levels of excellence in care should be made available to services delivering a similar range of services to help them raise their standard of care. These 'change' leaders would be Fellows of the Institute of Medicine and will share learning and lessons from their diverse fields of work.
They would be recognised as prestige appointees and this would be reflected in fast-tracking in the Clinical Excellence Awards Scheme.

Recommendation eleven: Reshaping the Clinical Excellence Award Scheme
The Clinical Excellence Awards Scheme should be altered to strengthen the link between demonstrated quality of care and financial reward. More extensive use should be made of data to prove quality improvement in the assessment criteria of the scheme.

Recommendation twelve: Employees as partners
A John Lewis-style partnership scheme should be created to enable NHS staff to share in the ownership of their NHS organisation. The permanent staff of an NHS organisation would in effect 'own' the organisation and share in its income and benefits. Each staff member would become a partner whose individual contribution to the organisation is recognised and rewarded fairly.
Recommendation thirteen: Never Events
Building on international experience, the NHS should agree a list of 'never events' that are serious, preventable and unacceptable. Systems should be developed to ensure that healthcare providers do not receive payment if these events ever occur.

Recommendation fourteen: A patient safety initiative
A patient safety initiative should be launched to embed the use of evidence and measurement into patient safety measures in the NHS. The preferred project would be called Matching Michigan, which would work across the 218 adult general critical care units in the NHS in England and aim to reduce catheter-related bloodstream infections by 60%.

THE 14 RECOMMENDATIONS IN-DEPTH

Goals and system accountability
Recommendation one: An accountability framework for better, safer care

78. During its review on the current status of quality improvement in the NHS, the Institute for Health Improvement repeatedly highlighted the lack of what they termed the 'system picture'. The assessment was that there is currently no clearly articulated vision of quality in the NHS.

> *It's hard to answer the question about 'How good is our quality' because we don't have an overall quality measurement framework, and so we only see what is under the lamp posts. What's under those lamp posts seems to be getting better, but what about what's not under the lamp posts?*
> **Stakeholder interviewee**

79. Without a clear set of system level goals that encapsulate the overall aims of the service it is difficult to examine the quality of services through a meaningful lens at national or local level.

80. Establishing a set of system level goals to a framework would focus all policies, plans and activities on quality within the four domains as set out in Our NHS, Our Future – fair, effective, personalised and safe. This mechanism would put quality at the heart of planning, delivering, managing and funding healthcare systems, shifting the language of the NHS from that of finance and productivity to one based on quality. With quality as the currency of the NHS a structured approach can be created from vision, through goals to quantifiable metrics **(Figure 8)**.

Figure 8: Quality in tomorrow's NHS

81. For example, instead of having detailed national targets for chronic disease, the proposed quality aim for chronic diseases (identifying early, slowing progression, improving quality of life) describes the desired outcomes in holistic terms. This approach serves to integrate all of the NHS in a simple purpose that can be well understood by staff, patients, commissioners and the public. It can be applied in strategic discussions about the health status of a large population. Or it can be applied at the front line, for example, within a specialised service where detailed metrics might be used to test performance against the system level goal for a patient being treated with epilepsy or diabetes: Was the disease identified early? Has progression been slowed? Has the care delivered improved the patients' quality of life?

Leadership and clinical accountability
Recommendation two: Clinical Dashboards
Recommendation nine: Clinical governance duties for every clinical team

Proposed system level quality goals

SAFE
- Make care safer by identifying the risks of care and taking action to reduce them

PERSONALISED
- Embed a patient-centred philosophy of care in all processes, procedures and encounters (with patients and their families)

EFFECTIVE
- Ensure all clinical and care decisions are appropriate to the patient's needs, evidence-based and cost-effective
- Identify chronic diseases early and organise care so as to slow their progression, preventing complications and maintaining health

FAIR
- Strive to achieve and demonstrate the highest standards and best outcomes of care when judged against the leading services in the world

82. Having established a quality framework for the NHS, clinicians and patients should view its performance similarly. Clinicians and managers would be able to judge themselves and be held accountable for their successes in meeting the quality goals. The transparent display of performance data would enable the public and commissioners to make truly informed choices about healthcare.

83. The international commissions found that there is currently a gulf between clinicians and managers in their perception of what good quality care is. The system level quality goals address this problem but clinical teams also need to have a clear and explicit understanding of what they are responsible for. Building on the insights gained by observing the high performing services it is proposed that a formal set of clinical governance duties for clinical teams is agreed. The list might look like this:

Proposed quality responsibilities of clinical teams
- Identify, report and analyse adverse events, sources of risk and near misses and as a result demonstrably improve safety
- Continuously assess clinical performance (outcomes and compliance with processes of care) for the main conditions treated by the team, compare results against current best practice and demonstrate regular improvements
- Maintain a clinical dashboard to show clinical activity against standards agreed by clinical specialty
- Adopt (or work to adopt) NHS Preferred Clinical Pathways
- Establish clinical governance arrangements to ensure that quality responsibilities are delivered

84. The concept of a clinical team is at present not well developed but a working definition is 'all the healthcare staff sharing responsibility for the same core set

of patients'. The configuration of clinical teams would be decided locally, in order to increase ownership of the process. A clinical team in a hospital might be the staff working in an intensive care unit, or an antenatal clinic or an endoscopy service for gastroenterology patients.

85. In primary care a clinical team could be defined as the team in a single shared practice. This would include all those working for the practice (including district nurse, practice nurse, receptionist) not just the general practitioners.

86. Good clinical data will be key to enabling clinical teams to drive forward quality improvement. Currently data collection is often seen as a 'feeding the beast' activity with no added value. Yet, a common feature of high performing clinical teams is that they take ownership of service performance with service goals, express them as clinical benefits to patients and use data as an integral part of their work. They compare their performance over time, in relation to others and benchmark against best practice.

87. Our key recommendation to enable all clinical teams to focus on quality improvement is the concept of a clinical dashboard. A dashboard would allow for real time visualisation of performance across a variety of measured variables. The clinical teams would decide what is important for their local services, and choose indicators they wish to focus on to improve quality. They could use data that are already routinely collected and would also decide what additional data they would like to collect to populate indicators reflecting local health population needs. Clinical teams would own and monitor their own performance against measures that they themselves consider valuable. This would allow them to identify quality improvement needs and design initiatives to address them.

88. Allowing clinicians access to data about their performance would help to make quality improvement a scientific endeavour. By showing highly motivated individuals variation in performance, curiosity and competition will drive change. Clinicians would be able to apply academic rigour to quality improvement in a way that they have not previously been able to.

89. For commissioners and patients the dashboards would provide a real objective measure of the quality of one clinical team compared to another, creating a healthy competitive spirit amongst those clinical teams.

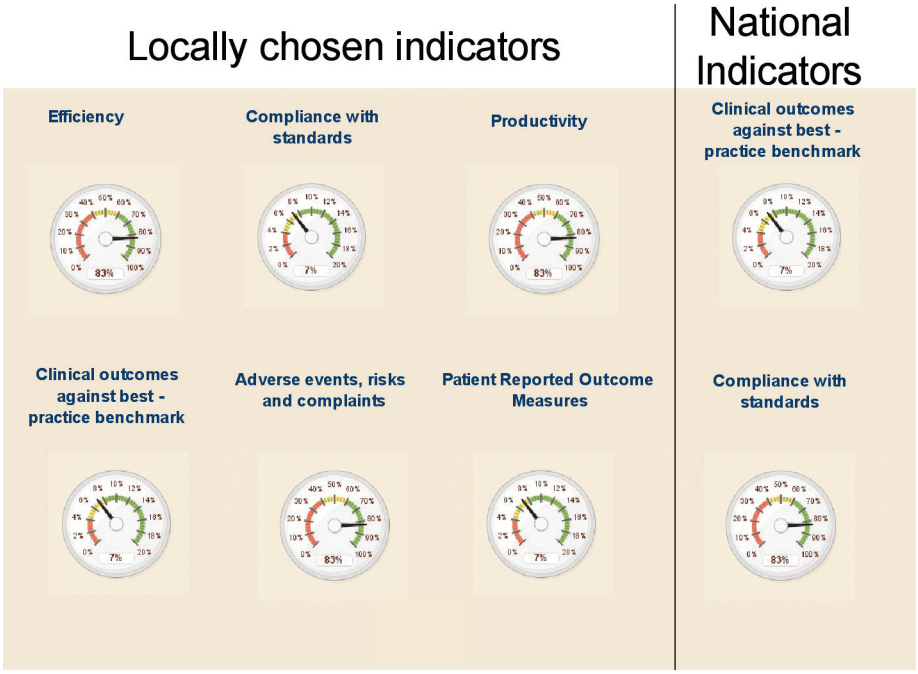
90. Dashboards have been used to drive quality improvement across a variety of industries. Within the NHS Professor Arulkumaran (currently President of the Royal College of Obstetricians and Gynaecologists) developed a dashboard in an initiative to turn around poor standards in the quality of care in the Maternity Department at Northwick Park Hospital.

91. The development of dashboards would be a challenging task. Local teams would come together to create their dashboards by selecting indicators at local level in discussion with patient representatives, the public and commissioners to reflect local concerns and interests. They would also rely on national standards and evidence of best practice, nationally and internationally.

92. A central issue would be the proportion of locally defined metrics on the dashboard compared to the nationally defined standards and metrics. A combination would be needed to ensure the correct balance between achieving local ownership and ensuring rigour in adhering to what is known nationally and internationally to achieve the best outcomes of care.

93. Dashboards would require well-developed, reliable data sources if they are to be effective. Sources used to power dashboards would include data collected nationally and locally by information technology systems, as well as data sets created locally and held on local databases. Delivering dashboards would require close collaboration with the Connecting for Health programme. At present information technology infrastructure does not collect quality related data in many areas. There would therefore be a requirement for local data collection mechanisms. Existing data sources such as the Confidential Enquiries and National Audits would also feed data into the dashboard system in certain clinical areas. Currently work is under way in association with Connecting for Health to develop prototype dashboards, based on real requirements of clinical teams.

Figure 9: An example dashboard for a hospital team



94. A hospital would have a wide range of dashboards reflecting the specialist services they provide and clinical teams running them. An overall picture could be gained at a hospital or regional level by considering a combination of relevant dials. In primary care, existing components of the Quality and Outcome Framework could form a considerable part of the dashboard.

Standards, knowledge and support from national level

Recommendation three: Rationalisation of existing standards and guidelines
Recommendation four: NHS Preferred Clinical Pathways
Recommendation five: An Institute of Medicine
Recommendation ten: Expanding excellence by making available proven high performing clinical leaders

95. One of the major barriers in developing a consistent approach to improve quality is the heterogeneity of standards and guidelines in existence. The variety of standards, their dissemination through different access points and the lack of co-ordination across standards and implementation tools makes great difficulty for clinical teams. They have to find, identify and prioritise the standards that are most evidence-based, relevant to them and likely to improve care for their patients. Under our recommendations, by combining the standard-setting function with the co-ordination of dashboard development there would be a coherent standard and method of measuring against it derived from a single body.

96. In reality, to ensure that patients with a particular condition receive the highest quality, safest care that can be promised means looking at the design of the whole service. This can only be done locally but it needs to draw in the best research evidence, the best knowledge of good practice (much of it in formal guidelines). It needs to use the best expertise in the design of processes of care and the experience and views of patients and families. The degree to which formal, explicit standards are included in this service design is a matter of judgement as well as knowing what it is essential to 'standardise' so that the best outcomes are assured.

97. As a consequence of the Next Stage Review approximately 1500 clinicians have become involved in assessing and formulating ideas for local services, these groups may be well placed to continue this role, supported by the Institute of Medicine.

98. There are a number of organisations who currently set standards. Some existing standards set by other organisations are greatly valued by clinicians, such as the work of the Royal Colleges and the National Institute for Health and Clinical Excellence (NICE), who produce high level, authoritative and widely respected guidelines. In implementing this recommendation care must be taken to protect the stability and integrity of those organisations which produce standards and support which is valued at the front line. The difficulty for clinical teams is in sifting through the large number of standards to identify which they should adopt locally.

99. In order to preserve existing standards, and to enable clinicians to identify the most relevant, the Institute of Medicine would have the ability to 'kitemark' standards. This kitemark would indicate that not only was that standard 'NHS preferred' but also whether it was a standard of best practice or if it represented a world class level of service.

100. The formation of an Institute of Medicine with this function creates the opportunity for a rationalisation of the organisations in the quality landscape. The other organisations which currently pursue

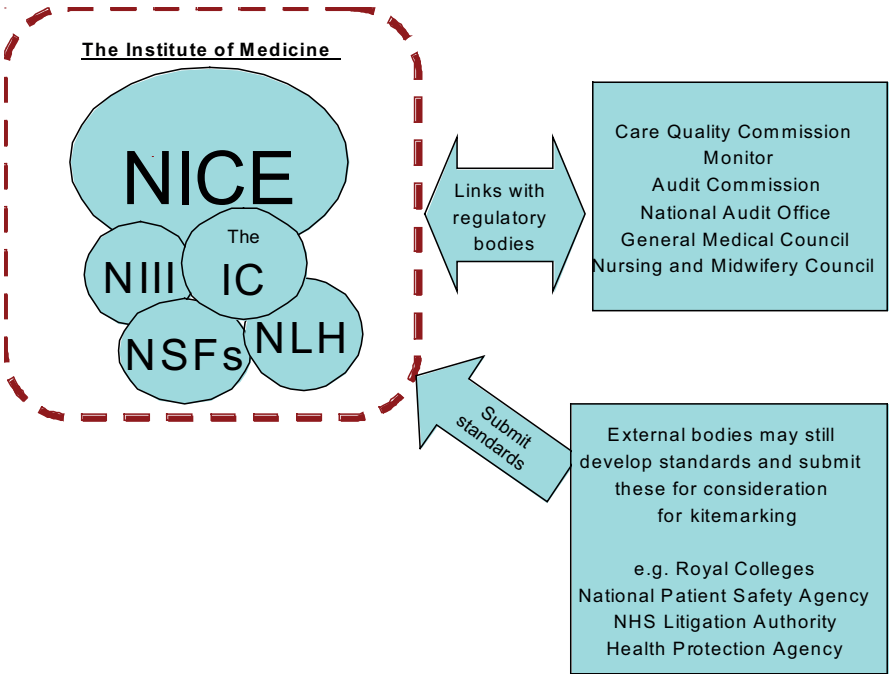
activities related to the Institute of Medicine are listed in Appendix 3. These would be merged if their primary function overlaps significantly with those of the Institute.

101. Other organisations, statutory or non-statutory, who wished to set standards would be required to submit these to the Institute of Medicine for kitemarking. Alternatively, organisations could choose to handover standard development to the Institute of Medicine, and focus instead on achievement of standards, and other functions. Where standards were inadequate, the Institute of Medicine would have the capability to produce or commission new standards.

102. The Institute of Medicine would incorporate the following existing functions and activities: the National Institute for Health and Clinical Excellence (NICE); the National Institute for Innovation and Improvement; the national Clinical Excellence Award Scheme; ongoing work on National Service Frameworks; the national Confidential Enquiries; the Centre of Clinical Evidence and the Information centre; the reformed medical education and training function proposed in Sir John Tooke's report, (Aspiring to Excellence).

103. In addition to incorporating existing bodies the new Institute would contain the proposed Center for Clinical Evidence, thereby drawing together knowledge management, standard development, leadership fostering and improvement support.

Figure 10: The Institute of Medicine



What will the Institute of Medicine do to rationalise standards?

- Integrate clinical knowledge
- Review all standards
- 'Kitemark' the best standard in each clinical area
- Convert standards into a measurable format suitable for clinical teams to use as a dial on local dashboards
- Set new standards where existing standards are lacking or inadequate
- Design preferred clinical pathways where:
  - key illnesses where variable performance leads to substandard care (e.g. stroke)
  - heavy resource consumption is associated with waste (e.g. cancer care)
  - there are serious risks attached to the process of care

In all these areas the Institute of Medicine should have a close working relationship with the Royal Colleges and other specialty specific organisations.

What will the Institute of Medicine do to support service improvement?

- Continue the function of the National Institute for Improvement and Innovation in promoting, supporting and disseminating improvements and innovation
- Fellowship scheme to promote clinical leadership and spread best practice
- Produce or commission toolkits to support the local implementation of dashboards
- Offer 'on-the-ground' assistance with local implementation and use for quality improvement of clinical team dashboards

104. The International Commissions have further reported barriers to spread and adoption of best practice. The Institute of Medicine would also have a central role in addressing this. Perhaps the vital component of spreading good practice is clinical leadership. Clinical leaders in the current system face multiple barriers: lack of peer support, inability to respond to national standards which are not relevant to their unit and a lack of incentives to improve the quality of their unit and share their learning more widely. The Institute for Healthcare Improvement (IHI) in its international review of support available to improve quality identified the paradox of an ever increasing response to national targets for quality diminishing the focus on the community they serve and their views on the service they desire.

105. Clinical leadership needs to be promoted and supported at a local level so that clinical leaders set clinical priorities. Where leadership is left to 'the managers' it is difficult to develop outstanding services. There is a need to move beyond talk of 'clinical engagement' and take practical steps to develop a leadership cadre — or 'change leaders'.

'NHS leaders should foster more confidence, risk-taking, learning, and cooperation among system elements and roles. Creating more will and capacity for NHS organisational leaders to look 'out' toward patients and families for signals about their priorities and ideas for improvement, instead of 'up' to please the NHS hierarchy, will accelerate improvement, foster local cooperation, and, probably, decrease waste.'

Institute of health improvment

106. The Institute of Medicine would recruit those with proven track records to become Fellows of the Institute. These Fellows would support or even turn around poorly performing units or teams. These pioneers would be encouraged and incentivised to use their knowledge and skills to assist other services in achieving transformational change. By nurturing clinical leaders in services achieving proven levels of excellence in care, the NHS will mobilise an enormous knowledge resource.

107. Being styled as Fellows of the Institute of Medicine these clinical leaders would have the authority to enact change as well as establishing a network of individuals engaged in similar work.

Recognising and rewarding excellence
Recommendation eleven: Reshaping the Clinical Excellence Award Scheme
Recommendation twelve: Employees as partners

108. Through the Fellowship a broader definition of clinical leadership can be encouraged by formally recognising those who are currently leading. These clinical leaders would be recognised as prestige appointees and this would be reflected in fast-tracking in the Clinical Excellence Awards Scheme. As well as rewarding academic or research prowess the new scheme would favour leadership ability. The Clinical Excellence Awards Scheme for consultants would be altered to strengthen the link between demonstrated quality of care and financial reward. The reformed Awards allocation process would make more extensive use of data, including the clinical dashboard to demonstrate quality improvement activity to reward excellence.

109. Clinical Excellence Awards are an effective mechanism for incentivising consultants because they provide significant financial rewards. Consultants are at the heart of clinical decision-making and service planning, and are therefore in a unique position to help embed high quality care in the NHS. Focussing the criteria for receiving Clinical Excellence Awards on quality improvement activities will create strong individual financial incentives to put quality improvement at the centre of hospital consultant activity.

110. Use of objective evidence of quality improvement would allow the award process to become more transparent and fair. Current criticism of the awards suggests that measurable quality improvement does not receive that emphasis that it should do and that once awarded, they fail to provide continuing incentive to improve.

111. The proposed mechanism for introducing objective evidence of quality improvement activity to the award is to link the new clinical dashboards to the selection process. Recipients of awards would be required to demonstrate measurable improvements in quality in their own clinical teams, or continuously high levels of quality, via their own dashboards or those of the services they are visiting. Consultants would be required to demonstrate maintained quality improvement activity in order to maintain their awards at high levels. This would ensure that the momentum of quality improvement is continued throughout consultants' careers.

112. It is not just the team leader who should be recognised and rewarded for a team's success. A John Lewis-style partnership would enable all NHS staff to share in the ownership of their NHS organisation and to be financially rewarded as a team for improving the quality of their service.

113. Staff would own a share in their organisation. They would receive a bonus at the end of the year based on the organisation's overall performance. The percentage of salary that this represents would be the same for the Chief Executive as a porter. This would motivate all staff to focus on working together to improve the quality outcomes of their services and hospital and generate a fascination with information reflecting quality and improvement. It would contribute to a culture of cooperation, staff engagement in quality improvement, and be a mandate to all staff to be involved in improving quality.

114. The John Lewis experience has shown that providing an organisational incentive, not only generates team spirit but also a competitive drive, as teams strive for high performance.

115. The permanent staff of an NHS organisation would in effect 'own' the organisation and share in its income and benefits. Each staff member would become a partner whose individual contribution to the organisation is recognised and rewarded fairly. In primary care many General Practitioners and Practice Managers are already partners in their General Practice. This recommendation would encourage extension of partnership to all members of staff, including for example nurses, receptionists, cleaners and on-site pharmacists.

116. John Lewis has a reputation for quality in its goods and customer service that the

NHS should aspire to. The John Lewis partnership model has been a success for business reputation, organisational culture and profits. It has been widely imitated by others in industry e.g. Pepsi Cola, Tesco's and Royal Mail. The John Lewis reputation for quality means that this recommendation would reinforce the message that quality should be at the heart of the NHS, and this would be apparent to staff and the public.

117. One of the barriers identified by several of the international commissions is the gulf between clinicians and managers. A John Lewis-style staff partnership would build clinical teams around the shared goal of improving patient care and replicate the features of the high performing units, through a shared financial incentive that reflects progress towards the goal that all clinicians and managers share: improving patient care.

118. Staff partnerships should first be piloted to develop a prototype and to evaluate the scheme. Chief Executives could be invited to volunteer to pilot staff partnership in their organisation. Foundation Trusts are likely to be suitable sites for the pilot. General Practices in which partnership could be extended to all staff would also be suitable.

119. Partnership could be designed as a cost neutral project, in which current salaries may be paid between, for example, 98 – 102 % depending on performance and the bar is set such that the average is 100%. Achieving this balance requires an estimation of the current level of quality to set the bar at an appropriate level. Pilot sites could be 'early adopters' who may have a higher level of quality than average and so pilot sites may earn more through the scheme. The risk of treating this as a cost neutral project is that it may lead to negative perceptions within the NHS in which it is seen as penalising services who are struggling as much as rewarding those who are achieving. Alternatively, a budget could be allocated to providing bonuses, and salaries could vary between, for example, 100 – 104% of current levels.

Regulation and Accreditation

Recommendation Six: A regulatory framework

120. A Bill is currently going through Parliament that proposes the merger of the main regulators of the health and social care system, the Healthcare Commission and the Commission for Social Care Inspection. The Mental Health Act Commission will also be part of the merger. Under the new system requirements will be set for health organisations providing services to NHS patients and *inter alia* for private health and social care providers (not described here) to be 'registered' with the Care Quality Commission.

121. Current thinking within the Department of Health's team dealing with regulation is that most NHS providers will immediately be registered under a 'grandfather clause'. Those which the existing Healthcare Commission has concerns about will be reviewed for fitness for registration. Also within current thinking is the idea that registration requirements or 'essential standards' would be drawn out from a broader-based quality improvement type standard.

122. For example, proposed standard 1 in the current draft of the consultation document *A framework for registration of health and adult social care providers* is expressed thus:

'Ensure that people have their health and/or social care needs assessed, and that care and treatment is planned and delivered to appropriately meet those needs, having regard in particular to ensuring their health, safety and welfare and taking account of current evidence-based guidance for relevant professional or expert bodies'.

123. There are 17 other standards, most of which are similarly broad-based making the construction of one or two aspects of each as 'essential standard' an enormously challenging task. The approach risks falling into the difficulty that minimum standards are being placed within a framework of quality improvement. This creates a clash of philosophies. As one NHS chief executive officer put it: 'we don't just want to be ordinary, we want to be excellent'. In aligning regulation with the quality and safety agenda set out in this report we advise that:
- basic registration requirements ('essential standards') should be just that: a list of 'must dos' covering issues such as qualified personnel, clean environment, kitemarked equipment
- basic registration requirements need to be consistent with the private healthcare sector but not necessarily identical
- accreditation systems should be used by the Care Quality Commission as an adjunct to registration
- accreditation should be aimed at quality improvement (as well as checking for unsafe practice) based on standards set by the Institute of Medicine and to a large extent using local clinical dashboards
- the Care Quality Commission should act as the gateway for all accrediting organisations to prevent over-burdensome regulation: all data collection in the NHS for accrediting organisations should be conducted through the Care Quality Commission

124. As the functions of commissioning are increased, regulation of commissioners may become necessary. A special programme of quality standards and accreditation would be established for the commissioning function itself. This would ensure a process of continuous improvement in the mechanisms and levers used by commissioners to secure higher levels of quality and safety in the provider organisations they relate to.

125. Positive incentives will provide a degree of motivation but without the development of censure the ability to ensure safe care will be curtailed. Every provider of service within (or for) the NHS should be formally licensed. Registration licences could be qualified (or 'endorsed') where there is substandard care. In serious cases, retention of Foundation Trust status could be qualified. Endorsing of licenses, in a similar way to driving licenses, may produce effect through public criticism; equally Foundation Trusts may put at risk their autonomy by failure to reach licensing standard. More radical options include the ability of the licensing authority to remove management and impose temporary suspension of bonuses and additional remuneration.

The Business of Quality

Recommendation Eight: Commissioning of services will be linked to clinical dashboards
Recommendation Seven: Funding higher quality, safer care

126. Clinical teams do not work in isolation. At an organisational level, the current system of payment by results allows only the quantity of care delivered to be

rewarded. Refocusing financial incentives onto the quality of care provided will allow organisations to focus fully on supporting their clinical teams to achieve high quality care.

127. Commissioners would be able to look at a clinical team's dashboard when deciding what service to commission. Commissioners would have improved access to information on what 'best' looks like, through the Institute of Medicine's rationalisation of standards and guidelines. Using the national and local indicators, commissioners would be able to identify which services are providing high quality care and commission care from them.

128. More than this, commissioners would be able to use the lever of commissioning to effect change. Services that are not performing well face the challenge of failure to be commissioned, or alternatively hospital management utilising other levers such as buying in clinical expertise to effect turnaround. The effect of commissioning can be strengthened as an enabler of quality.

129. In addition to local commissioners deciding which service to commission, they should be able to vary their tariff payment based on the quality of service demonstrated by clinical dashboards. In essence the commissioning contract would be able to vary to 102.5% based on achievement of locally set aims. High performing services would not only win contracts but their organisations would be rewarded for maintaining and developing their services in line with local needs.

130. As many indicators would be locally determined, commissioning would therefore be sensitive to local needs. However commissioners would need to be wary that local indicators are not chosen only because success can be demonstrated (i.e. set up to guarantee a 'win'). It would be incumbent on the commissioners to ensure that the variety of indicators used is such that services are stretched to improve within a local context.

Strengthening patient safety
Recommendation thirteen: Never Events
Recommendation fourteen: A patient safety initiative

131. Based on the quality demonstrated by the clinical dashboard, commissioners would be able to choose which services to commission and vary the tariff to reflect the quality of the service they are commissioning. There are occasions when stronger action is called for. 'Never events' are defined by the US National Quality Forum as 'adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability.'

132. Consensus is growing that never events need greater recognition and action to prevent occurrence. In the United States, a wide variety of organisations have declared that they will not pay for an episode of care where a 'never event' occurs, and this has been successful in promoting patient safety.

133. Several States have enacted laws requiring the disclosure of never events at hospitals and various remunerative or punitive measures for such events.

134. A recent Leapfrog Group Study found that roughly half the 1,285 hospitals that responded to their survey waive fees for never events, and that hospitals that do

waive fees are much more likely to have perfect scores on the Leapfrog Safe Practices Score survey. Minnesota's hospitals have agreed to stop charging patients and insurance companies for the 27 types of 'never events' first identified by the National Quality Forum in 2002. State law has required hospitals to report them since 2004. In 2006 Minnesota hospitals reported 154 of these 'never events', in 8 million patient visits.

135. Health insurance companies have adopted different lists of never events to drive improvements in patient safety. In 2004, HealthPartners announced it would not pay for the National Quality Forum never events. Medicare has announced eight preventable conditions it will not pay for, including healthcare-associated infections. Only three National Quality Forum conditions are on the Medicare list.

136. This approach is likely to be most successful when the financial disincentive is combined with a renewed focus on implementing best practice guidance. This is demonstrated by the recent success at Geisinger Health System, a three hospital not-for-profit organisation in Danville, USA. It offers coronary artery bypass surgery for a flat fee that covers any complications occurring within 90 days. As part of the programme, surgeons adhere to 40 best practice measures. After 117 cases, the death rate had reduced from 1.5% to 0%, readmission within 30 days of surgery from 6.6% to 5.1% and length of readmissions and hospital charges were reduced by 5.2%.

137. The incidence of never events in the NHS is unknown, but may be high. To avoid sudden financial difficulties for care providers, and to allow prevention measures to focus fully on one never event at a time for maximum impact, the never events could be phased in, perhaps one a year.

138. In the short term, providers would receive assistance with implementing measures to prevent never events, but would have to pay the costs of episodes of care in which patients experienced never events. The Department of Health could fund the assistance with preventive measures by reducing the funding to commissioners, as they would no longer be paying the cost of episodes of care in which never events were experienced.

139. Care providers would have a financial incentive to focus on preventing serious preventable adverse events. This would renew the focus on patient safety across the NHS. Staff would be encouraged and enabled to put best practice into practice. The funds made available to pump prime measures designed to reduce never events would help clinicians and managers to improve the safety of their practice.

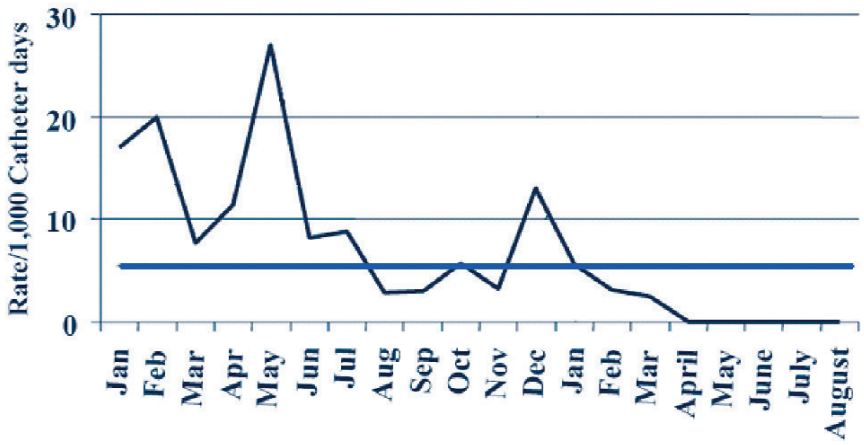
140. A patient safety initiative should be launched to embed measurement and evidence into the approach to patient safety in the NHS. The preferred project would be Matching Michigan, addressing catheter-related blood stream-infections in Intensive Care Units. A team from Johns Hopkins School of Medicine led a programme to reduce catheter-related blood-stream infections across 103 intensive care units in Michigan, USA; infection levels were reduced by over 60% after 18 months (Figure 11). This would be an opportunity to prove that quality improvement can be achieved within the NHS.

141. Professor Peter Pronovost, an intensive care physician at Johns Hopkins Hospital, Baltimore, USA, led the catheter-related bloodstream infection (CRBSI) reduction programme in 103 intensive treatment units (ITUs), representing 85% of all ITU beds in Michigan State, USA.

142. The five procedures promoted were hand washing, using full-barrier precautions during the insertion of central venous catheters, cleaning the skin with chlorhexidine, avoiding the femoral site if possible, and removing unnecessary catheters. These were selected based on evidence that they were effective in reducing infections with minimal barriers to implementation.

143. The methods used for promoting these interventions included: clinician education; a checklist for infection-control practices, enforced by preventing clinicians inserting catheters if they were not following this checklist; consideration of catheter removal at every daily round; provision of a 'cart' containing all the supplies needed to insert a catheter according to the guidelines; and monthly and quarterly team feedback on the number and rates of CRBSIs.

Figure 11: Reductions in ICU catheter-related bloodstream infections across the State of Michigan USA



144. These were in the context of a wider package of interventions, including: a daily goals sheet for improving communication among clinicians; a unit-based safety programme to generate a culture of patient safety; and the coaching of a doctor and nurse to lead local implementation.

145. This programme led to a sustained reduction (up to 66%) in rates of CRBSIs that was maintained throughout the eighteen month study period. The median rate of catheter-related bloodstream infection decreased from 2.7 infections per 1000 catheter-days at baseline to 0 within the first 3 months after implementation.

146. The Intensive Care National Audit and Research Centre (ICNARC) estimates that there are 218 adult general critical care units in England. Matching Michigan in England would thus be on roughly twice the scale of Peter Pronovost's work.

PERSPECTIVES

147. The following perspectives show how the system would look to a doctor and a patient before and after these recommendations are implemented.

Through the eyes of a clinician

Today

Dr Vijay Patel works in a busy respiratory unit of a District General Hospital. He was appointed as a consultant 10 years ago and considers himself 'mid-career.' He has struggled to improve the infrastructure of his department. Some of the equipment is a little outdated, there is one other consultant in the team but the workload would justify a third consultant. The turnover of nursing staff is very high with 15% agency nurses. His representations to the medical director and chief executive officer of the hospital were listened to sympathetically but he was told that the priority was for cancer and heart disease services. There were national targets for these conditions but not for respiratory disease. Following the discussion he was awarded three 'local points' in the Clinical Excellence Award scheme in recognition of his hard work and commitment.

Later that year, a new business manager, Thomas Knowle-Wheetall, was appointed to the Directorate of Medicine in the hospital. Knowle-Wheetall arranged a weekly meeting with Dr Patel in which he would set quarterly targets on access times, the number of patients to be seen and the costs of clinical tests and investigations. Dr Patel tried to protest that these measures did not reflect the things that really needed to be done to improve the service but was told by Knowle-Wheetall that 'if I'm going to get my annual bonus, and become a chief executive officer in the future, we need to hit these targets'. Dr Patel became increasingly demoralised and questioned whether the values that he had when he came into medicine were being reflected by the NHS.

One day, Dr Patel received an invitation to attend a seminar hosted by the Chief Medical Officer in London to discuss 'Quality in the 21st century NHS'. When he arrived to register for the meeting it was clear that his name had been confused with someone else and he had been invited in error. However, one of the organisers told him that he should stay because he was 'more in touch with reality than many of the other people here'.

Dr Patel found himself in a small group discussion in which all his frustrations poured out. He was nominated to make the 'flipchart feedback' on the barriers to good clinical quality. He identified: the disempowerment of the clinical team due to excessive managerial control; the absence of good data; the failure to manage to patient outcomes and experience rather than numbers and money; and disagreement on what standards should govern a service's operation.

As a result of his presentation, Dr Patel was asked to take part in a pilot study to implement some of the changes in the NHS Next Stage Review.

Tomorrow

The hospital was proud of being selected to be a pilot in implementing clinical dashboards as part of the NHS Next Stage Review. Dr Patel was asked to do a presentation to the Board.

He was able to describe the main groups of respiratory disease that his service treated. He expressed the strategic aims in relation to the NHS system level quality goals: slowing the

progress of chronic respiratory disease, monitoring standards for diagnosis, treatment and after-care as well as marking out what excellence looked like.
In preparing for the Board presentation, Dr Patel felt that for the first time he had a plan for what his service should be achieving and how success could be judged, a plan that made sense in clinical and patient benefit terms.

A team headed by a Fellow of the Institute of Medicine (who led on respiratory medicine) visited Dr Patel's Unit for a few days to help him and his team construct their clinical dashboard. Over this time Dr Patel and his team also constructed their own local pathway for patients with respiratory disease.

For the clinical dashboard and pathway work, they identified the standards the team wanted to use which blended evidence based best practice with local 'patient flow' considerations. They drew in information from the latest patient experience survey of respiratory services and they identified the best performing service in the world as their gold standard. Efficiency and financial performance data were also included. Not all dashboard domains could be populated with all the data the team suggested but a timetable was agreed through which the right data would be available.

The hospital's Chief Executive Officer then facilitated a meeting where the team's infrastructure was reviewed against their capacity to deliver against standards in the dashboard and the NHS Preferred Clinical Pathways for respiratory disease. Major changes were made and the team decided to establish beginning and end of the week timeouts to review performance.

A year later, Dr Patel and his team are in discussion with the primary care trust commissioning team. They are considering how to develop the service for respiratory disease.
By this time, the team's clinical dashboard is well populated with data. Everyone acknowledges that: all standards are being met in full and the service has gained quality payments above the tariff. Patient satisfaction falls short of what the team had hoped for. The service's patient representative identified some key problems with the coordination of primary care follow up after hospital discharge that is causing the greatest negative feeling amongst users of the service. The commissioning team agrees to discuss this with local general practitioners to find a solution.

A large part of the discussion turns on the team's aspiration to climb higher towards excellence. The senior nurse in the team reports on her visit to the Mayo clinic in the USA. She identifies five areas where, if improvements were made, the respiratory service could get from its present 65% of the Mayo Clinic's performance to 85% over the next two years. The Commissioning Team agrees a modest extra investment to enable this and it is also decided to ask the Institute of Medicine for help in reviewing the potential for necessary service re-design as the team acknowledges that they need to revisit their pathway of care against national standards and international best practice.

At the end of a long and very satisfactory day, Dr Patel goes home to his family knowing that he is leading a service that is delivering high quality care to most of his patients. He also knows that his leadership and the commitment of his team could one day match the best in the world.

Through the eyes of a patient

Today

Clara Hempster is a 49 year old mother of four. Apart from her childbirths, and an occasional visit to her General Practitioner for sore throats or coughs, she has hardly used the health service.

On a sightseeing visit to London from her home in Sheffield she collapsed outside the Houses of Parliament. She was revived by a Member of the House of Lords, Lord Dexterity of Keyhole, who told her she had had a diabetic episode. She was deeply grateful to this gentleman. A policeman at the entrance to the House of Lords told her that she was very lucky because it was only at certain times of the day that Lord Dexterity patrolled the parliamentary precinct looking for people who had collapsed or may be on the verge of collapse.

When she got back to Sheffield she went to see her General Practitioner to ask him to refer her to the best diabetic service in South Yorkshire. She had been advised by her husband, Freddy Greentree, a struggling actor, to press very hard to go somewhere good because his agent had gone blind with 'diabetic eyes', having had no check-ups for 10 years.

Clara's General Practitioner could give her no firm information about which was the best diabetic service but told her that the one at the local hospital was in his opinion "fair to middling". Clara was disappointed. Since her diagnosis she had trawled the internet and realised that how long diabetics lived, whether they went blind and their quality of life could all depend on how good the service was that cared for them and how closely it worked with the General Practitioner and his team.

Tomorrow

Clara Hempster was lucky for a second time. She read in the newspaper that South Yorkshire was to be a pilot area for a new scheme in which assessment of the quality of the local NHS was going to be made available to the public.

Through the internet she was able to access information on five diabetes services which were within an hour of her home. Information on their services was set out like a car dashboard so she could see how each compared to national standards set by the Institute of Medicine. She could also see how far each fell short of international best practice. She could check out how well each service controlled the progress of diabetes (eg, how many patients had eye complications, how many patients had regular high glucose levels and how many were overweight or obese). She could also see what feedback patients had given on the service.

One of the five services stood out from the others. All national standards were being complied with. Complications of diabetes were very low compared to the other services. Also the service had come third in the 'International Diabetic Service of the Year' awards. Patient feedback was uniformly positive. Clara clicked on the comments of the last 30 new patients to use the service and also those of patients who had been treated for more than five years. There was only one negative comment and that was from an elderly woman whose ambulance was delayed.

Clara asked her General Practitioner to refer her to this service. She was seen within the week and underwent a range of baseline assessment tests. Following that she had an in-depth discussion with her diabetes team about

her future. She was given a lifetime plan with key milestones and advised of the steps she needed to take to slow the progress of her illness and the warning signs to look for. She was put in touch with the local Expert Patients Programme to help her to develop skills in self-management.

The nurse from her practice was present during this initial clinic visit and she agreed with Clara the follow-up arrangements with her primary care team. She was asked to telephone if she had any worries or problems but in any case she would be receiving a monthly telephone call from the hospital diabetic team checking on her progress.

Clara remained in the area for the rest of her life. She became something of an 'anorak' on diabetic clinical dashboards. She regularly looked at the dashboards of her own service but also other around the country, particularly the four in South Yorkshire and watched with interest as they all began to catch up with the best.

Through the eyes of the patient

NOW	FUTURE
No information on the performance, complication or adverse event rate of the hospital or clinical team administering treatment	Clinical dashboards available publicly in an understandable way. For example, infection rates, readmission rates, mortality rates and complications in surgery rates all available and easily comparable for the patient to make informed choices
Internet searches leading to multiple numerous websites and guidelines (governmental and non) describing different standards and pathways of care; what to expect and how to deal with their disease	Still lots of information available, but a nationally recognised and publicly available IOM gold standard and pathway and an accompanying patient's version explaining what the best they can expect should be
Hospitals and clinical teams not performance managed so not possible for patients to compare or understand 'who's best' and 'who's worst'	Hospitals and clinical teams accredited based on their performance on key metrics displayed on the dashboard. Information publicly available so the patient can see who is accredited to a basic and high standard based on their performance and ultimately offering best care
Patients have little idea about which clinical teams perform to a high standard	A plethora of clinical leaders commissioned to work in underperforming centres would be known by patients who would be able to have increased confidence in their local service realising that expert input was underway
Patient satisfaction not measured nationally or taken notice of	Patient satisfaction scores for every patient on every admission feed into one of the main indicators on the clinical dashboard, meaning that if patients are satisfied staff are rewarded
Unsafe events in hospital not sufficiently publicised and their causes explained	Set of never events publicly available, national promise that these events should never occur in hospital

Through the eyes of the clinical team

NOW	FUTURE
Little objective measurement of the quality of care provided by the team	Regular, systematic measurement of the quality of care provided by the team via dashboards
Quality improvement activity takes place on a sporadic and ad hoc basis	Continuous approach to quality improvement facilitated by dashboards and system level quality goals
A lack of data to allow full assessment of the quality of care provided by the team	Data on quality collected and analysed regularly by the team, creating a more scientific approach to quality improvement
No way to compare yourself against other teams within the hospital and against similar teams in other units	Dashboards allow comparison between teams and encourage a culture of competitiveness to drive up standards
The team is measured against centrally set targets, some of which they do not agree with or are not appropriate to the local service	The team picks indicators to measure itself against that it feels are important to the local service Teams feel ownership over their quality improvement activities
A lack of clarity about which standards should be used to inform the clinical practice of the team	Clearly defined, 'kite marked' standards from the Institute of Medicine give clarity about what the team is aiming for
No team based reward if they provide high quality care, instead all reward goes to the consultant via clinical excellence awards	All members of the team rewarded for quality care through a partnership model
A lack of skills in quality improvement	Teams supported by the IOM to implement quality improvement initiatives. If necessary clinical leader can be drafted in from high performing units to help
Clinical teams disengaged from the quality improvement process	Clinical teams empowered and motivated to take part in quality improvement

Through the eyes of a director of commissioning at a PCT

NOW	FUTURE
A lack of data on the quality of care provided by clinical teams, making decisions about who to commission care from difficult	Dashboards for all clinical teams provide accurate and relevant information on performance in their service. Commissioners are empowered to put quality at the heart of the decision making process on the basis of objective evidence from the dashboards
Confusion about which standards represent best practice when commissioning services	Clearly defined 'kite marked' standards from the Institute of Medicine provide definite examples of best practice. Commissioners able to identify those services providing best practice and then to buy their services
Very little flexibility to alter payments to provider organisations to reward high quality care	Commissioning contracts which include an element of variability in payment on the basis of demonstrated quality of care provided, as measured on dashboards. The better the care, the more they get paid
Having to pay for care, even when it has gone disastrously wrong	No payment made to the providers when a 'never event' occurs. And hopefully fewer never events occurring as providers do more to stop them from happening

Through the eyes of a hospital chief executive

NOW	FUTURE
Erratic availability of data showing clear measures of performance at the level of the clinical team	Clinical dashboards giving sense of basic measures for all clinical teams e.g. mortality rate, infection rate, specialty specific key indicators (e.g. hernia occurrence rates post-operatively in general surgery) Ability to aggregate dashboards at a hospital and level to inform where help is needed to improve performance
No way to hold clinicians accountable to practise best standards as best standards not clear	A nationally recognised and publicly available IOM gold standard and pathway to use for performance measurement
Inability to prove minimum standards of care or clearly show improved performance	Hospitals and clinical teams accredited based on their performance on key metrics displayed on the clinical dashboard
Regular disputes over unfair clinical excellence awards	Clinical excellence awards based on performance measures on clinical dashboards, little room for dispute in face of quantitative fact
Inability to summon support to improve services	A plethora of clinical leaders commissioned to work in underperforming centres would be available to 'buy in' to improve local performance
Patient satisfaction not measured nationally or taken notice of	Patient satisfaction scores for every patient on every admission feed into one of the main indicators on the clinical dashboard, meaning that if patients are satisfied staff are rewarded
Not able to reward staff for high performance	All NHS staff in partnership arrangements with their hospitals (cf. John Lewis) with rewards for improved patient satisfaction and highly performing teams e.g. Improved pay, preferred medical treatment, air miles, membership at local gym, free dentist etc.

Through the eyes of government

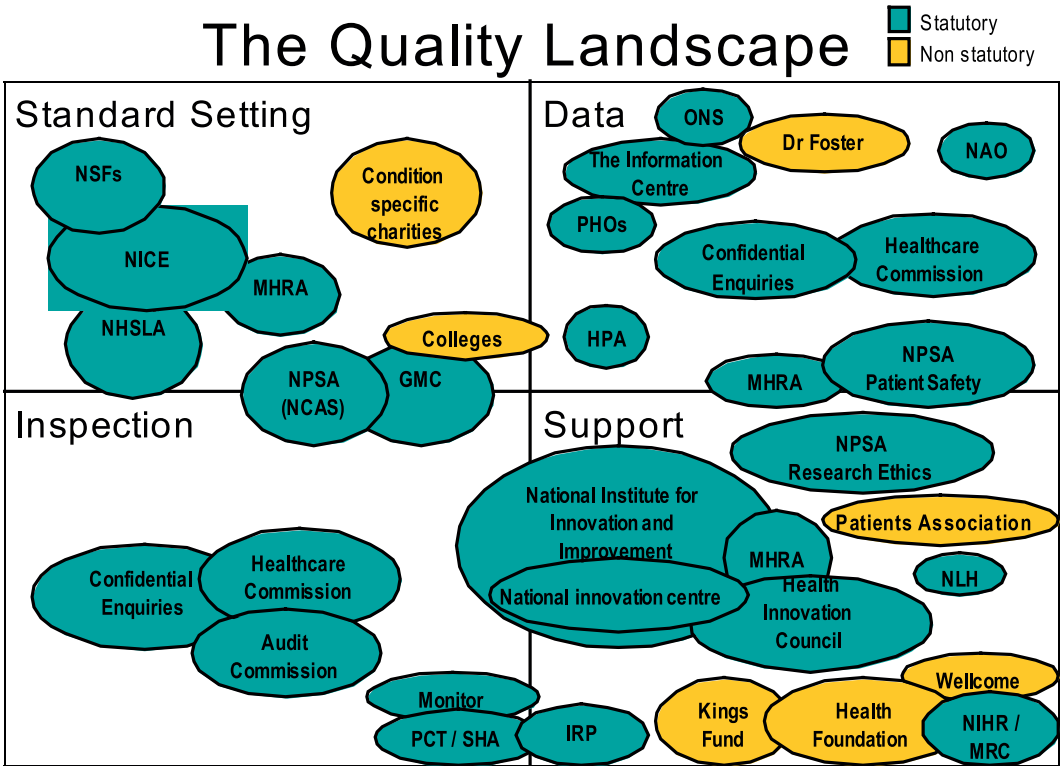
NOW	FUTURE
Erratic availability of data showing clear measures of performance at the hospital level e.g. standards for better health, dr. foster etc… No data on clinical team performance	Aggregated clinical dashboards Clear sense of basic measures for all clinical teams e.g. mortality rate, infection rate, specialty specific key indicators (e.g. hernia occurrence rates post-operatively in general surgery) Ability to aggregate dashboards at a hospital and regional level to inform spending plans
Liaison with multiple bodies to determine the best standards of treatment and the views of the medical profession on gold standard treatment e.g. Royal Colleges, Societies, Arms Length Bodies etc. Complicated cross-governmental and non-governmental strategies to ensure all stakeholders involved in key decisions Regular embarrassment at significant duplication of work across commissioned agencies	Still lots of information available, but a nationally recognised and agreed existence of an IOM which houses all of the NHS' knowledge, agrees and delivers the gold standards for healthcare professionals and patients and holds a fellowship of clinical leaders who itinerantly improve performance across poorly performing services No need to consult Royal Colleges, host multiple working groups and waste resources duplicating work as the IOM will have universal 'buy in' and be the voice of the profession to government
Inability to properly regulate hospitals and healthcare professionals, prove minimum standards of care or clearly show improved performance	Hospitals and clinical teams accredited based on their performance on key metrics displayed on the clinical dashboard Ability to prove to the public that problems can be picked up early against measured standards and action taken
Regular disputes over unfair clinical excellence awards	Clinical excellence awards based on performance measures on clinical dashboards, little room for dispute in face of quantitative fact
More than a million disillusioned, disenfranchised NHS staff	All NHS staff in partnership arrangements with their hospitals (cf. John Lewis) with rewards for improved patient satisfaction and highly performing teams e.g. Improved pay, preferred medical treatment, air miles, membership at local gym, free dentist etc.
Panic over media picked-up adverse events that seem to occur repeatedly	Financial levies applied to trusts for the occurrence of never events, reducing their incidence and assuring the public action is being taken

APPENDIX 1

The current quality landscape

An overview of the arms length bodies and other agencies tasked with monitoring, maintaining and improving the quality of healthcare services in the NHS in England reveals a quality landscape that is diverse with multiple quality foci. Several organisations have overlapping responsibilities. There are few examples of communication and cooperation to ensure complementary, rather than redundant or contradictory, work to improve quality in the NHS.

Figure 12: The Current Quality Landscape



Key to acronyms:

GMC	General Medical Council
HPA	Health Protection Agency
IRP	Independent Reconfiguration Panel
MHRA	Medicines and Healthcare Products Regulatory Agency
MRC	Medical Research Council
NAO	National Audit Office
NCAS	National Clinical Assessment Service (part of NPSA)
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NLH	National Library for Health
NPSA	National Patient Safety Agency
NSFs	National Service Frameworks
ONS	Office for National Statistics
PCT	Primary Care Trust
PHOs	Public Health Observatories
SHA	Strategic Health Authority

DATA

The **National Patient Safety Agency (NPSA)** aims 'to put patient safety at the top of the NHS agenda through encouraging greater transparency and accountability for the provision of safer healthcare in all settings' (www.npsa.nhs.uk).

The NPSA has three divisions. The Patient Safety Division collects patient safety incident reports from the NHS in England and Wales, raises awareness of these, for example by publishing rapid responses, and works to improve patient safety. The National Clinical Assessment Service advises NHS bodies who have concerns about the performance of doctors and dentists. The National Research Ethics Service promotes an ethical approach to participants in research.

The NPSA was established in 2001, and expanded to include the National Clinical Assessment Service and the National Research Ethics Service in 2005.

The NPSA manages the contracts for the three **Confidential Enquiries**. These publish anonymised data collected from institutions on three specific clinical issues (http://www.saferhealthcare.org.uk/IHI/ProgrammesAndEvents/ConfidentialEnquiries).
The Confidential Enquiry into Maternal and Child Health (CEMACH) investigates maternal and perinatal mortality and is planning to start investigating into child health; the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) examines the quality of care delivery and recommends action based on peer review of data; and the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (NCISH) investigates every suicide and homicide within UK mental health services.

The **Health Protection Agency** is a Special Health Authority, established in 2003, which 'protects the health and well-being of the population'. (www.hpa.org.uk)

It provides support and advice to the NHS, local authorities, emergency services, other Arms Length Bodies, the Department of Health and the Devolved Administrations on infectious diseases, radiation, chemical and environmental hazards and emergency preparedness. It is also developing its involvement in international work. Its key areas of work are: infectious diseases; chemicals and poisons; radiation; emergency response; local and regional communicable disease services; and a business support network which generates income.

It is accountable to the Secretary of State for Health, and subject to the Healthcare Commission's Annual Healthcheck.

The **Medicines and Healthcare Products Regulatory Agency (MHRA)** exists to 'enhance and safeguard the health of the public by ensuring that medicines and medical devices work and are acceptably safe' (www.mhra.gov.uk).
In April 2003 the Medicines Control Agency and the Medical Devices Agency merged to form the MHRA, which is an executive agency of the Department of Health. The MHRA monitor medicines and devices and act on safety problems. It has the power to withdraw products from the market and to suspend production of medicines. The MHRA licences medicines for use in the United Kingdom, and is responsible for regulating organisations that licence medical devices.

The **Healthcare Commission** describes itself as the 'Health watchdog for England' who 'check that healthcare services meet the required standards in safety, cleanliness, waiting times

and many other areas' (www.healthcarecommission.org.uk). An independent body that inspects both NHS and independent healthcare institutions in England, it was launched on April 1st 2004 following the Health and Social Care Act 2003.

The Healthcare Commission runs an 'annual health check' on NHS units, piloted in 2005/6 and run fully in 2006/6. Each NHS trust is awarded a performance rating on the basis of an assessment of the quality of the service provided. The Healthcare Commission also publishes a wide range of reports, including surveys of patients and staff, review of services such as diabetes, and more wide-ranging reports on topics such as gender equality and complaints handling in the NHS. NHS complaints that are not dealt with locally are handled by the Healthcare Commission.

The Information Centre's (The IC) mission is 'to be the recognised source of authoritative comparative data, providing an independent perspective on the quality, validity and application of information to support improvement in health and social care' (www.ic.nhs.uk).

It is an independent NHS Special Health Authority that provides facts-and-figures to help the NHS and social services run effectively. They collect data from across the sector, analyse it, and convert it into useful information. The data collected, such as Hospital Episode Statistics and many of the audits funded by the Healthcare Commission, are routinely used in healthcare delivery, management, policy and research. Information is aimed at NHS frontline management, clinicians, information and care professionals, policy makers, patients and the media. Information needs across healthcare are monitored to guide the collection of data. They are planning work with the Healthcare Commission, Department of Health, NHS Connecting for Health and the independent sector to agree a strategy for standardising data collection between the NHS and the private sector. Other projects include: identifying the proportion of drugs prescribed but not collected, for NICE to include in their analysis of prescribing behaviours; extending data collection to the private sector; developing financial performance indicators; promoting the adoption of the Electronic Staff Record; planning the collection of social care data; and promoting data analysis at SHA and clinician level.

The 12 **Public Health Observatories** (PHOs) monitor and forecast trends in health status, disease and the effects of healthcare interventions (www.apho.org.uk).

PHOs publish a range of reports, briefings, information and develop indicators of particular public health issues such as alcohol misuse. They develop training programmes for health intelligence staff and respond to enquiries about public health. They publish guides to monitoring and analysing public health data, for example providing modelling tools for NHS organisations to assess the impact of different strategies on meeting targets such as the Public Service Agreement targets.

In England each PHO receives a core resource from the Department of Health and is accountable via its Regional Director of Public Health to the Chief Medical Officer. PCTs, SHAs, the Department of Health and government, and other bodies also commission the PHOs to deliver specific additional work.

They are co-ordinated by the Association of Public Health Observatories (APHO) across England, Scotland, Wales, Northern Ireland and the Republic of Ireland. Public Health Observatories are also working with their local cancer registries, health protection agencies and other colleagues to develop a more integrated health intelligence function for their respective areas.

The **Office for National Statistics** (ONS) collects and publishes official statistics about the UK's society and economy, including administering the ten-yearly census (www.statistics.gov.uk).

The Health Statistics Quarterly publication includes data on deaths, childhood mortality, cancer survivial, abortions, congenital anomalies and morbidity, as well as feature articles on public health topics such as alcohol-related deaths.

The UK **National Audit Office** (NAO) scrutinises public spending on behalf of Parliament (www.nao.org.uk). It is currently examining the results of the NHS Arms Length Body Review 2004, and is due to report early in 2008.

Dr Foster Intelligence is a public-private partnership between Dr Foster LLP and The Information Centre. Launched in February 2006, it aims 'to improve the quality and efficiency of health and social care through better use of information' (www.drfoster.co.uk).

For the public, Dr Foster Limited provides a service to compare hospitals by clinical outcome factors such as average length of stay, readmission rates for common operations, staffing levels, as well as more patient-centred standards such as mixed sex bays and pleasant surroundings. This is based on Hospital Episode Statistics and an annual questionnaire, used to form the Hospital Guide annually. It also runs databases of consultants, infertility clinics (with the HFEA), diabetic services (with diabetes UK), breast cancer clinics (with Breast Cancer Care) and complementary therapists.

For healthcare services, Dr Foster provides tools for analysing and using data, such as the Clinician Outcomes and Benchmarking Tool and Real Time Monitoring. Clinician Outcomes and Benchmarking (COB) is an web-based tool designed for consultants and medical directors. It presents monthly outcome data, casemix adjusted for age, gender and deprivation . It automatically alerts clinicians to potential problem areas where their performance has varied significantly from the departmental or national average. Data presented for common procedures and diagnoses include in-patient mortality rates, lengths of stay, and readmissions.

STANDARD SETTING

The Medicines and Healthcare Products Regulatory Agency (MHRA) and the National Clinical Assessment Service (NCAS) in the National Patient Safety Agency (NPSA) have roles in standard setting, outlined under their description in the 'Data' section.

National Institute for Health and Clinical Excellence (NICE) has the role of 'providing national guidance on promoting good health and preventing and treating ill health' (http://www.nice.org.uk).

NICE is an independent organisation established following the 2004 White Paper 'Choosing health: making healthier choices easier'. It replaced the National Institute for Clinical Excellence (NICE), which was set up in 1999. The tasks of the Health Development Agency (HDA) moved to NICE on 1 April 2005. It produces guidance on health technologies and clinical practice for the NHS, and on public health for a wider audience. Topics may be suggested online by any interested parties to inform the Department of Health in commissioning guidance

Centres	Topic	Countries	Status
Clinical Practice	Clinical Practice	NHS England & Wales	Authoritative
Health Technology	Technology Appraisals	NHS England & Wales	
	Intervention procedures	NHS in England, Wales and Scotland	
Public Health	Public Health Interventions and Programmes	England	Under development

NICE also runs a research and development which commissions research, and has set up an implementation support programme. NHS organisations in England and Wales have been required to fund medicines and treatments recommended by NICE in its technology appraisals guidance since January 2002. Three months are allowed for implementation.

The **NHS Litigation Authority (NHSLA)** manages indemnity schemes for NHS bodies. One of its functions is to 'contribute to the incentives for reducing the number of negligent or preventable incidents' (www.nhsla.com).
The NHS Litigation Authority is a Special Health Authority established in 1995. It is not an insurance company, but manages indemnity schemes for NHS bodies. Membership is voluntary and was universal in 1995. NHSLA strands of work include handling negligence claims against the NHS in England, active risk management to raise NHS standards and reduce negligence claims, monitoring human rights case-law, handling family health service appeals and dealing with equal pay claims for the NHS.

As part of risk management, it produces NHSLA Standards for different clinical areas, based on evidence assessed by other statutory bodies such as the MHRA. The focus of these standards is on strategies with the potential to reduce negligence claims.

The **General Medical Council (GMC)** sets and regulates standards of professional behaviour for doctors (www.gmc-uk.org).
All doctors must be registered with the GMC to practise in the United Kingdom. If the GMC judges that a doctor has breached the standards it sets in Good Medical Practice it may issue a warning, place conditions on the doctor's registration or remove or suspend the doctor from the register.

The GMC also set and monitor standards for education and training in the UK as an undergraduate and in the first year of training. Medical schools are inspected to ensure the standards in Tomorrows Doctors are met in training and assessment. This is achieved through inspection visits and annual submission of information from the medical schools.

The **Nursing and Midwifery Council** (NMC) sets standards for professional conduct and maintains a register of qualified nurses and midwives (www.nmc-uk.org).
The Nursing and Midwifery Council judges allegations of misconduct or unfitness to practise, and has the power to remove nurses from the register. The NMC also sets standards for nursing and midwifery education and has appointed HLSP, a healthcare consultancy, for quality assurance of education.

Royal Colleges exist for most specialties of medicine. The most active in the quality field are arguably the Royal College of Physicians of London and the Royal College of Surgeons of England. Colleges also exist for general practitioners, pathologists, ophthalmologists, obstetricians and gynaecologists, radiologists, anaesthetists, paediatrics and child health, occupational medicine and public health medicine. Several of the colleges are UK wide, but the surgeons and physicians have separate colleges in the devolved administrations.

Entrance to a medical specialty is by achieving membership of a college examination; examinations for this are set and administered by the relevant college, who are thus directly involved in standard setting for medical practice. Colleges issue guidelines on clinical topics and more general issues such as medical education. National audits are often led by the colleges, for example the Royal College of Physicians' Lung Cancer Programme. Organisations such as National Institute for Health and Clinical Excellence (NICE) and the Department of Health often use the colleges as a source of medical expertise for standard setting committees.

The **Academy of Medical Royal Colleges** is formed of representatives from all the colleges (medical and surgical, including those in Scotland and Northern Ireland). It issues reports and guidance to doctors and healthcare organisations on healthcare issues relevant to all specialties, such as continuing professional development.

National Service Frameworks ((NSFs) are 'long term strategies for improving specific areas of care. They set measurable goals within set time frames'
(http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/DH_4070951).

NSFs set out standards that should be achieved and propose mechanisms for doing so. They are developed by an external reference group, managed by the Department of Health. Topics covered so far include cancer, mental health, diabetes, renal services, chronic obstructive pulmonary disease (COPD), paediatric intensive care and coronary heart disease. NSFs are one of the main mechanisms of implementing the NHS Improvement Plan 2004. Earmarked funds are available to Primary Care Trusts (PCTs) for implementation of the NSFs.

Condition specific charities play diverse roles in the quality landscape, but some are particularly significant in standard setting, such as the British Thoracic Society (BTS www.brit-thoracic.org.uk), which publishes authoritative clinical guidelines for respiratory conditions, as well as educational material and audit tools. Others play a more indirect role in standard setting, by lobbying to represent the interests of patients with particular conditions.

INSPECTION

The Confidential Enquiries (administered by the National Patient Safety Agency, NPSA) and the Healthcare Commission play significant roles in inspection, described when they appear in the 'Data' section.

The **Audit Commission** is 'an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively' (www.audit-commission.gov.uk).
The Audit Commission audits NHS trust, primary care trust and strategic health authority financial systems, and produces reports on financial management improvement. It is currently implementing the data assurance framework for payment by results, which includes developing benchmarks for the quality of the data that is used to measure the quality of care.

Monitor is an 'independent regulator of NHS Foundation Trusts' (http://www.monitor-nhsft.gov.uk).
Monitor assesses applicants for NHS foundation trust status, and regulates foundation trust management. It was established in January 2004 and its role is set out in the National Health Service Act 2006.

Inspection of foundation trust performance is carried out by the Healthcare Commission. Monitor receive the inspection results and assigns a risk rating to each of the 77 foundation trusts for its finance, governance and mandatory service provision. It can intervene in trust management if they are failing to comply with their terms of authorisation.

Primary Care Trusts (PCTs), Trust Boards and Strategic Health Authorities have statutory responsibilities regarding the quality of services they provide.

Primary Care Trusts are responsible for ensuring quality services are delivered by healthcare providers, through commissioning and contracting of services. PCTs in turn are accountable to Strategic Health Authorities, and to their local populations directly and through Overview and Scrutiny Committees (OSCs). PCTs are led by Trust Boards, which have a lay majority.

Strategic Health Authorities (SHAs) are responsible for ensuring that PCTs deliver a high quality service. SHAs monitor through assessments and performance management, and have the power to regulate performance through commissioning and contracting arrangements.

SUPPORT

The Medicines and Healthcare Products Regulatory Agency (MHRA) and the NPSA's Research Ethics branch play some role in support, outlined when these organisations were included in the 'Data' section.

The **NHS Institute for Innovation and Improvement (NIII)** exists 'to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership' (www.institute.nhs.uk).

The NIII develops packages of tools to support NHS providers and managers in achieving high quality service delivery. The 'No Delays' package is designed to help service providers and commissioners achieve the target for maximum waits of 18 weeks in all NHS services. It includes an online statistical analysis tool and a range of products designed to help services improve their patient flow. 'Care Outside Hospital' is a package in development to aid implementation of care in the local community. 'Quality and Value' offers assistance in comparing benchmarking several indicators of productivity. It also includes booklets which focus on particular aspects of clinical care, such as acute stroke, giving advice about running services effectively and efficiently. More generally, the 'Building Capability' programme offers tools for operations management in the NHS. The NIII also provides a forum for sharing ideas and good practice; 'NHS Live'.

The National Institute for Improvement and Innovation incorporates the **National Innovation Centre** (NIC), whose remit is to 'speed up healthcare technological innovations that give patients the greatest benefit' (www.nic.nhs.uk).

The National Innovation Centre has three main areas of work, known as 'hubs'. The 'Innovation Hub' identifies areas of need for new technology and supports NHS staff to develop pre-market products that fit the identified need. The 'Training Hub', based in Imperial College, London, works with industry and universities to improve training in new technology use. The 'Adoption Hub' in Manchester identifies factors that enhance rapid adoption of new technologies by the NHS.

The **Health Innovation Council** was established in Lord Darzi's interim review, Our NHS, Our Future, to be: 'guardians of innovation, from discovery to adoption' (Our NHS, Our Future). The Health Innovation Council will lead and advocate the introduction of high-technology devices, diagnostics and drugs in the NHS. It will be chaired by Lord Darzi; NICE, the National Institute for Health Research and the NHS Institute for Innovation and Improvement will all participate.

The **Independent Reconfiguration Panel (IRP)** was established as 'the independent expert on NHS service change' (www.irpanel.org.uk) The Independent Reconfiguration Panel was established in 2003 to provide independent advice on contested cases of change in the NHS service provision. To try to prevent these events, it also offers advice throughout the NHS on implementing change in service provision, and spreading good practice.

The **National Institute for Health Research** is committed to 'establishing the NHS as an internationally recognised centre of research excellence through supporting outstanding individuals, working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public' (www.nihr.ac.uk).

It was established as part of the Best Research for Best Health government strategy, and is directed by the Department of Health's Director General of Research and Development. Its remit covers research capacity development, developing research networks, reducing bureaucracy in research governance, providing an infrastructure for research in the NHS and funding research programmes.

The Office for Strategic Coordination of Health Research (OSCHR) will take an overview of the budgetary division and research strategy of both the Medical Research Council (MRC) and NIHR.

The **Medical Research Council** is a publicly-funded organisation dedicated to improving human health by funding medical research. It funds biomedical and clinical research according to the priorities it identifies and publishes in its strategy documents.

Wellcome Trust is a charity funding research in biomedicine, the medical humanities such as ethics and the commercial application of research technology. It also supports project promoting public engagement with science (www.wellcome.ac.uk).

It plays a significant role in medical development, investing more than £400 million per year in biomedical research. Projects funded by Wellcome Trust have included the sequencing of the human genome, development of the antimalarial artemisinin and the evidence base for steroid treatment for premature babies.

The **King's Fund** is an independent charity, aiming to develop: 'informed policy, by undertaking original research and providing objective analysis; effective services, by fostering innovation and helping put ideas into action; and skilled people, by building understanding, capacity and leadership' (www.kingsfund.org.uk).

The King's Fund publishes respected and thorough reports and papers on health and social care policy and practice, runs leadership development courses, holds conferences, and funds healthcare research in London. Recent reports include the Wanless Healthcare Spending Review and Assessing the Implementation of Agenda for Change. Current projects include an examination of commissioning, providers, regulation and performance in the NHS.

The Health Foundation is an independent charity, 'working to improve the quality of healthcare across the UK and beyond' by 'bridging the gap between policy, practice and research' (www.health.org.uk).

It spends £20 million annually on funding projects to improve healthcare quality, for example initiatives to engage clinicians in quality improvement and the Safer Patient Initiative, which aims to support healthcare organisations improve patient safety. It also runs leadership schemes, including prestigious fellowships, and publishes reports on research, evaluations and public consultations.

They are currently funding the Quest for Quality and Improved Performance (QQUIP). This initiative will provide independent reports on a wide range of data about the quality and performance of healthcare provided in the UK, which will be highly relevant to the Next Stage review.

The Patients Association is a registered charity, 'committed to making a difference to the 'Patient Journey" by asking patients for their experiences of health services and sharing this with the NHS to try to improve services from a patient perspective (www.patients-association.org.uk).

Current campaigns centre on healthcare associated infections, chronic pain in the elderly, counterfeit medicines, increasing voluntary organ donation, the GP contract, access to dentistry, patients' rights, and mixed sex wards.

Of relevance to the Next Steps review, it is currently surveying patients views on the future of the NHS for its 60th anniversary.

The National Library for Health (NLH) exists 'to help patients and professionals use best current knowledge in decision-making' (www.library.nhs.uk).

The National Library for Health runs a single-point-access national digital library, as well as national specialist libraries. In each healthcare organisation it plans that a board member will be identified as Chief Knowledge Officer, each to be supported by a librarian working as Knowledge Manager; this scheme has received a commitment from 1,275 librarians.

APPENDIX 2.

STANDARDS: TERMINOLOGY, TAXONOMY AND USE

Selected clinical quality assurance and improvement tools: definitions

Standards are short statements (sometime incorporating numerical data) of the required level of performance of a clinical service in relation to aspects of diagnosis, treatment, technical procedure or care. Standards may be set so as to achieve minimal acceptable, optimal or 'best' performance and may be derived from research evidence (preferable) or professional consensus.

Practice or clinical guidelines are longer statements setting out optimal or 'best' practice in relation to the diagnosis, treatment or care of a particular illness or group of patients, the use of a particular intervention or the clinical organisation of a service. They aim to align practice with the guideline and thereby promote good practice. To achieve compliance with best practice in more specific terms. they can incorporate explicit standards or be used to derive them.

Clinical pathways are descriptions of the desired process of care for particular diseases or patient groups. This may be done in several ways: as a set of steps that should be incorporated (sometimes expressed as explicit standards), as a flow of care with each linked stage defined (again sometimes incorporating explicit standards) or as a formal algorithm or decision tree (with or without standards). Clinical pathways can cover the process of care within an episode, sector or institution or more widely, for example addressing the coordination of care across its primary, secondary and community elements.

Care bundles are sets of specific evidence-based interventions or actions aimed at improving outcomes or reducing risks of care in a defined area of care (e.g. intensive care, acute care, healthcare infection). This relatively new quality

Source: Donaldson L.J. (2008)

Selected clinical quality assurance and improvement tools: a taxonomy

Concept	Characteristics	Purpose	Necessary clarifications
Standard	Short description of what is to be achieved; may incorporate numerical material as well as narrative statement.	Achieve a particular level of performance in relation to quality of care.	• State whether standard is minimal, optimal or 'best' • Specify the criteria to be used for assessment • State whether the standard is based on research evidence or professional consensus
Guideline	Describes the preferred treatment or approach to care of a disease or group of patients. Often includes algorithms or options for different subgroups of patients. May include or be used to define explicit standards.	Promote good practice in specified field of care.	• State whether based on research evidence or professional consensus
Pathway	Specifies process of care; in some cases limited to a segment of the care (e.g. in hospital); in other cases embracing the whole of care including movement between sectors (primary, secondary, community); may or may not incorporate explicit standards.	Standardise care to improve outcomes, efficiency, patient convenience and satisfaction.	• Make clear which elements are national and which local
Care Bundle	Collection of evidence-based processes known to achieve particular outcomes of care or reduce specific risks.	Improve outcomes or safety of care in a service unit (e.g. intensive care) or across a group of service units (e.g. intensive care units in a region).	• Must be evidence based • Interventions must all be applied together

APPENDIX 3

PRINCIPLES OF THE NHS

The NHS Plan in 2000 was underpinned by a set of core principles, which key stakeholders supported. Some restated founding principles of the NHS, others reflected issues that were important at the time.

Principles of the NHS
As providers of care to NHS patients we commit ourselves to the following 10 principles:

1. The NHS will provide a universal and comprehensive service with equal access for all, free at the point of use, based on clinical need, not ability to pay.
   Healthcare is a basic human right. Unlike private systems, the NHS will not exclude anyone because of their health status or ability to pay. Access to the NHS will continue to depend upon clinical need, not ability to pay. Unless a charge has been specifically sanctioned by the NHS (eg for prescriptions or dental treatment), we will not charge a fee or require a co-payment from any NHS patient. We will provide appropriate care for all those referred to us, within our clinical competence.

2. We will help keep people healthy and work to reduce health inequalities.
   We will continually seek opportunities to promote health, as well as to treat illness. Recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition, we will work with other services as appropriate to prevent ill health and reduce health inequalities.

3. We will work continuously to improve quality and safety.
   We will ensure that services are driven by a cycle of continuous quality improvement. Quality will not just be restricted to the clinical aspects of care, but include the entire patient experience. We will work with our staff, our patients and the public, those commissioning care and the regulators to make the care we provide ever safer and support a culture where we can learn from and effectively reduce mistakes. We will provide information about the outcomes of the treatment we provide, complying with national inspections and regulation.

4. We will strive for the most effective and sustainable use of resources.
   We will continuously seek to improve our efficiency, productivity and performance in order to provide the best value for tax payers' money, recognising that best care and best value go together. We are committed to the sustainable use of resources and will aim to reduce our use of energy and other natural resources, minimise production of waste and contribute to the sustainable development of the wider community.

5. We will treat every patient with dignity and respect.
   We will treat every patient, service user and carer as a valued individual, with respect for their dignity and privacy. Our aim is to give each patient the care and service we would want for ourselves and our families.

6. We will shape our services around the needs and preferences of individual patients, their families and their carers.
   As far as possible, we will design our services around the needs of our users and their carers, rather than expecting them to fit around our convenience. Wherever possible, we will offer patients and the

public more choice and a greater say in their treatment, and will seek to engage them, individually and jointly, in designing and improving services.

7. We are committed to equality and non-discrimination.
   We are committed to equality for patients and service users no matter what their age, gender, disability, sexual orientation, race, language, religion or national, ethnic or social origin. We will seek to provide services that are culturally appropriate to the needs of different communities.
8. We will support and value our staff.
   The strength of our organisation lies in our staff, whose skills, expertise and dedication underpin all that we do. They have the right to be treated with respect and dignity. We will continue to support, recognise, reward and invest in individuals, providing opportunities for staff to progress in their careers and encouraging education, training and personal development. Professionals and organisations will have opportunities and responsibilities to exercise their judgement within the context of nationally agreed policies and standards.

9. We will work in partnership with others to ensure a seamless service for patients.
   We will work in partnership and co-operation with others providing and commissioning NHS and social care services, including in the public, voluntary and private sectors, to ensure a seamlessly co-ordinated, patient-centred service. We will share clinical information with other providers of care to ensure that patients receive a seamless service, wherever they are.

10. We will respect the confidentiality of individual patients and provide open access
    to information about services, treatment and performance.
    We will respect the confidentiality of patients and service users throughout the process of care, including access to their information. Wherever possible, we will provide high quality information and support to patients and the public about services and treatments that are available, and their performance, to improve transparency and accountability. Where technology can improve patient safety, we will use it. We will publish information about our clinical and operational performance to allow the NHS to assure quality and enable patients to make informed choices.

APPENDIX 4

RELATIONSHIPS WITH THE FUNCTIONS OF THE INSTITUTE OF MEDICINE

Organisations which currently pursue activities related to Institute of Medicine functions include:

a. Integrate clinical knowledge systems to a single access point
   - i. The National Library for Health
   - ii. The Information Centre
   - iii. Office for National Statistics
   - iv. Public Health Observatories
   - v. National Patient Safety Agency
     - Patient safety division
     - Confidential Enquiries
   - vi. Medicines and Healthcare Products Regulatory Agency
   - vii. Dr Foster (non-statutory)
   - viii. National Audit Office
   - ix. National Clinical Audit Advisory Group and national audits
   - x. Healthcare Commission

b. Set authoritative standards:
   - xi. The National Institute for Health and Clinical Excellence
   - xii. ongoing work on National Service Frameworks
   - xiii. NHS Litigation Authority
   - xiv. General Medical Council
   - xv. Nursing and Midwifery Council
   - xvi. Medicines and Healthcare Products Regulatory Agency
   - xvii. National Patient Safety Agency
   - xviii. Royal Colleges (non statutory)
   - xix. Condition specific professional organisations and charities (non statutory)

c. Support service improvement
   - xx. National Institute for Innovation and Improvement
   - xxi. Medicines and Healthcare Products Regulatory Agency
   - xxii. The King's Fund
   - xxiii. Health Foundation

d. Administer Clinical Excellence Awards
   - xxiv. the Clinical Excellence Award Scheme

e. Accredite against preferred standards
   - xxv. Healthcare Commission
   - xxvi. Audit Commission
   - xxvii. Monitor
   - xxviii. Confidential Enquiries

APPENDIX 5

NATIONAL QUALITY AND SAFETY FORUM NEVER EVENTS (www.qualityforum.org)

1. Artificial insemination with the wrong donor sperm or donor egg
2. Unintended retention of a foreign object in a patient after surgery or other procedure
3. Patient death or serious disability associated with patient elopement (disappearance)
4. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
5. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
6. Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
7. Patient death or serious disability associated with a fall while being cared for in a healthcare facility
8. Surgery performed on the wrong body part
9. Surgery performed on the wrong patient
10. Wrong surgical procedure performed on a patient
11. Intraoperative or immediately post-operative death in an ASA Class I patient
12. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
13. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
14. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
15. Infant discharged to the wrong person
16. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
17. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
18. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
19. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
20. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
21. Patient death or serious disability due to spinal manipulative therapy
22. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
23. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
24. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
26. Abduction of a patient of any age
27. Sexual assault on a patient within or on the grounds of the healthcare facility

APPENDIX 6

PUBLIC CONSULTATIONS

Recommendation	Submission supports recommendation	Submission identified recommendation theme as area of importance
1. Accountability and System level goals	• Monitor • NICE • Impress • Age Concern • Health Foundation	• Northgate
2. Dashboards	• Director, Innovation, Business Development and Performance, South West Essex Primary Care Trust • Royal College of Obstetricians and Gynaecologists	• British Heart Foundation • Imperial College • Northgate • Monitor • Royal College of General Practioners • Which? • NICE • University Hospitals of Leicester, Renal Unit • The Princess Royal Trust for Carers • Age Concern • Director of Information Systems, Addenbrook's Hospital • Breakthrough Breast Cancer • MRSA Action UK • Deltex Medical Group • Appointments Commission • BUPA • Health Foundation • Asthma UK • Faculty of Public Health • NHS Confederation • Director of Clinical Development South Staffordshire and Shropshire Healthcare
3. Rationalisation of standards	• NICE	• Dignity in dying • Age Concern • Foundation Trust Network

Recommendation	Submission supports recommendation	Submission identified recommendation theme as area of importance
4. NHS Preferred Pathways	• Novartis	• Royal College Of Paediatrics and Child Health • Clinical Director, Mental Health Research Center, Durham University • St Thomas Medical Group Research Unit • Alliance Boots
5. Institute of Medicine	• Centre for Evidence-based Purchasing • Royal College of Obstetricians and Gynaecologists • Health Foundation	• Northgate • Monitor • Breakthrough Breast Cancer • The Society of Radiographers • NHS Confederation
6. Regulatory Framework	• Royal College of Surgeons of England • Royal College of General Practioners• • Tuke Institute of Medicine • Pharmaceutical Services Negotiation Committee	• RCGP Tamar Faculty • Health Professions Council • Alliance Boots • Breakthrough Breast Cancer • Health Foundation
7. Funding for quality	• Royal College of Surgeons of England • Diabetes UK • Deltex Medical Group • Monitor • ABPI • Impress • Milliman Care Guidelines	• Brook • Terrence Higgins Trust • Bliss • Unison • Royal College of Obstetricians and Gynaecologists
8. Commissioning	• Monitor • NICE	• Royal College of Surgeons of England • Unison • Macmillan Cancer Support • British Association for Perinatal Medicine

Recommendation	Submission supports recommendation	Submission identified recommendation theme as area of importance
9. Duties of a team	• Health Foundation	• Monitor • Social Enterprise Coalition • Impress • National Health Service Retirement Fellowship
10. Clinical leaders facilitating change		• British Heart Foundation • Keep our NHS public (Oxford) • Monitor • Workforce Review Team • Health Foundation
11. Reshaping Clinical Excellence Awards		• Monitor • NHS Confederation
12. Employees as partners	• Cancer Reform Strategy	• Keep our NHS public(Oxford)•
13. Never events	• Monitor	
14. Patient Safety Initiative		

RESTRICTED - MANAGEMENT

Next Stage Review: Quality and Safety National Group

ourNHS
our future

Final Submission to Lord Darzi
March 2008
Accompanied by report Best and Safest Care

Quality and Safety Workstream: Executive Summary

Vision of the Work of Quality and Patient Safety Strand of the NHS Next Stage Review

- To make quality and patient safety the common currency of the NHS through which services are planned, designed, managed, assessed and funded
- To ensure that every NHS organisation's business plan and quality plan are one and the same document
- To achieve greater consistency in the delivery of accepted standards of best practice
- To drive sustained reduction in the risks of healthcare

Aims of Quality and Patient Safety Strand

- The overall aim of this strand of work is to mainstream quality and patient safety within all aspects of the work of the NHS: in policy-making, in planning and commissioning, in design and delivery of services. The studies of high performing services provided a clear and consistent picture of the nature of clinical teams that deliver excellence on a day-to-day basis. The challenge is how to make this the norm throughout the NHS and to move away from the situation where there are only the isolated 'islands of excellence' described by one member of NHS staff
- It is intended that the proposals in this report will help NHS Next Stage Review to make quality and safety the currency of the modern NHS in a way and on a scale that has not been possible in the past;
  - **There are no quality improvement goals at system level**
  - **Heterogeneity of standards and guidelines with confusion about their definition, use and importance**
  - **Clinical leaders in the current system face multiple barriers: lack of peer support, inability to respond to national standards which are not relevant to their unit and a lack of incentives to improve the quality of their unit and share their learning more widely**
  - **Information on clinical quality is poor, so too are clinical skills in improvement science and performance assessment**
  - **The commissioning function is not aligned to levering regular and sustained improvements in quality and patient safety**
  - **There is a great absence of patients and family members in the planning and commissioning of services**

Recommendations

- As a result of this context, experience and analysis, 14 proposals for action have been made aimed at:
  - Establishing an accountability framework for quality and safety at the system level and applicable in all service settings
  - Rationalising, defining and clarifying the standards used to drive higher quality, safer care and placing this in the hands of an independent, expert body
  - Simplifying the quality landscape to clarify roles, responsibilities and relationships of different bodies and agencies
  - Redesigning the funding flows and incentives within the NHS to reward higher quality and penalise poor or unsafe care
  - Laying down a set of duties and responsibilities for clinical teams to lead, deliver and demonstrate quality
  - Creating a patient safety initiative to galvanise action, show that risk can be reduced and gain the commitment of patients, the public, the health professionals and managers to a programme of safety
  - Establishing within the new proposed system of regulation of health and social care services, a framework to promote higher quality care

High-level vision for Quality and Safety

	From…	To…
Patients	• Patient satisfaction not measured nationally or paid attention to • Internet searches leading to different standards and pathways of care; unclear what to expect and how to deal with their disease	• Patient satisfaction scores for every patient on every admission input to the clinical dashboard: if patients are satisfied staff are rewarded • Nationally recognised and publicly available IOM gold standard and an accompanying patient's version explaining the best quality of care which can be expected
Public	• Unsafe events often perceived by public as not openly acknowledged or fully adddressed: media panic when they occur • No information on the performance, complication or adverse event rate of hospitals or clinical teams	• Set of never events publicly available, national promise that these events should never occur in hospital • Clinical dashboards publicly demonstrate quality of care delivered by clinical teams. Hospitals and clinical teams accredited based on their performance on key dashboard metrics Information publicly available and understandable
Staff	• More than a million disillusioned, disenfranchised NHS staff • The team is measured against centrally set targets, some of which they do not agree with or are not appropriate to the local service	• All NHS staff in partnership arrangements with their hospitals (cf. John Lewis) with rewards for improved patient satisfaction and highly performing teams • The team picks indicators that it feels are important to the local service. Teams feel ownership over their quality improvement activities

Where we are today on Quality and Safety

Despite the stronger quality and patient safety ethos that exists in the NHS now compared to 10 years ago, fundamental problems remain

Issue	Where we are today
Fair	• Variation in standards of care around the country is extensive
Effective	• Some of the basics (notably cleanliness and health care infection) have been neglected
	• Best practice (based on research evidence) is adopted too slowly and inconsistently
Personalised	• Many patient complaints reveal repetition of the same problems: disrespect for patients and their families, bad communication and poor coordination of care
Safe	• The avoidable risks of health care are still too high
	• Incidents of serious failures in standards of care still occur

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Where we are today on Quality and Safety

Quality and patient safety are not yet embedded in the planning, design and delivery of NHS services

Issue	Where we are today
Shared vision	• There are no quality improvement goals at system level
Clear standards	• Heterogeneity of standards and guidelines with confusion about their definition, use and importance
Barriers to spread and adoption of best practice	• Clinical leaders in the current system face multiple barriers: lack of peer support, inability to respond to national standards which are not relevant to their unit and a lack of incentives to improve the quality of their unit and share their learning more widely
Capacity to improve quality	• Information on clinical quality is poor, so too are clinical skills in improvement science and performance assessment
Drive to improve quality	• The commissioning function is not aligned to levering regular and sustained improvements in quality and patient safety
Patient involvement	• There is a great absence of patients and family members in the planning and commissioning of services

Overview of key recommendations and expected impact

Recommendation	Rationale	Expected Impact on patients, public, staff
1. An accountability framework for better, safer care A set of goals at system level should be established to focus all policies, plans and activities within the NHS on quality and safety	• There is currently no clearly articulated vision of quality in the NHS	• This mechanism will put quality at the heart of planning, delivering, managing and funding healthcare systems, shifting the language of the NHS from that of finance and productivity to one based on quality. With quality as the currency of the NHS a structured approach can be created from vision, through goals to quantifiable metrics
2. Clinical Dashboards Each clinical team in the country should be required to maintain a clinical dashboard to monitor and benchmark performance against standards agreed nationally and locally designed performance indicators. Clinical dashboards would be statutory requirements, publicly available and presented in a common format that is easily understood	• Good clinical data will be key to enabling clinical teams to drive forward quality improvement. A common feature of high performing clinical teams is that they take ownership of service performance, express service goals in terms of clinical benefit to patients and use data as an integral part of their work	• Clinical teams will own and monitor their own performance against measures that they themselves consider valuable and allow them to identify quality improvement needs and design initiatives to address them. Clinicians and managers will be able to judge themselves and be held accountable for their successes in meeting the quality goals. The transparent display of performance data will enable the public and commissioners to make truly informed choices about healthcare

Overview of key recommendations and expected impact

Recommendation	Rationale	Expected Impact on patients, public, staff
3. Rationalisation of existing standards and guidelines Existing standards and guidance should be reviewed to produce a set of preferred standards for all clinical areas	• There are a plethora of standards, pathways and guidelines issued to the NHS from a variety of statutory and non-statutory bodies that often overlap. Front-line clinicians are often left to decide which to prioritise and adhere to and which to ignore leading to a high level of variation in the quality and standards of care	• Staff will be able to understand clearly the standards of care they should be aiming to provide, and base the design of their services around this. Patients will be able to understand the standards of care that they can expect to receive, as the preferred standard will be 'kitemarked'
4. NHS Preferred Clinical Pathways Agreed standardised pathways should be designed for a number of key illnesses	• Pathways can be helpful to standardise the process of care where variable performance leads to substandard care (e.g. stroke), where heavy resource consumption is associated with waste (e.g. cancer care) or where there are serious risks attached to the process of care	• Staff will be able to model local service design around these pathways, adapting them to suit local needs. Patients with certain conditions will follow a set pathway of care, ensuring the receive the highest quality of care
5. An Institute of Medicine An Institute of Medicine should be created to fulfil an independent role in standard setting, knowledge management and support for quality improvement	• The quality landscape is cluttered and confusing. A large number of organizations currently have a role in healthcare quality in England, whether in setting standards, providing support for improvement on the front line or in knowledge management to describe the highest standard of care. There is significant overlap in the roles of many organisations. Creation of an Institute of Medicine will act to rationalise the current quality landscape. It will reduce waste in the form of duplication of functions between existing governmental organizations	• Patients will have greater access to a single set of clear standards, and will be able to compare these to the care they receive. Staff will find it easier to identify and prioritise best practice guidelines and will have access to joined-up help on implementing standards. This will allow staff to improve the quality of patient care they deliver, by providing tools and removing barriers

Overview of key recommendations and expected impact

Recommendation	Rationale	Expected Impact on patients, public, staff
6. A regulatory framework A regulatory framework should be developed to assure quality and penalise poor standards of care	• Current regulation is overburdensome and mixes essential standards with the pursuit of quality	• A strong regulatory framework with explicit essential standards will provide the public and patients with a reassurance that they are receiving an acceptable level of care. Accreditation will drive staff to improve quality in their units as they work to demonstrate excellence. Accreditation will also empower patients to choose service which have demonstrated that they have reached a certain standard of care
7. Funding higher quality, safer care Funding flows should be redirected to support higher quality, safer care. Through variations to the tariff (or extra-tariff payments), the funding levels for higher quality and safer care will be made bigger	• Current Payment by Results (PBR) policies do not financially reward high quality care compared to care of a lower standard. Paying more for high quality care will incentivise healthcare providers to provide a higher quality service. Healthcare providers will strive to deliver high quality care in order to boost organizational revenue	• Staff will be motivated to provide the best care they can to maximise the income of their unit. Aligning incentives can effect considerable change. Patients will receive better, safer care as providers are motivated to provide a higher quality service. The public will be reassured that those providing the best care receive the largest reward.
8. Commissioning of services will be linked to clinical dashboards Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission	• By using clinical indicators which cover both national and local priorities, commissioners will be able to identify which services are providing high quality care and commission care from them. More than this, commissioners will be able to use the lever of commissioning to effect change	• The effect of commissioning will be strengthened as an enabler of quality. This should serve as an incentive for clinicians to take part in both commissioning and also quality improvement. For patients this will result in better, safer care. The public will be able to see clearly through the clinical indicators how well services are doing, enabling them to make choices right for their health status and needs.

Overview of key recommendations and expected impact

Recommendation	Rationale	Expected Impact on patients, public, staff
9. Clinical governance duties for every clinical team All clinical teams should have a specified range of clinical governance duties agreed to ensure the quality and safety of their service	• Clinical teams lack a sense of ownership over the quality of their service. Team duties will ensure that individual clinicians have a clear and explicit understanding of their roles in quality improvement, and promote the accountability by clinical teams to assess and improve the quality of care they provide to patients	• The articulation of quality responsibilities of clinical teams will contribute to a culture in which clinicians are empowered to take ownership of the quality agenda. This will motivate staff, and improve the quality of services for patients. These responsibilities will underpin the facilitation of clinical teams to improve quality by the Institute of Medicine
10. Expanding excellence by making available proven high performing clinical leaders Clinical leaders in units achieving proven levels of excellence in care should be made available to units delivering a similar range of services to help them raise their standard of care	• Clinical leadership needs to be promoted and supported at a local level so that clinical leaders set clinical priorities. Where leadership is left to "the managers" it is difficult to develop outstanding services. We need to move beyond talk of "clinical engagement" and take practical steps to develop a leadership cadre — or "change leaders"	• By nurturing clinical leaders in services achieving proven levels of excellence in care, the NHS will mobilise an enormous knowledge resource. These entrepreneurial pioneers will be encouraged and incentivised to use their knowledge and skills to assist other services in achieving transformative change
11. Reshaping the Clinical Excellence Award Scheme The Clinical Excellence Awards Scheme should be altered to strengthen the link between demonstrated quality of care and financial reward	• Consultants are at the heart of clinical decision-making and service planning, and are therefore in a unique position to help embed high quality care in the NHS. Focussing the criteria for receiving clinical excellence awards on quality improvement activities will create strong individual financial incentives to put quality improvement at the centre of hospital consultant activity	• A reformed clinical excellence award would act to improve the public perception of the awards, and the consultant workforce, by demonstrating that those doctors providing the best service for the patients get the highest rewards. Consultant activity would be likely to alter to focus on quality improvement in order to maximise the likelihood of achieving high levels of financial reward

Overview of key recommendations and expected impact

Recommendation	Rationale	Expected Impact on patients, public, staff
12. Employees as partners A John Lewis-style partnership scheme should be created to enable NHS staff to share in the ownership of their NHS organisation	• Emulating the John Lewis model with its reputation for quality will reinforce the message that quality should be at the heart of the NHS. The John Lewis experience has been that this generates team spirit and competitive drive as teams strive for high performance	• Staff will own a share in their organisation. This will contribute to a culture of cooperation, engage staff and be a mandate to all staff to be involved in improving quality. Patients will receive higher quality care and benefit from the fostering of a stronger team culture
13. Never Events Building on international experience, the NHS should agree a list of 'never events' that are serious, preventable and unacceptable	• Consensus is growing that never events need greater recognition and action to prevent occurrence. This will increase public accountability, make explicit a standard of safety for the NHS, and provide a financial disincentive towards unsafe care	• Patients will receive safer care. Public accountability will be improved through better reporting of never events. Care providers will have a financial incentive to focus on preventing never events. This will renew the focus on patient safety across the NHS
14. A patient safety initiative A patient safety initiative should be launched to take life-saving action to reduce catheter-related bloodstream infection nationwide	• Matching Michigan's success in saving lives in ICUs will embed a measurement and evidence-based approach to patient safety	• The implementation of the scheme will make care safer for patients. Openness in recording and reporting the incidence of catheter-related bloodstream infections will increase public accountability. Staff will be encouraged and enabled to put best practice into practice to reduce catheter-related bloodstream infections; and Michigan's example shows it can be done

High-level sequencing and associated cost outlines

Recommendation	Implementation sequence/timing	Anticipated cost implication
1. An accountability framework for better, safer care	• July 08 Set framework	• Developing the system level quality goals cost negligible
2. Clinical Dashboards	• July 08 Pilot three dashboards • 2008-9 Roll out nationwide	• Pilot (£500,000 - £1m) will inform better estimate of short to medium costs of dashboard development
3. Rationalisation of existing standards and guidelines	• July 08 Establish mechanism • 2008-9 Prioritisation of topics • 2009-14 Kitemarking programme	• Cost will depend on mechanism chosen to rationalise standards
4. NHS Preferred Clinical Pathways	• July 08 Establish mechanism • 2008-9 Selection of topics • 2009-18 Pathway development	• Cost will depend on number of pathways chosen and mechanism
5. An Institute of Medicine	• July 08 Establish IOM structure • 2008-9 IOM functions start up	• Cost will depend on functions included in the IOM and existing bodies merged
6. A regulatory framework	• 2008-9 Establish regulatory framework • Spring 2010 Care Quality Commission begins registration	• Running an accreditation scheme may cost more than acting as the gatekeeper for data collection on behalf of other accreditors
7. Funding higher quality, safer care	• 2008 Scope tariff variability • 2008-9 Pilot tariff variation • 2009-12 Roll out nationwide	• Could be cost neutral

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High-level sequencing and associated cost outlines

Recommendation	Implementation sequence/timing	Anticipated cost implication
8. Commissioning of services linked to clinical dashboards	• 2009-10 Run at dashboard pilot sites • 2010-18 Roll out nationwide	• Developing the system level quality goals would require relatively few new resources
9. Clinical governance duties for every clinical team	• July 08 Establish duties	• Setting out duties negligible cost Support to implement covered by other recommendations
10. Making available proven high performing clinical leaders	• 2008 Establish Institute of Medicine • 2008-9 Recruit Fellows	• Low cost to support and reward small number of individuals
11. Reshaping the Clinical Excellence Award scheme	• 2008 Establish Institute of Medicine • 2008-9 Reshape CEAs	• Cost neutral
12. Employees as partners	• 2008-9 Pilot in volunteer Trusts • 2009-14 Roll out nationwide	• Could be run as cost neutral but likely to be more effective if invest
13. Never events	• 2008 Identify never events • 2009 Require full reporting • 2009-18 Introduce tariff penalty (stagger: events one at a time)	• Short term cost neutral (support service to reduce event incidence, save on tariff) Long term cost saving
14. A patient safety initiative	• 2008 Task NPSA • 2009-10 *Matching Michigan*	• Reducing catheter-related bloodstream infections saves costs Initiative coordination low cost

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Recommendation 1: An accountability framework for better, safer care

A set of goals at system level should be established to focus all policies, plans and activities within the NHS on quality and safety

"It's hard to answer the question about 'How good is our quality' because we don't have an overall quality measurement framework, and so we only see what is under the lamp posts. What's under those lamp posts seems to be getting better, but what about what's not under the lamp posts?"
Stakeholder interviewee

- During its review on the current status of quality improvement in the NHS, the Institute for Health Improvement repeatedly highlighted the lack of what they termed the 'system picture'. The assessment was that there is currently no clearly articulated vision of quality in the NHS

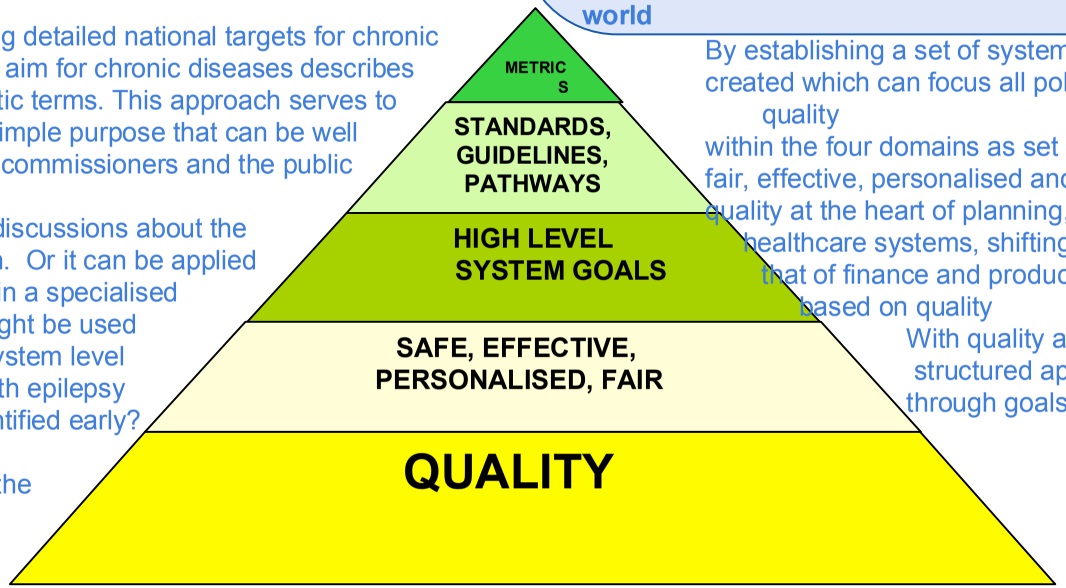
- Without a clear set of system level goals that encapsulate the overall aims of the service it is difficult to examine the quality of services through a meaningful lens at national or local level

- For example, instead of having detailed national targets for chronic disease, the proposed quality aim for chronic diseases describes the desired outcomes in holistic terms. This approach serves to integrate all of the NHS in a simple purpose that can be well understood by staff, patients, commissioners and the public

- It can be applied in strategic discussions about the health status of a large population. Or it can be applied at the front line, for example, within a specialised service where detailed metrics might be used to test performance against the system level goal for a patient being treated with epilepsy or diabetes: Was the disease identified early? Has progression been slowed? Has the care delivered improved the patients' quality of life?

Proposed system level quality goals

SAFE
Make care safer by identifying the risks of care and taking action to reduce them
PERSONALISED
Embed a patient-centred philosophy of care in all processes, procedures and encounters (with patients and their families)
EFFECTIVE
Ensure all clinical and care decisions are appropriate to the patient's needs, evidence-based and cost-effective
Identify chronic diseases early and organise care so as to slow their progression, preventing complications and maintaining health
FAIR
Strive to achieve and demonstrate the highest standards and best outcomes of care when judged against the leading services in the world



By establishing a set of system level goals a framework will be created which can focus all policies, plans and activities on quality within the four domains as set out in *Our NHS, Our Future* – fair, effective, personalised and safe. This mechanism will put quality at the heart of planning, delivering, managing and funding healthcare systems, shifting the language of the NHS from that of finance and productivity to one based on quality

With quality as the currency of the NHS a structured approach can be created from vision, through goals to quantifiable metrics

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Recommendation 2: Clinical Dashboards

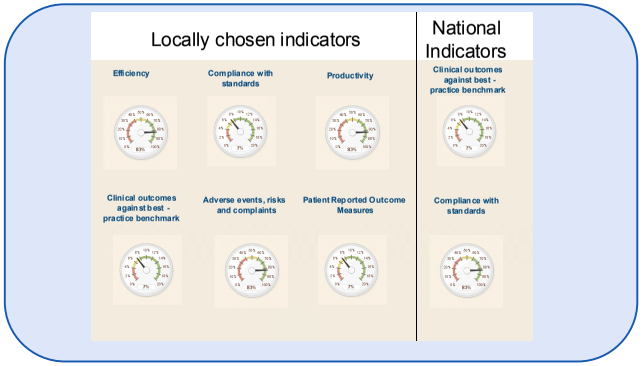
Each clinical team in the country should be required to maintain a clinical dashboard to monitor and benchmark performance against standards agreed nationally and locally designed performance indicators. Clinical dashboards would be statutory requirements, publicly available and presented in a common format that is easily understood

- Our key recommendation to enable all clinical teams to focus on quality improvement is the concept of a clinical dashboard. A dashboard would allow for real time visualisation of performance across a variety of measured variables. The clinical teams will decide what is important for their local services, and choose indicators they wish to focus on to improve quality. They could use data that are already routinely collected and would also decide what additional data they would like to collect to populate indicators reflecting local health population needs. Clinical teams will own and monitor their own performance against measures that they themselves consider valuable. Allowing clinicians access to data about their performance will help to make quality improvement a scientific endeavour. By showing highly motivated individuals variation in performance, curiosity and competition will drive change. For commissioners and patients the dashboards will provide a real objective measure of the quality of one clinical team compared to another, creating a healthy competitive spirit amongst those clinical teams

- Dashboards have been used to drive quality improvement across a variety of industries. Within the NHS Professor Arulkumaran (currently President of the Royal College of Obstetricians and Gynaecologists) has developed a dashboard in an initiative to turn around poor standards in the quality of care in the Maternity Department at Northwick Park Hospital

- The development of dashboards will be a challenging task. Local teams will come together to create their dashboards by selecting indicators at local level in discussion with patient representatives, the public and commissioners to reflect local concerns and interests. They will also rely on national standards and evidence of best practice, nationally and internationally. A central issue will be the proportion of locally defined metrics on the dashboard compared to the nationally defined standards and metrics. A combination will be needed to ensure the correct balance between achieving local ownership and ensuring rigour in adhering to what is known nationally and internationally to achieve the best outcomes of care

- Dashboards will require well-developed, reliable data sources if they are to be effective. Sources used to power dashboards will include data collected nationally and locally by information technology systems, as well as data sets created locally and held on local databases. Delivering dashboards will require close collaboration with the Connecting for Health programme. At present information technology infrastructure does not collect quality related data in many areas. There will therefore be a requirement for local data collection mechanisms. Existing data sources such as the Confidential Enquiries and National Audits would also feed data into the dashboard system in certain clinical areas



A hospital would have a wide range of dashboards reflecting the specialist services they provide and clinical teams running them. An overall picture could be gained at a hospital or regional level by considering a combination of relevant dials. In primary care, existing components of the Quality and Outcome Framework could form a considerable part of the dashboard

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Recommendation 3: Rationalisation of existing standards and guidelines

Existing standards and guidance should be reviewed to produce a set of preferred standards for all clinical areas. This process of rationalising and defining preferred standards would be expected to lead to the generation of outcome indicators for use in clinical team dashboards

- One of the major barriers to clinicians and teams trying to improve quality is the heterogeneity of standards and guidelines. The view reflected to the international reviewers by the NHS stakeholders and staff when they spoke to us was that there are too many standards in the NHS at present. Their heterogeneity is unhelpful. Different organisations set different standards, using different methods and with variable use of evidence. It is not clear which standards must be followed and which are optional as a matter of local discretion. The NHS lacks a clear overarching framework for quality to unite these disparate standards. The variety of standards, dissemination through different access points and lack of coordination across standards and with implementation tools make it difficult for any clinician or team to find, identify and prioritise the standards that are most evidence-based, relevant to them and likely to improve care for their patients. It can also cause confusion for commissioners when trying to assess the quality of the service they are commissioning. A function to co-ordinate the setting of standards, their dissemination and support for implementation is badly needed

- Existing standards set by other organisations are of an internationally respected standards and greatly valued by clinicians. In implementing this recommendation care must be taken to protect the stability and integrity of those organisations which produce standards and support which is valued at the front line. There are a number of organisations who currently set standards. Some existing standards set by other organisations are greatly valued by clinicians, such as the work of the Royal Colleges and the National Institute for Health and Clinical Excellence (NICE), who produce high level, authoritative and widely respected guidelines

Recommendation 4: NHS Preferred Clinical Pathways

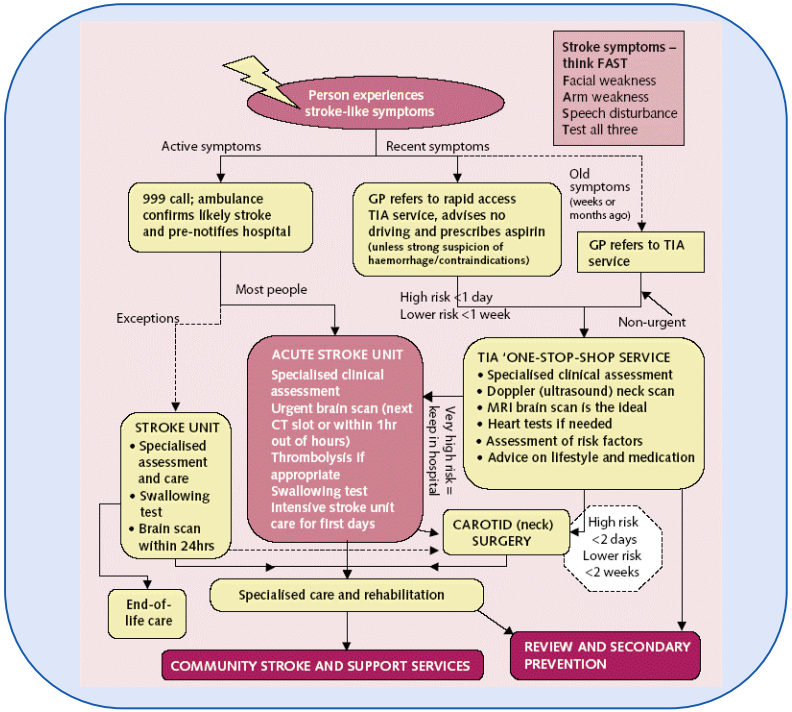
Agreed standardised pathways should be designed for a number of key illnesses based on those where variable performance leads to substandard care (e.g. stroke), where heavy resource consumption is associated with waste (e.g. cancer care) or where there are serious risks attached to the process of care

- To ensure that patients with a particular condition receive the highest quality, safest care that can be promised means looking at the design of the whole service. This can only be done locally but it needs to draw in the best research evidence, the best knowledge of good practice (much of it in formal guidelines). It needs to use the best expertise in the design of processes of care and the experience and views of patients and families. The degree to which formal, explicit standards are included in this service design is a matter of judgement as well as knowing what it is essential to 'standardise' so that the best outcomes are assured

- The concept of **clinical pathways** can be traced back to the 1950s when a so-called Critical Path method was used in other industries, but in the USA in the 1980s the techniques was first widely used in healthcare. The concept has been taken up more recently in the UK. Again it is a term that means different things to different people.

- Creating a pathway involves concentrating on the process of care to:
  - make it more evidence based
  - coordinate more effectively the different stages of care and remove redundant steps
  - make it more 'patient friendly'
  - allow different practitioner groups to understand how their roles and those of others are contributing to the overall plan of care
  - Agreed standardised pathways should be designed for a number of key illnesses based on those where variable performance leads to substandard care (e.g. stroke), where heavy resource consumption is associated with waste (e.g. cancer care) or where there are serious risks attached to the process of care

- **Establishing and agreeing a pathway to achieve consistently high quality can often be a very complex process covering:**
  - **the desired flow of patients through a local or regional health system**
  - **detailed procedural guidance (including clinical protocols)**
  - **explicit standards**
  - **guidance on the organisation and infrastructure of the service**



National Stroke Strategy

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Recommendation 5: An Institute of Medicine

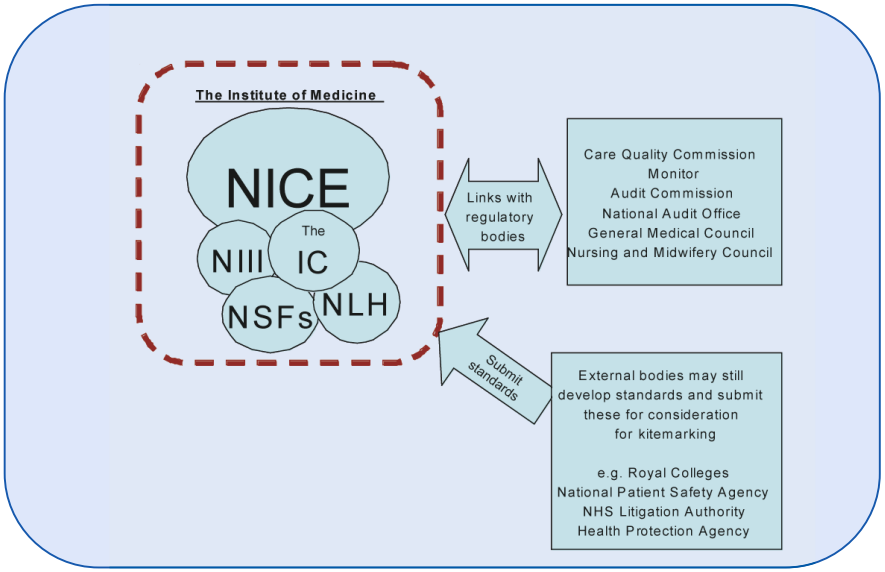
An Institute of Medicine should be created to fulfil an independent role in standard setting, knowledge management and support for quality improvement

What will the Institute of Medicine do to support service improvement?

- Continue the function of the National Institute for Improvement and Innovation in promoting, supporting and disseminating improvements and innovation
- Run a Fellowship scheme of clinical leaders helping drive change in other teams
- Produce or commission toolkits to support the local implementation of dashboards
- Offer 'on-the-ground' assistance with local implementation and use for quality improvement of clinical team dashboards
- In addition to incorporating existing bodies the new Institute would contain the proposed Center for Clinical Evidence, thereby drawing together knowledge management, standard development, leadership fostering and improvement support

It is proposed that the Institute of Medicine should also:

- administer the reformed Clinical Excellence Awards
- accredit clinical teams
- run the NHS Medical Education England body proposed by Sir John Tooke in his report, Aspiring to Excellence



What will the Institute of Medicine do to rationalise standards?

- Integrate clinical knowledge to a single access point
- Review all standards
- 'Kitemark' the best standard in each clinical area to form a set of authoritative standards
- Convert standards into a measurable format suitable for clinical teams to use as a dial on local dashboards
- Set new standards where existing standards are lacking or inadequate
- Design preferred clinical pathways where:
  - key illnesses where variable performance leads to substandard care (e.g. stroke)
  - heavy resource consumption is associated with waste (e.g. cancer care)
  - there are serious risks attached to the process of care
- In all these areas the Institute of Medicine should have a close working relationship with the Royal Colleges and other specialty specific organisations.
- Other organisations, statutory or non-statutory, who wished to set standards would be required to submit these to the Institute of Medicine for kitemarking. Where standards were inadequate the Institute of Medicine would have the capability to produce or commission new standards

The formation of an Institute of Medicine with these functions creates the opportunity for a rationalisation of the organisations in the quality landscape. These will be merged if their primary function overlaps significantly with those of the Institute.

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Recommendation 6: A regulatory framework

A regulatory framework should be developed to assure quality and penalise poor standards of care. This would require every provider of service within (or for) the NHS to be formally licensed to do so. Licences of this sort could be qualified (or 'endorsed') where there is substandard care. A programme of regulation for the commissioning function would be established

Aligning regulation with the quality and safety agenda

- A Bill is currently going through Parliament that proposes the merger of the main regulators of the Healthcare Commission and the Commission for Social Care Inspection. The Mental Health Act Commission will also be part of the merger. Under the new system requirements will be set for health organisations providing services to NHS patients and *inter alia* for private health and social care providers (not described here) top be 'registered' with the Care Quality Commission
- Current thinking within the Department of Health's team dealing with regulation is that most NHS providers will immediately be registered under a 'grandfather clause'. Those which the existing Healthcare Commission has concerns about will be reviewed for fitness for registration. Also within current thinking is the idea that registration requirements are 'minimum standards' would be drawn out from a broader-based quality improvement type standard
- For example, proposed standard 1 in the current draft of the consultation document *A framework for registration of health and adult social care providers* is expressed thus:
"Ensure that people have their health and/or social care needs assessed, and that care and treatment is planned and delivered to appropriately meet those needs, having regard in particular to ensuring their health, safety and welfare and taking account of current evidence-based guidance for relevant professional or expert bodies"
- There are 17 other standards, most of which are similarly broad-based making the construction of one or two aspects of each as 'essential standard' an enormously challenging task. The approach risks falling into the difficulty that essential standards are being placed within a framework of quality improvement. This creates a clash of philosophies. As one NHS chief executive officer put it: "we don't just want to be ordinary, we want to be excellent"

In order to align regulation with the quality and safety agenda, we advise that:

- Basic registration requirements ('essential standards') should be just that: a list of 'must dos' covering issues such as qualified personnel, clean environment, kitemarked equipment
- Basic registration requirements need to be consistent with the private healthcare sector but not necessarily identical
- Accreditation systems should be used by the Care Quality Commission as an adjunct to registration
- Accreditation should be aimed at quality improvement (as well as checking for unsafe practice) based on standards set by the Institute of Medicine and to a large extent using local clinical dashboards
- The Care Quality Commission should act as the gateway for all accrediting organisations to prevent over-burdensome regulation: all data collection in the NHS for accrediting organisations should be conducted through the Care Quality Commission
- Positive incentives will provide a degree of motivation but without the development of censure the ability to ensure safe care will be curtailed. Every provider of service within (or for) the NHS should be formally licensed. Registration licences could be qualified (or 'endorsed') where there is substandard care. In serious cases, retention of Foundation Trust status could be qualified. Endorsing of licenses, in a similar way to driving licenses, may produce effect through public criticism; equally Foundation Trusts may put at risk their autonomy by failure to reach licensing standard. More radical options include the ability of the licensing authority to remove management and impose temporary suspension of bonuses and additional remuneration

As the functions of commissioning are increased, regulation of commissioners may become necessary. A special programme of quality standards and accreditation will be established for the commissioning function itself. This will ensure a process of continuous improvement in the mechanisms and levers used by commissioners to secure higher levels of quality and safety in the provider organisations they relate to

Recommendation 7: Funding higher quality, safer care

Funding flows should be redirected to support higher quality, safer care. Through variations to the tariff (or extra-tariff payments), the funding levels for higher quality and safer care will be made bigger. A proportion of the funding of NHS providers of care would be based on independently conducted surveys of patient experience of the service concerned

- Clinical teams do not work in isolation. At an organisational level, the current system of payment by results allows only the quantity of care delivered to be rewarded. Refocussing financial incentives onto the quality of care provided will allow organisations to focus fully on supporting their clinical teams to achieve high quality care

- Local commissioners should be able to vary their tariff payment based on the quality of service demonstrated by clinical dashboards. In essence the commissioning contract would be able to vary to 102.5% based on achievement of locally set aims. High performing services would not only win contracts but their organisations would be rewarded for maintaining and developing their services in line with local needs

Recommendation 8: Commissioning of services will be linked to clinical dashboards

Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission

- Commissioners will be able to look at a clinical team's dashboard when deciding what service to commission. Commissioners will have improved access to information on what 'best' looks like, through the Institute of Medicine's rationalisation of standards and guidelines. Using the national and local indicators, commissioners will be able to identify which services are providing high quality care and commission care from them

- More than this, commissioners will be able to use the lever of commissioning to effect change. Services that are not performing well face the challenge of failure to be commissioned, or alternatively hospital management utilising other levers such as buying in clinical expertise to effect turnaround. The effect of commissioning can be strengthened as an enabler of quality

- As many indicators will be locally determined, commissioning will therefore be aided to be sensitive to local needs. However commissioners will need to be wary that local indicators are not chosen only because success can be demonstrated. It will be incumbent on the commissioners to ensure that the variety of indicators used is such that services are stretched to improve within a local context

Recommendation 9: Clinical governance duties for every clinical team

All clinical teams should have a specified range of clinical governance duties agreed to ensure the quality and safety of their service

- **The international commissions found that there is currently a gulf between clinicians and managers in their perception of what good quality care is. The system level quality goals address this problem but clinical teams also need to have a clear and explicit understanding of what they are responsible for. To meet this need it is proposed that a formal set of clinical governance duties for clinical teams is agreed**
- The concept of a clinical team is at present not well developed but a working definition is "all the healthcare staff sharing responsibility for the same core set of patients". The configuration of clinical teams will be decided locally, in order to increase ownership of the process. A clinical team in a hospital might be the staff working in an intensive care unit, or an antenatal clinic or an endoscopy service for gastroenterology patients
- In primary care a clinical team could be defined as the team in a single shared practice. This would include all the team working for the practice (including district nurse, practice nurse, receptionist) not just the general practitioners

Proposed quality responsibilities of clinical teams

- Identify, report and analyse adverse events, sources of risk and near misses and as a result demonstrably improve safety
- Continuously assess clinical performance (outcomes and compliance with processes of care) for the main conditions treated by the team, compare results against current best practice and demonstrate regular improvements
- Maintain a clinical dashboard to show clinical activity against standards agreed by clinical specialty
- Adopt (or work to adopt) NHS Preferred Clinical Pathways
- Establish clinical governance arrangements to ensure that quality responsibilities are delivered

Recommendation 10: Expanding excellence by making available proven high performing clinical leaders

Clinical leaders in services achieving proven levels of excellence in care should be made available to services to help them raise their standard of care. These 'change' leaders would be Fellows of the Institute of Medicine.These clinical leaders will be recognised as prestige appointees and this would be reflected in fast-tracking in the Clinical Excellence Awards Scheme

- Clinical leadership needs to be promoted and supported at a local level so that clinical leaders set clinical priorities. Where leadership is left to "the managers" it is difficult to develop outstanding services. There is a need to move beyond talk of "clinical engagement" and take practical steps to develop a leadership cadre — or "change leaders"

- The Institute of Medicine will recruit those with proven track records to become Fellows of the Institute. These Fellows will support or even turn around poorly performing units or teams. These pioneers will be encouraged and incentivised to use their knowledge and skills to assist other services in achieving transformative change. By nurturing clinical leaders in services achieving proven levels of excellence in care, the NHS will mobilise an enormous knowledge resource. Through the Fellowship a broader definition of clinical leadership can be encouraged by formally recognising those who are currently leading

- Being styled as Fellows of the Institute of Medicine these clinical leaders will have the authority to enact change as well as a network of individuals engaged in similar work

Recommendation 11: Reshaping the Clinical Excellence Award Scheme

Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission

- The Clinical Excellence Awards Scheme for consultants will be altered to strengthen the link between demonstrated quality of care and financial reward. As well as rewarding academic or research prowess the new scheme will favour leadership ability. The reformed awards allocation process would make more extensive use of data, including the clinical dashboard to demonstrate quality improvement activity to reward excellence

- Clinical Excellence Awards are an effective mechanism for incentivising consultants because they provide significant financial rewards. Consultants are at the heart of clinical decision-making and service planning, and are therefore in a unique position to help embed high quality care in the NHS. Focussing the criteria for receiving clinical excellence awards on quality improvement activities will create strong individual financial incentives to put quality improvement at the centre of hospital consultant activity

- Use of objective evidence of quality improvement would allow the award process to become more transparent and fair. Current criticism of the awards suggests that measurable quality improvement does not receive that emphasis that it should do and that once awarded, they fail to provide continuing incentive to improve

- The proposed mechanism for introducing objective evidence of quality improvement activity to the award is to link the new clinical dashboards to the selection process. Recipients of awards would be required to demonstrate measurable improvements in quality in their own clinical teams, or continuously high levels of quality, via their own dashboards. Consultants would be required to demonstrate maintained quality improvement activity in order to maintain their awards at high levels. This would ensure that the momentum of quality improvement is continued throughout consultant careers

Recommendation 12: Employees as partners

Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission

The John Lewis partnership

- **A John Lewis-style partnership will enable all NHS staff to share in the ownership of their NHS organisation and to be financially rewarded as a team for improving the quality of their service.**
- Staff will own a share in their organisation. They will receive a bonus at the end of the year based on the organisation's overall performance. The percentage of salary that this represents will be the same for the Chief Executive as a porter. This will motivate all staff to focus on working together to improve the quality outcomes of their services and hospital. It will contribute to a culture of cooperation, staff engagement in quality improvement, and be a mandate to all staff to be involved in improving quality
- The permanent staff of an NHS organisation will in effect 'own' the organisation and share in its income and benefits. Each staff member will become a partner whose individual contribution to the organisation is recognised and rewarded fairly. In primary care many General Practitioners and Practice Managers are already partners in their General Practice. This recommendation will encourage extension of partnership to all members of staff, including for example nurses, receptionists, cleaners and on-site pharmacists
- John Lewis has a reputation for quality in its goods and customer service, that the NHS should aspire to. The John Lewis partnership model has been a success for business reputation, organisational culture and profits. It has been widely imitated by others in industry e.g. PepsiCola, Tesco's and Royal Mail. The John Lewis reputation for quality means that this recommendation will reinforce the message that quality should be at the heart of the NHS, and this will be apparent to staff and the public
- One of the barriers identified by several of the international commissions is the gulf between clinicians and managers. A John Lewis-style staff partnership will build clinical teams around the shared goal of improving patient care and replicate the features of the high performing units, through a shared financial incentive that reflects progress towards the goal that all clinicians and managers share: improving patient care
- Staff partnerships should first be piloted to develop a prototype and to evaluate the scheme. Chief Executives could be invited to volunteer to pilot staff partnership in their organisation. Foundation Trusts are likely to be suitable sites for the pilot. General Practices in which partnership could be extended to all staff would also be suitable
- Partnership could be designed as a cost neutral project, in which current salaries may be paid between, for example, 98 – 102 % depending on performance and the bar is set such that the average is 100%. Achieving this balance requires an estimation of the current level of quality to set the bar at an appropriate level. Pilot sites are likely to be 'early adopters' who may have a higher level of quality than average and so pilot sites may earn more through the scheme. The risk of treating this as a cost neutral project is that it may lead to negative perceptions within the NHS in which it is seen as penalising services who are struggling as much as rewarding those who are achieving. Alternatively, a budget could be allocated to providing bonuses, and salaries could vary between, for example, 100 – 104% of current levels

Recommendation 13: Never events

Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission

"Never events' are defined by the US National Quality Forum as "adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability."

- They include such events as:
  - Wrong surgical procedure performed on a patient,
  - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
  - Patient death or serious disability associated with a medication error
- Consensus is growing that never events need greater recognition and action to prevent occurrence
- In the short term, providers would receive assistance with implementing measures to prevent never events, but would have to pay the costs of episodes of care in which patients experienced never events. The Department of Health should fund the assistance with preventive measures by reducing the funding to commissioners, as they would no longer be paying the cost of episodes of care in which never events were experienced
- Care providers will have a financial incentive to focus on preventing serious preventable adverse events. This will renew the focus on patient safety across the NHS. Staff will be encouraged and enabled to put best practice into practice. The funds made available to pump prime measures designed to reduce never events will help clinicians and managers to improve the safety of their practice

'Never events' in the United States

In the United States, a wide variety of organisations have declared that they will not pay for an episode of care where a 'never event' occurs, and this has been widely successful in promoting patient safety

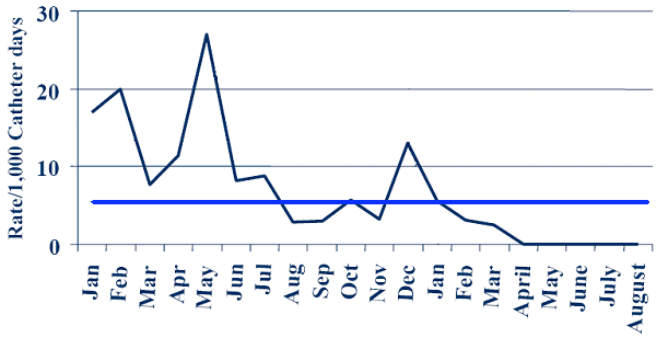
- Several states have enacted laws requiring the disclosure of never events at hospitals and various remunerative or punitive measures for such events
- A recent Leapfrog Group Study found that roughly half of the 1,285 hospitals that responded to their survey waive fees for never events, and that hospitals that do waive fees are much more likely to have perfect scores on the Leapfrog Safe Practices Score survey. Minnesota's hospitals have agreed to stop charging patients and insurance companies for the 27 types of "never events" first identified by the National Quality Forum in 2002. State law has required hospitals to report them since 2004. In 2006 Minnesota hospitals reported 154 of these "never events", in 8 million patient visits
- Health insurance companies have adopted different lists of never events to drive improvements in patient safety. In 2004 HealthPartners announced it would not pay for the National Quality Forum never events. Medicare has announced eight preventable conditions it will not not pay for, including healthcare-associated infections. Only three National Quality Forum conditions are on the Medicare list
- This approach is likely to be most successful when the financial disincentive is combined with a renewed focus on implementing best practice guidance. This is demonstrated by the recent success at Geisinger Health System, a three hospital not-for-profit organisation in Danville, USA. It offers coronary artery bypass surgery for a flat fee that covers any complications occurring within 90 days. As part of the programme, surgeons adhere to 40 best practice measures. After 117 cases, the death rate had reduced from 1.5% to 0%, readmission within 30 days of surgery from 6.6% to 5.1% and length of readmissions and hospital charges were reduced by 5.2%

Recommendation 14: A patient safety campaign

Dashboards should be used as a key component of the commissioning process. Commissioners will make choices informed by clinical dashboards and assessed by the Care Quality Commission

- **Efforts to prevent never events should be supported by a series of initiatives. The first will address catheter-related blood stream-infections in Intensive Care Units called *Matching Michigan***
- **This would be an opportunity to prove that quality improvement can be achieved within the NHS**
- **The Intensive Care National Audit and Research Centre (ICNARC) estimates that there are 218 adult general critical care units in England. *Matching Michigan* in England would thus be on roughly twice the scale of Peter Pronovost's work**

Reductions in ICU catheter-related bloodstream infections across the State of Michigan USA



Michigan's Example

- Professor Peter Pronovost, an intensive care physician at Johns Hopkins Hospital, Baltimore, USA, led a catheter-related bloodstream infection (CRBSI) reduction programme in 103 intensive treatment units (ITUs), representing 85% of all ITU beds in Michigan State, USA
- The five procedures promoted were hand washing, using full-barrier precautions during the insertion of central venous catheters, cleaning the skin with chlorhexidine, avoiding the femoral site if possible, and removing unnecessary catheters. These were selected based on evidence that they were effective in reducing infections with minimal barriers to implementation
- The methods used for promoting these interventions included: clinician education; a checklist for infection-control practices, enforced by preventing clinicians inserting catheters if they were not following this checklist; consideration of catheter removal at every daily round; provision of a 'cart' containing all the supplies needed to insert a catheter according to the guidelines; and monthly and quarterly team feedback on the number and rates of CRBSIs
- These were in the context of a wider package of interventions, including: a daily goals sheet for improving communication among clinicians; a unit-based safety programme to generate a culture of patient safety; and the coaching of a doctor and nurse to lead local implementation
- **This programme led to a sustained reduction (up to 66%) in rates of CRBSIs that was maintained throughout the eighteen month study period. The median rate of catheter-related bloodstream infection decreased from 2.7 infections per 1000 catheter-days at baseline to 0 within the first 3 months after implementation**

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Cross-cutting issues identified and key interdependencies

Dashboards	• Working with the informatics workstream to develop and pilot local dashboards in three sites for clinical teams
Institute of Medicine	• Working with the innovation team to explore synergies with the Centre for Clinical Evidence • Integrating the Fellowship of the Institute of Medicine with the leadership programme of the workforce work stream
Regulation	• Supporting the systems and incentives workstream to develop a regulatory framework
Commissioning	• Supporting the systems and incentives workstream to use objective measures of quality to drive the commissioning process, including developing mechanism for varying the tariff according to the quality of care
Patient Safety	• Working with the National Patient Safety Agency to develop a Matching Michigan initiative
Excellence awards/ Partnerships	• Supporting the workforce and systems and incentives work streams to reshape Clinical Excellence Awards and scope a John Lewis-style partnership

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Summary of impact assessment

- There is evidence to suggest that higher quality care is cheaper in the long run as a result of lower bed occupancy and fewer complications requiring further treatment
- By putting in a Quality Improvement System the quality improvement agenda will be underpinned and move the NHS beyond the essential requirements of quality and safety as framed in the Health and Social Care Bill towards best quality care
- Higher quality care also produces more cost effective use of resources, through encouraging adherence to best practice guidelines and reducing unnecessary variation in care
- Many of the recommendations will be cost neutral and some are potentially cost saving
- More detail is provided in the attached impact assessment

Summary of equality assessment

- The recommendations in the report focus on developing a system of quality improvement across specialties and provider organisations. They aim to create a transparent and fair system through the creation of publicly available data allowing individuals to make informed health choices

- Through the development of metrics co-ordinated through a national centre health risks can be recognised and addressed earlier. Unequal outcomes in care will be identified through easily and routinely available data allowing corrective action to be taken as appropriate

- A systemic approach to quality improvement will work to reduce unnecessary variation across care reducing health inequality through the acceleration of adoption of best practice

- More detailed assessment should be developed when recommendations are selected for implementation