# A First Class Service

*Quality in the new NHS*

The new NHS

# Contents

# Foreword by the Secretary of State

All patients in the National Health Service are entitled to high quality care. This should not depend on the geographic accident of where they happen to live.

The Government is determined that all patients should receive a first class service. The unacceptable variations that have grown up in recent years must end.

Fair and prompt access to modern and dependable treatment, should be the goal. And it must be delivered with courtesy and a real understanding of patients' fears and worries. Clinical decisions should be based on the best possible evidence of effectiveness, and all staff should be up to date with the latest developments in their field.

The Government is determined to place quality at the heart of healthcare. For too long the emphasis has merely been on counting numbers, of measuring activity, of logging what could be logged, but this ignored the real needs of patients.

Efficiency is also important. High quality and cost-effectiveness are two sides of the same coin. Both are needed. The Government is providing new tools to ensure they are achieved. There is no room for second best in the NHS.

The National Institute for Clinical Excellence will ensure authoritative national guidance is available for all health professionals on the latest drugs and technologies.

National Service Frameworks will lay down the care that different groups of patients should expect, building on the work already being carried out for cancer services.

Local NHS organisations will be obliged to take on responsibility for clinical governance – making sure standards are met.

Staff will be enabled to take part in a process of lifelong learning, to keep their skills continually up to date, and the Government is committed to ensuring that standards of professional self-regulation are rigorous and in line with the valid expectations of patients.

The Commission for Health Improvement will carry out a rolling programme of spot checks, and act as a trouble-shooter, to ensure the highest standards are being met.

A national Performance Framework will measure the things that really matter to patients.

A new, annual National Survey of Patient and User Experience will ensure that the voice of the people who depend on the NHS is heard, and acted on.

All these measures will complement and reinforce each other to ensure that high quality care becomes the norm everywhere.

The changes will not happen overnight. They are part of our 10 year programme of modernisation for the health service in England. We will continue to build on and support the expertise and innovation in clinical practice demonstrated by NHS staff. The aim is simple: the best care for all patients, everywhere.

Frank Dobson

*Secretary of State for Health*

# 1

# Introduction

> "*The new NHS* will have quality at its heart. Without it there is unfairness. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality care when they need it. Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality."
>
> Paragraph **3.2** *The new NHS Modern • Dependable*
> Cm 3807:December 1997

*'high quality care should be a right for every patient in the NHS'*

**1.1** High quality care should be a right for every patient in the NHS. The Government wants an NHS that is both modern and dependable. Such a *National* Health Service should guarantee fair access and high quality to patients wherever they live.

**1.2** Over the last fifty years the NHS has done a remarkable job. It has banished the fear of becoming ill for millions of our fellow citizens. Every day its staff treat one million people. It is little wonder that the NHS is our country's most popular organisation.

**1.3** But no organisation, however great, can afford to stand still. The NHS faces more challenges than ever. They are challenges that are common to other health care systems elsewhere in the world coping with greater and faster medical advances. The challenges posed by a better informed and more demanding public. And the challenges that come from shifts in family structures, changes in working life and an ageing population.

*'a series of well published lapses in quality have prompted doubts in the minds of patients about the overall standard of care they may receive'*

**1.4** Today, the public is more likely to question the ability of the NHS to meet these modern challenges. Public confidence has also been undermined by three further factors. By fragmentation in decision-making that has prompted accusations of a lottery in care with patients being denied treatment available in neighbouring areas. The sense that the NHS does not match modern expectations of rapid access to high quality services. And a series of well-publicised lapses in quality that have prompted doubts in the minds of patients about the overall standards of care they may receive.

*'in a National Health Service there must be a guarantee of excellence for all patients'*

**1.5** This Government believes that the NHS can meet these challenges and overcome them. But it must be prepared to change and focus on the things that really matter to patients; high quality prompt services wherever they live. At its best the NHS delivers these services and betters anything anywhere in the world. But it is not good enough for such services to be available to some patients while they are unavailable to others. Every patient judges the performance of the whole NHS by the quality of the care he or she receives in their local GP surgery, their local hospital, from their local midwife or health visitor, their local laboratory. In a *National* Health Service there must be a guarantee of excellence for all patients.

In one region, amongst 35 surgeons, rates of mastectomy for breast cancer varied from nil (meaning all women had breast conservation surgery) to 80%. The average was 18%. Similarly, knee replacement is highly effective in removing pain and improving about 90% of cases. Although the number of replacements is increasing, there is still variation even taking into account the different age profiles of local populations with the rate of elective knee replacements ranging from 18-62 per 100,000 population.

**1.6** Today's NHS does not fulfil the highest expectations for everyone. For a national public service like the NHS there are unacceptable variations in performance and practice. The inequalities go beyond the provision of medicines and other treatments. There are inequalities in the way that some proven treatments get introduced to the NHS too slowly while other unproven treatments can be introduced too quickly. There are inequalities in waiting times for operations; in the time it takes for patients to receive test results; in the number of people given screening tests. There are inequalities in clinical practice – and in clinical outcomes.

There is concern when it is thought patients are being denied potentially beneficial new treatments. But a wider, if less reported, concern is the number of patients being denied proven treatments because of a delay by health professionals and managers in acting on published evidence. The clot-busting drug streptokinase for heart attack victims and blood-thinning drugs such as heparin, to prevent potentially fatal thrombosis after surgery, all took years to come into routine use despite increasing evidence of their benefits. The time lag between research paper and bedside practice means many patients are being denied effective therapy.

**1.7** The variations in quality have complex causes but boil down to four main factors. First, the advent of the internal market shattered the national unity of the NHS into hundreds of small competing businesses where there were no incentives to share best practice. Second, even before the internal market, there were no clear national standards of care which all parts of the NHS were expected to achieve. Third, in the history of the NHS there has never been any coherent assessment of which treatments work best for which patients. Fourth, the NHS as a public service has not been sufficiently open and accountable about the quality of the services it offers to the public.

**1.8** The variation in care that has resulted is wasteful as well as unfair. The cost to individual patients – let alone the taxpayer – is unacceptable. Patients suffer if resources are not used to best effect, just as they suffer if quality standards vary. And such widely differing performance saps the confidence of the public in the very idea of a *National* Health Service. Taxpayers have the right to expect cash spent wisely. Patients have the right to expect services provided fairly. The Government will ensure there is accountability for both efficiency and quality throughout the NHS.

**1.9** The Government has embarked on a ten year programme of modernisation that will see the NHS getting better year by year. Fragmentation in decision-making and two-tier health care are being tackled by abolishing the internal market introduced by the previous government. Quicker access to services will be brought by reducing hospital waiting lists and by the nationwide introduction of the new 24-hour telephone advice service *NHS Direct*. More money is being made to invest for change. The biggest new hospital building programme in the history of the NHS is now underway to give health service staff the modern facilities they need to deliver modern forms of care.

*‘putting quality at the top of the NHS agenda.’*

**1.10** This document spells out how the Government’s modernisation programme will be taken forward by putting quality at the top of the NHS agenda. The objective is to ensure fair access to effective, prompt high quality care wherever a patient is treated in the NHS. The Government’s intention is to ensure clear national standards for services. These will be supported by consistent, evidence-based guidance to raise quality standards in the NHS.

**1.11** This will not mean that local variations in need or the different characteristics of different communities will be ignored. Patients experience the NHS as a local service and the needs of the East End of London are different from the needs of East Surrey. Similarly, it must be for the individual clinician to decide what is in the best interest of the individual patient. Each patient is different and treatment must be tailor-made to their specific needs.

*'a partnership between the Government and the clinical professions'*

**1.12** This document describes the Government's approach to matching consistency in quality across the NHS with sensitivity to the needs of the individual patient and local community. In so doing it moves beyond the NHS models both of the late 1970s and the early 1990s. It rejects the grey uniformity of central control as irreconcilable, both with clinical judgement and with individual patient needs. Equally it dismisses laissez faire local competition as inefficient and incompatible with the drive to ensure that all patients, wherever they live, have access to the same high quality care.

**1.13** We propose a new model which marries clinical judgement with clear national standards. It involves a partnership between the Government and the clinical professions. In that partnership, the Government does what only Government can do and the professions do what only they can do.

**1.14** The Government's third way involves setting clear national standards but with responsibility for delivery being taken locally and being backed by consistent monitoring arrangements. National yardsticks, drawn up through joint working between the Department of Health and the professions, will guide local decisions by managers and clinicians, not tie their hands. Devolution of responsibility will be matched with accountability for performance – as it has to be in a national public service as important as the NHS. *(See Figure1)*

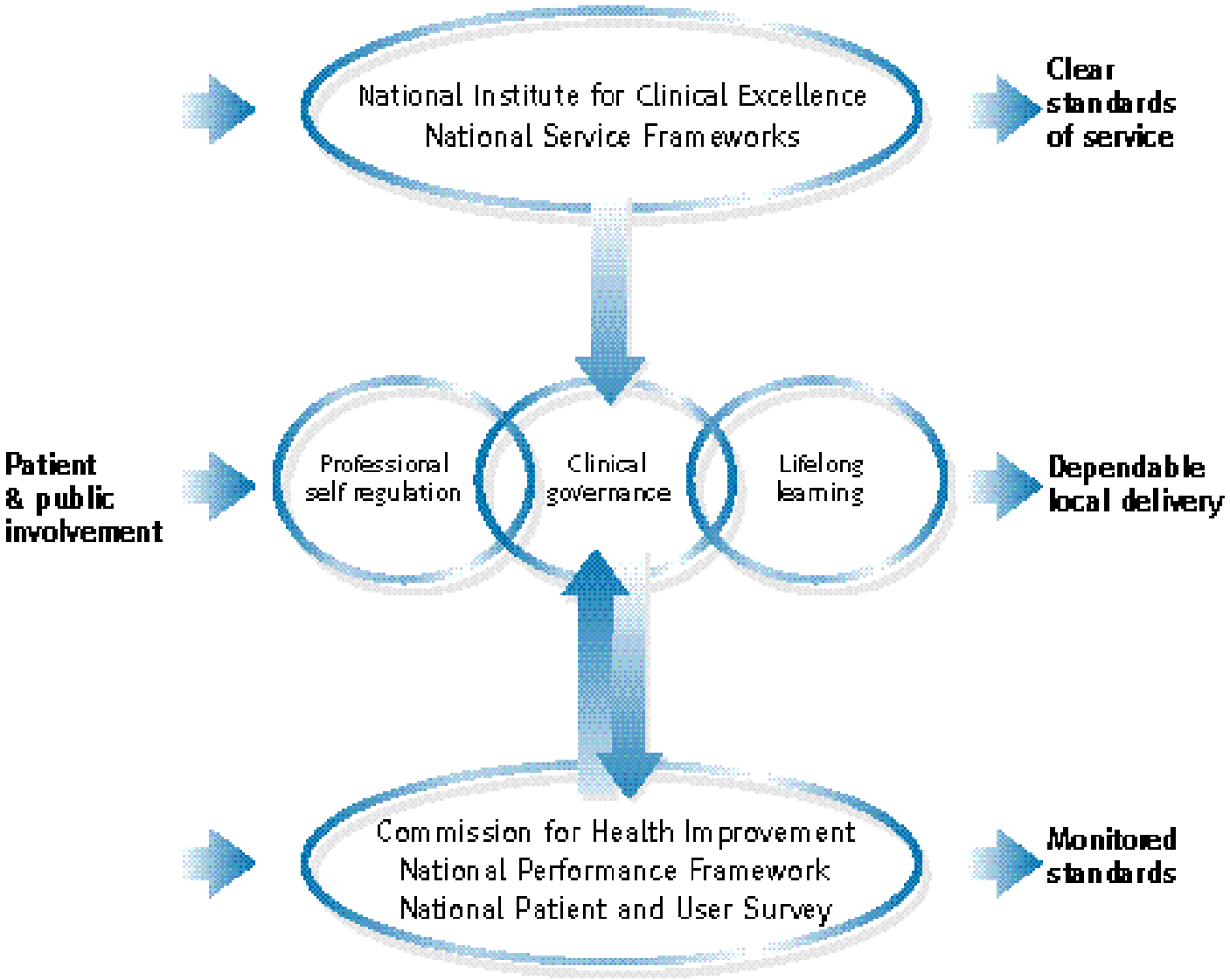
*'National Standards will be set'*

**1.15** National standards will be set through National Service Frameworks and through a National Institute for Clinical Excellence (NICE):

- the National Service Frameworks will spell out how services can best be organised to cater for patients with particular conditions and the standards that services will have to meet. In all parts of

*Figure 1*

## Setting, delivering, monitoring standards



the country the NHS will be required to organise its services to ensure the best quality and the fairest access. The National Service Frameworks, for example, will decide which services are best provided in primary care, in hospitals and in specialist centres:

- NICE will produce clear guidance for clinicians about which treatments work best for which patients. It will assess new drugs, treatments and devices for their clinical and cost-effectiveness. It will mean looking, for example, at whether new medicines could replace existing products or reduce the need for complicated surgery.

**1.16** Standards will be delivered locally through a new system of clinical governance, extended lifelong learning among staff and modernised professional self-regulation:

*'standards will be delivered locally'*

- clinical governance will be the process by which each part of the NHS quality assures its clinical decisions. Backed by a new statutory duty of quality it will introduce a system of continuous improvement into the operation of the whole NHS. Clinical governance, for example, will provide a means for hospitals to identify and address weaknesses in post operative care
- lifelong learning will give NHS staff the tools of knowledge to offer the most modern, effective and high quality care to patients. It will provide staff with the opportunity to continuously update their skills and knowledge. Lifelong learning, for example, will allow NHS staff to identify training needs across professions to aid clinical team-working

*'standards will be monitored'*

- professional self-regulation provides clinicians with the opportunity to help set standards. A modernised regulatory system will allow the professions to more openly account for how standards are set and enforced. Modern professional self-regulation, for example, will play a fuller part in the early identification of possible lapses in clinical quality.

**1.17** Standards will be monitored through three new mechanisms – a Commission for Health Improvement, a National Framework for Assessing Performance and an annual National Survey of Patient and User Experience of the NHS:

- the Commission for Health Improvement will provide an independent means of guaranteeing quality throughout the NHS. Through a rolling programme of reviews of Trusts and the ability to investigate when things are going wrong, the Commission will nip problems in the bud. It will have the power, for example, to intervene at the Government's request, in a hospital where clinical problems have been identified and report to Ministers on remedial action that is needed
- the Performance Framework will judge how well each part of the NHS is doing to deliver quality services. The Framework will hold local services to account against objective criteria which measure performance from the patients' point of view. It will, for example, publish information about whether patients have fair access to similar services in all parts of the country
- the National Survey of Patient and User Experience will ask those who use the services for their views about clinical quality. Conducted and published annually, the Survey will find out whether local services are meeting patients' needs. The Survey, for example, could trigger the involvement of the Commission for Health Improvement if services in a particular area are consistently failing to deliver patient satisfaction.

*'a new emphasis on quality at all levels in the NHS. One that no longer tolerates failure but celebrates success'*

**1.18** Setting standards, delivering standards, monitoring standards – these are the routes to consistent, prompt, high quality services throughout the NHS. There will be a new emphasis on quality at all levels in the NHS. One that no longer tolerates failure but celebrates success. The approach outlined in this document involves the Government taking responsibility for guaranteeing fair access and high quality throughout the health service. For the first time in the history of the NHS standards will be set for how services should be delivered.

*'involving both clinicians and patients'*

**1.19** But the Government cannot deliver high standards by itself. We need the active participation and partnership of clinical professionals and patients throughout the NHS. That is why NICE and the Commission will involve both clinicians and patients. It is why clinical governance arrangements must be developed locally in the NHS. And it is why the Government is setting such store on the views of patients acting as a positive lever for change.

**1.20** The drive to place quality at the heart of the NHS is not about ticking checklists - it is about changing thinking. This document describes how we will do just that. It sets out the Government's approach and, in some places, asks for views about how best our objectives can be achieved. Driving up standards will rely on the commitment and expertise of all those who work in the health service. The staff of the NHS want a first class service. Patients and the Government want it too. By working in partnership we will deliver first class services to patients wherever they live.

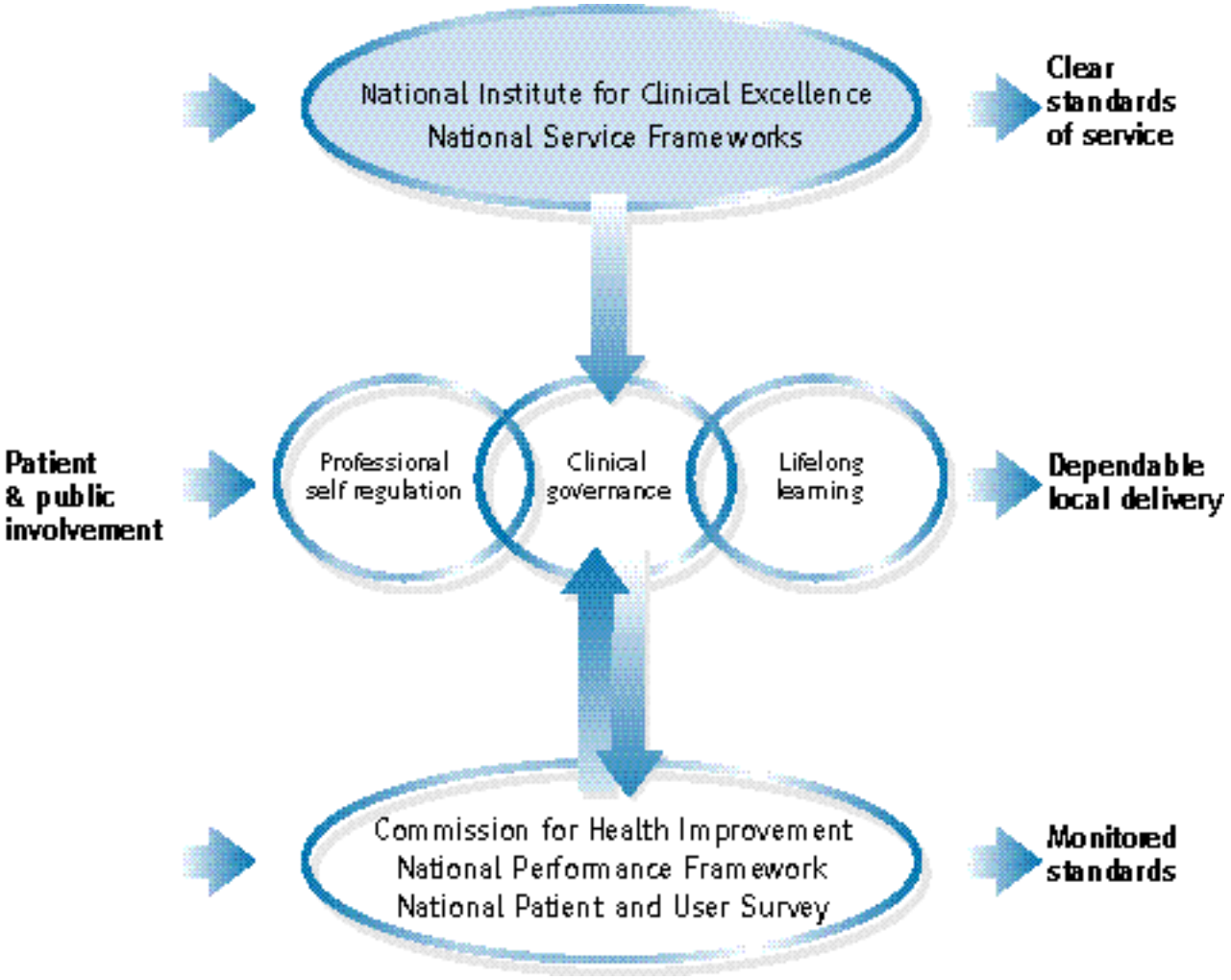
*'The drive to place quality at the heart of the NHS is not about ticking checklists - it is about changing thinking'*

# 2

# Setting quality standards

*Figure 2*

## Setting standards




*National Service Frameworks will set out common standards across the country for the treatment of particular conditions. The National Institute for Clinical Excellence will act as a nation-wide appraisal body for new and existing treatments, and disseminate consistent advice on what works and what doesn't.*

**2.1** High quality services should be available for all patients. At present, there are unacceptable variations in the quality of care available to different NHS patients in different parts of the country. This has to change.

*'at present, there are unacceptable variations in the quality of care available to different NHS patients in different parts of the country'*

**2.2** Improving the quality and consistency of NHS services is an important part of improving the overall health of the population and tackling inequalities in both health and access to care. This Government wants to see a *National* Health Service which offers dependable, high standards of care and treatment everywhere.

**2.3** To achieve this, we need to meet three continuing objectives:

- to improve continually the overall standards of clinical care
- to reduce unacceptable variations in clinical practice
- to ensure the best use of resources so that patients receive the greatest benefit.

Care provided should be:

- appropriate – to peoples' needs
- effective – drawing on best available clinical evidence
- efficient and economic – to maximise health gain for the population.

**2.4** The development of national guidance based on reliable evidence of clinical and cost-effectiveness, on the experience of health professionals and managers, and on the values and wishes of patients will be an essential part of achieving these objectives.

**2.5** The NHS Research & Development (R&D) strategy is now providing access to a rapidly expanding evidence base on health care interventions and services, but the development of guidance from this is confused. In some areas, staff have to decide between apparently contradictory advice about the services to be provided; whilst in others, there is a lack of evidence to guide local staff.

*'this Government wants to see a National Health Service which offers dependable, high standards of care and treatment everywhere'*

**2.6** To remedy this, and to set clear national standards (of what patients can expect to receive from the NHS) the Government intends to establish:

- a new *National Institute for Clinical Excellence* (NICE) promoting clinical and cost-effectiveness through guidance and audit, to support

*'these initiatives will set clear quality standards which all parts of the NHS will be expected to meet'*

frontline staff. It will advise on best practice in the use of existing treatment options, appraise new health interventions, and advise the NHS on how they can be implemented and how best these might fit alongside existing treatments

- a programme of evidence-based *National Service Frameworks* to set out what patients can expect to receive from the health service in major care areas or disease groups. The Frameworks will build on the model being developed for cancer services and children's intensive care.

**2.7** Together these initiatives will set clear quality standards which all parts of the NHS will be expected to meet. Their work will be built on a partnership between the Government, the NHS, the professions and patients. They will set out which services and treatments are most clinically and cost-effective and how these are best delivered for the benefit of patients.

## THE NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (NICE)

"A new National Institute for Clinical Excellence will be established to give new coherence and prominence to information about clinical and cost-effectiveness. It will produce and disseminate:

- clinical guidelines based on relevant evidence of clinical and cost-effectiveness
- associated clinical audit methodologies and information on good practice
- in doing so it will bring together work currently undertaken by the many professional organisations in receipt of Department of Health funding for this purpose
- it will work to a programme agreed with and funded from current resources by the Department of Health.

The National Institute's membership will be drawn from the health professions, the NHS, academics, health economists and patient interests. It will need to have access to an appropriate range of skills, including economic and managerial expertise as well as specialist input on specific issues. The Government will consider developing the role and function of the National Institute as it gathers momentum and experience."

Paragraph **7.11-7.12** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**2.8** The work of the National Institute for Clinical Excellence (NICE) in producing authoritative national guidance is part of the overall approach to achieving consistent clinical standards across the NHS. This approach consists of six stages:

*Stage 1: Identification*

- for *new* health interventions – 'scanning the horizon' (that is, identifying at an early stage through available intelligence) for new interventions, including drugs, devices and procedures which are likely to have a significant impact on the NHS
- for *existing* interventions – examining current practice to identify unjustified variations in use, or uncertainty about clinical and cost- effectiveness

*Stage 2: Evidence collection* – undertaking research to assess the clinical and cost-effectiveness of health interventions

*Stage 3: Appraisal and guidance* – carefully considering the implications for clinical practice of the evidence on clinical and cost-effectiveness and producing guidance for the NHS

*Stage 4: Dissemination* of the guidance and supporting audit methodologies

*Stage 5: Implementation* at a local level, through clinical governance and other approaches

*Stage 6: Monitoring* the impact and keeping advice under review, taking into account the views of patients and their representatives and any relevant new research findings.

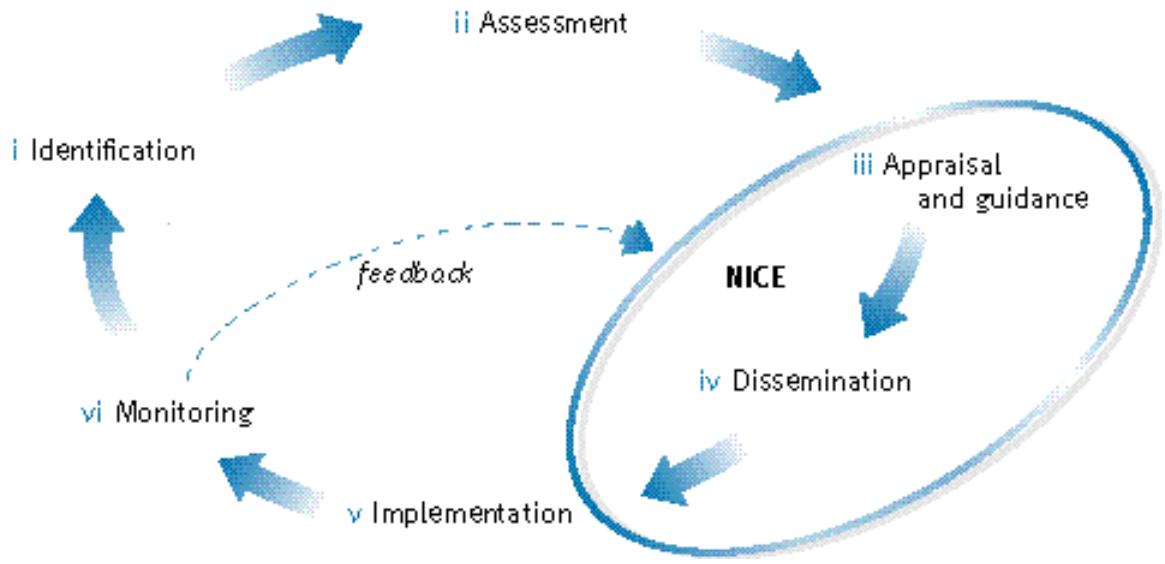
These six stages are illustrated in *Figure 3* below.

## Horizon Scanning

The purpose of this work is to identify new interventions and products under development at the earliest possible stage and certainly well before they become available for general use in the NHS. This involves gathering information from a variety of sources, such as published material, contacts with researchers and health care industries and through communication with similar horizon scanning groups abroad, and using expert judgement to assess the potential significance to the NHS.

*Figure 3*

### Developing best clinical practice: the role of NICE



**Horizon Scanning Centre (HSC),** *University of Birmingham in association with National Prescribing Centre and Drug Information Pharmacists Group (DIPG-NPC Joint Initiative)*

- covers medicines and non-medicine technologies
- alerts the Department of Health to new and emerging interventions of likely significance that will require assessment
- provides technology briefings on selected topics as basis for detailed assessments
- advises on possible need for new or updated guidelines
- draws upon international links and expertise

**2.9** NICE will be responsible for appraisal and the production of guidance *(Stage 3)* and its dissemination to the NHS *(Stage 4)*. NICE will need to receive feedback on the application of its guidance as this is monitored through clinical audit and through performance assessment *(Stage 6)*.

**2.10** To fulfil this key role, NICE will need to respond promptly to emerging evidence and may sometimes need to draw attention to gaps in the evidence base. In particular, it will need to be kept aware of:

- information emerging from horizon scanning work *(Stage 1)* to be provided by the Horizon Scanning Centre of the University of Birmingham in association with the National Prescribing Centre and the Drug Information Pharmacists Group
- research findings from the NHS R&D programme and other sources *(Stage 2)*. In the course of its own work, NICE will identify gaps in evidence and these will be addressed through the NHS R&D programme.

## Appraisal and guidance

**2.11** There is currently no coherent approach to the appraisal of research evidence and the subsequent production of guidance for clinical practice. Guidance is issued by numerous bodies, at national, regional and local levels, each of which have different ways of appraising the evidence and developing recommendations. The status and implications of the products are not always clear, nor what actions are expected to follow as a result of them. This is confusing for clinicians wanting to know what care they should be expected to give, and for patients wanting to know what care to expect. NICE will reduce duplication of this activity and maximise the use of the academic and professional expertise needed to produce credible guidance. It will provide a single, national focus for appraisal of significant new and existing interventions, with subsequent guidance. NICE will replace progressively the need for this activity to be duplicated at regional and district levels by such bodies as the regional Development and Evaluation Committees (DECs), the West Midlands Therapeutics Review Advisory Committee (MTRAC) and the North of England Guidelines Group.

*'there is currently no coherent approach to the appraisal of research evidence and the production of guidance for clinical practice'*

**2.12** As a body involving professionals, patients and managers, NICE will ensure the production of high quality, evidence-based, guidance to a programme set by the Department of Health. This programme will be driven by the information emerging from the horizon scanning work, by the development of National Service Frameworks *(see below)* and other major service priorities.

*'NICE will end this confusion by providing a single, national, focus'*

**2.13** Guidance from NICE will include guidelines for the management of certain diseases or conditions and guidance on the appropriate use of particular interventions. Wherever appropriate, NICE guidance will cover all aspects of the management of a condition – from self care through to primary care, secondary care and more specialist services. It is envisaged that NICE will carry out annually 30-50 appraisals of the most significant new and existing interventions. The various industries which produce drugs and devices involved in these treatments will need to enhance their capacity to produce evidence of clinical and cost-effectiveness. Where evidence of this has not become available at the point that a product comes to market, NICE may recommend that in the first instance the NHS *channels* its use through well controlled research studies, so that patients can be assured of the benefit of treatments used widely throughout the NHS.

**2.14** An outline of the proposed appraisal process for new interventions (as it might eventually operate) is set out overleaf.

**2.15** In undertaking this function, it is anticipated that NICE will draw on the expertise that has been developed in bodies such as the regional Institutes of Public Health, the NHS Centre for Reviews and Dissemination at the University of York in its production of the Effective Health Care Bulletins, and the National Prescribing Centre. NICE will also need to liaise closely with the Medicines Control Agency (MCA) and the Medical Devices Agency (MDA) which carry out related statutory functions. The MCA licensing medicines on the basis of safety, quality and efficacy, and the MDA in assessing the safety and performance of health care products.

## Conflicting clinical advice

Current guidelines from the British Hypertensive Society are ambivalent about the role of ACE inhibitors as a first line treatment for uncomplicated hypertension. Some clinicians hold that there is now sufficient evidence to justify using these medicines as the preferred treatment, in place of the previously recommended thiazide diuretics or beta-blockers. However, there is still no unequivocal guidance available for clinicians. In such cases, NICE will look at the evidence and make a clear recommendation, issue appropriate guidance and advise on what further research is needed.

## Appraisal of new interventions: Outline of proposed process

- Department of Health 'scans horizon' for new interventions (technologies) in development and assesses potential impact on the NHS
- Well in advance of expected launch on NHS, the most significant interventions are selected for probable appraisal
- Discussion with sponsoring company on likely information requirements
- One year before expected launch: Department of Health formally asks NICE to carry out the appraisal and asks sponsoring company to submit evidence
- Four-six months before: Sponsoring company submits evidence
- NICE secretariat will critically review the submitted evidence and add commentary including further analysis of the likely impact on the NHS. Sponsoring company has opportunity to see and add any further comments
- Multi-professional appraisal group, under the oversight of NICE, reviews all the evidence, draws up draft recommendations and information for patients. Sponsoring company/Department of Health have opportunity to comment on recommendations
- Appraisal group finalise recommendations and information. NICE issues to NHS summary of evidence considered in time for launch of the product
- NICE may require further research after the initial launch, if evidence is insufficient to reach a clear judgement
- Recommendations can be reviewed in the light of new information for example on improved forms of new technology

**2.16** We will shortly be issuing a more detailed discussion paper on the proposed appraisal process, in particular on:

- the criteria for selecting particular interventions for appraisal
- the evidence which will be required from sponsoring companies

We will be seeking views from the professions, patient groups, NHS management and the pharmaceutical and health care industries. All these perspectives will be taken into account in the final decisions on the appraisal process and on the framework within which NICE will operate.

*'interventions with good evidence of clinical and cost-effectiveness will be actively promoted so that patients have faster access to treatments known to work'*

**2.17** Such national guidance will mean that interventions with good evidence of clinical and cost-effectiveness will be actively promoted, so that patients have faster access to treatments known to work. Equally, it will help protect patients from new interventions with inadequate evidence of clinical and cost-effectiveness and ensure that interventions which are effective only in limited circumstances are appropriately used.

**2.18** Health professionals need to be able to assess the care they give against established clinical standards. This can be done through clinical audit, which allows them to look at what they are doing against agreed standards and, where necessary, make changes to practice. But health professionals need support in using clinical audit to best effect. Local ownership is vital to the success of implementation and NICE will need to build on and support new and innovative clinical practice at a local level. For that reason, NICE will develop a range of audit methodologies that can be adapted for local use to support the guidance it produces. This will build on the work undertaken by the National Centre for Clinical Audit (NCCA), whose function will be incorporated into NICE.

**2.19** Initially, NICE will focus on clinical issues. We recognise there are a range of other interventions, including screening programmes and other public health and health promotion programmes which could come within its orbit in the future.

*'local ownership is vital to the success of implementation'*

**2.20** We propose to bring together under the umbrella of NICE the four established National Confidential Enquiries which look at clinical performance. This will give greater clarity and coherence to the status of their findings. All relevant hospital doctors and other health professionals will be required to participate in the work of the National Confidential Enquiries. Results from their findings will be fed into appropriate NICE guidance and standard setting and will be an important part of ensuring effective clinical governance locally *(see Chapter 3)* which is to be independently scrutinised by the Commission for Health Improvement *(see Chapter 4)*.

## National Confidential Enquiries

- *National Confidential Enquiry into Perioperative Deaths (NCEPOD)*

  Began in 1988 the NCEPOD is concerned with maintaining high standards of clinical practice in anaesthesia and surgery, through audit of hospital deaths which occur within 30 days of any surgical or gynaecological operation.

- *Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)*

  Began in 1991 and seeks to identify ways in which stillbirths and deaths in infancy might be prevented, and to indicate areas where more research is required.

- *Confidential Enquiry into Maternal Deaths (CEMD)*

  Began in 1951 and aims to assess main causes of, and trends in, maternal deaths; to identify avoidable or substandard factors; to recommend improvements (including audit) to health commissioners and professionals, and to suggest directions for future research and audit locally and nationally.

- *Confidential Inquiry into Suicide and Homicide by People with Mental Illness (CISH)*

  Began in 1991 to carry out a national audit of suicide and homicide by people who have had a history of contact with mental health services; and to make recommendations to Ministers on clinical practice and policy in mental health which could be applied nationally to reduce such deaths.

## Dissemination

**2.21** Clear credible guidance and the production of robust audit methodologies are essential. But in themselves, these will not achieve change. Information needs to reach the right people – health professionals, patients, carers and those commissioning services – and be locally owned and acted on in the right way.

*'clear, credible guidance'*

**2.22** NICE will have a key role in co-ordinating the range of current activity in both the active dissemination of information and in responding to specific inquiries. It will provide a single reference point for information on standards and audit methodologies, and will support and complement the new NHS Information Strategy which aims to provide universal desk top access to NICE guidance (on the lines of the PRODIGY computer aided, decision-support system for GPs).

**2.23** There is much still to learn on how practice can be changed and this is being actively investigated in the NHS R&D programme (including an emerging Service Delivery and Organisation R&D Programme). NICE will have a developing role in providing information about implementation methodologies to help local clinical teams. There will also be a need to ensure that its clinical guidance is integrated into other appropriate activities, including professional education and training, seminars and workshops, patient education and information, and audit.

*'information needs to reach the right people and be acted on in the right way'*

**2.24** There is already a range of tools available to encourage the implementation of clinical guidance. These include local prescribing policies; formularies and guidelines; audit programmes; and lifelong learning. NICE will provide the focus for such initiatives and for reviewing clinical behaviour and practice. As each NICE guideline is produced, we expect that in each Health Authority area, lead clinicians will be designated to have the responsibility for leading the implementation process.

In 1998, we will publish a new Information Strategy for the NHS to harness the enormous potential benefits of IT in supporting the drive for quality and efficiency in the NHS. The aim will be to create a powerful alliance between knowledgeable patients advised by knowledgeable professionals as a means of improving health and health care.

## Monitoring

**2.25** Although NICE will produce clinical guidance against which performance can be assessed, it will not have a direct role in

Clinical Audit involves systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient. Audit is a valuable tool to improve the quality of professional care and, ultimately, patient choice.

monitoring the uptake of its guidance and audit tools. This will be undertaken through a range of initiatives, in particular through the National Framework for Assessing Performance with its new emphasis on standards and outcomes; through professional self-regulation; and an independent scrutiny of implementation to be provided by the new Commission for Health Improvement through its rolling programme of spot checks on NHS Trusts and Primary Care Trusts. The Commission will also conduct systematic service reviews in which it will follow through the implementation of National Service Frameworks and NICE guidance *(see Chapter 4)*. Feedback to NICE will also be provided through the National Survey of Patient and User Experience and its work with a range of other organisations *(see below)*. However, lessons from this monitoring activity will be reported to NICE to ensure its guidance is sensitive to the needs of the NHS and is responsive to the lessons learned.

*'lead clinicians will be designated to have responsibility for leading the implementation process'*

**2.26** The introduction of clinical governance will mean that variations from expected good practice, as recommended by NICE, will increasingly be challenged locally. We will expect the guidance produced by NICE to be implemented consistently across the NHS. How well this happens in practice, to ensure that unacceptable variations in care for patients are not allowed to persist, will determine whether and how NICE's and the Commission for Health Improvement's powers will be strengthened in the future.

## How will NICE work?

*'we will expect the guidance produced by NICE to be implemented consistently across the NHS'*

**2.27** NICE will create a new partnership between the Government, the NHS and clinical professionals. By establishing NICE, the Government will take responsibility for helping to clarify, both for patients and professionals, which treatments work best for which patients and those which do not. For the first time in the history of the NHS the Government, working with clinical bodies, will systematically appraise medical interventions before these are introduced into the NHS. Clear, authoritative, guidance on clinical and cost-effectiveness will be offered to front line clinicians. NICE will offer doctors, nurses and midwives more support than they have had before in making the complex decisions about individual patient care often required in modern health care. That support will enhance the ability of individual clinicians to make such decisions. It will also inform the decisions of those commissioning care.

**2.28** To support its work, NICE will need to develop a network of relationships:

*At a local level:* To work with NHS Trusts, other service providers, and with patient representatives to ensure the dissemination of guidance is effective. It will also work with Health Authorities, Primary Care Groups and other service commissioners

*At a regional level:* To receive feedback from Regional Office performance monitoring, to address gaps in guidance, and to support local implementation

*At a national level:* To develop a detailed work programme with the Department of Health; to work with the national Royal Colleges, professional associations, academic units and health care industries that have the specialist expertise required; and to ensure that information from the Commission for Health Improvement's systematic service reviews is fed into further clinical guidance or audit methodologies.

*'NICE will offer doctors, nurses and midwives more support than they have had before in making complex decisions about patient care'*

**2.29** We propose to set up NICE as an arm's length Special Health Authority from early 1999. NICE will be accountable to the Secretary of State for Health for its resources, delivery of its work programme and for the guidance it produces for the NHS. The proposed structure will be:

*NICE Board:* The Board will need to reflect a range of expertise, including the clinical professions, patients and user groups, NHS managers and research bodies. Members will be appointed on merit rather than as representatives of a particular organisation or interest. As a small body of executives and non-executives, appointed by the Secretary of State for Health, the Board will ensure that NICE conducts its business on behalf of the NHS in the most effective way. The Chief Executive will be accountable to the Board for progress on the agreed programme and the use of resources.

*NICE Partners' Council:* This will be formed of representatives of all the key stakeholder groups (patients and carers, the health professions – including the professional Royal Colleges, academics, NHS service interests and the pharmaceutical and other health care industries). The Council, which will be appointed by the Secretary of State for Health, will review NICE's annual progress report and contribute to the development of the work programme, commissioned by the Department of Health.

*NICE Secretariat*: Initially, staff from the Department of Health will provide technical and administrative support. Professional, academic

Special Health Authorities have unique national or supra-regional functions which cannot be effectively undertaken by other kinds of NHS bodies – for example, the Prescription Pricing Authority.

*'the Board will need to reflect a range of expertise, including the clinican professions, patients and user groups, NHS managers and research bodies'*

*'NICE will take over the funding, commissioning and oversight of a range of functions'*

and managerial skills will also be needed in commissioning and managing the guidance and audit programmes and to support the national appraisal function. The Secretariat will have a wider role in the co-ordination of NICE's work programme across a range of organisations.

**2.30** NICE will take over the funding, commissioning and oversight of a range of functions currently undertaken by a number of different groups funded by the Department of Health and bring these together, including:

- the National Prescribing Centre appraisals and bulletins
- the clinical guidance contained in PRODIGY (a computer aided decision-support system for GPs to assist in their prescribing practice)
- the National Centre for Clinical Audit
- the Prescriber's Journal
- the Department of Health funded National Guidelines Programme and Professional Audit Programme
- Effectiveness Bulletins.

*'patients – and the public – will have access to NICE information'*

**2.31** NICE will be funded out of the money currently being spent on similar organisations and activities to those whose roles it will take on. These funds will now be directed towards a single resource supporting a common agenda for action to the overall benefit of patients and health professionals.

## How NICE will help patients

NICE will assist doctors, nurses, midwives and other health professionals to provide the most effective treatments and will help protect patients from ineffective care. NICE will do this by providing authoritative, timely advice on best clinical practice and on the effectiveness of interventions, and ensuring this reaches all parts of the NHS. Patients – and the public – will have access to NICE information on health and best treatment through the Internet and other emerging public access media (such as digital TV).

## NATIONAL SERVICE FRAMEWORKS

"The Government will work with the professions and representatives of users and carers to establish clearer, evidence-based National Service Frameworks for major care areas and disease groups. That way patients will get greater consistency in the availability and quality of services, right across the NHS. The Government will use them as a way of being clearer with patients about what they can expect from the health service.

The new approach to developing cancer services in the Calman-Hine Report, and recent action to ensure all centres providing children's intensive care meet agreed national standards, point the direction. In each case, the best evidence of clinical and cost-effectiveness is taken together with the views of users to establish principles for the pattern and level of services required. These then establish a clear set of priorities against which local action can be framed. The NHS Executive, working with the professions and others, will develop a similar approach to other services where national consistency is desirable. There will be an annual programme for the development of such frameworks starting in 1998.

Paragraph **7.8-7.9** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**2.32** The work of NICE will be vital in making sure that the NHS has access to the right information to help improve clinical practice. But clinical practice is only part of the picture. In key service areas, we need a systematic approach to models of service provision.

*'patients will get greater consistency in the availability and quality of services, right across the NHS'*

**2.33** That is why we have announced a programme of National Service Frameworks to address unacceptable variations in services across the country.

**2.34** National Service Frameworks (NSFs) will:

- set national standards and define service models for a specific service or care group
- put in place programmes to support implementation
- establish performance measures against which progress within an agreed timescale will be measured.

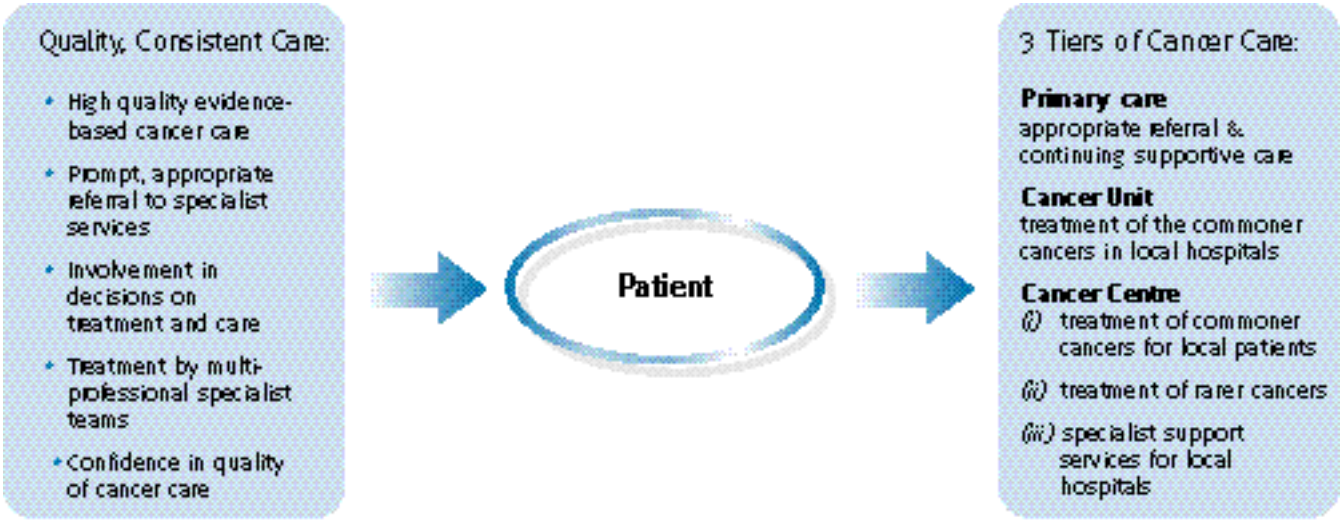
National Service Frameworks will bring together the best evidence of clinical and cost-effectiveness with the views of service users to determine the best ways of providing particular services.

*'National Service Frameworks will set national standards and define service models for a specific service or care group'*

**2.35** Each National Service Framework will set out where care is best provided and the standard of care that patients should be offered in each setting. For example, as *Figure 4* below shows, the Calman-Hine NSF for cancer services defined three levels of care needed to provide high quality, comprehensive cancer services throughout the country – primary care (to provide appropriate referral and follow up care for cancer patients), designated Cancer Units (in many district general hospitals to support clinical teams with facilities and expertise to manage the commoner cancers) and designated Cancer Centres (in regional hospital centres providing expertise in the management of all cancers for local patients and the less common cancers as referral centres, and specialist support services, such as radiotherapy, for Cancer Units). Work has also been undertaken to reach local agreement on where and what cancers should be treated at each individual Cancer Unit and Cancer Centre.

*Figure 4*

## What can the patient expect from the Calman-Hine Cancer Service Framework?



## Developing a National Service Framework

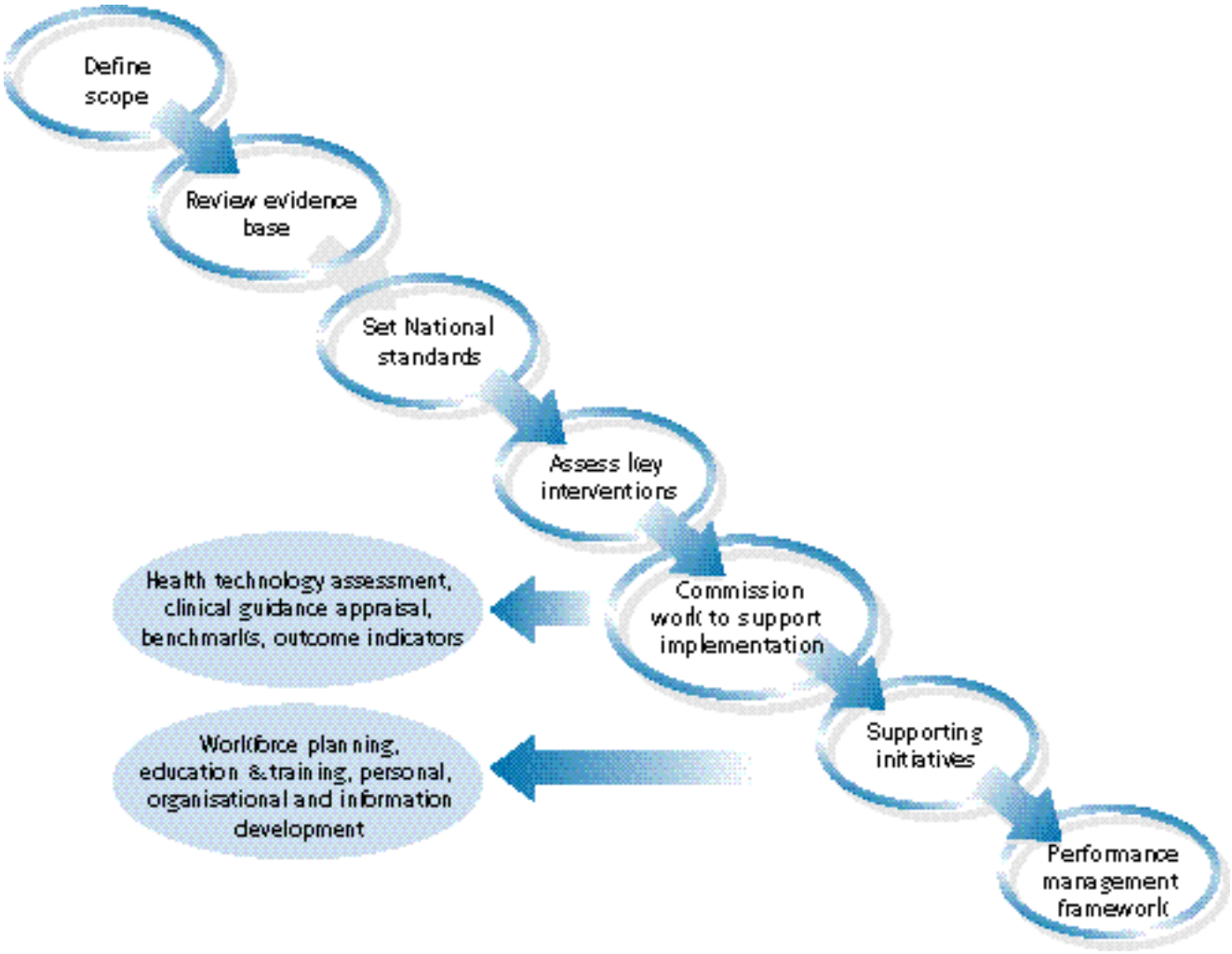
**2.36** HSC 1998/074, issued in April, set out a programme of work to develop National Service Frameworks (described in *Figure 5*). Each will be developed with the help of an expert reference group. These groups will need to engage a full range of views, bringing together health professionals, service users, carers, health service managers, partner agencies and other relevant groups.

### Each National Service Framework will include:

- a definition of the scope of the Framework
- the evidence base
  - needs assessment
  - present performance
  - evidence of clinical and cost-effectiveness
  - significant gaps and pressures
- national standards, timescales for delivery
- key interventions and associated costs
- commissioned work to support implementation
  - appropriate R&D, including through the NHS R&D programme (including Health Technology Assessments – HTA)
  - appraisal
  - benchmarks
  - outcome indicators
- supporting programmes
  - workforce planning
  - education and training
  - personal and organisational development (OD)
  - information development
- a performance management framework

*Figure 5*

## Development of a National Service Framework




*'National Service Frameworks will address the 'whole system of care' '*

**2.37** National Service Frameworks will provide the NHS with explicit standards and principles for the pattern and level of services required. But they can only be implemented through concerted local action by the NHS and its partners.

**2.38** National Service Frameworks will address the 'whole system of care'. Implementation will require partnerships with a wide range of organisations. Partners who are likely to be involved include social care providers, the wider local authority, the voluntary sector, business and industry and other Government Departments.

*'implementation through Health Improvement Programmes'*

**2.39** National Service Frameworks will include performance measures against which progress will be assessed. These measures will be monitored through the new National Framework for Assessing Performance, the independent rolling programme of spot checks by the Commission for Health Improvement and its systematic service reviews *(see Chapter 4)* as well as the National Survey of Patient and User Experience.

## The first National Service Frameworks

**2.40** The programme of work will begin with mental health and coronary heart disease (CHD). Their priority status will also be reflected in guidance on Health Improvement Programmes.

*'the programme of work will begin with mental health and coronary heart disease'*

**2.41** The reference groups for the new National Service Frameworks will begin their work in Summer 1998. Emerging findings will be available in the Autumn 1998, prior to publication of the National Service Frameworks in Spring 1999. This will enable Health Authorities, together with their partners, to plan for implementation through their Health Improvement Programmes from April 1999.

## Future National Service Frameworks

**2.42** The National Service Framework rolling programme will usually include not more than one major new topic each year. Candidates for the next tranche are already being considered and suggestions have been invited for future topics.

**2.43** Criteria which will inform selection of topics for future National Service Frameworks will include:

- demonstrable relevance to the Government's agenda for health improvement and tackling health inequalities, set out in *The new NHS, Our Healthier Nation* and wider policies on social exclusion

- an important health issue – in terms of mortality, morbidity, disability or resource use
- an area of public concern
- evidence of a shortfall between actual and acceptable practice, with real opportunities for improvement
- an area where care for a patient may be provided in more than one setting (for example hospital, GP surgery or at home) and by more than one organisation (for example, NHS and/or local authority/voluntary sector)
- an area where local services need to be reorganised or restructured to ensure service improvements
- a problem which requires new, innovative approaches.

The programme will also be informed by the Chief Medical Officer's Annual Report.

## How National Service Frameworks will help patients

National Service Frameworks will set standards to achieve greater consistency in the availability and quality of services for a range of major care areas and disease groups. The clear aim will be to reduce unacceptable variations in care and standards of treatment, using the best evidence of clinical and cost-effectiveness.

## Questions for consultation

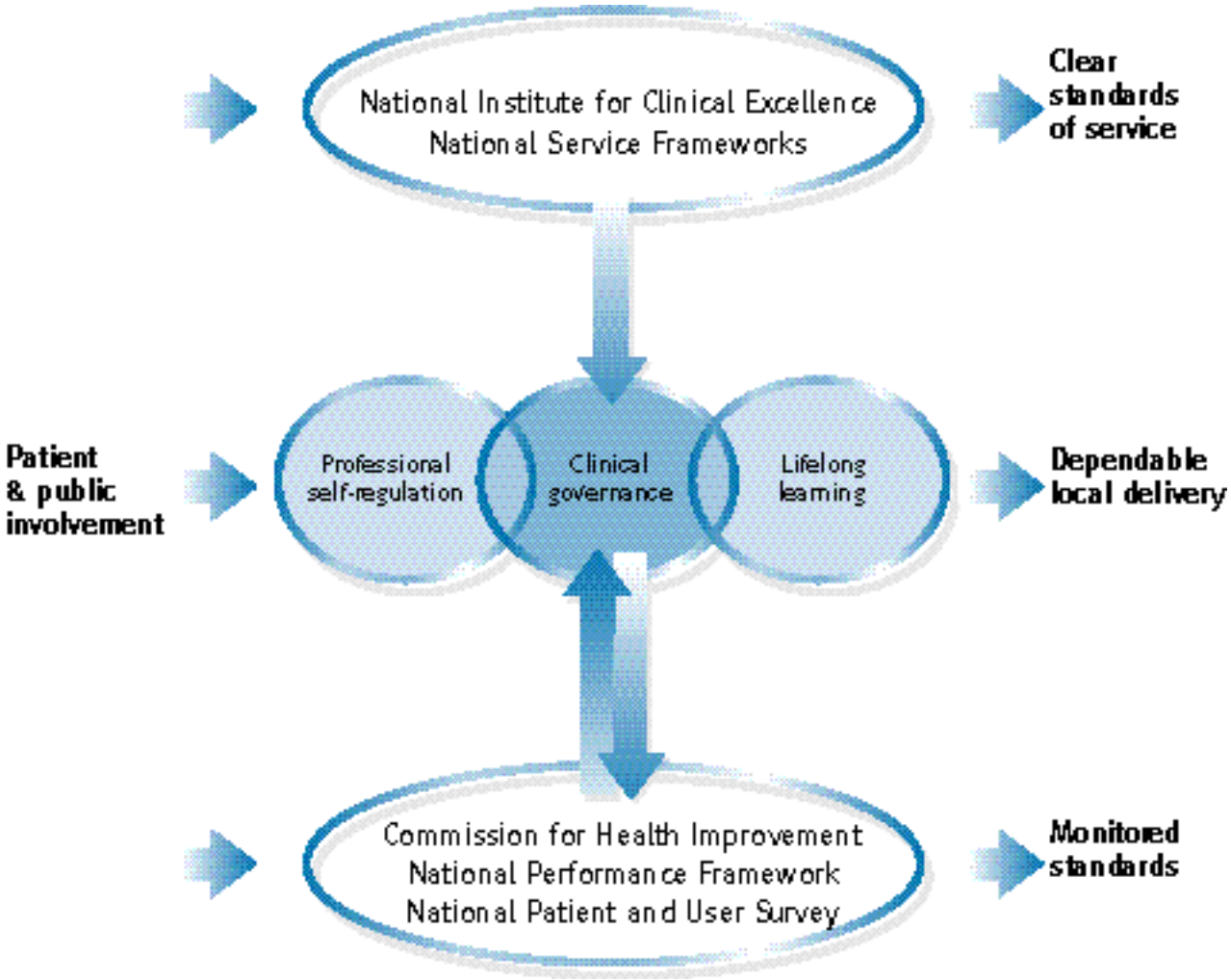
- Should NICE have a role in broader based functions, including screening and other public health interventions?
- In what ways might NICE co-ordinate work currently undertaken by the four existing National Confidential Enquiries?
- Is there potential for other work which might be usefully brought under the umbrella of NICE?
- How might NICE best approach the development of effective partnerships, particularly with patients, service users, carers and the wider public?
- In what ways can NICE network with other organisations to share good practice?
- In what ways might we ensure patients and their carers receive the information they need about National Service Frameworks in coronary heart disease and mental health?
- How can staff in the NHS and elsewhere best be supported in implementing the organisational and cultural changes which may flow from the introduction of National Service Frameworks?
- How best can partnerships between all the agencies involved in National Service Frameworks be fostered?

# 3

# Delivering quality standards

*Figure 6*

## Delivering improved quality




*National Service Frameworks will set out common standards across the country for the treatment of particular conditions. The National Institute for Clinical Excellence will act as a nation-wide appraisal body for new and existing treatments, and disseminate consistent advice on what works and what doesn't.*

> "Professional and statutory bodies have a vital role in setting and promoting standards but shifting the focus towards quality will also require practitioners to accept responsibility for developing and maintaining standards within their local NHS organisations. For this reason, the Government will require every NHS Trust to embrace the concept of 'clinical governance' so that quality is at the core, both of their responsibilities as organisations and of each of their staff as individual professionals."
>
> Paragraph **6.2** *The new NHS Modern • Dependable*
> Cm 3807:December 1997

**3.1** Setting in place National Service Frameworks and a National Institute for Clinical Excellence will provide clear, consistent messages on what is expected of the NHS in improving access across the country to responsive, high quality services. But setting national standards is not enough. We need consistent action locally to ensure that national standards and guidance are reflected in the delivery of services. That action will be guided by a single, robust framework – a new system of clinical governance – to monitor health care quality at a local level. This will be backed up by lifelong learning by staff, through rigorous professional self-regulation and through a new system of external monitoring.

*'we need consistent action locally to ensure that national standards and guidance are reflected in the delivery of services'*

## CLINICAL GOVERNANCE

**3.2** An emphasis on quality and the need for financial responsibility are not contradictory or incompatible aims - both sides of the coin are needed. We need to move away from merely counting numbers and making income and expenditure balance. Clinical governance will help ensure that quality resumes its rightful place at the heart of the NHS.

**3.3** A range of tools are already in use (such as clinical audit) to improve and assure quality but application and results vary greatly across the NHS. Clinical governance provides NHS organisations and individual health professionals with a framework within which to build a single, coherent, local programme for quality improvement.

### What is clinical governance?

Clinical governance can be defined as a framework through which NHS 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.

## Ways in which effective clinical governance will make a difference to patients:

*Example 1*

Where the use of catheters results in higher than average incidence of urinary tract infection, the NHS Trust clinical governance committee will address the possible reasons for this. For example, poor technique in fitting and maintaining catheters will highlight a need for in-house training, through lifelong learning, to reduce infection rates. The committee will take action to ensure that training is provided and monitor progress in reducing infection rates.

**3.4** Clinical governance has an important role to play in restoring public confidence in the NHS, providing reassurance on what is being done to improve the quality of health services locally. NHS Trust clinical governance reports will set out progress made and demonstrate to local people that their confidence in the NHS is well placed.

## Clinical and corporate governance

**3.5** Clinical governance will be part of an overall NHS governance framework. It deliberately echoes the principles of corporate governance. The Chief Executive of each NHS Trust, as accountable officer, will sign an assurance statement on behalf of the Board. A statement to the public on financial risk management and control systems will appear in the 1997/98 Annual Accounts for NHS Trusts and Health Authorities. In future years, this process will be extended to statutory responsibilities in non-financial areas. For the first time in the history of the NHS, there is more than a requirement to meet financial statutory duties.

**3.6** Under clinical governance, Chief Executives will be accountable on behalf of NHS Trust Boards, for assuring the quality of NHS Trust services and will provide Boards with regular reports on quality in the same way as they do for finance.

**3.7** The principles of clinical governance apply to all those who provide or manage patient care services in the NHS. The principles supporting quality improvement will be the same for large and small organisations. In practice, clinical governance locally will need to take account of the needs, complexity and size of individual NHS organisations. But the emphasis must be on processes that are simple to use and which, above all, produce results. The requirements of clinical governance will be backed by the new statutory duty for quality which will be placed on NHS Trusts and Primary Care Trusts.

*‘ The principles of clinical governance apply to all those who provide or manage patient care services in the NHS.’*

**3.8** For the first time, the NHS will be required to adopt a structured and coherent approach to clinical quality, placing duties and expectations on local health care organisations as well as individuals. Effective clinical governance will make it clear that quality is everybody’s business.

**3.9** Clinical governance requires partnerships within health care teams, between health professionals (including academic staff) and managers, between individuals and the organisations in which they work and between the NHS, patients and the public.

*'effective clinical governance will make it clear that quality is everybody's business'*

**3.10** Effective involvement of patients and carers is essential to ensuring that everyone is fully engaged in the drive for quality, and that this focuses on what really matters.

## The clinical governance framework

**3.11** We will introduce a clinical governance framework that:

- modernises and strengthens professional self-regulation and builds on the principles of performance review
- strengthens existing systems for quality control, based on clinical standards, evidence based practice and learning the lessons of poor performance.

It should include all activity and information that allows an NHS organisation, and those who work within it, to improve the quality of services locally. This will include work to:

- identify and build on good practice
- assess and minimise the risk of untoward events
- investigate problems as these arise and ensure lessons are learnt
- support health professionals in delivering quality care.

**3.12** Key components of the framework will include:

- a comprehensive programme of quality improvement activity (such as clinical audit and evidence-based practice) and processes for monitoring clinical care using effective information and clinical record systems. Internal scrutiny within each hospital needs to be supplemented by open and external review. From next year, all hospital doctors will be required to participate in a national audit programme appropriate to their specialty or subspecialty and approved as such by the new Commission for Health Improvement
- clear policies aimed at managing risk, including procedures that support professional staff in identifying and tackling poor performance

### Ways in which effective clinical governance will make a difference to patients:

*Example 2*

The rate and reasons for unplanned readmission of patients to hospital will provide important information about the quality of patient care. High rates of readmission might reveal problems with discharge planning due to the quality of the procedure undertaken or to poor, communication and liaison between nursing staff, the primary health care team and social care agencies. This information might be further supported by patients' complaints. Clinical governance systems will highlight the need to improve communications and support the development of better protocols for discharge planning.

## Main components of clinical governance: *NHS Trusts*

*Clear lines of responsibility and accountability for the overall quality of clinical care through:*

- the NHS Trust Chief Executive carries ultimate responsibility for assuring the quality of services provided by the Trust
- a designated senior clinician responsible for ensuring that systems for clinical governance are in place and monitoring their continued effectiveness
- formal arrangements for NHS Trust Boards to discharge their responsibilities for clinical quality, perhaps through a clinical governance committee
- regular reports to NHS Trust Boards on the quality of clinical care given the same importance as monthly financial reports
- an annual report on clinical governance

*A comprehensive programme of quality improvement activities which includes:*

- full participation by all hospital doctors in audit programmes, including specialty and subspecialty national external audit programmes endorsed by the Commission for Health Improvement
- full participation in the current four National Confidential Enquiries
- evidence-based practice is supported and applied routinely in everyday practice
- ensuring the clinical standards of National Service Frameworks and NICE recommendations are implemented
- workforce planning and development (i.e. recruitment and retention of appropriately trained workforce) is fully integrated within the NHS Trust's service planning

- continuing professional development: programmes aimed at meeting the development needs of individual health professionals and the service needs of the organisation are in place and supported locally
- appropriate safeguards to govern access to and storage of confidential patient information as recommended in the Caldicott Report on the Review of Patient-Identifiable Information
- effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information
- processes for assuring the quality of clinical care are in place and integrated with the quality programme for the organisation as a whole

*Clear policies aimed at managing risks:*

- controls assurance which promote self-assessment to identify and manage risks
- clinical risk systematically assessed with programmes in place to reduce risk

*Procedures for all professional groups to identify and remedy poor performance, for example*

- critical incident reporting ensures that adverse events are identified, openly investigated, lessons are learned and promptly applied
- complaints procedures, accessible to patients and their families and fair to staff. Lessons are learned and recurrence of similar problems avoided
- professional performance procedures which take effect at an early stage before patients are harmed and which help the individual to improve their performance whenever possible, are in place and understood by all staff
- staff supported in their duty to report any concerns about colleagues' professional conduct and performance, with clear statements from the Board on what is expected of all staff. Clear procedures for reporting concerns so that early action can be taken to support the individual to remedy the situation

*'successful clinical governance will rely on proper arrangements for accountability, which are seen to be effective by the public'*

- clear lines of responsibility and accountability for the overall quality of clinical care. For Trusts, that will include regular reports to the Board and an annual report on clinical governance.

**3.13** A more detailed framework for clinical governance is set out on the previous pages. This particular framework applies to NHS Trusts and will need to be tailored to meet the needs and circumstances of the different parts of the NHS providing services for patients.

**3.14** Clinical governance will provide a systematic framework that can be extended into the clinical community at all levels. Successful clinical governance will rely on proper arrangements for accountability, which are seen to be effective by the public, the wider health service and individual practitioners. Local systems for monitoring quality should be open and fair (whilst respecting the requirement to safeguard patient confidentiality). As a result of participation in national comparative clinical audit, individual hospital doctors will be able to compare their own performance with national averages. Individual doctors will be required to share their results with the medical director of their Trust and the Trust's lead clinician responsible for clinical governance. In turn, doctors from the Commission for Health Improvement will have access to these data when they visit the Trust to review local standards and clinical governance processes.

**3.15** Strengthened external audit will help assure patients that services at their local hospital are being monitored and are of a consistently high standard. Doctors with results that fall short of these norms will need to take urgent action to improve their results. Where the outcome has unacceptable mortality or complications, it might be necessary for the clinician to stop performing the procedure. Fellow professionals could provide extra training, supervision and support to correct what had been going wrong. In appropriate circumstances, the General Medical Council would be involved.

## NHS Trusts and Primary Care Trusts

*'a new statutory duty for the quality of the services'*

**3.16** Quality will be a top priority for all Trusts. NHS Trusts and the new Primary Care Trusts will be required to:

- ensure proper processes are in place for assuring and improving the quality of the clinical services they provide

- nominate a single person to lead on the development of clinical governance and take responsibility for ensuring these arrangements are in place. That named person will be accountable to the Chief Executive and the Board. *The new NHS* suggests that this might be undertaken through a Board committee, led by a named senior consultant, nurse or other health professional
- publish annual reports on what they are doing to improve and assure quality, including self-assessment of progress in implementing local clinical governance; how these systems meet national quality standards; and the Trust's future plans for improving the quality of services.

*'we expect primary care organisations and individual health professionals to develop the quality of services'*

**3.17** The responsibilities of NHS Trusts and Primary Care Trusts will be reinforced by a new statutory duty in respect of the quality of the services they provide. Quality and financial duties will be given equal weight in statute to reflect their central importance in the new NHS. The intention is to frame the duty in such a way as to provide meaningful support to the continuing improvement of quality by NHS Trusts and Primary Care Trusts, whilst recognising the need to prevent unnecessary litigation which saps valuable resources, effort and time from the NHS.

**3.18** NHS Trust performance will be monitored by the NHS Executive and, for Primary Care Trusts, by Health Authorities. In addition the Commission for Health Improvement, will provide independent external scrutiny of whether NHS Trusts and Primary Care Trusts are meeting their responsibilities *(see Chapter 4)*.

## Primary Care Groups

*'in working towards Primary Care Trust status, Primary Care Groups must demonstrate a systematic approach to monitoring and developing clinical standards'*

**3.19** Most people receive care outside hospital, from nurses, GPs and other health professionals providing primary care services. We expect primary care organisations and individual health professionals to continue to develop the quality of services and to demonstrate that they are doing so through reporting arrangements.

**3.20** Health Authorities will have a key role in encouraging individual primary care health professionals, Primary Care Groups and Primary Care Trusts in the development of clinical governance. In doing so, they should agree quality markers and offer, where appropriate,

*'professional organisations will play an important part in supporting quality improvement'*

expert support. Inevitably, a greater degree of Health Authority support will be needed for smaller organisations and individual practitioners. In many areas, Health Authorities have already begun quality improvement or development programmes, making good use of local professional input and external validation. These have objectives similar to clinical governance. But the pace of local development will vary according to local circumstances and experience.

**3.21** Arrangements in Primary Care Trusts will be close to those in NHS Trusts. In working towards Primary Care Trust status, Primary Care Groups must demonstrate a systematic approach to monitoring and developing clinical standards within Primary Care. Primary Care Group members will need to support each other in developing the quality of primary care services they provide (for example, through clinical audits covering the whole Primary Care Group).

**3.22** Primary Care Trusts should make senior level appointments for oversight and development of clinical standards. Levels 1 and 2 Primary Care Groups should also nominate a senior professional to take the lead on clinical standards and professional development, as part of the Group's overall responsibility to demonstrate that quality of care is important.

## Primary care and public health professionals

**3.23** All family health services professionals will be expected to make use of clinical governance principles to underpin local arrangements for quality assurance and development which will be developed by Health Authorities with Primary Care Groups.

**3.24** Professional organisations will also play an important part in supporting quality improvement. For example, the Royal College of General Practitioners' new Criteria for Membership by Assessment of Performance provides GPs with useful suggestions for quality standards in approaching clinical governance.

**3.25** Most specialists in public health are employed by Health Authorities. There will need to be clear responsibility for leadership on standards and professional development. This is likely to be the Director of Public Health, reporting to the Chief Executive.

## What next?

**3.26** Responses to this consultation document will inform NHS Executive work on national guidance on clinical governance to be issued in the Autumn. This will support the introduction of basic clinical governance requirements for NHS Trusts by early 1999. All hospital doctors will be required to participate in a national external clinical audit during 1999/2000 and thereafter. NHS Trusts will be required to produce their first clinical governance reports in Spring 2000.

*'NHS Trusts will be required to produce their first clinical governance reports in Spring 2000'*

**3.27** Health Authorities will be expected to provide support to family health services professionals in developing clinical governance principles.

### How will clinical governance help patients?

For patients – and the wider public – clinical governance will mean better quality care and greater confidence in NHS services. Each of the component parts will contribute to improving standards of care and access to services. By establishing a new mindset, where quality is uppermost, unacceptable variations in care will be properly tackled. For the first time in the history of the NHS, the patient will have a guarantee of quality in NHS services.

*'patients and their families place their trust in health professionals. They need to be assured that their treatment is up to date and effective and is provided by those whose skills have kept pace with new thinking and new techniques'*

## LIFELONG LEARNING

"Integrated care for patients will rely on models of training and education that give staff a clear understanding of how their own roles fit with those of others within both the health and social care professions. The Government will work with the professions to reach a shared understanding of the principles that should underpin effective continuing professional development and the respective roles of the state, the professions and individual practitioners in supporting this activity. "

Paragraph **6.10** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**Continuing Professional Development (CPD)** is a process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential.

**3.28** Clinical governance needs to be underpinned by a culture that values lifelong learning and recognises the key part it plays in improving quality.

**3.29** Patients and their families place their trust in health professionals. They need to be assured that their treatment is up to date and effective, and that it is provided by those whose skills have kept pace with new thinking and new techniques. Where individual health professionals fail to meet the standards set by their profession, when things go wrong, people expect matters to be openly investigated, explanations provided and, where appropriate, action taken to prevent similar problems.

**3.30** Continuing Professional Development (CPD) programmes need to meet both the learning needs of individual health professionals to inspire public confidence in their skills, but importantly they also need to meet the wider service development needs of the NHS.

**3.31** Lifelong learning is an investment in quality. The NHS must keep pace with a changing world; with medical advance, with fast changing new technologies and new approaches to patient care. Greater public awareness of these advances has rightly created increased expectations of what the NHS can deliver.

*'where individual health professionals fail to meet the standards set by their profession, when things go wrong, people expect matters to be openly investigated, explanations provided and appropriate action taken to prevent similar problems'*

**3.32** Health professionals in all healthcare settings need the support of lifelong learning through CPD programmes. Individual health professionals and NHS employers should value CPD as an integral part of quality improvement. Professional and other bodies have a key role to play in supporting effective CPD by:

- influencing or setting the standards of clinical practice
- promoting professional self-regulation
- supporting audit of practice and relating it to learning needs
- promoting lifelong learning amongst professional staff..

## A new approach

**3.33** There is broad consensus on the principles of continuing professional development (as evidenced in the recent Chief Medical Officer's report *CPD in General Practice*). A great deal of good CPD is already in practice throughout the NHS. But links between CPD programmes, audit, clinical-effectiveness and R&D have often been poorly developed; and there has been inequality of access. We need a more integrated approach that successfully matches the legitimate aspirations of individual health professionals and also responds to local service development needs and patient expectations. This new approach, encompassing the needs of the NHS, the professions and individual health professionals will be essential to the development of clinical governance at a local level, and the new quality agenda nationally.

*'CPD programmes are best managed locally to meet both local service needs and those of individual professionals'*

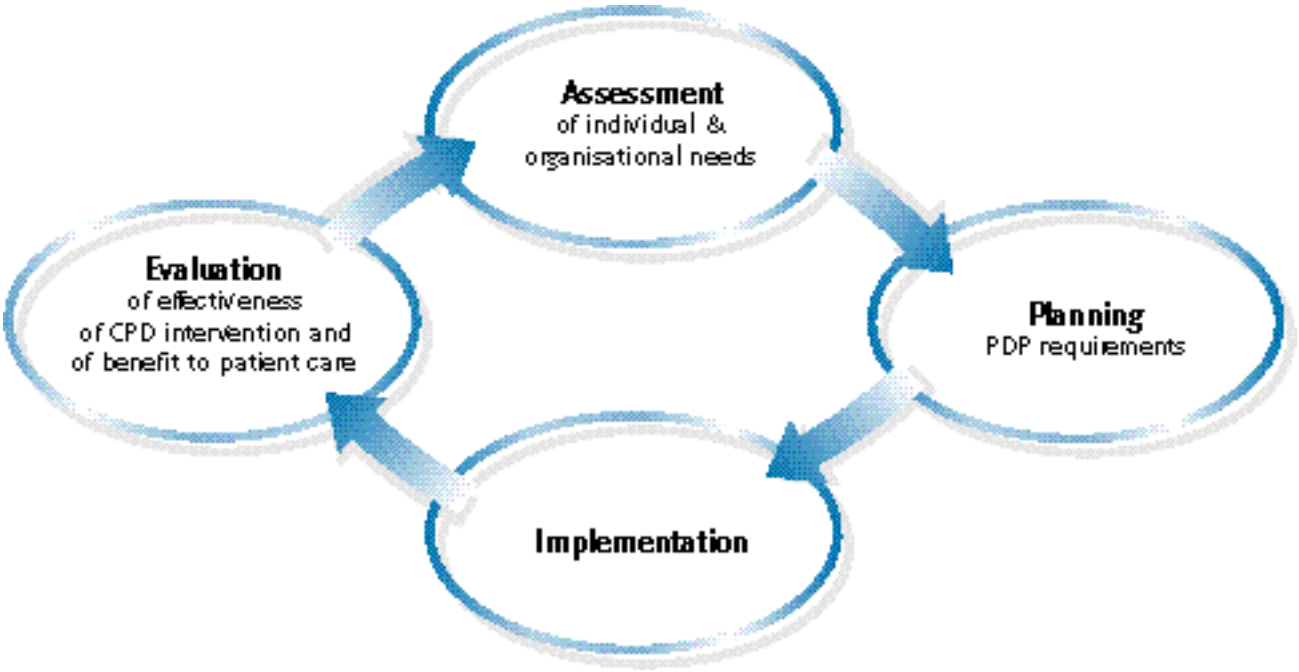
**3.34** CPD programmes are best managed locally to meet both local service needs and those of individual professionals. Higher education providers and local education consortia will have a key role to play in the development of CPD, including innovative approaches to work based learning.

**3.35** In primary care, some Health Authorities have run successful professional and practice development planning, leading to positive educational activity related to improving patient care. For example, Croydon Health Authority has trained and appointed local education advisers to support GPs in deciding educational needs; Enfield & Haringey Health Authority facilitated learning groups; and, as part of their commitment to quality, Sheffield Health Authority expects practices to review annually plans to meet training needs and that individual GPs maintain portfolios of personal development.

**3.36** Overleaf*(see Figure 7)* is a model for developing CPD at a local level, which applies to the organisation and the individual health professional.

*Figure 7*

## A model of a CPD cycle




*Continuing professional development – lifelong learning – follows a circular pathway through assessment, planning of personal development plans (PDP), implementation and evaluation.*

## Investing in lifelong learning

*'in an increasingly competitive labour market, local health employers must recognise the value of appropriately managed CPD programmes'*

**3.37** In an increasingly competitive labour market, local health service employers must recognise the value of appropriately managed CPD programmes in attracting, motivating and retaining high calibre professionals and managers and other health care workers. We support the identification of professional and service needs in a Personal Development Plan (PDP) developed by individual health professionals in discussion and agreement with colleagues locally. This should take account of different learning preferences (such as peer group or individual learning), clearly identify where team or multi-professional learning offers the best solution, and take full advantage of opportunities for learning on-the-job. CPD does not necessarily mean going on courses. Organisations will be encouraged to complement individual PDPs with organisational development plans.

**3.38** CPD is currently financed in a variety of ways (for example, local training and development budgets, charitable and educational trust funds and industry sponsorship). Arrangements vary among the different professions and there are clearly significant inequities. Most health professionals share financial responsibility for their own professional development. The total resource (including opportunity costs) devoted to CPD is substantial but we believe this investment can, and should, be targeted more effectively.

*'a locally-based approach to CPD, centred on the service development needs of the community and the learning needs of the individual'*

**3.39** Health professionals, professional bodies and local employers need to discuss a locally-based approach to CPD, centred on the service development needs of the local community and the learning needs of the individual. It is for local health service employers to decide on the level of investment needed to support CPD programmes for professional, managerial and other staff. Clinical governance provides the framework for a more coherent approach to local CPD which will, in turn, support improvements in service quality.

## Next steps

**3.40** The aim should be for all NHS employers to have training and development plans in place for the majority of health professional staff by April 2000. Progress will depend on local circumstances.

*'training and development plans in place for the majority of health professional staff by April 2000'*

**3.41** We will work with professional and educational bodies, staff representative organisations and NHS employers to explore a range of practical issues including:

- the role of monitoring, peer review and appraisal
- the role of new technology and distance learning in maximising learning opportunities and customising the process
- how the expertise of professional and statutory bodies can best support local CPD, within the context of clinical governance
- the educational infrastructure required to identify and meet CPD needs.

**3.42** Later this Summer, we will issue an NHS human resource strategy which will include ways of developing the ability of staff to contribute to the improvement of services – through organisational change and through individual development. Some practical tools will be needed to support CPD and local personal and organisation development

*'the professions must be properly accountable for the standards they set and how these are enforced'*

planning, and further guidance will be issued this Winter on the development of a locally-based approach to lifelong learning.

### How will lifelong learning help patients?

Local communities and individual patients can be confident that local service development and the skills and knowledge of those providing their care and treatment are keeping pace with change. A continuing process of updating and maintaining expertise will support the delivery of high quality, modern, effective healthcare in a fast changing world.

## PROFESSIONAL SELF-REGULATION

"The Government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice. Professional self-regulation must remain an essential element in the delivery of quality patient services. It is crucial that the professional standards developed nationally continue to be responsive to changing service needs and to legitimate public expectations. The Government will continue to work with the professions, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation by ensuring that they are open, responsive and publicly accountable."

Paragraph **7.15** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**3.42** Clinical governance and lifelong learning will help instill quality at a local level throughout the NHS. Both are founded on the principle that health professionals must be responsible and accountable for their own practice.

**3.43** Professional self-regulation gives health professionals the ability to set their own standards of professional practice, conduct and discipline. To justify this freedom and maintain the trust of patients and their families, the professions must be openly accountable for the standards they set and the way these are enforced. These standards must take account of legitimate public expectations and the realities of service delivery locally, including how the professional and regulatory bodies deal with matters of professional conduct and discipline.

*'our systems of professional self-regulation must be modernised and strengthened'*

**3.44** Recent events have dented public confidence in the quality of clinical care provided by the NHS. The challenge for the professions is to demonstrate that professional self-regulation can continue to enjoy public confidence. If this confidence is to be restored, our systems of professional self-regulation must be modernised and strengthened to ensure that they are:

- open to public scrutiny
- responsive to changing clinical practice and service needs
- publicly accountable for professional standards set nationally, and the action taken to maintain these standards.

*'the challenge now is for the Government and clinical professionals to work together to modernise that framework so that it is fit for the next century'*

**3.45** We welcome work by the professional and regulatory bodies to ensure that the professional standards they set keep pace with changes in clinical practice and expectations placed on health professionals. Examples include the General Medical Council's revision of its guidance *Good Medical Practice*, which will set out the standards by which doctors will be judged; the recently strengthened UKCC Code of Conduct; the General Dental Council's *Maintaining Standards* and the Statement of Conduct produced by the Disciplinary Committees of the Boards of the Council for Professions Supplementary to Medicine.

**3.46** These important developments now need to be built on to address public concerns about the effectiveness of the regulation of health professionals, particularly when lapses in quality have occurred. The organisation of professional self-regulation still owes more to history than to the needs of patients in a modern NHS. The challenge now is for the Government and clinical professionals to work together to modernise that framework so that it is fit for the next century.

## How will professional self-regulation help patients?

Patients have a high regard for the expertise and commitment of health professionals. Modern, professional self-regulation provides added confidence that their expectations of high quality care will be met. That confidence will be further supported by greater openness in the standards set for individual health professionals by their profession and prompt action by the regulating bodies to tackle problems when these occur.

### Duties of a doctor

The duties of a doctor as set out by the GMC in the latest version of its guidance *Good Medical Practice* include responsibilities to:

- "make the care of your patient your first concern
- respect the rights of patients to be fully involved in decisions about their care
- keep your professional knowledge and skills up to date
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise"

## Questions for consultation

- How far does the clinical governance framework reflect the key components that should make up clinical governance?
- How can effective partnerships be developed between health professionals and managers within NHS organisations? How might these be extended to partnerships within the wider NHS?
- How can we achieve the closer involvement of patients and the wider community?
- How can the public be more closely engaged in local clinical governance reporting arrangements? (For example, through links to existing complaints procedures?)
- Is there a need for guidance for NHS Trusts in setting in place local arrangements for leading on clinical governance?
- Is there a need for guidance for NHS Trusts on the content of clinical governance reports and arrangements for publication?
- What are the practical ways in which clinical governance can be implemented in general medical and dental practice and in community pharmacy and optometry?
- How can we make use of current thinking and practice in primary care quality improvement?
- What might be expected of Primary Care Groups at each level of development?
- How might we develop the systematic approach to clinical governance so that this has practical value in the field of public health?
- What other support might be useful (for example, toolkits for quality improvement supported networks to help spread learning and good practice)?

## Questions for consultation

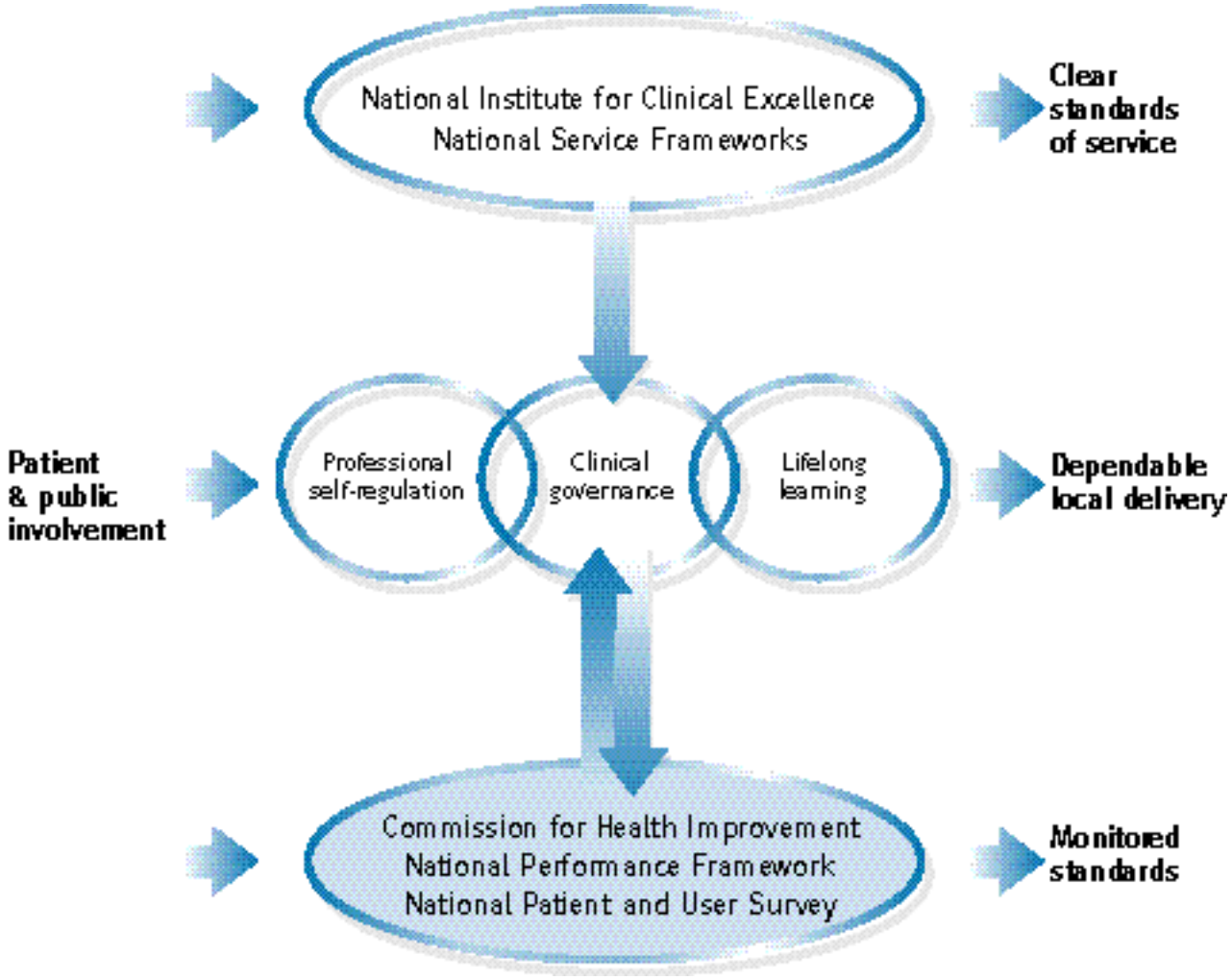
- A working definition is given of lifelong learning (CPD) – does this reflect its broad aims and values?
- How can we target lifelong learning (CPD) more effectively, within the context of clinical governance, to address both service development and individual health professional needs?
- How can the close links between clinical governance, lifelong learning and clinical and cost-effectiveness be fostered and implemented across traditional boundaries of care?
- What further guidance and practical support is needed to support local lifelong learning (CPD) and organisational development?
- How can personal development plans (PDPs) be best encouraged?
- How far are PDPs relevant to the different staff groups and what might be a realistic timescale for the majority of professional staff to have PDPs?
- How might we best work with the health professions to modernise and strengthen professional self-regulation?

# 4

# Monitoring quality standards

*Figure 8*

## Monitoring performance




*The Commission for Health Improvement will carry out local reviews, with a troubleshooting role to ensure delivery of quality services. A new National Framework for Assessing Performance will focus on quality, outcomes and efficiency. An annual National Survey of Patient and User Experience will provide feedback from patients and service users.*

**4.1** The Government, the NHS and the public need to know whether services really are delivering the high quality care that patients have a right to expect.

*'the Government, the NHS and the public need to know whether services really are delivering the high quality care that patients have a right to expect'*

**4.2** We will address these issues in three main ways:

- by establishing a new statutory body, the Commission for Health Improvement, to provide independent scrutiny of local efforts to improve quality and to help address any serious problems
- by strengthening the way in which we assess the performance of the NHS, using measures that are relevant to the standards of care delivered and by making public information on clinical quality
- by introducing a new National Survey of Patient and User Experience to provide systematic and comparable information on patient and user experiences.

## THE COMMISSION FOR HEALTH IMPROVEMENT

"To ensure the drive for excellence is instilled throughout the NHS, the Government will create a new Commission for Health Improvement. It will complement the introduction of clinical governance arrangements. Past performance on quality has been variable, and the health service has sometimes been slow to detect and act decisively on serious lapses in quality. As a statutory body, at arms length from Government, the new Commission will offer an independent guarantee that local systems to monitor, assure and improve clinical quality are in place. It will support local development and 'spot-check' the new arrangements. It will also have the capacity to offer targeted support on request to local organisations facing specific clinical problems.

Where local action is not able to resolve serious or persistent problems, the Commission will be able to intervene on the direction of the Secretary of State or by invitation from Primary Care Groups, Health Authorities and NHS Trusts. In these instances the Commission will both investigate and identify the source of the problem, and work with the organisation on lasting remedies. It will also be able to recommend to the Secretary of State other immediate action. He will have the power to remove NHS Trust Chairs and non-executive directors where there is evidence of systematic failure. The Commission may also undertake an agreed programme of systematic service reviews, following through implementation of the National Service Frameworks and the guidelines developed by the Institute. The Commission will have a membership drawn from the professions, NHS, academic and patient representatives. It will be funded from existing resources."

Paragraph **7.13 -7.14** *The new NHS Modern • Dependable*
Cm 3807:December 1997

*'action is needed to strengthen external oversight of NHS activity to improve quality'*

**4.3** We believe that further action is needed to strengthen external oversight of NHS activity to improve quality, to provide a reassurance to the public that the NHS is fulfiling its responsibilities for quality, and to help NHS organisations put things right when serious problems occur.

**4.4** We propose to establish a new statutory body, the Commission for Health Improvement, to support and oversee NHS activity to assure and improve clinical quality.

**4.5** The Commission's role should be seen in the context of proposals for developing clinical governance *(see Chapter 3)* and the more general challenge of strengthening the mechanisms the NHS has at its disposal for improving clinical quality. The Commission will not replace mainstream NHS performance assessment and management, but will complement and reinforce these processes.

**4.6** The Commission's core functions will be to:

- provide national leadership to develop and disseminate clinical governance principles
- independently scrutinise local clinical governance arrangements to support, promote and deliver high quality services, through a rolling programme of local reviews of service providers
- undertake a programme of service reviews to monitor national implementation of National Service Frameworks, and review progress locally on implementation of these Frameworks and NICE guidance
- help the NHS identify and tackle serious or persistent clinical problems. The Commission will have the capacity for rapid investigation and intervention to help put these right
- over time, increasingly take on responsibility for overseeing and assisting with external incident inquiries.

*'help the NHS identify and tackle serious or persistent clinical problems'*

**4.7** The Commission will concentrate on clinical issues but will also have the scope to become involved in management issues where these lie behind clinical problems.

## National leadership on clinical governance

**4.8** Chapter 3 seeks views on what sort of guidance, and how much guidance, NHS organisations might need to support implementation of clinical governance locally. Through its local review visits and other work, the Commission will be well placed to develop expertise about what works best on the ground and on good 'markers' of progress.

*'the Commission should have a leading role in developing advice and guidance for the NHS on clinical governance'*

**4.9** The Commission will have a leading role in advice and guidance for the NHS on clinical governance. The Commission will also have responsibility for endorsing external audit programmes in which all hospital doctors, in the relevant speciality and subspeciality will have to take part.

## Reviewing local clinical governance arrangements

**4.10** The NHS Executive Regional Offices will lead in overseeing the implementation of local clinical governance arrangements. The Commission will complement and strengthen these mechanisms, by providing a further external and independent check on local arrangements.

**4.11** We propose that the Commission should conduct a rolling programme of reviews, visiting every NHS Trust and Primary Care Trust provider over a period of around 3-4 years. It will look for evidence that clinical governance arrangements are working, that these are consistent with established standards, and can develop and sustain quality services. Local processes will be assessed on their capacity to support the delivery of quality services. NHS organisations will receive notice of the Commission's visits.

*'the Commission should conduct a rolling programme of reviews, visiting every NHS Trust and Primary Care Trust provider over a period of around 3 – 4 years'*

**4.12** This rolling programme of reviews will focus on both processes and outcomes. In looking at outcomes, it will take into account strengths and weaknesses which performance management processes and the new Patient Survey may have already identified within specific Trusts. There will be scope to accelerate the place of a particular Trust in the programme if a Regional Office has identified it as needing particular attention. Types of processes the Commission might examine include (for example) complaints handling – ensuring in particular that important lessons from complaints and the

*'the Commission's reports will not just be about identifying areas for improvement, but will also provide a way of identifying and acknowledging success and good practice and encouraging its dissemination'*

Ombudsman's reports are being identified and acted on. A clinical member of the Commission's review teams will have access to individual clinician's external clinical audit results. Recent tragedies demonstrate all too clearly the necessity for supplementing a hospital's internal processes with independent, external, review of clinical quality by the Commission.

**4.13** The Commission's findings will be reported to the Trust concerned and shared with the appropriate Health Authority or Regional Office. A summary will be made public. The Commission's reports will not just be about identifying areas for improvement, but will also provide a way of identifying and acknowledging success and good practice, and encouraging its dissemination.

**4.14** Regional Offices and Health Authorities will be responsible for ensuring that the recommendations from review visits are acted on, but the Commission may also have a role in following up specific recommendations for action. Follow-up action plans for addressing any identified deficiencies should be agreed between NHS Trusts and Regional Offices (or Primary Care Trusts and Health Authorities), and these plans should be reported to the Commission. An NHS Trust, Health Authority or Regional Office may also wish to invite the Commission to review progress where a need for major development work has been identified; for example, the Commission might agree to accelerate the place of a particular NHS Trust within its next cycle of local reviews.

**4.15** The Commission's rolling programme of reviews will cover all NHS Trusts and all Primary Care Trusts. It will not focus explicitly on commissioners of NHS services, though we propose that the Commission should have the power to look at Health Authorities and Primary Care Groups in the course of a review if it considers that their actions are impacting on the issues it is examining. For example, the Commission is likely to take a particular interest in what Health Authorities and Primary Care Groups are doing to encourage the development of clinical governance principles, both in Trusts and in other parts of primary care; and in securing the implementation of National Service Frameworks and NICE standards.

**4.16** There will be occasions when the Commission needs to look at those aspects of care delivered in primary care settings in examining whether the whole system of NHS care is working well (for example, for people suffering from heart disease as part of the monitoring of

the coronary heart disease National Service Framework). It is right that there should be a strong focus on quality throughout primary care. The principles of clinical governance need to apply in primary as well as secondary care, and all the contractor professionals are expected by their regulatory bodies to deliver the best care they can. We will be working with the relevant professional bodies to explore ways in which other mechanisms – within the framework of the existing national contracts – can in the first instance be used to support quality improvement and the principles of clinical governance in the contractor professions.

*'the principles of clinical governance need to apply in primary as well as secondary care'*

## National Service Frameworks and NICE guidance

"The Commission may also undertake an agreed programme of systematic reviews following through implementation of National Service Frameworks and guidelines developed with the Institute....

Paragraph **7.14** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**4.17** Part of each review visit should be devoted to a review of local activity on implementing National Service Frameworks and NICE guidance (for example, by seeking evidence of specific examples where clinical practice has changed). But we also believe that there is merit in reviewing and comparing this work in a more systematic way nationally.

**4.18** We propose that the Commission should conduct national 'sample' studies of activity to implement National Service Frameworks and associated NICE guidance. The results of these studies should inform the Commission's local review work, as well as wider NHS work to implement the Frameworks.

**4.19** Similar national review work is already undertaken by the Clinical Standards Advisory Group (CSAG). As an independent statutory body, the Commission will have the authority and resource to take on the work of CSAG. It will also have the freedom and capacity to decide the balance of use to be made of the expertise provided by its own members and staff and that of external consultants (for example, those with specific academic or research experience). Subject to Parliamentary approval, we propose to abolish CSAG and subsume its programme of service reviews within the Commission for Health Improvement.

*'reviewing and comparing in a more systematic way'*

**4.20** In carrying out these national reviews, the Commission will need to work closely with the Regional Offices. They will have access to a wealth of information about National Service Framework implementation, and the Commission should aim to build on this knowledge base rather than 're-invent the wheel'.

**4.21** The Commission's local and national review programmes should be closely co-ordinated with the Audit Commission's work programme. We will expect the two organisations to agree a joint programme of national work, and to conduct local and national reviews in a way which makes best use of their particular expertise and their combined resources.

## Addressing serious or persistent problems

*'when performance is not up to scratch in NHS Trusts, there will be rapid investigation and, where necessary, intervention'*

"In the new NHS, when performance is not up to scratch in NHS Trusts, there will be rapid investigation and, where necessary, intervention. This will take five forms:

- firstly, Health Authorities will be able to call in the NHS Executive Regional Offices when it appears that an NHS Trust is failing to deliver against the Health Improvement Programme
- secondly, NHS Executive Regional Offices will be able to investigate if there is a question over compliance with their statutory duties
- thirdly, the Commission for Health Improvement could be called in to investigate and report on a problem
- fourthly, Primary Care Groups will be able to signal a change to their local service agreements, where NHS Trusts are failing to deliver
- fifthly, the Secretary of State could remove the NHS Board."

Paragraph **6.20** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**4.22** *The new NHS* clearly sets out the measures available to address poor performance in NHS Trusts. Health Authorities can trigger the involvement of the Regional Offices if there are concerns about the failure of NHS Trusts to deliver, and the Regional Offices can also investigate failures to comply with statutory duties. The Commission will supplement not supplant these mechanisms. Most problems will continue to be dealt with by local providers working with Health Authorities and the Regional Offices.

*'it will be able to respond quickly and decisively to help identify and address serious problems, providing extra support to managers and clinicians to help put them right'*

**4.23** The Commission for Health Improvement will provide external help where it is needed. In the past, there has been too much uncertainty about how and when to bring in outside help. The Commission's independence, objectivity and expertise will support its role as an effective 'trouble-shooter'. It will be able to respond quickly and decisively to help identify and address serious problems, providing extra support to managers and clinicians to help put them right. In doing so, it will need to work very closely with existing sources of expertise (for example, relevant national professional bodies).

## *Triggering the Commission's involvement*

**4.24** Strong clinical governance means that problems are far more likely to be identified and addressed at the local level. And strong performance management and the new Patient Survey *(see below)* means that there will be a number of 'triggers' to sound alarm bells where difficulties continue despite local efforts. Where concerns are raised, service providers, Health Authorities and Regional Offices will have the opportunity to invite support from the Commission to investigate services at a particular Trust.

**4.25** Primary Care Groups and Primary Care Trusts will be able to invite the Commission in to look at services provided by their members as contractor professions, but only where other avenues, such as action through contracts, have been shown not to work.

*'there will be a number of "triggers" to sound alarm bells where difficulties continue despite local efforts'*

**4.26** Where the Commission has been invited in to investigate a local problem, follow-up action will be the responsibility of the NHS organisation in question, overseen by the Regional Office or Health Authority. The relevant NHS organisation should share with the Commission its plans for addressing any recommendations for action, and the Commission might be involved in this follow-up action at local request. The Commission is likely to pay particular

attention to the implementation of its recommendations when it next visits the organisation as part of its rolling review programme.

*'key findings and recommendations should be made public'*

**4.27** The Commission will work closely with the Regional Offices to ensure that best use is made of its resources and to ensure that help is targeted where most needed. Where the Commission helps to investigate and resolve a problem, a summary of key findings and recommendations will be made public.

## *Sending in the Commission*

**4.28** We believe that the Commission must operate in the context of mainstream mechanisms for managing NHS performance and investigating problems. So it will operate to an agreed work programme.

**4.29** There may be cases where there is an unacceptable delay in putting serious problems right, or a persistent failure to act. In such cases, the Secretary of State for Health (or Health Authorities for Primary Care Trusts) will be able to ask the Commission to investigate the problem and make recommendations for rapid action. This will usually happen only where there are very serious concerns about the quality of clinical services. NHS organisations will be required to release information that will assist the Commission in its investigation.

**4.30** The Commission will not itself be able to impose sanctions on Trusts. Action on its recommendations will usually be followed up through the NHS performance management system. But the Commission may also have a role in follow-up activity, in agreement with a Health Authority or Regional Office. Where there has been serious default in meeting statutory duties, or confidence in the quality of local services has been gravely compromised, the Secretary of State may decide to remove the Trust Board.

*'NHS organisations will be required to release information that will assist the Commission in its investigation'*

**4.31** If the Commission discovers or suspects that there are problems with the performance of individual clinicians, it will refer these to the appropriate professional regulatory body (for example, the General Medical Council) for it to take action.

## Inquiries

**4.32** There is obvious scope for overlap between the Commission's work and the inquiries which NHS organisations or the Secretary of State may sometimes establish into serious service failures. Activity on inquiries is not well co-ordinated and, again, it is often unclear where services can turn for advice.

**4.33** We propose that the Commission should, over time, increasingly take on responsibility for overseeing and assisting with external incident inquiries. It should be able to develop the knowledge and expertise to facilitate access to a range of people to serve on inquiry teams, and to help inquiries themselves run more efficiently and effectively.

*'overseeing and assisting with external incident inquiries'*

## Working with other bodies

**4.34** The Commission will also need to link with a range of other bodies in the performance of its functions. As well as working closely with NHS bodies, the Audit Commission and the NHS Executive, the Commission will need to develop effective working relationships with organisations such as:

- the Health Service Commissioner, whose statutory role is to investigate complaints about NHS services which have not been resolved through the NHS complaints procedure
- professional regulatory bodies, such as the GMC, the GDC and UKCC, which are set up under statute to guide and regulate doctors, dentists, nurses and other health care professionals
- professional organisations, such as the Royal Colleges, which represent their members and which in some cases set standards for postgraduate education
- the Health and Safety Executive, which routinely inspects NHS providers and their health and safety management systems to ensure the health and safety of employees and patients
- Social Services organisations and associated regulatory bodies (for example, the Social Services Inspectorate).

*'the Commission will need to develop effective working relationships'*

## Patients' experiences and the NHS complaints procedure

*'service failure, from the patient's viewpoint, could trigger a Commission investigation'*

**4.35** Information about patients' experiences of the NHS, captured through a new Patient Survey will form an important part of our overall assessment of NHS performance. This assessment will in turn help to inform the Commission's work, including decisions on the issues it examines during its rolling programme of local reviews and on any additional targeted investigations which might be needed. Service failure, from the patient's viewpoint, could trigger a Commission investigation.

**4.36** There will also need to be an appropriate link between the NHS complaints procedure and arrangements for triggering the involvement of the Commission for Health Improvement. This might be through the independent complaints review panels, which will be able to recommend to NHS organisations that the Commission be invited in to help investigate and resolve a significant, wider, clinical problem which has been highlighted by a complaint.

## The independent sector

**4.37** We are currently looking at options for future regulation of the independent acute sector. The Commission's role in this area may need to be assessed more fully in that light. In the meantime, we believe that the Commission's main task should be helping to drive and support improvements in the quality of NHS services.

*'the Commission's main task should be helping to drive and support improvements in the quality of NHS services'*

**4.38** Some aspects of the Commission's role – for example, its systematic service reviews – might need to encompass independent providers where they provide a significant proportion of services to NHS patients; mental health services are one example. We propose that the Commission's remit should be drawn sufficiently widely to permit this with the agreement of the Secretary of State.

## Resourcing

**4.39** The new Commission will be funded from within existing resources. The money which currently supports the work of the Clinical Standards Advisory Group will be redirected to fund the Commission's national systematic service review work. And we are looking at how we can fund other aspects of the Commission's work by making better use of other NHS funds which are currently spent on non-care areas.

*'the new Commission will be funded from within existing resources'*

**4.40** At least initially, we do not envisage the Commission charging individual NHS organisations directly for the bulk of its local review work. But in the longer term, as its role develops more fully, we believe that there is merit in moving to a system where more of the Commission's work is funded locally (as for example with the Audit Commission). This will encourage greater local involvement in review and investigation work, and more ownership of the results. But if it is not to be at the expense of direct patient care any charges will need to be offset by reductions in non-care expenditure elsewhere – for example, by ensuring other external audit work meets stringent value for money tests.

**4.41** The bulk of major inquiry work, which will increasingly come under the Commission's remit, will continue to be funded locally, but the Commission's expertise will help services secure better value for money.

## Setting up the Commission for Health Improvement

**4.42** Subject to Parliamentary approval, the Commission will be established as an independent statutory body, directly accountable to the Secretary of State. The Commission will be required to report annually on progress made in developing clinical governance within the NHS, and on the major issues emerging from its work.

**4.43** The Chair and Board members will be appointed by the Secretary of State. The Commission will need to provide a balance of expertise and experience and this will be reflected in its membership which will be drawn from patients, the professions, the NHS, and academia. We believe that there would be considerable merit in appointing a lay Chair, and that members should be appointed on their own merits rather than as representatives of a particular organisation or interest. The Commission's executive powers will be discharged through a new post of Director of Health Improvement.

*'a new post of Director of Health Improvement'*

*'we consider it essential that there should be lay representation on its review teams, as well as clinicians and managers'*

**4.44** The Commission will also need to draw on a wide range of expertise, both 'in house' and external, in the performance of its work. We consider it essential that there should be lay representation on its review teams, as well as clinicians and managers.

**4.45** We will introduce legislation at the earliest opportunity to establish the Commission during 1999/2000.

### How will the Commission for Health Improvement help patients?

The Commission for Health Improvement will provide an independent reassurance to patients that effective systems are in place to deliver high quality services throughout the NHS. It will also be available to offer rapid support where there is a need to help local NHS organisations resolve particularly difficult problems. The Commission has an important role in working to reduce variations in services across the NHS through its systematic reviews of services, providing feedback into the National Service Frameworks, and its monitoring of uptake of NICE guidance.

## A NATIONAL FRAMEWORK FOR ASSESSING PERFORMANCE

*'measuring how local services are progressing'*

"There must be improvements in quality and efficiency. Improvements in speed of access to care. Improvements in health, tackling past inequalities. The Government requires the new NHS to make progress on all these fronts. A new national performance framework, measuring how local services are progressing against their targets, will help shape NHS services to meet the challenge."

Paragraph **8.2** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**4.46** The Commission will have an important role in assessing quality in the NHS. Its work will be complemented by a new National Framework for Assessing Performance.

**4.47** Any system for monitoring and assessing the performance of a service itself sends powerful messages about what that service is expected to

deliver. For too long the emphasis has been on measuring activity, but this ignores some of the real needs of patients. Cutting waiting lists and waiting times matters to patients, so does the overall quality of care they receive.

*'true value for money includes an assessment of quality and outcomes as well as quantity and cost'*

**4.48** Financial efficiency is important – the NHS has a duty to make the best use of resources and to deliver good value for money. But true value for money includes an assessment of quality and outcomes as well as quantity and cost. We need a balanced range of information on all these things to make a truly meaningful assessment of NHS performance.

## The new approach

**4.49** Earlier this year, we consulted on proposals to introduce a new Performance Framework. This will provide a more balanced view of NHS performance by focusing on six main areas:

- health improvement
- fair access to services
- effective delivery of appropriate healthcare
- efficiency
- patient and carer experience and
- health outcomes of NHS care.

The table overleaf explains these areas in more detail.

*'the Performance Framework will support the drive for higher quality standards by ensuring that performance assessment is focused on the delivery of effective, appropriate and timely health services which meet local needs'*

**4.50** The Performance Framework will support the drive for higher quality standards by ensuring that performance assessment is focused on the delivery of effective, appropriate and timely health services which meet local needs. It will be an integral part of NHS accountability arrangements, ensuring that both quality and efficiency are central to the way the NHS is held to account. And it will underpin the planning and management agreements within the healthcare system (such as the performance agreement between a Health Authority and its Regional Office, the NHS contribution to the Health Improvement Programme and the service agreement between a Primary Care Group and an NHS Trust).

| Areas | Aspects of performance |
|---|---|
| i **Health improvement** | The overall health of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies |
| ii **Fair access** | The fairness of the provision of services in relation to need on various dimensions:<br>• geographical<br>• socio-economic<br>• demographic (age, ethnicity, sex)<br>• care groups (for example, people with learning difficulties) |
| iii **Effective delivery of appropriate healthcare** | The extent to which services are:<br>• clinically effective (interventions or care packages are evidence-based)<br>• appropriate to need<br>• timely<br>• in line with agreed standards<br>• provided according to best practice service organisation<br>• delivered by appropriately trained and educated staff |
| iv **Efficiency** | The extent to which the NHS provides efficient services, including:<br>• cost per unit of care/outcome<br>• productivity of capital estate<br>• labour productivity |
| v **Patient/carer experience** | The patient/carer perceptions on the delivery of services including:<br>• responsiveness to individual needs and preferences<br>• the skill, care and continuity of service provision<br>• patient involvement, good information and choice<br>• waiting and accessibility<br>• the physical environment; the organisation and courtesy of administrative arrangements |
| vi **Health outcomes of NHS care** | NHS success in using its resources to:<br>• reduce levels of risk factors<br>• reduce levels of disease, impairment and complications of treatment<br>• improve quality of life for patients and carers<br>• reduce premature deaths |

**4.51** The Performance Framework will also provide a basis for publishing information about the results achieved by each part of the NHS. It will be complemented by the publication of progressively more detailed clinical information comparing each unit's performance for a range of conditions. As a first step, a range of clinical indicators will be published in October 1998 on a named hospital basis across England.

*'publication of more detailed information comparing hospital deaths'*

## Next steps

**4.52** Responses to our consultation are still being considered, but have indicated widespread support for a move to a broader view of NHS performance.

**4.53** We acknowledge that it will take time to develop a comprehensive set of indicators which reflect priorities for health and healthcare and provide useful information to the NHS about its own performance. But since patients fund the NHS they have a right to know what is going on in a public service. As part of the Performance Framework, we will develop and publish sophisticated measures of clinical quality on a speciality by speciality and named hospital basis.

*'sophisticated measures of clinical quality on a specialty by specialty and hospital by hospital basis'*

**4.54** We need to make sure we are comparing like with like. So, over time, figures will need to be 'risk adjusted' to standardise for factors such as age, severity, casemix and concurrent illnesses. These measures will vary between specialties and procedures. For example, death rates might be a good measure after cardiac surgery. But for hip joint replacements, a better measure may be the length of time the 'new' hip joint lasts. In many cases, valid measures already exist – say in cardiac surgery and intensive care – but they are only used patchily.

**4.55** In future, when expert reference groups are drawing up National Service Frameworks *(see Chapter 2)*, they will identify valid clinical quality indicators. The reference group set up for coronary heart disease will identify by the end of 1998 a robust set of clinical performance indicators for cardiac services. These will then be collected, published and monitored in every NHS hospital in the country. Each year, as we develop a new National Service Framework covering another condition or disease, it too will contain new measures. These figures will compare like with like, by reflecting the condition of the patient and the complexity of the treatment. This is a 10 year rolling programme to improve our clinical performance information.

*'a revised Framework published in time for implementation in 1999/2000'*

**4.56** The next stage in the Performance Framework's development will take place over the Summer. This will involve testing the Framework and high-level indicators with individual Health Authorities, both in their accountability to the NHS Executive and in securing healthcare services for their populations. The results will be evaluated in the Autumn, and a revised Framework published in time for implementation in 1999/2000.

### How will the National Framework For Assessing Performance help patients?

By measuring what counts for patients, the Performance Framework will focus the NHS on delivering what counts for patients. It will provide information not only on the number of patients treated but on the effectiveness of that treatment.

## NATIONAL SURVEY OF PATIENT AND USER EXPERIENCE

*'the views and experiences of the people who use the NHS should form an important element of any assessment of its performance'*

"The Government will introduce a new national survey of patient and user experience. It will be carried out annually, at Health Authority level, and the results will be published both locally and nationally. This means that for the first time in the history of the NHS there will be systematic evidence to enable the health service to measure itself against the aspirations and experience of its users, to compare performance across the country and to look at trends over time. The survey will give patients and their carers a voice in shaping the modern and dependable NHS. The first survey will take place in 1998".

Paragraph **8.10** *The new NHS Modern • Dependable*
Cm 3807:December 1997

**4.57** As with any service, the views and experiences of the people who use the NHS should form an important element of any assessment of its performance. This is reflected in the explicit inclusion of patient and carer experience as part of the new National Framework for Assessing Performance. Information about patients' experiences can be an important lever for change, both highlighting where, and what sort of, quality improvements are needed.

*'we will ask patients about the issues which really matter to them'*

**4.58** There are already a number of ways in which patients and the public can make their views known about the quality and availability of services in their local community – for example, through the NHS complaints procedures, and also through positive feedback in comments, letters of praise and thanks to professional staff who have provided care and treatment. Patients and the public can also feed in views through their local Community Health Council.

**4.59** But we need a more systematic way of ensuring that information on patient and user experiences is collected and made available both to the NHS and more widely. Our planned National Survey of Patient and User Experience will provide an important new source of information, on how local people view the services they get. We will shortly be tendering for a specialist survey provider to develop this work with us, and will actively involve users and carers in the development process. The first Patient Survey will take place later this year.

**4.60** We will ask patients about the issues which really matter to them, such as the ease of access to services, how long they have to wait for treatment, and whether they are happy with the quality of information provided about their care. We want to explore patients' views of the efficiency of the medical and technical aspects of their care. We also want to cover areas such as the privacy and dignity of their care, especially with regard to mixed sex accommodation in hospital, as well as the courtesy and helpfulness of staff.

**4.61** The Patient Survey will give us valuable background information about patients' general state of health and their social circumstances, as well as patients' views on the important issue of continuity of care between their GP, the hospital and community services. We are considering how the Survey might best be linked with National Service Framework topics.

*'the first Patient Survey will take place later this year'*

*'the results will highlight areas where the NHS needs to make changes to respond to patients' views'*

**4.62** A sample of views will be taken from people treated in each Health Authority area, giving a comprehensive national view from a very large number of patients. We will publish the results in annual national reports which will focus on local performance, so that people can assess the progress their local services are making over time and compare their performance with services elsewhere. The results will highlight areas where the NHS needs to make changes to respond to patients' views.

**4.63** Local NHS organisations will need to demonstrate to the Regional Office that they have taken action to address issues raised by the Patient Survey. The NHS Executive will also use the data as part of the Performance Framework to show where improvements are needed and to help boost performance. Consistently poor results might trigger action to involve the Commission for Health Improvement in identifying and putting right any serious underlying problems.

## How will the National Survey of Patient and User Experience help patients?

The Patient Survey will ensure that patients' and users' views of the quality of care are made known to the NHS. This will help patients by:

- enabling local managers and health professionals to take direct account of patients' and users' concern so as to improve services
- providing benchmarks against which patient experiences locally can be assessed, and highlighting potential for improvement
- demonstrating to patients and users that their views on services are important.

## Questions for consultation

- In what ways might it be helpful for the Commission to provide advice and guidance on developing clinical governance?
- In what ways might the Commission develop its rolling programme of local reviews to ensure that it is of maximum value to the NHS and to patients?
- How might the Commission best develop and perform its 'troubleshooting' work?
- How can the Commission best build on the work of the Clinical Standards Advisory Group?
- What important linkages, other than those already highlighted, might the Commission need to make?
- Is the suggested balance of membership of the Commission appropriate?
- In what ways might the Commission for Health Improvement work best with the Audit Commission?
- How might the results of the Patient Survey best be used to help drive up quality in the NHS?

# 5

# Action for quality

> "The Government will work closely with those in the NHS, users and carers, and partner organisations on implementation. There will be early consultation papers on some issues. Others will be taken forward locally, but with arrangements to identify and share good practice as it develops. In parallel, the NHS Executive will work with the health service locally to promote the organisational and personal development that must support clinicians and managers as they put these new arrangements in place and respond to the new challenges."
>
> Paragraph **10.4** *The new NHS Modern • Dependable*
> Cm 3807:December 1997

## A vision for quality

*'assuring quality, improving equity of access, tackling unacceptable variations in services'*

**5.1** *The new NHS* set out a modernisation programme to deliver more consistent and higher quality care for patients. This document is an integral part of that modernisation programme. It sets out a process for quality improvement in the NHS. The main elements are:

- clear national standards for services and treatments, through National Service Frameworks and the work of the National Institute for Clinical Excellence
- local delivery of high quality healthcare, through clinical governance underpinned by lifelong learning and professional self-regulation

- effective monitoring of progress, through the work of the Commission for Health Improvement, a new National Framework for Assessing Performance, and a new National Survey of Patient and User Experience.

*'we want to keep and build on what works, on existing good practice but most of all the experience and commitment of NHS staff'*

**5.2** These components will come together to help assure quality, improve equity of access and tackle unacceptable variations in services. They will support local services in working to improve the quality of services for patients.

**5.3** The Government and the NHS share a responsibility to patients and the taxpayer for the provision of cost-effective, high quality services. The Government wants to forge a partnership for quality with the NHS, and to develop an approach which is coherent both nationally and locally. It is recognised that the NHS needs support to achieve greater consistency in standards and services across the country. It is the Government's job to deliver that support.

**5.4** We have set out a vision for change. That it is achievable is already being demonstrated by many of those working in the NHS. There is much excellent work on which to draw, but too often it is fragmented in its approach and dependent on the enthusiasm of individuals rather than the commitment of whole organisations or whole health systems. We want to keep and build on what works, on existing good practice, but most of all on the experience and commitment of NHS staff.

**5.5** We have already made it clear that the modernisation of the NHS cannot happen overnight. It is a 10 year strategy, but the NHS must change to respond to a changing world.

## Making it happen

*'empower those who work in the NHS to improve quality locally'*

**5.6** The point has been made repeatedly to us that achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in *culture*, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally. One of the key challenges is to engage health organisations wholeheartedly, from top to bottom, in developing and delivering a common agenda for quality improvement.

*'we want to create a culture in the NHS which celebrates and encourages success and innovation'*

**5.7** We want to create a culture in the NHS which celebrates and encourages success and innovation. But this must also be a culture which recognises that if the NHS is to have the confidence to strive for quality there must be scope for acknowledging and learning from past mistakes. This does not mean that we will tolerate poor quality and poor services. It is about recognising that it is not always possible clinically to achieve the perfect outcome – as individuals, patients will respond to treatment in different ways. Ongoing evaluation and review is essential to this evolutionary process. Making the best use of good practice and lessons learned are an important, integral, part of a continuous programme for quality improvement.

**5.8** The achievements of the NHS in response to the challenges of the last fifty years have been immense. Part of the challenge of the future will be in meeting the modern aspirations of patients and the public for up to date, open and accountable high quality services. *The New NHS* set out a way of driving up quality and improving efficiency through partnership, not competition. It also set out a vision of a more open and accountable NHS – in partnership with the people it serves.

*'the NHS must be more open and truly accountable to the public'*

**5.9** Effective public partnership is not easy to achieve. But if patients are to receive high quality, responsive, integrated care services, the NHS must be more open and truly accountable to the public. Public partnership can act as a lever for quality improvement, through responding to public expectations of service:

- involving the public in decision-making and monitoring processes
- involving patients in service planning, development and implementation
- involving patients in their own treatment and care.

It is important that we constantly look at new ways of involving patients and the public and do not stand still. *The New NHS* offered a number of fresh opportunities for trying out new ideas and seeing how things can be improved.

*'poor quality is itself costly'*

**5.10** There is a view that high quality care costs more money. But this fails to recognise that poor quality is itself costly. Operations that need to be re-done, patients who need to be re-admitted within weeks or months, infections picked up on wards, unnecessary or inappropriate treatments, complaints and litigation, might all be reduced with higher quality care. Investment in quality is about more

than just money. It requires investment in time, understanding and commitment at every level of the organisation.

## Support from the centre

*'we recognise that some organisations are further advanced than others'*

**5.11** We recognise that some organisations are further advanced than others. We need to take account of the different stages reached, the different starting points for implementing the quality agenda and managing the changes. And we also need to take account of approaches to quality that cross organisational boundaries, with the people who use services.

**5.12** HSC(98) 21, *Better Health and Better Health Care,* issued in February 1998, provides an integrated programme and timetable for change set out in the White Paper. It identifies where further decisions or guidance are planned and provides a framework within which to plan local action.

*'an integrated programme and timetable for change'*

**5.13** Since then, we have consulted on our proposals for a new Performance Framework and responses are already being considered. In April, we announced the start of work on the first National Service Frameworks (in HSC 1998/074). This has been followed, in May 1998, with consultation on the first stage in developing a set of indicators to assess progress in securing clinical effectiveness in services (HSC 1998/085).

**5.14** The NHS R&D strategy is in place. Change management may be an imprecise science, but evidence is available on what works and what does not, and the NHS must make use of this. The new Service Delivery and Organisation Programme in the NHS R&D Programme will review existing research findings of relevance to change management and quality improvement in the NHS. It will also commission new studies to improve the knowledge base. This work will be made available in a user-friendly format for the whole NHS to draw on.

## Two key supporting strategies:

**Human resources**
a national HR strategy will be issued in the Summer

**Information**
a national strategy to support the drive for quality and efficiency will be issued later this Summer

**5.15** We are also about to announce two key supporting strategies which are critical to quality improvement.

**5.16** Human Resources: The consultation document, *Managing HR in the NHS – A Service Wide Approach*, issued in September 1997, has already provided important feedback on the capacity and capability of NHS organisations to make change happen. The NHS is a complex organisation and there can be no wholly uniform approach. But to support local organisations and help ensure consistency in achieving overall objectives for improving services, a national human resources strategic framework will be issued in the Summer. This will include ways of accessing specific help to develop leadership and strengthen local capacity, and ways of ensuring that staff contribute to changes to improve the services they deliver to their patients.

**5.16** *Information:* Patients, health care professionals, policy makers, managers and the public all need good quality information. In *The new NHS*, we announced that we would produce a new information strategy to support the drive for both quality and efficiency. This will be available later this Summer. The strategy will focus on improving access to information that supports co-ordinated clinical care to patients (for example, with more extensive use of electronic patient records) and which supports analysis of the quality and efficiency of the services provided.

Access to high quality information is essential for good clinical governance and effective performance management. Better information will support the use of best evidence, provide more accurate assessment of the quality of services to support clinical governance and performance management. It will allow better measurement of success, for example how new approaches have made a difference in the way services are delivered and how we make meaningful comparisons with other organisations (for example, through benchmarking).

*'high quality information is essential for good clinical governance and effective performance management'*

**5.18** The NHS Executive will continue to support the development of the quality agenda. It will issue guidance on clinical governance in Autumn 1998, and on the development of lifelong learning. We will also take careful account of responses to consultation in further work to set in place the National Institute for Clinical Excellence and the Commission for Health Improvement.

*'a clear commitment and involvement from the top'*

**5.19** The NHS Executive Regional Offices will have a pivotal role in providing developmental and other support to NHS organisations locally, working with Health Authorities and NHS Trusts to assess development needs and to facilitate local plans for change. For example, they will be able to work with NHS Trusts to guide and support the development of clinical governance arrangements, and with Health Authorities to support their important developmental role with Primary Care Groups and Primary Care Trusts.

**5.20** Professional bodies, such as the Royal Colleges, will also play their part in supporting their members in achieving change to deliver quality services across the NHS.

## Making it work at a local level

**5.21** We are looking at major cultural change for everyone. There is a need to develop organisations to support a change in culture and to deliver change. There are some crucial elements which are needed to drive change forward:

*'quality is not an add-on'*

Excellent leadership: A clear commitment and involvement from the top. Trust Boards and Chief Executives must sign up to the need for change and drive it forward through the whole organisation. Strong leadership is needed by, and from, both clinicians and managers

Involvement of staff: Total involvement of staff in shaping services and planning change, with open communication and collaboration, is one of the best ways in which the NHS can improve patient care

Involvement of patients: Patients provide a uniquely valuable perspective on services, and it is impossible to get the best from a change process without actively involving them.

## Priorities for change

*'a clear aim must be the involvement of patients and the public in the decision-making process'*

**5.22** It will be important not to let change overwhelm us. The philosophy will be to take it one step at a time; plan the pace of change and prioritise and understand that the aim is evolution not revolution.

**5.23** Quality is not an add-on. It must be an integral part of coherent, consistently applied systems that continually involve the whole organisation in work to plan, deliver and evaluate the quality of its services.

**5.24** The priority should be to put in place arrangements which set the quality of patient care first, and which operate across the continuum which links service development, organisational development and personal development. This will include how these fit with those in partner organisations (for example, if a patient is to move between service providers, there must be consistency in the systems that assure the quality of care provided).

**5.25** The driver for change must be the delivery of high quality clinical and cost-effective services for patients. A clear aim must be the involvement of patients and the public in the decision-making process. This should not be a discrete 'add-on' task but part of the way all NHS organisations work.

## Next steps

**5.26** Above we have outlined action already taken to begin the implementation of the quality agenda throughout the NHS, and how this fits within a coherent programme to modernise the health service set out in *The new NHS*.

*'we expect work to be already underway to assess the gaps and set the priorities for change'*

**5.27** A significant part of that timetable for change will be the implementation of action identified in this consultation document to drive forward quality in every part of the NHS. This will include bringing into use the new Performance Framework in six main areas *(see Chapter 4)*, new ways of commissioning health services, and the development of Health Improvement Programmes and Primary Care Groups. We expect work to be already underway to assess the gaps and set the priorities for change. Key action to improve quality

locally will be the development of clinical governance arrangements. For example, in *Chapter 3*, we have provided a checklist for a clinical governance system for NHS Trusts, which will need to have basic arrangements in place by early 1999 to produce their first clinical governance reports in Spring 2000. That checklist will also be a useful guide to other NHS organisations. In addition, emerging findings of the National Service Frameworks on coronary heart disease and mental health will be available in Spring 1999, which will enable Health Authorities – together with their partners – to plan for implementation through Health Improvement Programmes from April 1999.

*'NICE and the Commission for Health Improvement begin to make their contribution from 1999'*

**5.28** Initial progress can be built on as local experience and expertise increases and as the two new national bodies, NICE and the Commission for Health Improvement, begin to make their contribution from 1999.

## How will we know we are making progress?

**5.29** There will be a number of ways in which the Government, the public and NHS organisations, themselves, can gauge what progress the NHS is making in the drive for improved quality and consistency. For example, indications of progress nationally and locally will come from:

- performance management systems, and published information on clinical quality, using the new National Framework for Assessing Performance, with a management line through the NHS Executive. This will include monitoring of National Service Framework implementation
- NHS Trust, Primary Care Trust and Health Authority Annual Reports, supplemented by new local clinical governance reports, which will set out progress made and targets for improvement
- the local spot checks and national systematic service reviews undertaken by the Commission for Health Improvement
- the new National Survey of Patient and User Experience, and
- local monitoring of service agreements underpinning Health Improvement Programmes.

## Milestones for quality improvement

| Milestones | Timing |
|---|---|
| Publication of human resources strategy | Summer 1998 |
| Publication of NHS information strategy | Summer 1998 |
| Guidance on Health Improvement Programmes | Summer 1998 |
| National Service Frameworks: emerging findings reports on mental health and coronary heart disease | Autumn 1998 |
| Preliminary clinical indicators published for named NHS hospitals | October 1998 |
| Guidance on the implementation of clinical governance | October/November 1998 |
| Guidance on National Framework for Assessing Performance | November 1998 |
| Clinical quality indicators identified for cardiac services | December 1998 |
| Guidance on the development of a locally based approach to lifelong learning | Winter 1998 |
| First National Survey of Patient and User Experience | Winter 1998 |
| Introduction of basic clinical governance in NHS Trusts | Early 1999 |
| National Institute for Clinical Excellence to be set up as a Special Health Authority | Early 1999 |
| Coronary heart disease and mental health National Service Frameworks published | Spring 1999 |
| Commission for Health Improvement set up as an independent, statutory body (subject to legislation) | 1999/2000 |
| All hospital doctors participate in national external audit, endorsed by the Commission for Health Improvement | 1999 |
| First clinical governance reports from NHS Trusts | Spring 2000 |

## Conclusion

**5.30** This consultation document sets out a formidable agenda for change. We make no apology for this. Our agenda concentrates on what really matters – improving quality, standards, efficiency, openness and accountability. We can – and must – deliver a modern, dependable NHS. An NHS which will be judged on the quality of its services and how well it responds to the people it serves.

*'this Government wants to build a genuine partnership with the NHS to deliver change at a local and national level'*

**5.31** This Government wants to build a genuine partnership with the NHS to deliver change at a local and national level.

**5.32** That partnership for quality must include all those who work in and use our National Health Service. It must provide them with real opportunities to contribute and be involved in change. By encouraging the discussion and sharing of ideas, we will help to ensure that we achieve a modern NHS.

**5.33** We welcome your views on both the overall approach to quality improvement and its details. We have asked some specific questions at the end of each chapter and these are also summarised at the end of the document.

**5.34** Please send your responses by Friday 11 September 1998 to:
Quality Management Team
Room 605
NHS Executive Headquarters
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS
*Responses can also be sent via e-mail on* aburnett@doh.gov.uk

**5.35** Further copies of this document and a summary version, are available in writing from:
Department of Health
PO Box 410
Wetherby LS23 7LN

Or you can fax your order through on: *fax:* 0990 210 266

Both items can also be accessed on the Internet at the following address: http://www.open.gov.uk/doh/newnhs/quality.htm

If you work within the NHS you can order further copies through the: NHS Responseline: *tel:* 0541 555 455.

# Annex

## *Questions for consultation*

### National Institute for Clinical Excellence

- Should NICE also have a role in broader based functions – including screening and other public health functions?
- In what ways might NICE co-ordinate work currently undertaken by the four existing National Confidential Enquiries?
- Is there potential for other work which might be usefully brought under the umbrella of NICE?
- How might NICE best approach the development of effective partnerships, particularly with patients, service users, carers and the wider public?
- In what ways can NICE network with other organisations to share good practice?

### National Service Frameworks

- In what ways can partnerships between patients, carers, service users, and other key players be encouraged in developing and implementing National Service Frameworks?
- How can staff in the NHS and elsewhere be supported in implementing the organisational and cultural changes which may flow from the introduction of National Service Frameworks?
- How best can partnerships between all the agencies involved in National Service Frameworks be fostered?

## Clinical governance

- How far does the clinical governance framework reflect the key components that should make up clinical governance?
- How can effective partnerships be developed between health professionals and managers within NHS organisations? How might these be extended to partnerships within the wider NHS?
- How can we achieve the closer involvement of patients and the wider community in developing clinical governance?
- How can the public be more closely engaged in local clinical governance reporting arrangements (for example, through links to existing complaints procedures)?
- Is there a need for guidance for NHS Trusts in setting in place local arrangements for leading on clinical governance?
- Is there a need for guidance for NHS Trusts on the content of clinical governance reports and arrangements for publication?
- What are the practical ways in which clinical governance can be implemented in general medical and dental practice, and in community pharmacy and optometry?
- How can we make best use of current thinking and practice in primary care quality improvement?
- What might be expected of Primary Care Groups at each level of development?
- How might we develop a systematic approach to clinical governance so that this has a practical value in the field of public health?
- What other support might be useful (for example toolkits for quality improvement, supported networks to help spread learning and good practice)?

## Lifelong learning

- A working definition has been given of lifelong learning (continuing professional development) – does this reflect its broad aims and values?
- How can we target lifelong learning (CPD) more effectively, within the context of clinical governance, to address both service development needs and individual health professional needs?
- How can the close links between clinical governance, lifelong learning and clinical effectiveness be fostered and implemented across traditional boundaries of care?

- What further guidance and practical support is needed to support local lifelong learning (CPD) and organisational development?
- How can personal development plans (PDPs) be best encouraged?
- How far are PDPs relevant to the different staff groups and what might be a realistic timescale for the majority of professional staff to have PDPs?

## Professional self-regulation

- How might we best work with the health professions to modernise and strengthen professional self-regulation?

## Commission for Health Improvement

- In what ways might it be helpful for the Commission to provide advice and guidance on developing clinical governance?
- In what ways might the Commission develop its rolling programme of local reviews to ensure that it is of maximum value to the NHS and to patients?
- How might the Commission best develop its 'troubleshooting' work?
- How can the Commission best build on the work of the Clinical Standards Advisory Group?
- What important linkages, other than those highlighted, might the Commission need to make?
- Is the suggested balance of membership of the Commission appropriate?
- In what ways might the Commission for Health Improvement work best with the Audit Commission?

## National Survey of Patient and User Experience

- How might the results of the Patient Survey best be used to help drive up quality in the NHS?

# Glossary

### Caldicott Report

Review of Patient Identifiable Information with recommendations on appropriate safeguards to govern access to and storage of confidential patient information.
*(See Chapter 3)*

### Calman-Hine Report

A Policy Framework for Commissioning Cancer Services which recommended that cancer services be organised at three levels: primary care; Cancer Units in local hospitals to manage commoner cancers; and Cancer Centres in larger hospitals to manage less common cancers and provide support services for Cancer Units. *(See Chapter 2)*

### Clinical governance

A framework through which NHS organisations are accountable for continuously improving the quality of their services. *(See Chapter 3)*

### Clinician

Those directly involved in the care and treatment of patients, including doctors, dentists, nurses, midwives, health visitors, pharmacists, opticians, chiropodists, radiographers, orthoptists, physiotherapists, dieticians, occupational therapists, medical laboratory scientific officers, orthotists and prosthetists, therapists, speech and language therapists and all other health professionals.

### Commission for Health Improvement

A new national body to support and oversee the quality of clinical governance and of clinical services. *(See Chapter 4)*

### Community Health Councils

Independent statutory bodies which represent the interests of the public in the health service in their area.

### Continuing professional development (CPD)

See Lifelong learning below.

### Corporate governance

A framework through which NHS organisations are accountable for the standards in conducting corporate business including meeting statutory financial duties.

### Health Improvement Programmes

An action programme to improve health and healthcare locally. Led by the Health Authority, they will involve NHS Trusts, Primary Care Groups and other primary care professionals working in partnership with the local authorities and engaging other local interests. *(See The new NHS)*

### Health professional

See clinician.

### Hospital and community health services

The main elements of these are the provision of hospital services and certain community health services (for example, district nursing) mainly provided by NHS Trusts.

### Lifelong learning

A process of continuing development for all individuals and teams which meets the needs of patients and delivers the health care outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential. *(See Chapter 3)*

### Medical Devices Agency

Assesses the safety and performance of healthcare products.

### Medicines Control Agency

Licenses medicines on the basis of safety, quality and efficacy.

### National Confidential Enquiries

The four National Enquiries look at clinical performance to help develop clinical standards. These are Perioperative Deaths (CEPOD), Stillbirths and Deaths in Infancy (CESDI), Maternal Deaths (CEMD) and Suicide and Homicide by People with Mental Illness (CISH). *(See Chapter 2)*

### National Framework for Assessing Performance

The Performance Framework is designed to give a rounded picture of NHS performance and will cover six areas: health improvement; fair access to services; effective delivery of appropriate healthcare; efficiency; patient/carer experience; and health outcomes of NHS care. *(See Chapter 4)*

### National Institute for Clinical Excellence (NICE)

A new Special Health Authority *(see below)* to be established to promote clinical and cost-effectiveness. *(See Chapter 2)*

### National Service Frameworks (NSFs)

Evidence-based National Service Frameworks setting out what patients can expect to receive from the NHS in major care areas or disease groups. *(See Chapter 2)*

### National Survey of Patient and User Experience

A new annual National Survey on what patients feel about the care offered by the NHS. The first survey will take place in 1998. *(See Chapter 4)*

### NHS Executive

The NHS Executive is part of the Department of Health, with offices in London and Leeds and eight Regional Offices across the country. It supports Ministers and provides leadership and a range of central management functions to the NHS.

### NHS information strategy

A strategy to harness the enormous potential benefits of IT to support the drive for quality and efficiency in the NHS. To be issued in Summer 1998. *(See The new NHS)*

### NHS Trusts

Public bodies providing NHS hospital and community health care.

### Personal development plan (PDP)

Developed by individual health professionals as part of lifelong learning.

### Primary care

Family health services provided by family doctors, dentists, pharmacists, nurses, midwives, health visitors, optometrists and opthalmic medical practitioners.

### Primary Care Groups

New Groups announced in *The new NHS* which bring together family doctors and community nurses. These Groups will have the opportunity to become Primary Care Trusts. *(See The new NHS)*

### Primary Care Trusts

A new form of Trust for Primary Care Groups *(see above)* who wish to be free-standing and are capable of being so. *(See The new NHS)*

### Professional self-regulation

Standards set by national professional regulatory bodies (for example, the General Medical Council) for professional practice, conduct and discipline. *(See Chapter 3)*

### Regional Offices

See NHS Executive.

### Secondary care

Specialist care typically provided in a hospital setting or following referral from a primary care or community health professional.

### Special Health Authority

Health Authorities with unique national or supra-regional functions which cannot be effectively undertaken by other kinds of NHS bodies (for example, the Prescription Pricing Authority).

*The new NHS Modern • Dependable*

Command Paper 3807, published in December 1997. Sets out the Government's programme for the modernisation of the NHS.