

A clear road ahead

Creating a coherent quality strategy for the English NHS

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Executive summary

The *NHS five year forward view* (Forward View) highlighted ‘closing the care and quality gap’ as one of three strategic challenges facing the health service in England by 2020. This report considers how policymakers – the government and the main arm’s length bodies (ALBs) – can most effectively support the people and organisations actively engaged in delivering health care services to achieve high quality care for all within available resources.

The English NHS – unlike the situation in many other countries – remains a health system in which it is possible not only to construct an overall quality strategy, but where there are levers to design, plan, coordinate and implement the main elements. At varying points in the history of the health service there have been attempts at producing an overall strategy for how national decisions, plans and actions will support the people, teams and organisations at the front line. Most recently in England was *High quality care for all* – the final report of the Next Stage Review led by Lord Darzi, published in 2008. This was a conscious effort to put quality at the centre of policymaking. Scotland, Wales and Northern Ireland have all subsequently published explicit national strategies to improve quality in their respective health services. In England, the strategic framework set out in *High quality care for all* has never been formally replaced, but since 2008 there have been significant changes to all levels of the NHS.

The economic, political and policy implications of the recent vote for the UK to leave the EU will also add to an increasingly uncertain and complex outlook for the health and care system. The need to ensure the health service has a robust approach to improving quality has never been more pressing. The health service is moving forward to try to meet these challenges and the Forward View has brought the national bodies together behind a shared vision.

Given all this, a key question is how best to move forward and implement this vision? How to develop a strategy that is meaningful and useful, given the degree of complexity and change, and which accommodates political priorities as well as longer-term goals – and furthermore a strategy that can itself evolve? This report is the culmination of an eight-month programme of work by Professor Sheila Leatherman, working with a team at the Health Foundation, to try to find some answers.

What is the current strategy for improving health care quality in England?

The first stage of our work was to assess the recent array of organisations, initiatives and approaches to improve quality in the NHS and ask how they stack up as an emergent strategy.* Drawing on the whole of our research, we identified five frameworks – all relevant to the current state-of-play in England – as a set of helpful benchmarks to guide

* ‘Emergent’ can be defined as where a strategy emerges over time as intentions collide with and accommodate a changing reality. An emergent strategy should help an organisation or system to control its course while encouraging a process of learning from what works in practice.

us in the analysis of recent initiatives and approaches to improve quality. The first and foremost of these is the Juran trilogy, which posits the individual and collective importance of three equally important core functions in achieving high quality in any industry: planning, control and improvement. How these functions are currently discharged within the NHS, and the extent to which there is an appropriate balance between them, was a fundamental part of our analysis.

We identified a number of key issues that need to be addressed:

- **Improving quality remains a stated priority, but implementation is weak:** Following the second Francis Inquiry, strengthening control functions became an understandable and necessary priority, but there has not been a concomitant effort devoted to strengthening planning and improvement. The overall effect is that planning and improvement functions are underdeveloped and core functions are unbalanced.
- **Gaps in national leadership:** In England, responsibility for quality is distributed between the main national NHS bodies,* with no individual or organisation having presiding authority to lead the quality agenda on behalf of the system. Pursuit of a common agenda therefore depends heavily on the relationships between the national bodies, which have not always been without issue.
- **The complexity of the system architecture:** The organisational structure enacted through the Health and Social Care Act 2012 has created a system where more national bodies share responsibility for leading work to improve quality. Lack of clarity about the roles and responsibilities of different national bodies in relation to quality is not a new issue, but the reforms undertaken in the last parliament appear to have exacerbated the situation.
- **Control and improvement are out of balance:** Moves to strengthen systems of quality control at an institutional level in the wake of the Francis Inquiry were necessary, but in the absence of equal emphasis on developing improvement functions, the overall effect of the current approach to improving quality is likely to be perceived as overly punitive. The formation of NHS Improvement is an encouraging development, but the new organisation faces daunting objectives.
- **Opportunity costs from the surfeit of objectives and requirements:** There have been a large number of recent policy changes, beginning with the report of the NHS Future Forum on the Health and Social Care Bill and continuing in the wake of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Between June 2011 and the end of 2015, a total of 179 quality-related policy measures were announced by government – almost one a week. Such ‘priority thickets’ may lead organisations to resort to a defensive, compliance-based approach to meeting externally-imposed demands, at the expense of intrinsically-motivated efforts to improve quality.

* The Care Quality Commission, Health Education England, the National Institute for Health and Care Excellence, NHS England and NHS Improvement.

- **An unfocused approach to building capability:** There are a number of specific national programmes to support the development of new models of care. Beyond such initiatives, too little emphasis has been attached to building capability in the essential operational, analytical and change management skills needed to make sustained improvements in quality at all levels of the health service.
- **Inconsistent arrangements for local accountability:** The various frameworks used to oversee the performance of clinical commissioning groups (CCGs), foundation trusts (FTs), NHS trusts and primary care contain a number of differences in how national priorities are translated into local action. This is also reflected at regional level, where there are differences of approach between national bodies operating within the same locality, as well as how each body operates in different localities.
- **Asymmetries in measurement and reporting:** A large volume of data relating to quality is collected and published by the national bodies, but substantial gaps remain in important areas of NHS spending. At the same time, there is considerable duplication in reporting in other areas, such as general practice.

What has been the impact of initiatives to improve health care quality in England?

The second stage of our work was a review of evidence of the impact of selected national initiatives to improve the quality of care in the NHS in England over the past two decades. We developed a taxonomy to categorise the wide variety of policy levers and quality related interventions available for national health policy, with specific examples of each, to serve as a reference for English policymakers. We then organised and analysed some of the currently available evidence to understand the effect on quality of a selection of policy initiatives that have been implemented since 1996. Although this review was not exhaustive, it assesses the strength of evidence for key initiatives and can provide clues for what an emergent quality strategy should contain. It also identifies big gaps in evidence and what might be done to fill them.

Next steps for a stronger quality strategy

Establishing a stronger quality strategy need not be a burdensome and bureaucratic exercise that results in a one-off plan which gathers dust on a shelf. It can be an iterative ‘living’ approach based on a shared understanding of a framework leading to a clear ‘road’ ahead. It can build on history, shared understandings, current capabilities and existing infrastructure. In the first instance, a new quality strategy could form the means to implement current priorities on quality. In the medium term, however, it could become fully embedded as a strategic framework for driving improvements in quality across the health service, in a balanced and coherent way.

There is a clear and compelling case for developing an explicit quality strategy, but the question of who should lead its development is less straightforward. Quality is rightly described as ‘everyone’s responsibility’, but at national level those responsibilities have been distributed between a large number of ALBs. No one officeholder or organisation is solely responsible for quality, with the mechanisms for supporting coordination and collaboration still emergent and immature.

The Health and Social Care Act 2012 marked a major shift in the national governance of the NHS and left the Department of Health with a markedly different role to those of the majority of health ministries around the world. Responsibility for developing a new quality strategy, in the past led by the Department of Health, now instead falls to the national bodies, working within the current policy and legal framework. Recent planning guidance emphasises the need for local organisations to set aside institutional interests and work together as local systems. Through the Five Year Forward View Board (Forward View Board), the national bodies should aim to take a lead in showing how this can be done at national level. They should undertake coordinated action in the following areas:

- **Articulate a single set of quality goals and common definition of quality:** The national bodies should take the various priorities, actions, objectives and standards set out in a range of documents, and publish a consolidated and balanced set of quality priorities with explicit, measureable goals for improvement. The national bodies should agree a definition of quality to provide a shared conceptual framework and a common language for quality. The five questions used by the Care Quality Commission (CQC) in its inspections of care services is a reasonable option, given their link back to Lord Darzi’s quality definition of safety, effectiveness and experience, their salience with providers, and the role the regulator will take in assessing use of resources.
- **Provide unified national leadership for quality:** The Forward View Board currently provides a unified focus for action across the national bodies at the highest level. As such, for pragmatic reasons, the Board should become the main national committee for making decisions about quality. It should be supported in this role by advice from the National Quality Board (NQB), acting as the conscience and intelligence of the system on quality. The re-chartered NQB should act as an expert advisory group with a formal mandate to proactively develop and advance a national agenda for quality for agreement by the Forward View Board, as well as being commissioned to provide advice to the Board on specific issues. The NQB would benefit from an expanded membership to include a wider range of organisations operating at national level, such as Healthwatch England, and representation from professional organisations and regulators, to secure a greater range of public and professional involvement.
- **Build on experience and evidence:** Our evidence review concluded that research on the impact of policy on quality provides few definitive answers. However, sensitive use of the available evidence can guide policymakers towards a number of ‘best bets’: interventions that are more likely to have a meaningful impact and more prudently employ limited resources. Important components in a balanced approach to improving quality seem to be:

- setting evidence-based national standards
 - the creation of National Service Frameworks, involving strong clinical leadership and professional engagement in setting standards across a pathway
 - the focused use of inspection and performance targets
 - well-designed decision support tools for patients and providers.
 - developing new roles – such as community matrons and emergency care practitioners (ECPs)s – and building the capability of the NHS workforce
 - exploring and boosting the available evidence base, and actively working to fill the gaps that exist, forming part of a stronger national quality strategy.
- **Update a set of core quality metrics:** Based on advice from the re-chartered NQB, the Forward View Board should co-produce a unified set of core quality measures for the NHS, to be used as the basis of performance measurement by all national bodies. The development of the new CCG scorecard, along with a small set of sentinel metrics for GP practices, may provide a useful starting point. Work in this area will require meaningful engagement with a diverse range of stakeholders, but it should be possible to achieve a consensus on a core set of indicators that can be piloted in a small number of local health economies.
 - **Articulate a shared understanding of how improvements in quality and costs are linked and pursue both in tandem:** The national bodies also need to develop a more sophisticated and granular view of the relationship between quality and resources. The conventional wisdom that improving quality will result in lower costs is attractive, but the reality is likely to be more complex. Being explicit where investment and disinvestment may occur, with what intended effects and risk mitigation, would provide a transparent basis for addressing quality within a seriously resource-constrained NHS.
 - **Provide unified regional leadership for quality:** The Forward View Board should consider taking further steps to bring together their various regional and local presences to share information, develop joint working arrangements and streamline requests for information from commissioners and providers. This already happens to some extent, for example through quality surveillance groups, but there is clear potential for achieving much greater alignment.
 - **Inform the future quality agenda:** There are in effect twin tracks to developing a comprehensive quality strategy. The first is strategy development that is seen across many international health systems to ensure sustainability and progress in quality of care. The second involves short-term legitimate government priorities to operationally improve quality. The critical issue at stake now is to tend to both, ensuring the approaches are coherent, and that the balance between planning, control and improvement is healthy.

This report sets out a practical and feasible set of actions for a strategy to implement the shared vision in the Forward View, safeguard and improve quality within current priorities, as well as to support the development of the NHS for years to come.

Acronyms and abbreviations

AHSNs – Academic Health Science Networks

ALBs – Arm’s length bodies

ASCOT – Adult Social Care Outcomes Toolkit

BMJ – British Medical Journal

CCG – Clinical commissioning groups

CHD – Coronary heart disease

CHI – Commission for Health Improvement

CNS – Clinical nurse specialist

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation

DH – Department of Health

ECP – Emergency care practitioners

EPP – Expert Patient Programme

FT – Foundation trust

GMC – General Medical Council

HCAI – Health care associated infection

HCC – Healthcare Commission

HEE – Health Education England

HQIP – Healthcare Quality Improvement Partnership

HSCIC – Health and Social Care Information Centre

IOM – Institute of Medicine

MRSA – Methicillin-resistant Staphylococcus aureus

NAO – National Audit Office

NICE – National Institute for Health and Care Excellence

NMC – Nursing and Midwifery Council

NQB – National Quality Board

NSF – National Service Framework

OECD – Organisation for Economic Co-operation and Development

PHB – Personal health budget

QALYs – Quality adjusted life years

QEI – Quality enhancing initiatives

RCT – Randomised control trial

STP – Sustainability and Transformation Plan

TDA – Trust Development Authority

WIC – Walk-in centre

YOC – Year of Care

Introduction

Most Organisation for Economic Co-operation and Development (OECD) countries aspire to offer their populations high quality and affordable health care. The starting point is to ensure access for the whole population to comprehensive health care, with financing mechanisms to support that. But the next stage is to work towards care that is high quality in a number of domains including safety, effectiveness, timeliness, patient-centredness, efficiency and equity.¹ Achieving this needs a coherent and constantly developing strategy because of the many factors influencing quality of care, the long lead time needed to develop some of these factors, and their complex interaction. In England, the NHS is here to serve the population for the long term, yet so much of what shapes it is short term.

At varying points in the history of the health service there have been attempts to produce some kind of overall strategy for quality. In England this was seen most recently in *High quality care for all* – the final report of the Next Stage Review led by Lord Darzi, published in 2008.² This was a conscious effort to put quality at the centre of policymaking. *High quality care for all* provided a national definition of quality, announced the formation of the National Quality Board (NQB) to provide system leadership for quality and described an NHS Quality Framework, in part based on analysis set out in *The quest for quality: refining the reforms*.³

Scotland, Wales and Northern Ireland have all subsequently published explicit national strategies to improve quality in their respective national health services.^{4,5,6} In England, the strategic framework set out in *High quality care for all* has never been formally replaced, but since 2008 there have been significant changes to all levels of the NHS, including the following:

- There has been widespread reform to organisational structures and roles following the Health and Social Care Act 2012 (2012 Act).⁷
- The NHS has entered a period in which funding growth is much lower than ever before – projected to be 0.9% average real terms per annum between 2010 and 2020, against the long-term average of 3.7% – with an even more challenging settlement for social care.⁸ The full ramifications of the UK's recent vote to leave the European Union (EU) are impossible to know at this stage, but there is a very real possibility that the NHS financial challenge will get even harder.⁹
- Since 2010 there has been a significant focus in national policy on improving patient safety, following well publicised scandalous lapses in care and subsequent inquiries.^{10,11,12,13,14,15,16,17} The formal government response to these reports resulted in a great number of national initiatives and commitments – at least 179.
- Workforce planning – one issue needing a longer-term focus – has been inadequate and resulted in shortages of key staff, in particular nurses.^{18,19}

- There has been ongoing development at national and local level in more ‘technical’ areas, for example in developing payment reform, informatics and information, regulation, developing new models of care, advances in medical treatment, and other local care innovations.
- There has been growing recognition of the central value of patients and the public to developing the quality of health care, with associated initiatives.

This is not an exhaustive list.

The picture, therefore, is of dynamic and complex development with multiple players. While progress towards higher quality is being made,²⁰ there is huge opportunity for improvement. The *NHS five year forward view* (Forward View) highlighted ‘closing the care and quality gap’ as one of the three strategic challenges facing the health service by 2020.²¹ Furthermore, the NHS in England – unlike the situation in many other countries – remains a health system in which it is possible not only to construct an overall strategy, but which also has the levers to design, plan, coordinate and implement the main elements. The picture is also of a system in which political priorities, often reactive to events, inevitably and justifiably exist alongside evolving and longer-term ‘technical development’, in common with many other health systems in the world.

Given this, a key question is how best to move forward? How to develop a strategy that is meaningful and useful, given the degree of complexity and change, and which accommodates political priorities as well as longer-term goals? And furthermore a strategy that can itself evolve? This report is the culmination of an eight-month programme of work by Professor Sheila Leatherman, working with a team at the Health Foundation, to try to find some answers to these questions. The work focuses on the NHS in England.

The first stage of the work was to assess the recent array of organisations, initiatives and approaches to improve quality in the NHS. As such, this report is a preliminary evaluation of multiple sources of evidence. The fundamental question we asked was how do these stack up as an emergent strategy?*

To help, a set of useful conceptual frameworks were identified to make sense of the current situation.

This stage included a brief description of the government’s approach to quality through its response to independent reports. It also included analysis of the current system architecture – the self-described roles and responsibilities of the Department of Health (DH), the main arm’s-length bodies (ALBs)[†] and selected other national organisations – as they now exist to support quality. We also carried out a qualitative analysis of information from over 100 senior leaders – from the DH, ALBs, health care providers and commissioners, clinical leaders, patient groups and independent organisations. This aimed to construct an experiential-based perspective of the current approach to quality in the NHS in England.

* In *The rise and fall of strategic planning*,²² Mintzberg defines ‘emergent’ as where strategy emerges over time as intentions collide with and accommodate a changing reality. An emergent strategy should help an organisation or system to control its course while encouraging a process of learning from what works in practice.

† The Care Quality Commission (CQC), Health Education England (HEE), the National Institute for Health and Care Excellence (NICE), NHS England and NHS Improvement.

The second stage was a review of evidence of the impact of selected national initiatives to improve the quality of care in the NHS in England over the past two decades. We developed a taxonomy to categorise the wide variety of policy levers and quality-related interventions available for national health policy, with specific examples of each, to serve as a reference for English policymakers. We then organised and analysed some of the currently available evidence to understand the effect on quality of a selection of the policy initiatives that have been implemented since 1996. Although this review was not exhaustive, it assesses the strength of evidence for key initiatives and can provide clues for the emergent quality strategy. It also identifies big gaps in evidence and what might be done to fill them.

The report ends by drawing this information together, pulling out the main insights and suggesting what might be intelligent next steps. In our analysis and recommendations, we assume that funding pressures will remain a constant for the foreseeable future; that the current legal basis for the health service is unlikely to change substantially in the near future; and that the national bodies will retain current statutory functions and accountabilities, albeit with some degree of flexibility over how those functions are discharged.

The NHS in England is now halfway through the most financially austere decade in its history,⁸ with growing disaffection among staff²³ and increasing signs that some historic improvements in quality have stalled²⁴ or even gone into reverse.^{25,26} The economic, political and policy implications of the recent vote for the UK to leave the EU will also add to an increasingly uncertain and complex outlook for the health and care system. The need to ensure the health service has a robust approach to improving quality has never been more pressing. The health service is moving forward to try to meet these challenges and the Forward View has brought the national bodies together behind a shared vision. This report highlights some practical actions to help align individual plans, actions and resources in the most effective way to improve quality.

1. Putting together the pieces for a coherent emergent strategy

Identifying useful taxonomies

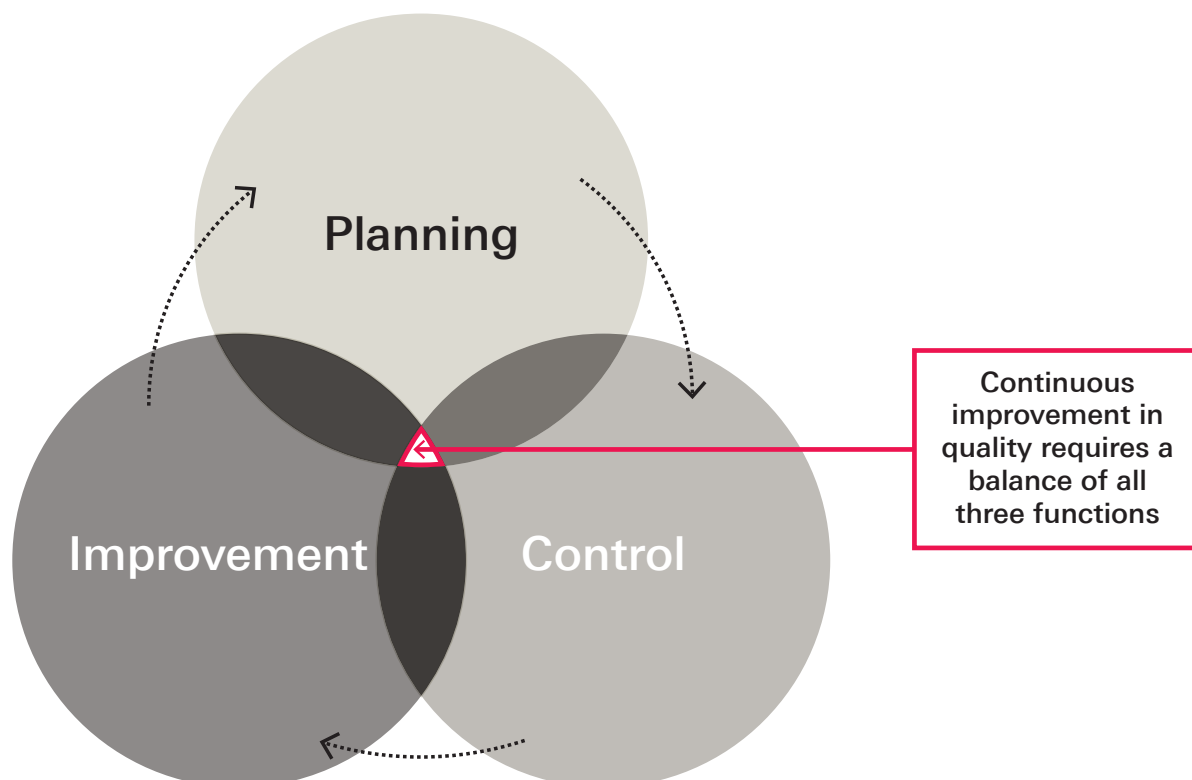
Improving the quality of health care within nations has become a global pursuit. According to the OECD, ‘There is no health care system that performs systematically better in delivering cost-effective health care. In fact, the efficiency estimates vary more within country groups sharing similar institutional characteristics than between groups’.²⁷ Just as there is no identifiable ideal model of health system, there is also no ideal model of what a quality strategy should look like.

In order to conduct this assessment of the ‘quality landscape’ in the NHS, we identified five frameworks. These were all relevant to the current state of play in England and supported in the published peer reviewed literature or drawn from the policy context of the English NHS. They provide a set of helpful benchmarks against which we compared the NHS to guide us in the analysis of recent initiatives and approaches to improving quality. These concepts are used throughout the report to identify the relative strengths and weaknesses of the NHS, as well as to identify potential gaps and duplication.

1. Core functions

The first framework is the Juran trilogy, which posits the individual and collective importance of three core functions in achieving high quality in any industry: planning, control and improvement.²⁸

Figure 1: The Juran trilogy



In the context of the health service, the Juran trilogy points to the need for robust national planning to set direction, the provision of meaningful support to the professionals and organisations delivering care, and the appropriate use of control mechanisms – including but not limited to regulation and inspection – to ensure risks are minimised and progress is made. Furthermore, Juran stressed the inter-relatedness of these functions, and thus the importance of achieving an appropriate balance between them as part of developing an effective approach to improving quality. How these functions are currently discharged within the NHS, and the extent to which there is an appropriate balance between them, was a fundamental part of our analysis.

2. The NHS Quality Framework

The second framework is a modified version of the NHS Quality Framework: the seven step model for achieving high quality care for all outlined in *High quality care for all*, which appears to remain the current strategic national framework for quality.²⁹ This framework has been used previously by the National Quality Board (NQB) to outline how the main national bodies work together to safeguard and promote quality. It offers a framework for classifying and organising quality-related activities. It remains highly relevant for simply describing the necessary functional capabilities that need to be addressed in the policy, managerial and service delivery functions of the NHS.

We used the NHS Quality Framework to make sense of the current responsibilities of the national bodies and the plethora of specific initiatives in order to identify potential gaps and areas of duplication. We made some slight modifications to the framework, which are described in appendix A. The version used in our analysis is shown in Box 1.

Box 1: Modified NHS Quality Framework (changes in brackets)

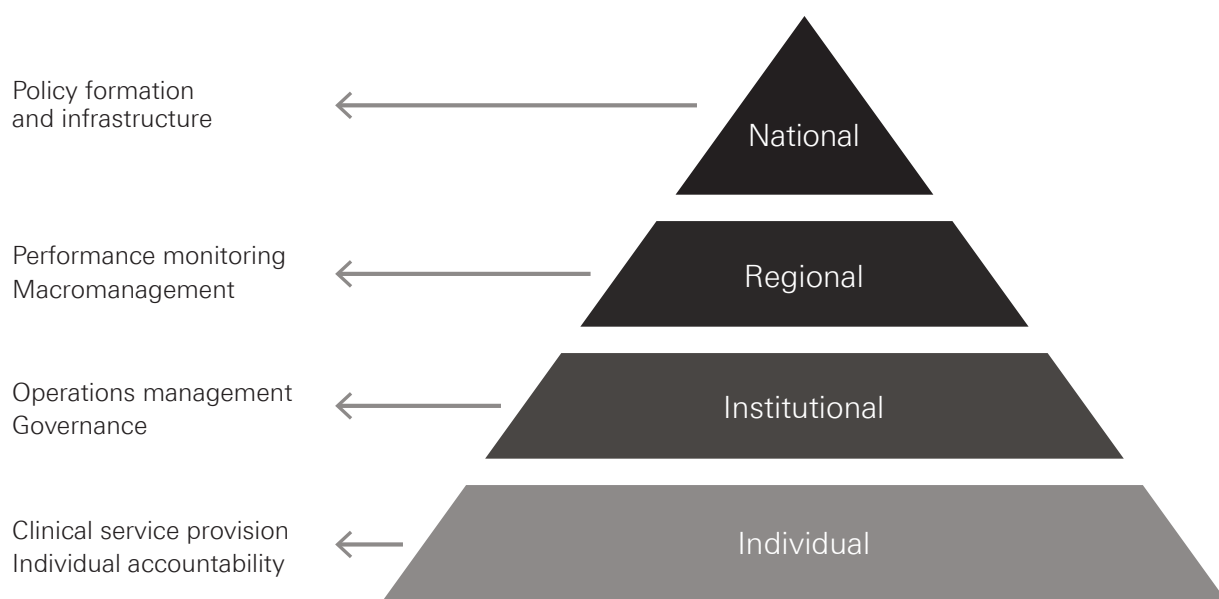
1. **SET DIRECTION AND PRIORITIES (new)**
Setting clear quality priorities and an agenda for the system based on policy initiatives from the Mandate,³⁰ other national reports (eg State of Care³¹) and desired outcomes and performance data.
2. **BRING CLARITY TO QUALITY**
Setting standards for what high quality care looks like across all specialties.
3. **MEASURE AND PUBLISH QUALITY (combined)**
Harnessing information to improve quality of care through performance and quality reporting systems that provide feedback to providers of care at systemic, institutional or individual levels; and information to users and commissioners of services for accountability and choice.³²
4. **RECOGNISE AND REWARD QUALITY**
Recognising and rewarding improvement in the quality of care and service through financial and non-financial recognition (eg enhanced reputation or prestige).
5. **SAFEGUARD QUALITY**
Using regulation to improve health care, to guarantee minimum acceptable standards and to reassure the public about quality of care.
6. **BUILD CAPABILITY (updated and renamed from RAISING STANDARDS)**
Improving leadership, management, professional and institutional culture, skills and behaviours to provide quality assurance and improvement.
7. **STAY AHEAD (expanded)**
Developing research, innovation and planning to provide progressive, high quality care.

3. Health system tiers

The third concept is that of creating multi-tiered capacity within a nation. This is depicted by a pyramid with four levels, allowing for the design of discrete and synergistic activities and interventions at various geopolitical and administrative levels.³ The four levels, shown in figure 2, where activity needs to occur are applicable in almost any country. They have been described as:

- **national** – policy formulation, resourcing, infrastructure and accountability to the public
- **regional/local** – translating national policy into the local context, macro-management and monitoring
- **institutional** – good governance, competent operational management and continuous quality improvement
- **individual** – this is the level of encounter between patients and health professionals where the key attributes of quality must be actualised through individual behaviours.

Figure 2: Multi-level model for building capacity for a national quality strategy



4. Classification of interventions

The fourth concept is needed to make sense of a bewildering and voluminous set of policy levers, interventions and programmes enacted over the past two decades to address quality in the NHS. We have grouped initiatives according to who or what is their intended target – people individually or collectively involved in health care delivery, or the various

organisations at national, regional and local level that form part of the health system. This framework was adapted from previously published work by Leatherman and Sutherland and is outlined in Box 2.³²

Box 2: Classification of quality enhancing interventions

	Focus of intervention	Definition
People-focused interventions	Patient and public	Interventions that recognise the importance of patients as active participants in health care at individual and collective levels
	Workforce	Interventions that focus on workforce planning and engagement
System-focused interventions	Improvement	Interventions that are concerned with quality aspirations and lead to innovation and learning for improved performance and organisational culture change
	Regulatory	Interventions with a regulatory focus that aim to improve health care, guarantee minimum acceptable standards, reassure the public about quality of care, and protect patients' rights
	System management	Interventions that are concerned with the functions and interactions of the different components of the NHS as a system and focus on defining, driving, measuring or reporting quality
	Health care delivery	Interventions that address the organisation and delivery of health care services

5. Domains of health care quality

The fifth and final yardstick is to measure quality-related policies and activities against the particular aspect(s) of quality they intended to improve. This report uses the Institute of Medicine's (IOM's) definition of six domains of quality: safe, effective, patient-centred, timely, efficient and equitable.¹

We used these frameworks to structure analyses described in the subsequent sections.

Analysis

Our analysis sought to give insights to the question: How do the current main initiatives (including the national organisational architecture and roles to improve quality, as well as recent initiatives) stack up as an emergent strategy and are there obvious gaps? We used the following methods to explore this:

- Qualitative evidence from surveys, roundtables and interviews conducted with system leaders across the NHS to explore the following topics:
 - Who is accountable for quality or leading key policies and programmes?
 - What are the key policies, approaches or programmes that are currently being used to improve quality?
 - What is the evidence of impact of previous policies, approaches or programmes?
 - What are the major gaps in the NHS's current approach to quality?
- A description of the government's approach to quality through its anticipation of, and response to, a series of independent reports into failures in care beginning with the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry published in April 2013.¹⁰
- A preliminary analysis of published literature on the current roles and responsibilities of the DH, ALBs and other national organisations in relation to quality.

1. Qualitative analysis of testimony by system leaders

In total, we spoke to around a hundred people working at various levels within England, through individual interviews, group meetings and via email. We interviewed 43 separate senior leaders, of whom three-quarters were from the DH or the national bodies (NHS England, Care Quality Commission (CQC), NHS Improvement, National Institute for Health and Care Excellence (NICE), Health Education England (HEE)) and one-quarter from organisations such as National Voices, General Medical Council (GMC), Healthcare Quality Improvement Partnership (HQIP), Patients Association, NHS Confederation, NHS Providers, royal colleges, NHS trusts and NHS clinical commissioners. In partnership with NHS Providers, we hosted a roundtable event attended by over 30 senior leaders from NHS and foundation trusts including chairs, chief executives, medical directors and nursing directors. A similar range of senior leaders from clinical commissioning groups (CCGs) attended a meeting co-hosted in partnership with the NHS Confederation.

The most striking result of this analysis was the unity of the message from system leaders. The vast majority – at a wide variety of levels and across a variety of organisations – agreed on the themes outlined below. While this could be due to an element of ‘group-think’, given that the majority of individuals belong to a relatively small community, it also indicates a shared perceived need to develop a more coherent strategy.

Thematic analysis* of information from the people we spoke to identified three key messages:

- There is a perceived imbalance between planning, control and improvement.
- There is a weak commitment to quality as the organising principle of the NHS.
- National bodies are not working together enough to engage the workforce effectively, use data efficiently and support regional and local leaders.

These messages are described in the following sections, along with illustrative quotes from interviewees and participants.

A perceived imbalance between planning, control and improvement

People generally struggled to identify the presence of a strategic approach to planning beyond the *Five year forward view* (Forward View). People agreed that the Forward View provided a shared vision but not a clear strategy for implementation. The absence of clear strategic direction was attributed to the lack of a national centre within the reformed system and perceived poor alignment between the national bodies, which has also led to a proliferation of top-down requests for assurance and a surfeit of national priorities. The NQB was broadly recognised as a committee that could provide greater coordination of activities, plans and resources, but there was little clarity about the role the Board currently plays.

‘There needs to be a single voice across the top of the system to ensure quality is kept on the agenda.’

Most people suggested control, primarily in the form of organisational regulation and inspection, has now become the primary driver of improvements in quality in the NHS. It was widely recognised that control is a necessary function and that the second Francis Inquiry† (and others) had identified this as one of a number of areas that needed to be addressed. However, many raised concerns about the increasing burden of regulation and inspection that has emerged since 2013, as well as mounting requests for assurance related to performance against key national targets. Few people questioned the need to address the issues raised through these processes, but several expressed concern that the time and resource required to respond to such requests detracted from local efforts to improve quality. There were mixed views as to whether control has become over-developed, but there was broad agreement that planning and improvement functions are under-developed.

‘Regulation should be the framework in which professionalism can flourish.’

* Using a process of inductive coding known as grounded theory.

† Robert Francis undertook two inquiries into the care failings at Mid Staffordshire NHS Foundation Trust. In this report we use ‘the Francis Inquiry’ to refer to the second of these which published its report in February 2013.¹⁰

The establishment of NHS Improvement was broadly welcomed as an encouraging development that should add capacity to the under-developed improvement function within the NHS. But several people raised concerns that the new organisation has a broad remit and a very challenging set of objectives. Most people were concerned that bringing together two organisations (Monitor and the NHS Trust Development Authority (TDA)) with fundamentally different regulatory roles and approaches will be enormously complicated, as will developing a programme of work that delivers on the mandate implicit in the name of the new organisation.

'It's going to take [NHS Improvement] a number of years for them to work out what they are supposed to be doing.'

A weak commitment to quality as the organising principle of the NHS

A number of people highlighted that implementation of the Health and Social Care Act 2012 has had major implications for the role of the DH, which was no longer seen to have responsibilities that are comparable to the health ministries in other countries. Several people suggested the DH should have an important role in developing the capability of the NHS (and the wider health and care system) to continually improve, but that it is now largely reactive and driven by responding to crises.

'There are two centres: the government and the ALBs around the 5YFV. They need to agree with each other... and be aligned and then hold firm and allow the system to respond.'

Most people had concerns that the national tier of the system is now fragmented and felt the coherence of policy and policymaking has diminished. The 2010–2015 parliament – including the reform and organisational restructuring that flowed from *Equity and excellence: Liberating the NHS* in 2010, as well as the need to respond to several high-profile failures of care – was frequently described as a highly turbulent period for the NHS. These changes, with national bodies taking on new roles, developing different ways of working and managing a major transition programme, were widely thought to have led to greater divergence in the approaches taken by national bodies, as well as increased duplication of effort.

'A lot of people at the centre think it's a lot clearer than it actually is.'

The ongoing challenges of maintaining equitable access to a comprehensive range of high quality health services within unprecedented financial constraints were universally acknowledged, and there was strong support for a clear national commitment that quality is of equal priority to financial performance. The relationship between funding levels and quality of care was widely recognised as being complex and not well understood. Some people raised concerns that the notion that higher quality would cost less was unlikely to prove universally correct, while others highlighted the need to streamline and reduce duplication of approaches to improving quality in an era of austerity.

'A thousand flowers blooming doesn't make sense in austerity.'

Most people suggested that, in the wake of the Francis Inquiry, there has been a necessary focus on improving safety, but several wanted to see a broader focus on all aspects of quality.

‘The narrative about safety is very dangerous because there’s a thought that there’s safe and not-safe, when in reality it’s 50 shades of quality.’

National bodies are not working together well enough to engage the workforce effectively, use data efficiently, and support regional and local leaders

There was a strong theme of wanting coherent and strong national leadership on quality – national bodies working together collaboratively – signalling that the quality of the NHS in England remains a national priority in the face of financial pressures. It was thought that the government should set standards to reduce unjustified variation, but then both allow and support local communities to set their own priorities as to how to deliver those standards since challenges are local. Many also thought that the NHS ‘lost something’ with the demise of the Strategic Health Authorities, and that the ‘regional level’ should be supported in coming up with solutions unique to their context, so long as national standards and other requirements are met.

‘Outcomes should be the same wherever, but how you deliver is a local operational issue.’

People were mostly clear that health professionals have the ability to use skill and judgement to make clinical excellence thrive everywhere, but this is sometimes crowded out by a lack of: national support for workforce engagement; training of clinical leadership; amelioration of unnecessary pressures. People reported spending considerable time measuring and reporting activity, but less time properly understanding the results or receiving feedback about where and how services could be improved. There was a clear sense that this activity could be more powerfully harnessed for learning and improvement if routinely embedded at the front line.

‘People are intrinsically motivated to do the right things for patients so I think we can reenergise people on that. I think it gets back to the heart of why they do this.’

‘The lack of data is absolutely at the heart of the ability to understand the population base quality, organisational quality, individual quality, or whether the patient is getting quality care.’

2. Analysis of the government’s approach to improving quality 2010–16

In the 2010 white paper *Equity and excellence: liberating the NHS* the coalition government set out ‘a bold vision for the future of the NHS’ based on increasing choice and control for patients, empowering the workforce, and a ‘relentless focus on clinical outcomes.’³³ The resulting Health and Social Care Bill outlined major reforms to the NHS and was highly contentious. The government appointed the NHS Future Forum to review the legislation during an unprecedented ‘pause’ of the parliamentary process and the Bill was subject to many amendments before receiving Royal Assent in March 2012.

Just eight weeks before the Act was brought into force, the final report of Sir Robert Francis' second inquiry into Mid Staffordshire NHS Foundation Trust¹⁰ was published and the government commissioned a number of further independent reviews into a range of issues raised by the Inquiry. These reviews, together with subsequent reports of investigations into quality of care, also made a number of recommendations for policy changes.

The government did not accept all of the recommendations made by these reports: some were accepted in full, some were accepted in principle but enacted through alternative means, while others were rejected outright. Rather than analyse the recommendations made by the various independent reports, we undertook an inventory of the specific changes in policy that were announced as part of the government's response to those recommendations (table 1). These were extracted from the four policy documents that were explicitly described as the government's formal response to the recommendations made in these reports: *Government response to the NHS Future Forum*,³⁴ *Hard truths: the journey to putting patients first*,³⁵ *Learning not blaming*³⁶ and *Patients first and foremost*.³⁷

Table 1: The number of initiatives resulting from the government responses to independent reports

Report	Year	Government response	Number of initiatives
<i>Proposed changes to the NHS</i> ¹¹	2011	<i>Government response to the NHS Future Forum</i> ³⁴	33
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry ⁹	2013–15	<i>Patients first and foremost</i> ³⁷ (2013) <i>Hard truths: the journey to putting patients first</i> ³⁵ (2014) <i>Learning not blaming</i> ³⁶ (2015)	68
<i>A promise to learn – a commitment to act</i> ¹²	2014	<i>Hard truths: the journey to putting patients first</i> ³⁵	12
<i>A review of the NHS hospitals complaints system</i> ¹³			21
<i>The Cavendish Review</i> ¹⁴			2
<i>Review into the quality of care and treatment provided by 14 hospital trusts in England</i> ¹⁵			5
<i>The report of the Morecambe Bay investigation</i> ¹⁶	2015	<i>Learning not blaming</i> ³⁶	15
<i>Investigating clinical incidents in the NHS</i> ¹⁷			20
Initiatives that were recommended by multiple reports ^{12,13,14}	2014–15	<i>Hard truths: the journey to putting patients first</i> ³⁵ <i>Learning not blaming</i> ³⁶	3
Total			179

As can be seen from table 1, 179 distinct initiatives were identified that had not previously formed part of government policy. We tagged each initiative according to several of the frameworks described earlier in this report: the broad approach of the intervention proposed; which of the seven steps in the NHS Quality Framework the initiative could be mapped to; and which of the six domains of quality (safe, effective, patient-centred, timely, efficient and equitable, as identified by the IOM¹) was prioritised, implicitly or explicitly. When possible, we documented which administrative tier of the system – national or regional/local – had been tasked with carrying out the initiative. We also tried to include any information as to the progress of each initiative.

Our analysis identified the following themes:

- **The sheer volume** of the government response to the crises of care in NHS trusts. In total, 179 new initiatives were announced by the government from June 2011 to December 2015 in just the four government responses chosen for this analysis. In the two and a half years after the Francis Inquiry there were 146 initiatives – more than one per week. Our analysis only examined the government’s formal response to the four main independent reports; there were numerous other initiatives and additional activities undertaken by independent and arm’s-length bodies (ALBs) at all levels of the system with the intention of improving quality.
- **There were asymmetries in the focus of initiatives:**
 - **More regulation than support for improvement:** 22% (39/179) of initiatives relied on regulation – mostly through transparency and inspection (31/179), such as the commitment for the Chief Inspector of Hospitals to publish an annual report on the themes of patient complaints. 13% (24/179) of initiatives focused on improvement, including the creation of the new health care safety investigation branch. While regulation is widely recognised as important in safeguarding quality, it is only one of three components of the Juran trilogy – control (regulation), improvement and planning.²⁸
 - **Heavy focus on safety versus other quality domains:** Nearly 70% (125/179) of the government initiatives had an identifiable focus on safety, and few initiatives focused on other components of quality, such as timeliness, equity of access or efficiency.
 - **More initiatives focused on ‘system’ and patients, less on workforce:** In the ‘people-focused’ branch of the taxonomy, 22% (39/179) of the initiatives were in the ‘patient and public’ focus of intervention, while only 16% (28/179) focused on people working in the NHS. If these numbers are broken down to initiatives targeted at patients or workforce, the imbalance is more marked: 8% of the initiatives were focused on involving and empowering patients (eg involving patients in CCG commissioning decisions), versus 2% focused on the workforce (eg through involving junior doctors in CQC inspections). However, workforce-focused initiatives were deemed particularly important by those we interviewed in the qualitative analysis. Furthermore, our subsequent evidence scan suggests that initiatives targeted at the workforce are one of the ‘best bets’ for protecting and enhancing quality.

- **Unclear accountability, follow up or assessment of impact:** Initiatives are being implemented at various timescales – in many instances without obvious accountability, follow up or evaluation. Many initiatives are still in the planning stage, highlighting the time lag between policy announcement and the system response. A greater percentage (approximately 50%) of the initiatives stemming from the government response to the NHS Future Forum¹¹ – published in 2011 – are completed and/or ongoing, than policies that have been announced subsequently. This indicates that it takes at least several years for an initiative to embed in the system, and it is likely that the full effect takes even longer to demonstrate.

In several instances, such as better supporting patients to pursue complaints, we found that the name of the organisation responsible for implementing the initiative had not been made explicit. Information on progress (or a clear decision to abolish the initiative) was often very difficult to find. We were able to find evidence that approximately one-third of the initiatives were completed or ongoing, and for another third we found evidence that progress was being made or that plans were in place for implementation. This number might be higher, but the information was not easily accessible.

Notably, this information was especially difficult to find when the initiative had been delegated to a regional or local level – to trusts or CCGs – as there does not seem to be a national or regional repository for data and/or reports produced by these organisations to be shared systematically or transparently. As such, from an external perspective it was an impossible task to track whether a national initiative is being carried out on a regional level.

- **Too much focus on levers that are not well supported by evidence of effectiveness,** such as changing organisational culture to improve quality. While associations between organisational culture and quality of care have been found (as evidenced by the responses to the NHS Staff and Patient Surveys),³⁸ a Cochrane review identified no evidence of ‘any effective, generalisable strategies to change organisational culture’.³⁹ A clear evidence base for the 16 initiatives in this area to improve organisational culture was therefore not present. However, we acknowledge that this is an area with too little rigorous evidence and where there is a strong case for more research and evaluation.
- **The burden of implementation is placed on national bodies, perhaps unsurprisingly given the lack of a clear line of command from DH to local organisations.** At least 59% (105/179) of the recommendations were explicitly or implicitly assigned as tasks to the ALBs. The majority of the initiatives (146/179) were launched after the 2012 Act, which introduced large-scale structural reorganisation that impacted the ALBs. Several new organisations were born in this era, including Healthwatch England, which was tasked with implementing 14 initiatives.

3. Analysis of the roles of key bodies 2010–16

Since it is abundantly clear that the national bodies are expected to play increasingly prominent roles in quality, partially explained by the diminished role of the DH following implementation of the 2012 Act, we attempted to depict their discrete and overlapping responsibilities. We identified the main national bodies as being: NHS England, NHS Improvement, the CQC, NICE and HEE. Information about the organisations was drawn from publicly available reports and other literature.

We identified the main roles of national organisations from their published mission statement and mapped them onto a framework based on the seven steps for quality identified in *High quality care for all* outlined earlier in the report.² The organisations are more complex in practice, but the mapping broadly showed the following:

- All of the national bodies covered by this analysis play some sort of role in relation to the quality of NHS care. None of these bodies has explicit responsibility to lead work on quality at national level, nor does any single body appear to have a *de facto* leadership role in this respect. The shared planning process appears to be an acknowledgement of this distribution of responsibilities.
- The various roles and responsibilities undertaken by the national bodies often cut across the three core functions in the Juran trilogy (planning, improvement and control). None of these organisations has a monopoly on any one of the core functions and all arguably have responsibilities that cut across at least two of the three functions. NHS England, for example, has responsibilities for planning as the national commissioning organisation, but also oversees the development of CCGs which involves significant functions in relation to both improvement and control. Given the inter-related nature of the three core functions and the distributed national leadership of the health service, this puts a premium on having effective mechanisms to share information, undertake joint planning and align actions.
- Multiple bodies are involved in setting national priorities and standards for the different types of local institution in the NHS. The national contract, commissioning guidance, quality standards and the inspection framework all impose explicit priorities and standards that local institutions are expected to address. The various assurance frameworks, financial incentives and data collections linked to performance may also be interpreted locally as important priorities that should be pursued. Some of these requirements flow directly from the government's mandate to NHS England,³⁰ but there appear to be some areas where these have been inconsistently translated into priorities for different local institutions.
- The accountability of local institutions for quality is cluttered. A foundation trust, for example, can expect to be held accountable for quality of care by local commissioners, the CQC as the national quality regulator and NHS Improvement as the independent regulator of FTs.

- There appear to be few national bodies heavily involved in building the skills of staff to provide high quality care and improve the quality of services. This role has arguably been left to local leaders, with consequent variation in capability across England. This is a gap that may be addressed by the leadership and capability strategy currently being led by NHS Improvement. There has also been a historic lack of support for improvement in primary care. CQC regulates primary care but NHS Improvement only aims to provide improvement support for secondary care. This is a gap that may be filled by the new programme of improvement support announced in the recent *Forward view for general practice*,⁴⁰ but this will inevitably take time to become fully embedded.

Table 2 outlines the role and responsibilities of each of the national organisations studied, based on the modified quality framework (see box 1).

Table 2: Seven strategic steps to building quality: Roles of selected national bodies

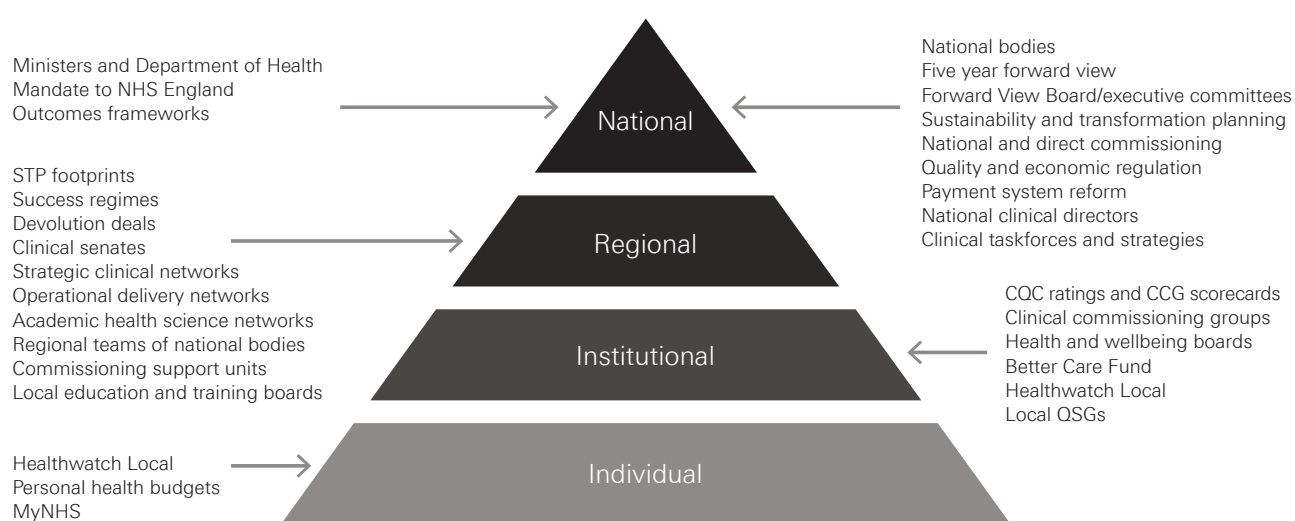
	Department of Health	NHS England	NHS Improvement	CQC	NICE	HEE	Selected others (organisations in brackets)
Set direction and priorities	Mandate to NHS England; business planning and accountability for national bodies; outcome frameworks for NHS, public health and adult social care	<i>NHS five year forward view</i> , planning guidance and STP process (shared by all five organisations, plus Public Health England)					
		Cancer taskforce and strategy; mental health taskforce and strategy; maternity review; RightCare programme	NHS provider roadmap				
Bring clarity to quality		CCG commissioning guidance; NHS standard contract		Five questions and inspection guidelines	Quality standards and guidelines	Medical education and continuing professional development	Clinical guidance (Royal Colleges)
Measure and publish quality		NHS staff survey; CCG outcome indicator set and assurance framework; Care.data; National Clinical Audit and Patient Outcomes Programme; Clinical Outcome Review Programmes; routine performance data; quality accounts	FT and trust accountability frameworks; National Mortality Case Record Review Programme; National Reporting and Learning Service; Never Events data	Quality and risk profiles; inspection reports; thematic reviews; national patient and user surveys; State of Quality report	Development of outcome indicators		Data on outcome frameworks for NHS, public health and adult social care, plus other routine data (HSCIC); provider-funded national clinical audits (trusts)

	Department of Health	NHS England	NHS Improvement	CQC	NICE	HEE	Selected others (organisations in brackets)
Recognise and reward quality	Clinical Excellence Awards	Determining scope of tariff; CQUIN; CCG quality premium; Better Care Fund pay for performance scheme; penalties and incentives in NHS standard contract	Determining tariff prices	Provider ratings	Shared learning awards		Quality and Outcomes Framework (NHS Employers, on behalf of NHS England); fellowships and accreditation (Royal Colleges)
Safeguard quality		Quality surveillance groups; special measures regime for GP practices and CCGs	Licensing of providers; special measures regime for FTs and Trusts; Serious Incident Framework; Never Events Policy and Framework; Healthcare Safety Investigation Branch (hosted)	Registration of health and care providers; monitoring and enforcement of fundamental standards; special measures regime for GP practices, FTs and Trusts		Sharing feedback from doctors in training	Professional regulation (professional regulators)
Build capability		Success regime; strategic clinical networks; Sustainable Improvement Team; direct commissioning; CCG development support; urgent and emergency care review	Success regime; National Leadership and Development Strategy; FT authorisation process; Q Initiative		Fellowships and scholarships	Local Education and Training Boards; Workforce planning, training and education	
Stay ahead		Vanguard programme; NHS Innovation Accelerator; Innovation scorecard			Technology appraisals	Workforce planning	

Tiers of responsibility, accountability and action within the national health system

We also mapped organisations and initiatives by tier of operation. While the list is not exhaustive, it does illustrate the number of actors and degree of activity at national, regional, institutional and individual levels (see figure 3). Our mapping was drawn from publicly available information about the roles and responsibilities of the various national, regional and local organisations operating in and around the health service. This does not aim to provide a complete picture of all activity at all levels of the health service, but rather illustrates the institutions, mechanisms and activities that have either been established or become more prominent since 2008.

Figure 3: Current actors and activities at national, regional, institutional and individual levels



This highlights the complexity of the system architecture at all levels of the health service, particularly at regional and local levels where the plethora of planning footprints, networks and regional outposts can contribute to perceptions of a lack of alignment at national level. This was a strong message from our qualitative interviews and meetings.

2. A structured review of the impact of selected policy initiatives and interventions in the English context

Methods

In the second stage of our work, we assessed the evidence base underpinning main national initiatives to improve the quality of health care in the NHS in England. We also looked at the impact of these main initiatives. To make the task more manageable, evidence was sought for a selected set of policy initiatives. Initiatives in social care and public health were included only if they directly involved NHS health care.⁴¹

The evidence was summarised and examined to develop ‘best bets’ – areas where, based on evidence, it seems most likely that high quality care would be the result of the investment made.

Framework for analysis

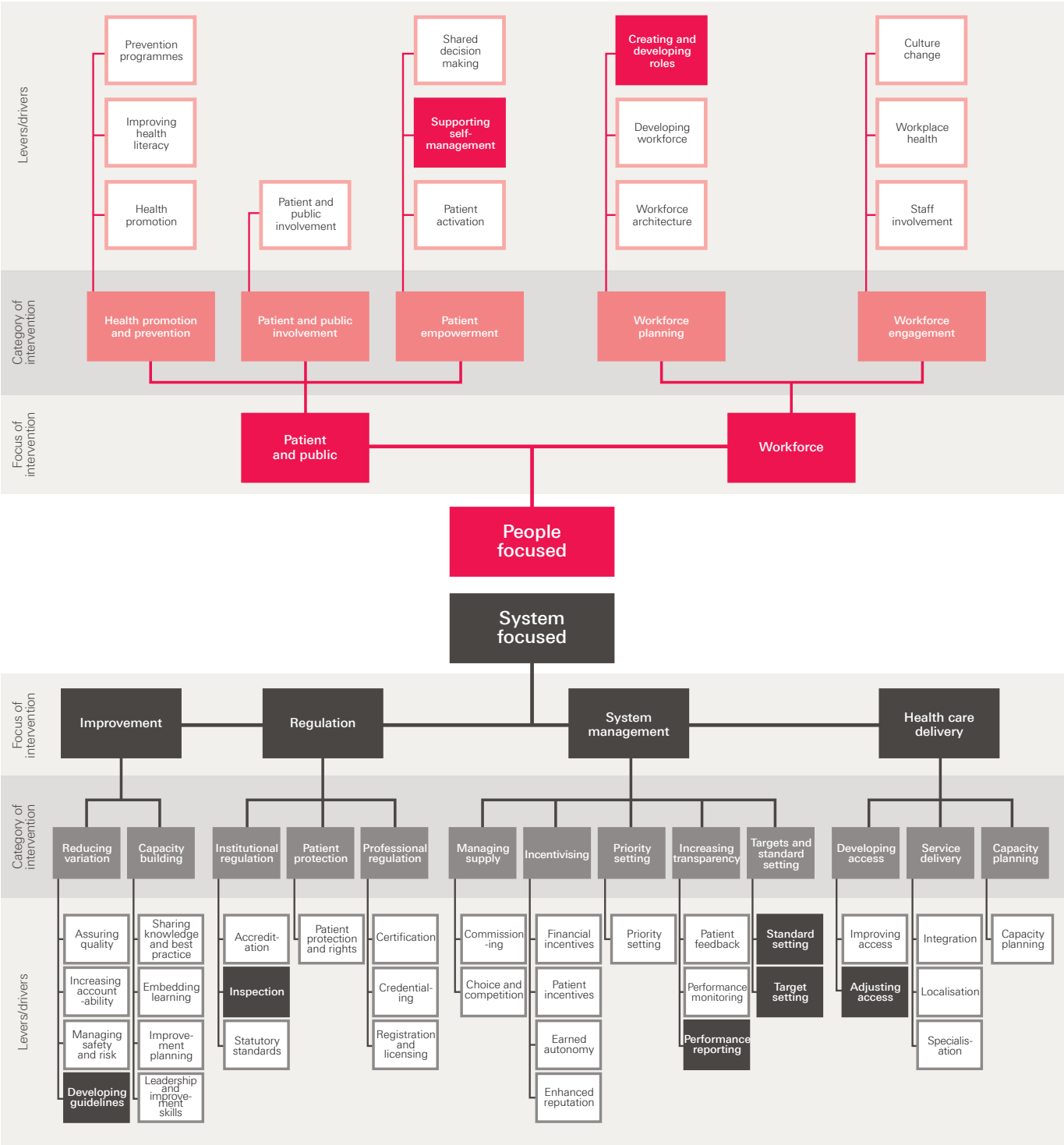
To help analyse the huge amount of information, we expanded the analytical framework presented in box 2. We grouped initiatives according to who or what is their intended target – people, local organisations directly delivering health care, or national ‘system’ organisations, adapted from previously published work by Leatherman and Sutherland.³² The expanded taxonomy is illustrated in figure 4.

In the taxonomy, we divided activity according to whether it is broadly focused on people (staff or patients) or the system. For ‘people-focused’ activities, these were subdivided into those focused on the NHS workforce or patients and the wider public. These were then subdivided as shown into broad categories of intervention. For ‘system-focused’ activities, these were subdivided into broad categories akin to the core functions of Juran’s trilogy – improvement, regulation (control) and system management (policy and planning) – as well as health care delivery (whether they were directly targeted at health care providers).

In the analysis we use the following definitions:

- **Policy lever:** a broad type of instrument or mechanism used to influence the performance of health care systems, either to improve quality or efficiency.⁴² The use of financial incentives to reward specific improvements in quality is an example of a policy lever.
- **Policy initiatives:** specific instruments or mechanisms through which policy levers exert challenge on the system to improve quality. A number of policy initiatives can be grouped under each ‘policy lever’. For instance, the clinical commissioning group (CCG) quality premium, CQUIN schemes and clauses in the standard contract are all examples of policy initiatives that use the financial incentives policy lever.

Figure 4: Illustration of NHS Taxonomy



Information was collected through website searches of all initiatives announced by the Department of Health (DH) designed to improve quality of health care. We defined quality using the Institute of Medicine (IOM) domains.¹ We looked at initiatives announced since 1996 in order to draw on examples of policy reform and implementation from the last 20 years. The impact of specific initiatives was examined rather than types of initiatives – NHS Direct, for example, rather than telephone triage. These were then grouped according to broad policy lever. Many of the initiatives had multiple aims and objectives, and so mapping them to just one lever was often difficult and involved a degree of subjectivity. This was particularly the case with National Service Frameworks, which were broad strategies covering multiple parts of the NHS Quality Framework. Appendix C gives more details about how the initiatives mapped to the taxonomy of the NHS, illustrated in figure 4.

Once the initiatives had been mapped, a targeted approach was used to identify relevant evidence that focused primarily on the measurable impact of each initiative. Measurable impact was defined as impact with quantified evidence. Where quantified evidence of impact was lacking, we considered (as appropriate) clearly identifiable qualitative examples of impact or reasonable consensus of impact, for example better clinical decision making, service improvements, or strategic focus.

Examining all levers and initiatives in the taxonomy to improve quality would be a huge task, and beyond the scope of the research, so initiatives were prioritised using the following criteria:

- High national profile, with significant political backing or investment.
- Sufficient time for implementation and evaluation.
- Sufficient scale for the findings to be relevant to policymakers at a national level.
- Known evaluation and reporting of impact available.

This resulted in a review of evidence of selected initiatives in eight policy levers (ie groups of initiatives) in the NHS in England – those highlighted in figure 4.

Search strategy

For the selected initiatives, a structured search of peer reviewed published literature was conducted using PubMed, Cochrane Library and NHS Evidence. ‘Grey literature’ was identified from broader internet searches and searches of databases and organisation websites, for example, British Medical Journal (BMJ), National Audit Office, House of Commons Health Select Committee, DH, University of York Centre for Reviews and Dissemination, national arm's length bodies (ALBs), The King's Fund, Nuffield Trust and the Health Foundation, and relevant specialist websites. A reference scan of key papers was also performed. The search was limited to English language studies published between January 1996 and January 2016.

The search strategy used three levels of core search terms: one related to the named initiative, the second related to the type of report, and the third drew out the themes (table 3).

Table 3: Examples of typical search terms

Level 1: Named initiative	Level 2: Report type	Level 3: Thematic searching
NHS 111 Year of Care (YOC) Modern Matrons	Review Impact Evaluation	Safe or safety Effective, effectiveness Outcomes, mortality

For initiatives where there were multiple descriptions, several expressions were used – for example: four hour target, four hour A&E standard, (A&E or ED) target, national target and (ED or A&E), A&E performance, etc. Databases were initially searched for the search terms in title, abstract and descriptor fields only. Where this did not identify relevant literature, the strategy was broadened to search the whole document.

Processing results

Following the exclusion of duplicate articles, reports and evaluations of the initiatives were identified for inclusion. Articles and abstracts were excluded if relevant terms were only included as background, or as part of the discussion. All conference abstracts, media reports and anecdotal evidence were also excluded. Commentary and qualitative overviews in reputable publications were used to check referenced evidence for inclusion. Primary data, such as NHS performance data, were not analysed although analysis often formed part of the evidence in the secondary sources reviewed.

The publications and reports of interest that were identified were reviewed in their entirety, and also using specific searches using the level 3 themes which refer to the six IOM domains of quality. However, we noted that for most of the selected initiatives, evaluations and reports do not provide outcome measures of impact grouped by our themes: our focus on the measurable impact of initiatives in the six domains of quality was therefore very specific and necessarily limiting. It also meant that useful information on the progress of implementation (ie process not outcomes) was often excluded. Broader commentary on improvements in ‘quality’ was excluded when unaccompanied by evidence of impact, although it was noted when strong or frequent. We included other impacts that related to quality when they did not map into the six domains.

A summary statement of the evidence of impact on quality was developed for each initiative. For each initiative, we also made an overall judgement on the impact on quality on the following basis, listed in box 3.

Box 3: Interpretation of levels of impact

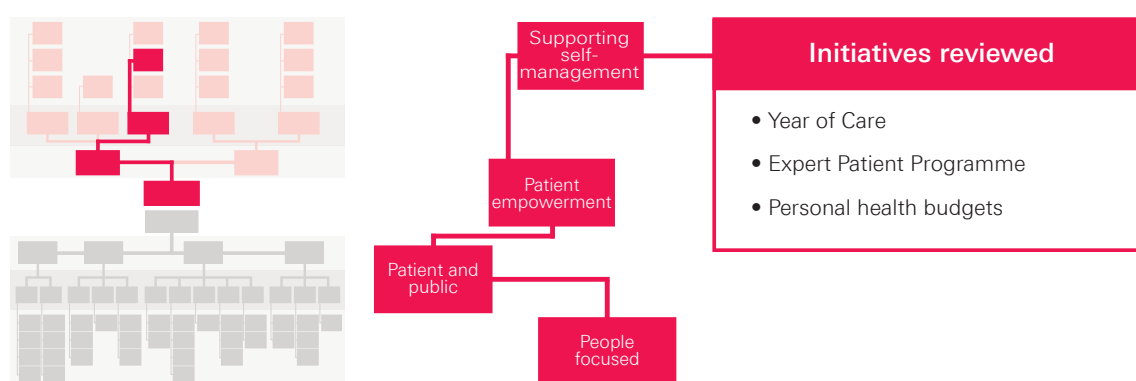
Level of impact	Interpretation
Strong impact	Clear evidence of improvements in quality
Some impact	Evidence of improvements in quality or suggestion of positive impact but no causal link established
Mixed impact	Contradictory evidence in single or discrete studies or reported variation in implementation. If clear positive and negative impacts, impacts are described separately
No impact	Evidence is present but shows no impact of the initiative on quality
Possible negative impact	No evidence of benefit but reported potential for significant burden or high opportunity cost
No evidence found	No evidence of impact found

Findings

In the sections below we summarise the results according to the taxonomy shown in figure 4, focusing on the highlighted areas. Each section ends with a summary table outlining the main initiatives selected, the broad evidence of impact, and an assessment as to the strength of the evidence.

A summary of the overall results is found in the conclusion to this chapter, including brief analysis of the overall evidence as well as the ‘best bet’ initiatives to develop for the future.

Patient and public-focused interventions: supporting self-management



Background

For high quality person-centred care, people need to be ‘empowered to shape and manage their own health and care and make meaningful choices, particularly for maternity services, people with long-term conditions and end-of-life care’.³⁰ The initiatives intend to improve knowledge, confidence, self-efficacy, behaviour, and understanding of the health care system. The overall aim is to improve individual health outcomes, as well as reduce the burden on the NHS in terms of avoidable admissions, ambulance call-outs, A&E and GP attendances.

International evidence

The Evidence Centre of National Voices reviewed 228 systematic reviews on self-management support.⁴³ The review found that there is strong evidence that self-management support increases people’s knowledge about their condition, how to provide self-care and when to appropriately use health services. Self-management support also increases patient satisfaction, confidence and reduces use of health services. There is mixed evidence on cost-effectiveness and the impact on clinical outcomes is small but statistically significant.

English evidence

The main evidence for each of the three initiatives (see table 4) was pilot evaluations. Other small studies have been conducted, though few randomised controlled trials, with little consistency in outcome measures, and a reliance on patient surveys and interviews.

Table 4: Description of initiatives reviewed for supporting self-management

Initiative	Description
Year of Care (YOC)	Partnership between Department of Health, NHS Diabetes, Diabetes UK and the Health Foundation. ⁴⁴ Pilots to establish whether personalised care planning could replace routine care as the standard in diabetes. By 2013 '3,000 practitioners in 26 communities have begun to introduce aspects of the house of care model via the Year of Care programme'. ⁴⁵
Expert Patient Programme (EPP)	Announced in 1999, ⁴⁶ 26 pilots rolled out in 2001. A set of free courses designed to teach self-management to patients based on US programme. ⁴⁷ In 2005, government pledged to treble investment in EPP. ⁴⁸ In 2007, EPP Community Interest Company formed, which by 2012, had supported 120,000 patients and recruited 1,700 volunteers. ⁴⁹
Personal health budgets (PHBs)	Pilots launched by DH in 2009. An allocation of funding given to individuals to support their health care/wellbeing needs. By 2020 '50-100,000 people to have a [PHB] or integrated personal budget (up from current estimate of 4,000)'. ⁵⁰
The lever of supporting self-care covers a variety of initiatives that were not reviewed as part of this analysis; for example, integrated personalised commissioning. ⁵¹ Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

The **Year of Care** initiative improved patient experience, information and satisfaction, and led to 'real changes in self-care behaviour' across diverse populations.^{52,53} Early improvements in biomedical outcomes were seen 'after 2–3 care planning cycles'. Further improvements were maintained and achieved after five years, which suggested that the Year of Care influences diabetes health 'in a way that can be sustained, so *the long-term burden* of the devastating complications of diabetes may be reduced for both people with diabetes and the NHS'. We found little evidence on the impact on efficiency, though an initial evaluation found that care planning was cost neutral with potential for savings for some practices.⁵²

The **Expert Patients Programme** improved self-efficacy and confidence, and led to small gains in quality adjusted life years (QALYs).^{54,55} Patients reported health improvements but no statistically significant gain in clinical outcomes was made.^{56,57} Patient surveys reported fewer unscheduled visits to GP or A&E, and extrapolation gives potential savings estimates of £1,800 per patient per year.⁵⁸ A DH internal evaluation (full report not seen) also found 'a 7% reduction in GP consultations; 10% reduction in outpatient appointments; 16% reduction in A&E visits; and 9% reduction in Physiotherapy appointments'.⁵⁹ The published report of pilot results stated that although the programme was likely to be cost-effective there was no significant impact on health utilisation at the level of community and primary care.⁵⁷ A further report determined the intervention was cost-effective.⁶⁰

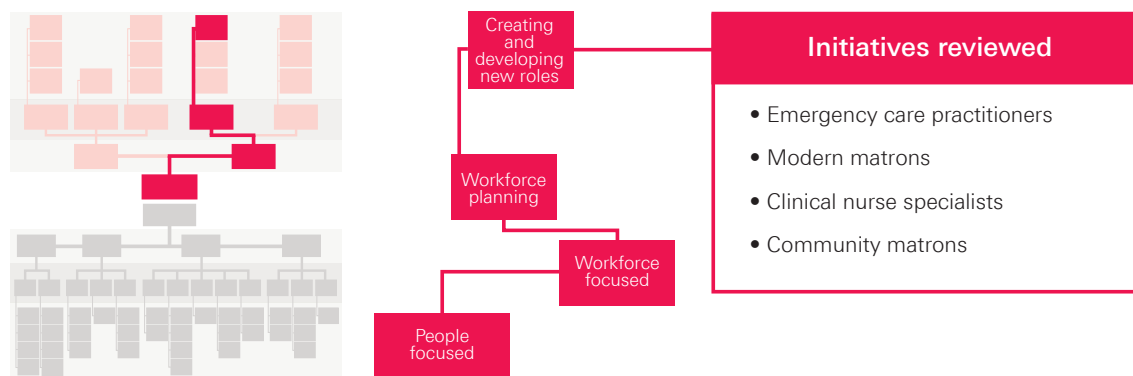
Personal health budgets (PHBs) had a positive impact on quality of life, independence and psychological wellbeing, but no observed impact on clinical outcomes.^{61,62} There was no significant difference in total costs between those patients receiving PHBs and those not; costs of wellbeing and other health services were higher for PHB holders, while costs such as inpatient care were significantly lower. Using care-related quality of life (Adult Social Care Outcomes Toolkit [ASCOT]⁶³) to measure net benefits, PHBs were ‘cost-effective relative to conventional service delivery (at the 90% confidence level)’.⁶² Although they may be cost-effective at an individual level, there was no evidence of the longer-term impacts on the system.⁶⁴

Table 5: Supporting self-management – summary of evidence by initiative

Domains of quality	Expert Patient Programme	Year of Care	Personal Health Budgets
Safe			
Effective	Results demonstrate some but not strongly significant impact on health outcomes	Limited data showing reported improvements in biomedical outcomes	
	Evidence of improvement of Quality Adjusted Life Years	Results take 3–5 years to be seen	
Efficient	Extrapolated evidence of cost-effectiveness, but not proven	Cost-neutral	Some evidence of cost-effectiveness at the individual level
	Mixed evidence around impact on use of service	Potential for productivity savings	No evidence on long-term impact on resources
Patient-centred	Improves patient self-efficacy	Improvement in relationship between health care provider and patients	Good responses to patient surveys giving evidence of improvement of quality of life
	Improves patient confidence	Patients more self-confident, motivated and engaged	Patients reported more independence Increased sense of wellbeing
Timely			
Equitable		Effective impact across diverse populations	
Number of references found	10	10	9

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

Workforce-focused interventions: Creating and developing new roles for quality



Background

Creating and developing new professional roles entails reconsidering traditional roles and hierarchies, restructuring teams and redefining responsibilities. It includes extending the role of non-physicians (eg clinical nurse specialists(CNSs)), or creating new roles (eg emergency care practitioners (ECPs)). New roles aim to facilitate better use of resources and person-centred care through, for example, supporting patients to avoid unnecessary hospital admission or GP consultations.

International evidence

Role redesign and developing new roles is thought to improve patient services, tackle staff shortages, increase job satisfaction, and may have wider but unproven benefits.^{65,66,67,68,69,70} There are relatively few systematic reviews and meta-analyses of the impact of new roles. However, single randomised studies show that if tailored to the local context, new roles have a positive impact on health care quality, though evidence on cost-effectiveness is mixed.⁶⁶ Most evaluations find a high patient satisfaction rate.⁷¹

English evidence

Pilot evaluations, mixed methods studies and qualitative research were found for most of the roles (see table 6) but with limited reporting of measurable impact on health outcomes and few systematic reviews. The effect of the new roles can be wide-ranging, complex and difficult to isolate from the broader service redesign of which they are often part. As these policies tended to rely on local implementation, an overall assessment of impact on quality of health care is difficult. We attempted to examine the role of national clinical directors for evidence of their impact on quality of health care but no formal evidence was identified, only subjective commentary.

Table 6: Description of initiatives reviewed for creating and developing roles for quality

Initiative	Description
Emergency care practitioners (ECPs)	This role evolved as part of the 2001-2005 Changing Workforce Programme. Training extended the clinical skills of staff (usually paramedics, also nurses) so they could work across the traditional boundaries of emergency and unplanned care. They were able to assess, diagnose, treat, refer and discharge certain patients without reference to a doctor. A number of advantages were foreseen, including reduced A&E attendances, improved patient care, and increased operational efficiency. In 2003, DH funded the Emergency Care Practitioner Trials, piloted across 17 sites. Following a positive first phase evaluation, the role was spread nationally. By 2007 there were 25 schemes in operation in England and Wales employing over 650 ECPs, with a further 210 in training.
Modern matrons	Introduced in 2001, modern matrons are in charge of 5–6 wards and have responsibility for the care delivered, with three main responsibilities: to promote high standards of clinical care and leadership; ensure administrative and support services; and provide visible, accessible and authoritative presence, particularly for patients and families. ‘Ten key responsibilities’ were outlined in 2004. In 2010 there were over 4,800 modern matrons in the NHS in England, and just under 4,000 in 2015. The NAO estimates that they cost £56m a year.
Clinical nurse specialists (CNSs)	The role of the CNS has been long been recommended as best practice. CNSs are experienced nurses with at least degree-level education, specialist knowledge, skills, competencies and experience. The roles they fulfil have a broad range but usually a clinical focus, and may also involve education, research, liaison and administration. The title ‘Clinical Nurse Specialist’ does not in itself indicate that the nurse is an advanced practitioner, and the specialty of an individual nurse may be focused, eg on diabetes or palliative care. Many CNSs are based within acute trusts, but some work in primary care, community settings or private and voluntary sector organisations. This research focuses on CNSs as opposed to the wider group of specialist roles within nursing.
Community matrons	First described in 2004, their role was expanded in 2005. Community matrons support patients living with long-term conditions to manage their condition, remain in their own homes and avoid unplanned admissions to hospital. Service design was based on the US Evercare model, which involved identifying patients at GP practice level and assigning a case manager. The original aim was to have 3,000 community matrons by 2007, to reduce unplanned admissions by 10-20%. However, following nine pilot evaluations and poor levels of recruitment, the aim was not met. By August 2015 there were 1,214 community matrons in England.
The lever of supporting creating and developing new roles for quality covers a variety of initiatives that were not reviewed as part of this analysis. Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

ECPs lead to reduced A&E attendance (30–45% versus 70–77% for traditional ambulances), reduced admissions and reduced referrals to other services.^{72,73,74,75} Research looking at the effectiveness of care provided by ECPs for specific patient groups saw a positive impact when dealing with older patients.⁷⁶ ECPs provide equivalent or better care processes (eg diagnosis, investigation, treatment) than practitioners with traditional roles,^{74,75,77} with decision making sometimes more appropriate than that of medically qualified staff⁷⁸ as well as improved communication skills.⁷⁹ ECPs lead to high patient satisfaction particularly in terms of ‘thoroughness of assessment’ and ‘explaining what would happen next’, reportedly due to ‘genuine concern and respect for the patient characterised by being compassionate, empathetic, considerate and non-judgemental’.^{75,77,80} Though ECPs spent more time on the scene than ambulance crews,⁷⁵ time from one call to availability for the next call was not significantly different for ECPs versus other ambulance staff.⁷⁹ A comparison of ECPs with an out-of-hours GP service found ECPs typically responded in 1 hour 10 minutes, compared to 3 hours 7 minutes for GPs.⁷² However, ECPs may not always be used in the most efficient and effective way: ‘the call categorisation system currently in use in most services is not sophisticated enough to direct practitioners to the most suitable calls’.⁸¹

Modern matrons lead to staff development, more consistency on wards, improved standards and reductions in drug errors, complaints and length of stay.^{82,83} Concerns over lack of influence due to organisational barriers (eg budgetary control) and professional hierarchies were reported.^{68,84,85} While the benefits of modern matrons are likely to outweigh the cost,⁸⁶ there is ‘enormous variability’ in implementation of the role.⁸²

Though the evidence for **CNSs** is often specialty-specific, there is strong evidence for financial savings. Benefits of CNSs – such as reductions in emergency bed days, routine follow-up appointments and GP visits – are estimated at £89m (£26m–148m)⁸⁷ or £175,168 per nurse per year.⁸⁸ In one study, 60% of patients said access to CNS telephone advice avoided a request to see a GP.⁸⁹ An RCT of lung cancer patients, comparing specialist nurse-led follow up to conventional medical follow up, found CNSs to be safe, effective and cost-effective.⁹⁰ CNSs led to better access to treatment, reduced drug errors, and earlier reporting of symptoms for patients with cancer.^{88,90,91,92} Patient satisfaction with CNSs in cancer care is high^{93,94} and CNSs often support self-management and decision-making.^{90,95} Variation in access to CNS services was reported.^{93,96}

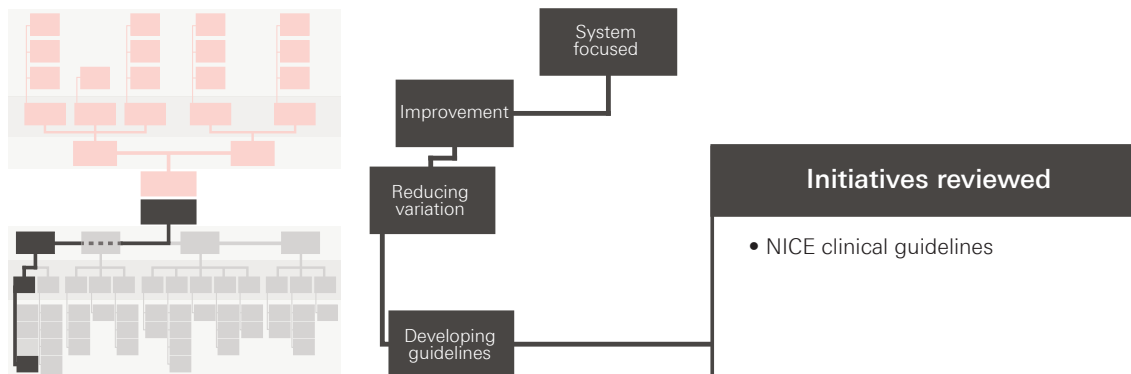
Patients and **community matrons** report a perceived reduction in unnecessary admissions,^{97,98,99,100} and specific examples of avoided admissions have been documented in pilot evaluations, but there is no evidence of a reduction in overall admission rates.¹⁰¹ Medication management, case management, decision making and self-management are all supported by community matrons.^{102,103,104} Their cost-effectiveness has not been established.¹⁰¹ Community matrons received a very positive response from patients.¹⁰¹ Qualitative interviews with patients found that they ‘felt better directly as a result of the service’ and that the continuity of care provided was appreciated, almost filling the role of a family doctor.¹⁰¹ One study found ‘patients enjoyed being seen as a whole and family carers appreciated the coordination aspect of the role’.¹⁰⁴

Table 7: New roles – summary of evidence by initiative

Domains of quality	Modern matrons	Community matrons	Emergency care practitioners	Clinical nurse specialists
Safe	Some evidence that they reduced drug errors and MRSA	Medications management aspect of role helped avoid adverse reactions	Found to be at least equally as safe as roles they substituted	Workload analysis showed significant time spent on medication management with suggested benefits
	Reports that influence was limited by their lack of empowerment			
Effective	Commentary suggesting that effectiveness was limited by some internal barriers	Reported as appropriate way of providing care	Evidence that care processes are as good or better than roles they substituted	Evidence that the involvement of CNS leads to increased chances of a patient receiving treatment
			Decisions appropriate and clinically effective	
Efficient	NAO conclusion that benefits were likely to outweigh the costs	Documented examples of avoided admissions and perceived reduction of unnecessary admissions in surveys, but no effect on overall rate of admission.	Evidence of reduced conveyance to A&E	Strong financial case Cost savings evidenced from reduction in emergency bed days, GP time, consultant appointments freed
			Suggestions that efficiencies not always exploited	
Patient-centred		Evidence that patients valued the psychosocial support, and close relationship	High patient satisfaction	High patient satisfaction Evidence they promoted self-management, supported decision making and patient wishes
		Encouraged self-care and management	Association with reduced conveyance valued Evidence that patients valued approach of ECPs to assessment and explaining situation/options	
Timely			One study showed improved response times compared with GP out-of-hours service Time from one call to next call was same as other ambulance services	
Equity				Evidence of variations in access geographically and by speciality
Number of references found	13	19	22	30

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

Improvement-focused interventions: developing guidelines



Background

NICE was originally set up in 1999 as the National Institute for Clinical Excellence, a special health authority, to reduce variation in the availability and quality of NHS treatments and care.¹⁰⁵ NICE produces evidence-based guidance and advice, develops quality standards and performance metrics and provides a range of informational services. NICE has a strong reputation internationally as ‘one of Britain’s greatest cultural exports’,¹⁰⁶ and its guidelines are arguably the most authoritative and best-evidenced advice on treating conditions in the world.

International evidence

Systematic review and synthesis of literature has established that guidelines can change clinical practice and improve patient outcomes, though the ways in which guidelines are developed, implemented and monitored influence the likelihood of adherence.¹⁰⁷ Guidelines can result in unintended consequences (eg unnecessary interventions, missed diagnoses and drug–drug interactions) and ensuring uptake and adherence to guidelines by health care practitioners is challenging.

English evidence

The overall impact of NICE guidelines does not appear to have been reviewed systematically. We found evidence on the impact of individual guidelines and groups of guidelines, although the studies have a very specific focus and draw from small data sets. In addition, there is evidence from the House of Commons Health Select Committee,¹⁰⁸ drawn from detailed submissions and in-depth interviews with stakeholders. The results give a complex and nuanced picture of the impact on quality of NICE guidelines and highlight gaps in evidence of impact. In reviewing the evidence, we found little focus on positive impact, perhaps identifying a need for a more rounded evaluation that takes into account the wide range of factors contributing to outcomes, including patient choice, established service pathways and other factors that may influence clinical decision making. NICE technology appraisals were not covered as part of this review.

Table 8: Description of initiatives reviewed for developing guidelines

Initiative	Description
NICE clinical guidelines	NICE considers the evidence of effectiveness and cost-effectiveness of interventions and technologies and plays a role in encouraging quality improvement. Clinical guidelines make recommendations for how health care professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. Clinicians, managers and commissioners use them. Their use is not mandated although compliance is monitored through the annual health check of NHS trusts.
The lever of guidelines covers a variety of initiatives that were not reviewed as part of this analysis. This includes: NICE Technology Appraisals, NICE Do Not Do recommendations, NICE Drug Reimbursement recommendations, Safe Staffing guidelines, Medicines Practice guidelines and other initiatives. Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

Two studies aimed to establish a link between NICE guidelines and improved outcomes. While NICE guidelines were ‘highly effective in improving access to, and quality of care’, no link with outcomes was established and improved data monitoring was recommended.^{109,110} One report suggests that NICE guidelines lead to drug–drug interactions for 14 common conditions (including type 2 diabetes, heart failure and depression, which often co-exist), and potentially harmful drug–disease interactions for patients with comorbid chronic kidney disease (but not other conditions).¹¹¹ There was a reported concern that the NICE traffic light system (for febrile children)¹¹² might give clinicians and parents false reassurance.¹¹³ A retrospective cohort study found that the traffic light system had a low specificity and low sensitivity for detecting serious infections.¹¹⁴ NICE has refuted the concern and emphasised that clinical assessment is an integral recommendation in the guideline.¹¹⁵

We found limited and conflicting evidence about cost-effectiveness of NICE guidelines. For example, one small study (across two A&E departments) concluded that the guideline on head injuries was cost neutral: the guideline led to an increase in CT head scans, but reduced admissions and skull x-rays, which ‘more than offset these costs without compromising patient outcomes’.¹¹⁶ A later, wider study on the same guideline found a marked increase in admissions with no clinical benefit.¹¹⁷ One study showed ‘NICE guidance in isolation had little impact on GP prescribing’¹¹⁸ and another showed a ‘highly significant 78.6% reduction (P<0.001) in prescribing of antibiotic prophylaxis’ (for infective endocarditis).¹¹⁹

The House of Commons Select Committee found that NICE guidelines encouraged a focus on cost-effectiveness.¹¹⁹ However, technology appraisals, which we did not examine, were also covered in their analysis. Conversely, we found a report of incongruence between guidelines and ‘real-world situation’ of budgetary constraints and variable local demands, suggesting NICE guidelines should provide more cost-effective focused recommendations, similar to NICE technology appraisals.¹²⁰ The NICE Adoption and Impact Programme Reference Panel has been established to support the development of implementation tools, including resource impact assessments for NICE guidance, which may address these concerns.¹²¹

The Health Select Committee has noted that the release of guidelines could be more efficient to avoid uncertainty around clinical decisions and prescribing.¹¹⁹ However, there is no further evidence about delays. One trust reported a 65% increase in the number of patients treated, referrals at an earlier stage for varicose veins and increased use of appropriate treatment.¹²² The guideline was regarded as being highly effective in improving access to, and quality of, care in the trust.

A survey of clinicians found low awareness of guidelines among patients and lack of use of guidelines to help patients assert their rights.¹²³ A qualitative analysis of in-depth interviews with patients found that they might see the more extreme manifestations of conditions reflected in guidance as removed from their personal experience and place trust in clinicians over guidelines.¹²⁴ The 2013 Health Select Committee recommended that NICE does better to ensure that the ‘patient voice is effectively and openly represented in all its work’.¹²⁵

There is a tendency for guidelines to account insufficiently for the complexity of individual patients or some of the patient populations served by the NHS. Specifically, patients in primary care¹²⁶ and older people¹²⁷ are not always well accounted for, as well as the ‘new normal’ of multi-morbidity.¹²⁸ One review assessed the extent to which five guidelines addressed comorbidity and found that adhering to guidance could lead to treatment burden, difficulties with treatment adherence and potentially over-treatment.¹²⁸ The risk–benefit balance of clinical decisions changes with older patients and this is not reflected in the guidelines.¹²⁷ The reason for this is suggested as the necessarily limited focus of clinical trials. One study noted that ‘patients over the age of 80 take up around 20% of hospital inpatient beds, but are not typically part of trials and evidence that informs the guidance’.¹²⁷ This problem is acknowledged by NICE. Guidelines on multi-morbidity are expected for September 2016.¹²⁹ These have been in development for some time and NICE has reported difficulties developing recommendations from existing single-disease-focused evidence.¹³⁰

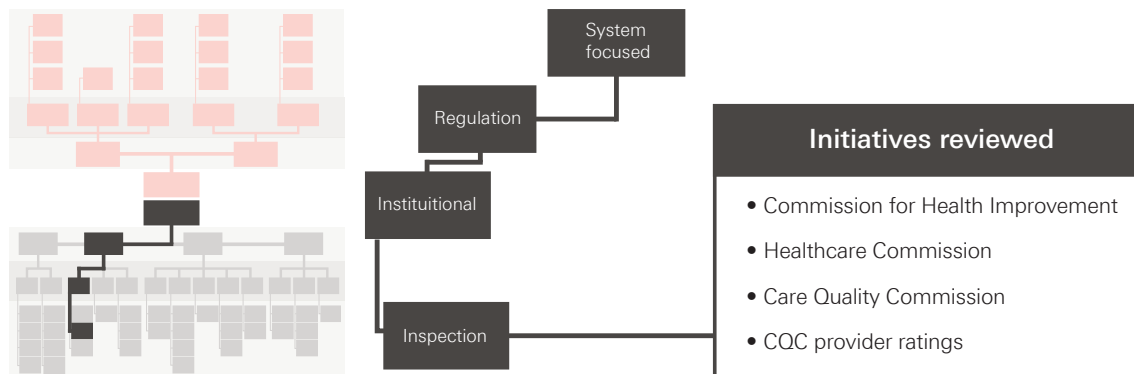
There is variable uptake of guidelines, with ‘perceived lack of resources, clinicians’ concerns about the undermining of their autonomy, ingrained practices, and general disagreement with the content’ cited as barriers to implementation.¹³¹ However, one study found that variations in usage of cancer drugs declines over time following release of NICE guidance.¹³² The Healthcare Commission (HCC) has reported variable implementation of NICE guidance in NHS trusts and guideline uptake may be varied in primary care. GPs reported ‘they were more likely to use guidelines where evidence was applicable to primary care’,¹³³ however, a review of 22 NICE guidelines (in 2010–11) concluded that ‘only 38% of recommendations examined were based on patients typical of those managed in the community’.¹²⁶ Uptake of guidelines may also vary depending on the guideline topic – for example, clinicians described guidelines on managing lower back pain as ‘unfamiliar and of limited relevance to practice’ and as having ‘relatively peripheral influence on clinical decision-making’.¹³⁴ We found one survey of NHS hospital staff where 50% of respondents stated that clinical guidelines were important for health care decisions.¹³⁵ Another survey found that NICE guidance were ‘of more importance and usefulness to managerial than clinical professionals’.¹²³

Table 9: Developing guidelines – summary of evidence by initiative

Domains of Quality	NICE clinical guidelines		
Safe	Report that traffic light systems may provide false reassurance but decision making safe when used with clinical expertise as recommended	Recommendations do not reflect risk/benefits of treatment for older people	Potential for drug–drug interactions if multiple recommendations followed
Effective	Highly significant reduction in prescribing of antibiotic prophylaxis	Mixed evidence of influence on clinical decision making	Concerns that guidance over-simplifies decision making
	Lack of evidence on whether guidelines improve outcomes as complex impact		
Efficient	Evidence of better prescribing or increased treatments/timely referrals	Survey suggests more useful for managers than clinicians	Mixed evidence on adherence to guidelines
	Reports of gap between guidelines and 'real world', especially on cost implications	Recommendations could lead to overtreatment Increase in unnecessary admissions from one guideline (head injuries)	
Patient-centred	Evidence that patients trust clinicians more than guidelines	Low awareness of guidelines among patients, guidelines don't help patients assert their rights Reports that patient focus is generic rather than explicit	One report that guidelines prohibit person-centred care
Timely	One study showed a guideline facilitated more timely access to treatment	Suggestion that slow release of guidelines causes delays but no evidence to support this	
Equity	One study showed that a guideline made access to cancer drugs more equitable	Variable implementation across the country	Evidence that certain patient populations are inconsistently accounted for, eg co-morbidities, primary care and older people
Number of references found	29		

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

Regulation-focused interventions: Inspection



Background

Regulation, and inspection as one method of regulation fit into the control part of the Juran trilogy.²⁸ In England, this inspection lever comprises organisations that periodically examine whether health care organisations are meeting national performance standards, legislative and professional requirements, and the needs of patients. Inspection can influence the quality of care at different stages. Initially, organisations receive signals from regulatory and inspection entities, usually in the form of standards, that increase awareness of what constitutes expected levels of performance or quality. The organisation will prepare for inspection and this can lead to greater self-awareness of performance and proactive moves to improve. The standards against which inspection will occur provide a set of priorities for an organisation to focus on. As a result of an inspection and the ensuing feedback, an organisation could then respond to recommendations, action points and re-prioritisation, and put in place changes that would lead to improved quality of care.

International evidence

The use of external inspections is based on the assumption that they can contribute to improving the quality of health care.¹³⁶ External inspections in health care can provide the inspected organisations with useful information for their initiatives and efforts to improve quality of health care.¹³⁷ External inspections can affect organisational practice, but there is limited evidence on how and whether such changes in practice lead specifically to improved quality.¹³⁸

English evidence

We identified several reports and investigations by the NAO and the House of Commons Select Committee on inspections of the NHS in England by the regulatory bodies the Care Quality Commission (from 2009) the HCC (2004–09) and the Commission for Health Improvement (1999–2004). Internal and external evaluations of the effectiveness of the HCC were performed, though as the organisation no longer exists, we were unable to source some of the original reports. We found surveys of NHS organisations that were inspected, describing their opinions on the process, implications and impact of the

inspections. The impact of inspection on quality is complex and difficult to establish.^{139,140} For this initiative, unlike others, we focused on activities and impact of organisations (see table 10), rather than interventions. There has been significant change in the regulation of the health care sector in the NHS in England, with three regulators for the sector introduced between 1999 and 2009. The lack of research examining the impact of inspection on the quality of care has been recognised¹⁴¹ and system-led reviews of the effectiveness and impact of inspection are ongoing.¹⁴²

Table 10: Description of initiatives reviewed for inspection

Initiative	Description
Commission for Health Improvement (CHI)	Set up in 1999 as an independent inspection body, its responsibilities included reviewing clinical governance arrangements, investigating suspected serious service failings and reviewing (with the Audit Commission) the implementation of the NSFs. The CHI did not set standards, but assessed against standards set centrally. It was the first national organisation responsible for assessing clinical governance of providers, through clinical governance reviews. With an initial budget of £1.5m, by 2003 it had a headquarters staff of more than 400, a budget of around £33m, and had recruited and trained over 1,000 part-time reviewers. Its role was extended in 2002 to include the Office for Information on Healthcare Performance, which covered a star rating system. The CHI was replaced by the Healthcare Commission in 2004.
Healthcare Commission (HCC)	Established with the responsibility of 'encouraging improvement in the provision of health care by and for NHS Bodies'. The legal name for the HCC, as it was generally known, was the Commission for Healthcare Audit and Inspection. Its main statutory functions included reviewing performance of NHS organisations, awarding an annual rating, regulating the independent sector, investigating serious service failures, and carrying out reviews of health care provision (including economic and efficiency aspects, assumed from the Audit Commission). In 2006 the HCC stopped clinical governance reviews and introduced the annual health check for NHS organisations, a standards-based assessment that included a self-assessment statement, examination of routine data, external commentary and selected inspection visits. Net operating costs were £67.8m in 2008-09, with 843 employees. The HCC was abolished in March 2009 and its functions absorbed into the newly formed Care Quality Commission.
Care Quality Commission (CQC)	The CQC is currently responsible for regulating the services provided by the NHS, private companies and not-for-profit organisations, operating at a much larger scale and scope than its predecessor. In 2015-6, with a budget of £249m, and nearly 2,700 employees, the CQC was responsible for regulating over 21,000 providers at almost 50,000 registered locations. The CQC regulation regime consists of monitoring compliance and registering providers against essential standards, and undertaking inspections in response to indications of risk. The CQC struggled with the scale and complexity of a phased introduction of the registration process across sectors, suffering persistent staffing issues, loss of public confidence and critical reports. ¹⁴³ A 3-year transformation programme increased inspections, appointed a Chief Inspector of Hospitals, emphasised improvement and tailored regulation models. In 2013 the new inspection model (inspections visits, data analysis, comprehensive inspection report) was phased in, starting with acute hospitals. The CQC still faces problems with staff shortages and skill levels, recently struggling to meet deadlines. The CQC will now assess the efficiency of hospitals and the 'Quality of care in a place' report will inspect a local area to assess how well local health and care services are coordinated.
CQC provider ratings	Following an inspection, the CQC rates a provider on a four point scale (outstanding, good, requires improvement and inadequate). In addition to an aggregate rating at provider level, the CQC produces ratings for individual services and locations. This aims to give patients and the public a fair, balanced and easy to understand assessment of the performance of a provider. Where a provider is rated inadequate, the CQC recommends their license provider puts them in 'special measures', which is a series of interventions to improve quality. This new approach is still being implemented, with some providers yet to receive a new rating.
The lever of inspection covers a variety of initiatives that were not reviewed as part of this analysis. Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

Inspections are reported to have a positive impact on institutional dynamics, improvement prioritisation and positive change,¹³⁹ though progress varies widely across the NHS.

A study examining the progress of 30 trusts against the **CHI** recommended actions suggested there was an over-emphasis on management and support processes rather than patient care and outcomes. It also found that only 40% were judged to have made progress in clinical effectiveness.¹⁴⁴ However, a survey of 30 acute trusts on CHI clinical governance reviews found that 70% of trusts reported the reviews caused progress in patient, service user and public involvement.¹⁴⁵

The proportion of NHS trusts rated ‘excellent’ or ‘good’ by the **HCC** increased from 46% in 2005/06 to 60% in 2007/08.¹³⁸ Other areas where improvements were seen were in risk management (63%) and use of information (70%).¹⁴⁶ In 2009, Professor Ian Kennedy (former HCC Chair) acknowledged, ‘No evidence exists of the particular costs to particular trusts, and, as I said, such costs will vary. But, no detailed scientific evidence exists as to its benefits either’.¹⁴⁷ An independent evaluation based on views of the HCC from 220 NHS trusts found that more than nine out of ten trusts made changes because of the annual health check and thought that it was a catalyst for change.¹⁴⁸ HCC annual health checks and HCC investigations were reported to improve safety and patient care, but patient confidence in the investigated trusts was not improved, and in some cases was perceived to be worsened. We found little evidence on the timeliness of inspections. While the HCC was recognised for contributing to exposing the failings of care in Mid Staffordshire, it was criticised for allowing delays in the detection and prevention of them.¹⁰

Responses from the annual **CQC** user survey showed a majority of providers agreed that outcomes for people who use the services had improved as a result of inspection.¹⁴⁹ The survey also found that the majority of respondents from secondary care providers agreed inspection had helped identify areas for improvement (70% of NHS trusts) and that outcomes for service users have or will improve as a result of inspection (74% of NHS trusts). GPs’ responses to the same questions were less positive, however, with 38% agreeing that CQC inspections had helped identify areas for improvement and 31% agreeing that service user outcomes have or will improve. Another 2015 survey – conducted by NHS Providers – found that 78% of provider trusts felt the overall regulatory burden had increased over the last 12 months and that data and evidence requests were ‘excessive’.¹⁵⁰ It also noted that only 32% of respondents believed that the benefits gained from a CQC inspection justified the ‘cost’ in trust resources of preparing for and hosting the inspection team. The CQC is undertaking further work to quantify the benefits and costs of inspection: ‘we are exploring what changes in ratings and analysis of external indicators of quality of care can tell us about the impact of [the] CQC’.¹⁵¹ The results will be published in a new externally developed annual assessment of impact and value for money later in 2016.^{152,153}

Interview data showed that changes in the **CQC ratings** were expected to improve quality. In a survey conducted by Manchester Business School and The King’s Fund to evaluate the CQC model of acute hospital regulation, ‘81% of survey respondents felt it was either ‘very’ (38%) or ‘quite’ (43%) likely that the inspection report will lead to service improvements’.¹⁵⁴

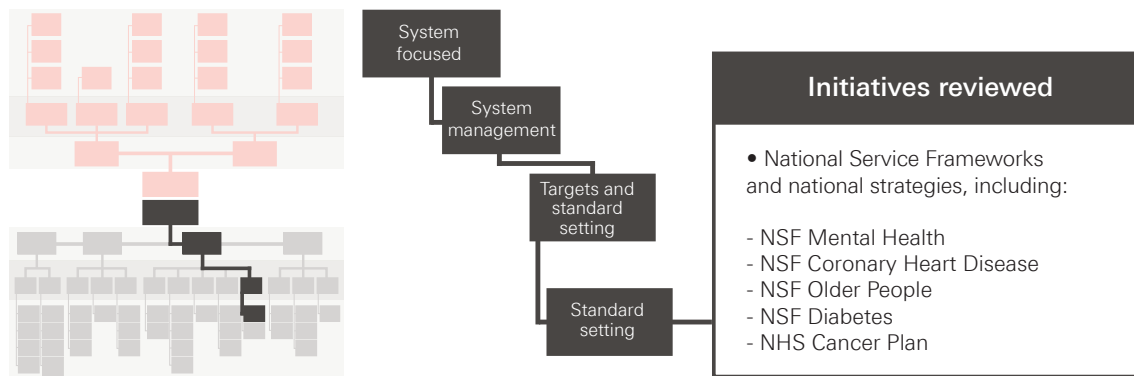
The Nuffield Trust also reported that their analysis ‘suggests that a system of provider ratings could act to improve accountability for the quality of care, provided ratings were simple and valid, and were reported publicly, widely and accurately’.¹⁴⁰ These studies were predicting potential impacts rather than measuring actual impact.

Table 11: Inspection – summary of evidence by initiative

Domains of Quality	Commission for Health Improvement	Healthcare Commission	Care Quality Commission	CQC ratings
Safe		<p>Majority of trusts report that the HCC focused attention on patient safety</p> <p>HCC’s investigations did not improve patient confidence for over half of trusts</p> <p>Francis report concluded inspection system did not prevent serious failings</p>		
Effective	No measurable impact	9/10 trusts agreed annual assessment was catalyst for change	Only 31% of GPs felt patient outcomes improved	Stakeholders report the new system leads to service improvements
	40% of sample of trusts reported improved clinical effectiveness		68% of CQC user survey felt patient outcomes improved	
Efficient	Recommendations followed and led to focus on improvement	Recommendations followed and led to improvements	Recommendations have been followed and led to focus on improvement	
	Acknowledged gap in evidence of cost–benefit trade-off		Regulatory burden for 78% of providers, with concerns about local cost–benefit trade-off	
Patient-centred	Reports that CHI helped 70% of providers improve patient and user involvement			
Timely				
Equitable				
Number of references found	11	6	8	4

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

System management-focused interventions: Setting and implementing standards for service delivery through NSFs



Background

This lever covers initiatives that support the NHS in delivering consistent and high quality services, setting out a blueprint for how care should be delivered for a specific area, issue or disease group. National Service Frameworks (NSFs) were first introduced in 1998 to improve quality and reduce variation¹⁵⁵ and were latterly intended to run over the period of the NHS Plan (2000–10).¹⁵⁶ Some were developed later.

NSFs were broad implementation strategies that not only set standards for the NHS but deployed a very wide range of interventions that covered multiple parts of the NHS Quality Framework and beyond, for example by identifying and garnering the additional resources required. Many initiatives in this evidence analysis could be categorised under more than one policy lever and we acknowledge that this is especially the case with NSFs. NSFs covered a major part of total NHS spending (the first five covered approximately 50%) and underpinned a full range of the health care continuum – health promotion, disease prevention, diagnosis, treatment, rehabilitation and care. NSFs were evidence-based programmes with strong clinical engagement that set national standards and defined service models for major disease or care areas. Many NSFs were implemented with practical strategies, significant resources (including workforce), clinical networks, and in some cases delivery configuration changes. Many NSFs also established performance measures and agreed timescales for evaluation. Most NSFs programmes are finished or have transitioned into other ongoing national strategies.

International evidence

Standards are designed to encourage health care organisations to improve quality and performance within their own organisations and the wider health care system.¹⁵⁷ Standards define the size, scope, responsibilities and implementation strategies of the associated initiatives and require measurement of outcomes and evaluation of impact.¹⁵⁸ National standards for health care are used in many countries all over the world,^{159,160,161,162} though there is limited evidence on the impact of setting standards on quality of health care, partly because the effect is difficult to isolate.

English evidence

Many of the NSFs have progress reports, by the DH or external organisations, or have been reviewed by the NAO. Evidence often focused on specific aspects of NSFs, but not typically on the overall impact, where commentary and assertion are the norm. The wide-ranging nature of NSFs make assessment of impact challenging. Impact on safety was not seen in the evidence we identified on NSFs, unless it was an aim within the NSF. Single-specialty NSFs (eg NSF Coronary Heart Disease) appear to have been more evaluated and to have been easier to implement than NSFs which span pathways or specialties (eg NSF Older People).

Table 12: Description of initiatives reviewed for setting standards

Initiative	Description
NSF Mental Health	Initiated in 1999, it covered mental health promotion, primary mental health care, services for severe mental illness, carers, and suicide prevention. It set a national target to reduce these issues by at least one-fifth by 2010. It provided a blueprint to improve timeliness and reduce inequalities. It was funded centrally with £700m over three years for implementation and £120m distributed via a Mental Health Modernisation Fund, and large overall increases in funding of mental health services.
NSF Coronary Heart Disease (CHD)	Initiated in 2001, it set 12 standards covering health promotion, risk reduction, treatment of acute myocardial infarction, rehabilitation, secondary prevention and revascularisation. Key targets were 40% reduction in deaths attributable to CHD and stroke in people aged up to 75 years by 2010, aiming to save some 200,000 lives. Specific funding was allocated in the earlier years and additional revenue was £392m (2000–05) and additional capital investment (2000–09) was £615m.
NSF Older People	Initiated in 2001, it set eight national standards and identified service models to provide person-centred care, remove age discrimination, promote older people's health and independence and to 'fit the services around people's needs'. Commitments for extra resources were made (£1bn for the development of health and social services for older people by 2004), but it is unclear whether this was allocated.
NSF Diabetes	Initiated with the publication of 12 standards for diabetes care in 2001, followed by a delivery strategy two years later (2003). The primary goal was to enable the person with diabetes, or at risk of developing diabetes, to manage their lifestyle and diabetes, by providing support and structured education as well as drugs and treatments. This was the first NSF to be written with clear links to other NSFs and to the DH modernisation and reorganisation programme.
NHS Cancer Plan	Commencing in 2000, it was a 10-year programme of fundamental reform of cancer services in England. It formally established cancer networks across the country, bringing together the organisations and health professionals that plan and deliver treatment and care for cancer patients. It was well resourced, with additional £693m spending over a three-year period, and largely implemented although revised and refocused by subsequent cancer strategies (NHS Cancer Reform Strategy (2007) and Improving Outcomes: A Strategy for Cancer (2011)).
The lever of setting standards covers a variety of initiatives that were not reviewed as part of this analysis. This includes Saving Lives and other initiatives. Some initiatives are examined under other levers elsewhere in this evidence review. Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

Evaluations of the overall impact of the **NSF Mental Health** are positive. A review by the National Director for Mental Health (Louis Appleby) in 2007 described the NSF Mental Health as 'a ground-breaking document, welcomed by patients and the professions, and is still the blueprint for service reform nearly eight years later'. He quotes WHO as saying that England has the best mental health services in Europe.¹⁶³ The NSF Mental Health changed workforce and professional culture and improved risk management through

assertive outreach and crisis interventions.¹⁶⁴ However, the impact of community-based care on admissions is variable. For example, crisis resolution teams reduced admissions but assertive outreach teams had no demonstrated impact on admission rates – although they successfully engaged people with very complex needs. Declining suicide rates were observed but not clearly associated with the NSF.¹⁶²

The **NSF CHD** ‘embodied aims and practices that are clinically-driven, consistent and widely supported by staff’ and the overall impact was positive.^{165,166} Premature deaths of people aged under 75 decreased by 39% between 2000–07.¹⁶⁴ Increased use of statins improved secondary prevention and saved lives – from 2,900 (2000) to 9,000 (2004).^{167,168} Patient access to thrombolysis within 30 minutes of arrival at hospital increased massively from 38% (2000) to 84% (2004).¹⁶⁶ Automatic external defibrillators definitely saved 61 lives (up to 2006).¹⁶⁹ One study found that improvements in mortality and thrombolysis were directly associated with the NSF CHD, but improvements in prescribing were the continuation of pre-existing trends.¹⁷⁰ Outcomes of cardiac rehabilitation were difficult to improve.¹⁶⁴ Though access to care varied, the NSF CHD reduced the absolute gap in mortality from CHD between the most and least deprived areas by one-third.^{164,171}

The **NSF Older People** had a positive impact on delayed discharge from hospital,^{172,173,174} but mixed patient feedback.¹⁷⁵ Patient engagement through the Older People’s Reference Group in shaping the NSF was noted as important in improving patient-centredness.¹⁷⁶ Overall impact was mixed: ‘less accessible but higher quality GP services, hurried but more flexible home care, faster but riskier hospital treatment’.¹⁷⁷ The NSF Older People has had a positive impact on age discrimination and removing age-based barriers in access to treatment, though ageism was reported to persist across all services.¹⁷⁸

There was variable implementation of the **NSF Diabetes**.¹⁷⁹ Commissioning of services was improved but diabetes prevention and management was not covered successfully.^{180,181} Lack of evidence of impact on safety was noted by the NAO with reported complications, especially for inpatients due to prescribing errors.^{178,182}

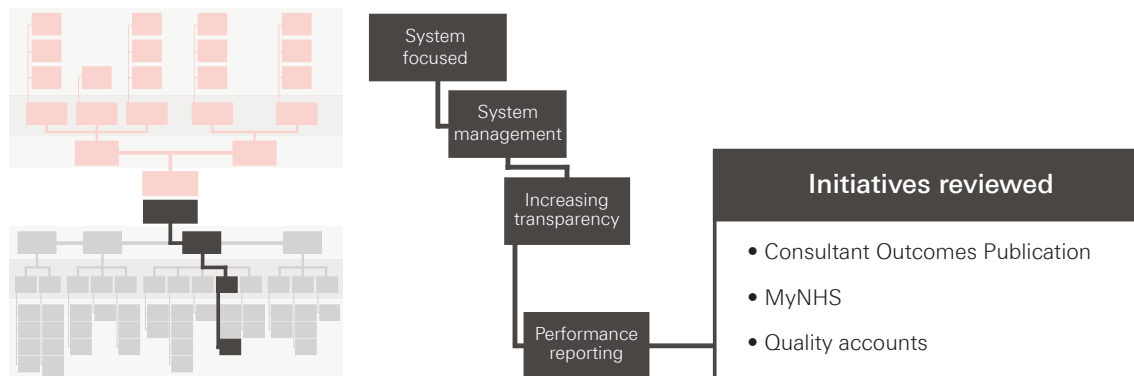
Over the period covered by the **Cancer Plan** and subsequent cancer strategies, there were improvements in survival rates. While these are likely to be linked,¹⁸³ successive NAO reports found it difficult to attribute them to the Cancer Plan.^{184,185} Significant service improvements and efficiencies are attributed to the Cancer Plan, including better screening and faster access to diagnosis and treatment.^{184,186} Some delays in diagnosis and treatment, especially late diagnosis, were attributed to limitations on capacity of the system. High levels of diagnosis in emergency settings represented a significant and potentially avoidable cost to the NHS and a negative impact for patient experience,¹⁸⁷ but such effects cannot be attributed to the Cancer Plan and specific action in this area has been included in subsequent strategies. CNSs are reported to have a particularly positive effect, as are other initiatives like Cancer Networks and multi-disciplinary teams.¹⁸⁸ Though a lack of information for patients at end-of-life was noted,¹⁸⁹ overall the Cancer Plan was regarded as a success: it raised ‘the profile of cancer among policy-makers and make it more of a priority in the NHS’.

Table 13: Setting standards – summary of evidence by initiative

Domains of quality	NHS Cancer Plan	NSF Older People	NSF Mental Health	NSF Diabetes	NSF Coronary Heart Disease	National Service Frameworks
Safe						
Effective	Some improvement in survival rates attributed to Cancer Plan Outcomes improved though less than anticipated	Increased elective surgery and better prevention	Decline in suicides but not directly attributable (difficult to assess effectiveness of less clinical areas)	Hindered by poor implementation, but view that would impact outcomes otherwise	Evidence of improvements in thrombolysis rates and mortality directly associated with NSF Better prevention and treatments	
Efficient	Impact on service improvement and efficiency Success in prevention Cancers detected in emergency settings and high level of admissions Cost-effectiveness not proven	Better community-based care eased pressure on admissions	Crisis resolution teams reduced admissions Assertive outreach teams costly but no reduction in admissions	Better information (clinical audits, practise registers) allowed resources to be used appropriately	New services developed with significant efficiency gains, eg pre-hospital and in-hospital thrombolysis	50% of commissioners used NSFs (and guidelines) to aid health care decisions Suggested impact on health care delivery/ resource management not confirmed
Patient-centred	Patients report better involvement in decisions and communication Positive impact of Clinical Nurse Specialists	Mixture of negative and positive feedback Improvements overall, but undermined by negative experiences over discharge			Improved patient choice	
Timely	Evidence of positive impact on referrals Unintended delays in diagnosis and treatment from system bottlenecks	Timeliness of primary care and hospital services improved Accessibility to GPs worsened			People treated more promptly Waiting times improved Better access to treatments	
Equitable	No impact on inequalities in outcomes and access	Age discrimination addressed, but still a problem in all services	Variation in implementation	Some reduction in inequalities, but still wide variations in the quality of care received	Inequalities in death rate from CHD in under-75s narrowed throughout NSF years but gap still significant	
Number of references found	15	13	13	14	13	5

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

System management-focused interventions: Performance reporting



Background

Performance reporting is concerned with improving access to information on the performance and quality of the health care system, to enable patients to make informed choices, allow health care providers to examine their performance using benchmarks and comparisons, and to drive quality improvement through accountability for health care performance and quality. Information that is made available includes process and outcome data, health care professional licensing information, malpractice case data and patient satisfaction survey results. The NHS is viewed as one of the most transparent health systems in the world and has been at the forefront of publishing comparative health care data.^{190,191} This commitment has consistently remained towards the top of the national policy agenda.^{10,192}

International evidence

There is moderate evidence to suggest that quality measures that are publicly reported improve over time.¹⁹³ However, rigorous evaluation of many major public reporting systems is lacking and the effect of public reporting on effectiveness, safety and patient-centredness remains uncertain.^{194,195} Public reporting is more likely to be associated with changes in provider behaviour, particularly at institutional level, rather than with selection of providers by patients or families.¹⁹² Easy-to-read presentation formats and explanatory messages improve knowledge about and attitude towards the use of quality information; however, the weight given to quality information depends on other features.¹⁹⁶ Although the potential for harm is frequently cited by commentators and critics of public reporting, the amount of research on harm is limited and most studies do not confirm the potential harm.¹⁹² Greater improvements in quality can be achieved with public reporting in combination with pay for performance.¹⁹⁷

English evidence

We found little evidence that looked at the impact of performance reporting on quality of care in the NHS in England. The lack of data has been recognised^{198,199} and evaluations are planned or underway for quality accounts, CQC provider ratings and MyNHS.^{200,201,202}

Table 14: Description of initiatives reviewed for performance reporting

Initiative	Description
Consultant Outcomes Publication (COP)	COP is an NHS England initiative, managed by the Healthcare Quality Improvement Partnership (HQIP), to publish quality measures for individual consultants using National Clinical Audit and administrative data. The first speciality-led efforts to publish individual consultants' results were in cardiology, which began in 2005, following a Freedom of Information request by <i>The Guardian</i> newspaper. The national COP initiative in its current form began with 10 National Clinical Audits in 2013 and expanded to 12 in 2014.
MyNHS	A web tool, launched in 2014, that allows health and care organisations, as well as the public, to compare the performance of services over a range of measures, at both local and national level. The site aims to drive improvement across the health and care system – encouraging organisations and professional teams to compare their performance and see where they can improve what they do and the services they offer.
Quality Accounts	Since June 2010 NHS health care providers have been required to produce an annual report about the quality of their services and their plans for improvement. The policy has been implemented initially in acute care and is rolling out to mental health, adult social care and GP practices. The quality of the services is measured through patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided. This initiative includes providers from the voluntary and private sectors who are contracted to provide services to the NHS.
Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

For **Consultant Outcomes Publication** we identified reports of the impact of publishing cardiology consultants' results. One study questioned the underlying principle of publishing mortality data, and examined cases in detail finding that 'most deaths cannot be prevented by the operating surgeon. They occurred through issues of patient comorbidity, lack of process or infrastructure. This casts doubt on SSMD (Surgeon Specific Mortality Data) publication alone as a tool for quality improvement'.²⁰³ However, significant falls in mortality rates for cardiac patients were associated with the publication of consultant results,^{204,205} although a causal relationship is yet to be proven.²⁰⁶ A Cochrane systematic review looked for evidence of the influence of publishing consultant outcomes on patients' choice of surgeons for elective surgery and concluded there was no evidence of this intended impact.

One of the arguments against the publication of consultant outcomes was a perception that it might make doctors more cautious and, for example, avoid higher risk surgeries, thus leading to reduced equity in access to care.²⁰⁷ We found mixed commentary around this subject, including a quote from John MacFie, president of the Federation of Surgical Specialty Associations: 'there is no doubt that anecdotally it is affecting surgeons' performance, and I'm worried that patients might suffer because of it'.²⁰⁸ However, we found little evidence to support this assertion. One study established a link between publishing consultant results and patient access to surgeries: The Society for Cardiothoracic Surgery in Great Britain & Ireland reported in 2008 (six years after individual consultant data was first published for this specialty) that the operative mortality rates for all major

operation groups was falling despite the patients being sicker, and increased numbers of older patients undergoing cardiac surgery of all types. The report concluded that: ‘Many have raised concern that publication of results for units and individual surgeons might lead to higher-risk patients being denied surgery – the data in this report should allay that fear’.²⁰⁹

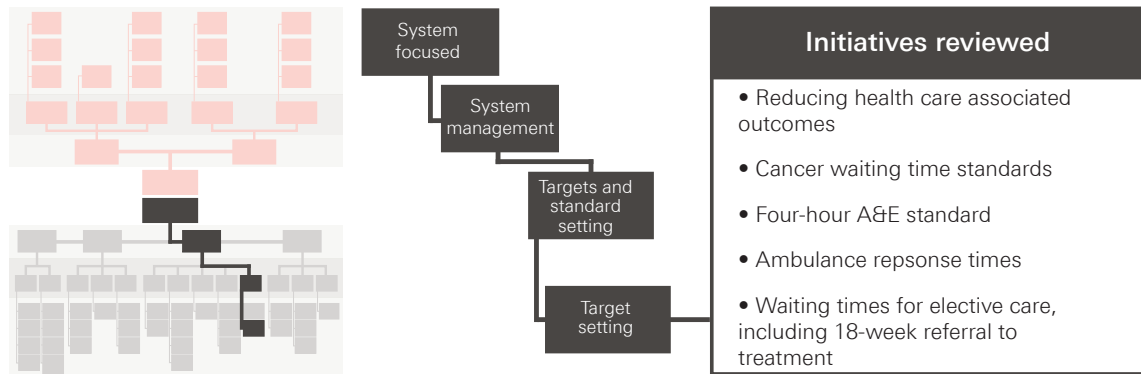
We found little evidence on the impact of **MyNHS**. One review expected that the efficiency comparisons on MyNHS could lead to real savings.²⁰² This aspect will be part of the proposed evaluation of MyNHS.²⁰²

Table 15: Performance reporting – summary of evidence by initiative

Domains of quality	Quality Accounts	Consultant Outcomes Publication	MyNHS
Safe			
Effective		Evidence from early profession-led initiative that publication of results was associated with improved outcomes but direct causal relationship not established	
Efficient			Anticipated cost-savings (under evaluation)
Patient-centred			
Timely			
Equitable		Discussion that publication of outcomes would lead to risk averse behaviour from surgeons but no evidence of this	
Number of references found	4	10	4

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

System management-focused interventions: National target setting



Background

This lever covers any performance objective, set at a national level, where relevant providers and/or commissioners of care are expected to achieve a minimum level of performance against particular metrics within a set deadline.²¹⁰ Targets have an important role in ensuring consistent national standards and setting expectations of what the public should expect from the NHS. They are a mechanism for holding providers to account to the government and the public; aligning performance to priorities; improving operational performance; and focusing contract terms.²¹¹

International evidence

Performance targets can improve accountability and transparency, and improve performance,^{212,213,214} but can also result in unintended consequences.^{215,216,217} Recent work by the Health Foundation that explored the effective use of performance targets in the NHS found that clarity, collaboration, robust evidence, clear accountability and a wide set of metrics were strongly associated with success.^{210,218}

English evidence

We identified few systematic reviews but many evaluations on the quality impact of targets. The NAO has frequently examined the value for money of targets. There were other evaluations and many smaller studies looking at other aspects of quality. There were reports on the lack of useful performance data to analyse the effect of targets.^{219,220}

Table 16: Description of initiatives reviewed for national targets

Initiative	Description
Reducing health care associated infections (HCAIs)	National targets were set to reduce two HCAIs. A target to reduce Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infections by 50% by 2008 was set in 2004. A subsequent target was set to reduce <i>C. difficile</i> cases by 30% by 2010–11 against a 2007–08 baseline. The targets relating to HCAIs were well funded, with spending rising from £6.5m on HCAIs in 2004–05 when the MRSA target was first introduced, to £24.5m in 2008–09. They were also supported by targeted initiatives such as ‘deep cleans’, legislative change and a systematic campaign to change behaviours, new equipment and cleaning staff. It seems likely that these investments supported achievement of the targets.
Cancer waiting time standards	The NHS Cancer Plan set a number of targets to improve access to cancer care. Three cancer waiting time standards were published as: two weeks to first outpatient appointment following urgent referral by a GP; 31 days to treatment following a diagnosis/decision to treat; and 62 days to first treatment following urgent referral. These targets were funded as part of the substantial funding behind the NHS Cancer Plan and subsequent cancer strategies and were supported by the raft of initiatives that underpinned these strategies. Local rapid access referral mechanisms were established and nine cancer networks were created aimed at optimising care and improving the experience and outcomes of care for patients. Together, these initiatives resulted in significant improvements in timely access to cancer care for the vast majority of patients.
Four hour A&E standard	A national target that patients should wait less than four hours from arrival to admission, discharge or transfer was part of the 2000 NHS Plan. Delivery of this target was supported by increases in overall spend on A&E. This target has been met and sustained, but more recently, compliance has declined and the target has become a key barometer for demand faced by A&E and a system under pressure.
Ambulance response times	This target has been subject to several revisions. In 2001, a new target was introduced for ambulance services to achieve 75% of responses from call to a crew arriving on scene within eight minutes for life threatening calls. This became more nuanced in 2011 so that calls were triaged by the ambulance service and allocated to one of a number of ‘Red’ or ‘Green’ categories. Patients within categories Red 1 and Red 2 were to be responded to within eight minutes, with less urgent cases having longer times for response. The current national target is for ambulance trusts to reach 75% of Red 1 cases within eight minutes, and 95% within 19 minutes. The time starts as soon as an emergency call is connected. Red 2 targets are currently the same, except that the clock start can be up to 60 seconds after a call is connected. Other measures supporting the target were the use of rapid response vehicles and the use of ‘standby’ where emergency vehicles wait at strategic locations in the community rather than ambulance stations, and the use of community first responders. There was no increase in the number of fully staffed ambulances. This target has been met and sustained, but has been revised and is now again under review.
Waiting times for elective care, including 18-week referral to treatment	The key target stated that 90% of patients admitted to hospital, and 95% of other patients, should have started consultant-led treatment within 18 weeks of being referred. This was achieved by 2008 and is now a right of patients, enshrined in the NHS Constitution. This standard has been revised over time. The original focused on patients recently added to waiting lists but, since April 2012, this has covered patients who are still waiting for treatment. In addition, from April 2013, NHS England introduced zero tolerance of any patient waiting more than 52 weeks, backed by a mandatory fine of £5,000 for each patient doing so. NHS received an additional £1bn in 2006–07 and £1.9bn in 2007–08 to help meet the growth in referrals, deliver existing waiting time initiatives, and to meet future waiting time standards. Since then, the standards have been met nationally, with few exceptions, within existing NHS funding limits.
Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

In response to the **HCAI targets**, aggregate reductions in MRSA and C. difficile were achieved in excess of the target reduction although these improvements were not uniform across the NHS.²²¹ The reduction in the number of cases coincided with fewer deaths from MRSA (from 480 in 2006 to 38 in 2012)²¹⁸ and C. difficile infection (from 7,816 mentions in 2007 to 3,550 in 2009).²²² The actions taken to achieve the targets demonstrated potential benefits in terms of better ward management of staff and harm avoided to patients, as well as a broader change in how organisations prioritise and approach infection prevention and control.²²³ However, some concern about unintended consequences may have been demonstrated by the NAO in identifying increases in other bloodstream infections and HCAI during this period, as well as increases in other risks as a result of the focus on achieving the specific targets.²²¹ This was echoed in another study, which noted that the narrow focus of the targets might leave patients at risk of other infections with the potential for an ‘an equal or larger burden of adverse outcome’.²²⁴ The targets were considered cost-effective, with decreases in treatment costs of between £141m–£263m commensurate with the costs incurred.²²¹

The **cancer waiting times standards** have been largely sustained by the NHS since the targets were first achieved,²²⁵ though a number of trusts and local health economies have struggled to achieve the standards.²²⁶ Early evaluation of the standards suggested there were some increases in waiting times for services not covered by the standards,²²⁷ particularly radiotherapy,²²⁸ which led to changes in subsequent strategies. A 2005 literature review commented on the potential psychological benefits to patients,²²⁹ and the standards were also felt to have reduced patient anxiety related to delays in being assessed, diagnosed with and treated for cancer.²³⁰ However, there is limited evidence linking the standards to improved outcomes and a 2005 study found no evidence of an impact of the two-week wait on survival.²²⁹ While the two-week wait standard has had a positive impact on the number of patients being diagnosed following an urgent referral,²²⁵ other studies have raised concerns about the high proportion of cancers that continue to be detected via other routes^{229,231,232} – almost one in four are detected only when a patient is admitted to hospital as an emergency.²²⁵ It has been suggested that more consistent use of the two week wait pathway by GPs could improve mortality.²²⁵ NICE lowered the threshold for symptoms warranting urgent referrals in 2014, but we found no evidence on whether this has impacted health outcomes so far.

The **four hour A&E target** achieved significant and sustained improvement in waiting times, and patient satisfaction with A&E services is persistently high. In successive reports, the target was found to have had a beneficial effect in focusing managerial and clinical attention on reducing delays by improving patient flow, increasing staffing levels and implementing innovative practice.²³³ Although the target was initially expected to have an adverse effect on health outcomes, this has not been reflected in the evidence and the NAO concluded that ‘no suitable data are available to demonstrate conclusively whether or not this has in fact occurred’.²³³ Most of the evidence highlights no impact or no detrimental impact, with no negative effects found in relation to increased mortality or return visits to A&E.^{234,235} There has, however, been a range of criticism associating the target with distorting behaviours and leading to clinically inappropriate decision making,^{236,237,238,239}

most notably at Mid Staffordshire NHS Foundation Trust. The target has also been linked with increased emergency admissions in some hospitals,^{240,241,242} which has been interpreted as evidence of more effective treatment processes,²⁴³ albeit with potential adverse consequences for the treatment of elective patients.²³⁹

Evaluation of the **ambulance response times targets** suggests that the targets led to better clinical outcomes for the small proportion of patients for whom fast response is potentially life-saving,²⁴⁴ but that there is no reliable evidence of an improvement in outcomes for all patients.²⁴⁵ The CQC has recorded high levels of patient satisfaction with ambulance response times, indicating that ‘service responsiveness was at the heart of... experience’.²⁴⁶ A review identified many experiences and reports by individual ambulance services suggesting that targets might be prioritised over patient safety.²⁴⁷ This concern is reflected in a survey of paramedics that also highlighted adverse effects on the health, safety, wellbeing and morale of the profession.²⁴⁸ To achieve the targets, ambulance services made a range of changes to their operations in order to improve response times and build capacity and capability in terms of greater funding, manpower, vehicles and infrastructure.²⁴⁵ Despite this, the targets have been linked with inefficient behaviours such as the over-allocation of response vehicles²⁴⁴ and non-urgent calls being incorrectly categorised, leading to unavailability of resources for genuinely life-threatening situations.^{249,250} Widespread variation in service delivery was interpreted by the NAO as a sign that ‘value for money is not being achieved across the entire network’.²⁴⁴

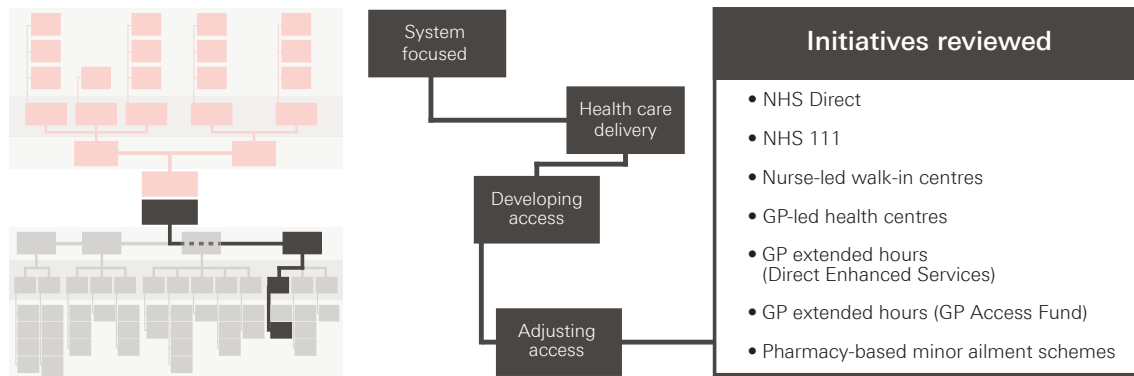
Waits for elective care reduced significantly in response to targets.²⁵¹ Between 1997 and 2007, waiting times in England for patients having elective hip replacement, knee replacement and cataract repair went down and the variation in waiting times for those procedures across socioeconomic groups was reduced.²⁵² However, the NAO has highlighted that median waiting times have steadily increased and that aggregate data masks a great deal of variability in actual waiting times.²⁵³ The original **18-week target** was identified as incentivising NHS trusts to focus unduly on patients recently added to waiting lists, at the cost of patients who may have been waiting longer,²⁵³ though this was subsequently addressed in a change to the target.²⁵⁴ Targets associated with longer-term **waiting times** were not seen to be associated with service improvements in the evidence we examined. Early NAO findings, from 2001, showed 20% of clinicians reported distortion had occurred frequently and 32% that it happened occasionally.²⁵⁵ A later report (2004) found that extensive clinical distortions [due to targets] are likely to have been fairly limited.²⁵⁶ Analysis of the impact of early efforts to target reduced waiting times pointed to gaming, with the NAO naming six NHS trusts where waiting lists had been inappropriately adjusted.²⁵⁵ One survey categorised ‘five types of output-distorting gaming response’ but wasn’t able to quantify the overall impact.²⁵⁷ There has also been criticism that patients do not fully understand their rights and responsibilities under the NHS Constitution – including their right to be treated within 18 weeks and how the time they wait can be affected if they cancel or do not attend appointments.²⁵⁸

Table 17: National target setting – summary of evidence by initiative

Domains of quality	Reducing HCAI	Cancer waiting time standards	Elective care waiting time standards, including 18 week RTT	Ambulance response times	Four hour A&E standard
Safe	Significant reduction in infections Shifted focus to prevention			Improved outcomes for small proportion of high risk patients, but potential impact of inefficient behaviours	
Effective	Significant reduction in infections achieved Reductions in deaths	More cancers detected No evidence of better health outcomes Evidence that faster access could improve cancer outcomes if less variation	Clinical distortions examined, but were limited	Did not improve health outcomes, except for a small proportion of high risk patients	Studies looking at outcomes saw no measurable changes
Efficient	Decreased treatment costs (because of fewer infections)	Felt to have led to service improvements Urgent referral route may not be maximised and so use of emergency routes still high	Opportunities to save money and develop services missed due to focus on target Shorter waits prioritised over patients waiting longer	Evidence of inefficient behaviours used to meet the targets	Focused trusts on wider service improvements Led to increased admissions Evidence of distorted behaviours and gaming
Patient-centred		Reduction in patient anxiety	Patient choices and rights not prioritised	Patients valued responsiveness	Patient satisfaction remains high
Timely		Reductions in waiting times but some adverse effects on other parts of the service	Shorter waiting times Increase in median waiting times Longest wait patients not always prioritised	Evidence that improvements were muted, but maintained in face of rising demand	Shorter waiting times Some evidence of impact on prompt care and time to see clinician
Equitable	Not all trusts able to deliver at same level	Variations in referral rates by GPs for 2-week referrals Not all trusts able to deliver at same level	Not all trusts able to deliver at same level		Evidence that variation between trusts reduced
Number of references found	6	12	12	27	12

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

Health care delivery-focused interventions: Adjusting access



Background

The adjusting access lever here covers initiatives aimed at altering the way patients access health care, especially at the point where a patient first interacts with the NHS. The stated aims are: widening opportunities to access the NHS and clarifying appropriate routes for patients. The initiatives have also been viewed as ways to manage demand and divert patients from overstretched parts of the NHS. Successive governments and strategies have focused on adjusting access to NHS services, and there have been a number of shifts of approach. Specific initiatives have not always been fully developed, implemented or evaluated, and so the long-term impacts have not been reported. Adjusting access initiatives are national initiatives, devised centrally but often implemented locally.

International evidence

Adjusting access as a policy goal aims to ensure the timely use of personal health services to achieve the best possible health outcomes.²⁵⁹ Problems resulting from access issues generate negative effects on health outcomes, patient satisfaction, health care utilisation and costs, and organisational reputation.²⁶⁰

English evidence

The initiatives covered within the adjusting access lever (see table 18) are high profile. We found some evaluations, generally of pilots, as well as individual case studies, which form the basis of the evidence. The evidence we examined did not give a consistent set of messages across the initiatives, or across individual schemes. There was a great deal of commentary and assertion that was often not backed up with evidence-based research relating to impact, but was rather a more general conclusion from observations, or from earlier, international or related work.

Table 18: Description of initiatives reviewed for adjusting access

Initiative	Description
NHS Direct	A nurse-led health advice channel and information service, introduced in 1997, to extend access. This was announced in the government white paper <i>The New NHS: Modern. Dependable</i> . This service was fully implemented, with running costs of £80m a year. The service was closed in 2014 and replaced by NHS 111.
NHS 111	24-hour, 7-day-a-week telephone service for non-emergency health problems, operated by trained non-clinical call handlers, with clinical support from nurse advisors. NHS Pathways software is used to triage calls to different services and home care. The service was piloted in 2010 and has since rolled out nationally. The commissioning of NHS 111 is now led by local CCGs. Around a million people per month use NHS 111.
Nurse-led walk-in centres (WICs)	Announced in 1999, nurse-led WICs aim to provide information and treatment for minor conditions for extended hours, 365 days a year. Initially £30m was invested in 20 centres. Centres were sited in easily accessible locations, such as town centres or adjacent to A&E departments. The range of services and care provided varies greatly. From 2000-10, the NHS opened more than 230 WICs across England. They are now managed by local CCGs.
GP-led health centres	The 2007 Equitable Access to Primary Medical Care programme required each PCT to commission at least one GP-led health centre. The first centre opened in 2008, offering a walk-in and appointments service with extended opening, from 8am–8pm, seven days a week, to registered and non-registered patients. The government initially made £250m available to invest in these centres, although this also included additional funding for 100 extra GP surgeries. The programme was fully implemented by PCTs, but there have been rationalisation and closures since.
GP extended hours	There have been several mechanisms to extend GP hours. We examined evidence of the impact of: <ul style="list-style-type: none"> Financial incentives for GPs to open longer: from 2007 GPs could opt to provide extended opening hours and receive extra funding through the Directed Enhanced Services for Extended Hours scheme. Prime Minister's GP Access Fund (previously Challenge Fund): two funded pilots to improve access and find innovative ways of providing primary care, have generally focused on extending opening hours. Initial funding of £50m for 20 pilot projects in 2013 was extended with a further £125m to fund a further 37 pilots in 2015.
Pharmacy-based minor ailment schemes	Aimed at encouraging patients to consult their community pharmacists about minor ailments rather than visit their GP or an urgent care service, pharmacy-based minor ailment schemes are 'enhanced' services within the community pharmacy contract. Unlike Scotland and Wales, this is not yet a national service but commissioned locally based on local needs.
The lever of adjusting access covers a variety of initiatives that were not reviewed as part of this analysis. This includes: GP out-of-hours services, Minor Injury Units, 3m lives, See and Treat / Hear and Treat and others. Please see appendix C for taxonomy with examples of initiatives.	

Impact on quality

The National Audit Office reporting on **NHS Direct** and **NHS 111** found that both triage services relieved pressures on out-of-hours services and that patients were satisfied with NHS Direct.^{261,262} However, there were unintended impacts, for example increasing access or capacity in one service did not actually reduce demand for another, or potentially generated demand. A review of specific cases dealt with by NHS 111 found that the triage service may increase the workload for A&E departments. Advice for callers to attend A&E

was the appropriate decision for only 27% of cases – 45% should have been advised to attend a primary care out-of-hours centre or a minor injuries unit, and 28% to have self-managed.²⁶³ A review of NHS 111 found that while A&E attendance was relatively rare following NHS 111 calls (7%), over 95% of patients attending A&E had been advised by NHS 111 to follow up with their GP.²⁶⁴ NHS Direct call handlers are also reported to have erred on the side of caution. Studies suggest NHS Direct was used less by ethnic minority groups, non-native English speakers, those in ill health and people from lower socio economic groups.^{265,266,267}

While a quality and safety report into NHS 111 indicated that the service was safe,²⁶⁸ an unpublished but widely reported NHS England review of the death of a 12-month-old child found multiple system errors and the safety of call handlers without medical training had contributed to his death.²⁶⁹ Professor Neena Modi, President of the Royal College of Paediatrics and Child Health, has commented that ‘It is uncertain – because studies have not been adequately conducted – whether or not the telephone triage service, such as NHS 111, is really going to be safe and effective for very small children’.²⁷⁰

For **WICs** the evidence is mixed. A health select committee reported mixed impact on demand for local A&E departments.²⁷¹ One study found WICs have higher costs per consultation than general practice, while another found costs were similar for hospitals with or without a WIC.^{272,273} WICs were not found to have any impact on waiting times to see a GP.²⁷⁴ Local commissioners have closed or reconfigured WICs recently and reported they generated demand and duplication of services.²⁷⁵ The contradictory nature of the available evidence highlights the difficulties in isolating and measuring the impact of adjusting access. Effects are often measured in just one area, preventing a more rounded picture of the dynamics of demand. This gap in the evidence has been observed.^{276,277} WICs performed adequately and safely.^{272,278} WICs appear to be popular with the public though it has been suggested that they increase access inequalities and cause confusion about where to go for care.²⁷⁵

Evidence looking at **GPs extended hours** found that, although demand for appointments increased, it was not only in practices with extended hours, and extended hours did not always replace A&E attendance.²⁷⁵ Promisingly, the first report assessing the **GP Access Fund** pilots found extended hours did not reduce emergency admissions, but self-presentation at A&E with minor illnesses was reduced by 15% and patient satisfaction had not changed.²⁷⁹

Care provided by **pharmacy-based minor ailment schemes** is appropriate and patient satisfaction is high.^{280,281,282} Studies of pharmacy-based minor ailment schemes have found that they saved NHS resources (especially in relation to GP consultations) by preventing patient use of alternative and more costly branches of the NHS.^{283,284,285} A key advocacy report to Pharmacy UK estimated that the average mean cost per consultation for a minor ailment was significantly lower in the pharmacy setting (£29.30), compared with general practice (£82.34) and A&E (£147.09).²⁸⁶ Extrapolating this data, assuming 2.9% of all A&E consultations and 5.5% of GP consultations could be successfully managed by community pharmacists, the NHS could save £1bn a year if they contracted a national service.²⁸⁷

Table 19: Adjusting access – summary of evidence by initiative

Domains of Quality	NHS Direct	NHS 111	Nurse-led walk-in centres	GP-led health centres	GP extended hours	GP Access Fund	Pharmacy Minor Ailment Schemes
Safe	Provided safe service	Reported as safe Unpublished review by NHSE found 16 system failures	Found to have performed adequately and safely				
Effective	Didn't reduce and sometimes increased demand on other services (eg A&E)		National evaluation reported appropriate care provided				Some evidence that pharmacy services are dealing effectively with patients
Efficient	Relieved some pressures on out of hours services	Mixed impact – may have increased A&E workload, while easing demand for out-of-hours services	Both savings and inefficiencies reported	Some centres closing as duplication of resources		Promising early results showing positive impact on minor self-presenting A&E cases	Case studies found positive effects on NHS resources as patients used cost-effective PMAS
Person-centred	Patient satisfaction high	Mixed impact with both complaints and reports of high patient satisfaction		Patient satisfaction generally good Caused confusion on where to go for care	Demand not related to extended hours No evidence on satisfaction	Not impact on patient satisfaction yet	Most evidence from patient surveys suggests patients satisfied
Timely							Patients satisfaction high and survey shows PMAS saved them time
Equitable	Evidence to suggest some inequity of use		Evidence to suggest some inequity of use			Evidence not yet available (but is being examined)	
Number of references found	17	8	17	7	8	5	19

■ Strong impact
 ■ Some impact
 ■ Mixed impact
 ■ No impact
 ■ Possible negative impact
 ■ No evidence

Discussion

The taxonomy presented in this report provides a way of organising the plethora of initiatives by their intention, sorting the evidence on impact and generating debate on this. It enabled us to identify what are known to be best bets to improve quality, and where evidence is ambiguous or lacking for continuing the use of specific approaches or initiatives.

To state the obvious, we found that evaluations of many initiatives are partial, absent and uneven in rigor. They may also not be using optimal methods for what are often not discrete interventions but complex ones which are heavily influenced by context, may have a long lag period and are evolving at varying speeds. We are therefore looking through a glass darkly, but argue that is likely to be more informative than not looking at all. The NHS in England has invested significantly in quality related initiatives and, relative to most international peers, their evaluation. The experience and evidence, such as it is, can have far more value if drawn together and examined. While it is not always possible for policy to be informed by evidence, a clear and identifiable process or mechanism for interpreting evidence could help to formulate reasonable options and design new initiatives to optimise impact. The taxonomy and evidence reviews provide a way of doing this.

Availability of evidence

We reviewed selected quality enhancing initiatives across seven policy levers that have been used to achieve high quality care in the NHS in England in the last two decades. Evidence on the impact on quality of many of these policy initiatives was not centrally collected, assessed or published. However, we identified a significant body of evidence – over 400 studies. The number of studies found is shown in table 20.

Interpreting impact on quality

In assessing the evidence for each initiative, the key challenge was isolating the impact. This was especially true for larger-scale and more complex initiatives. Most initiatives we examined were not implemented in isolation and were influenced by a range of mediating variables; this varied by lever and by initiative. This difficulty has been well described.³²

There were also differences in the scale of the initiatives we reviewed. National Service Frameworks (NSFs) were especially complex. NSFs were umbrellas for multiple policy levers with a range of organisational and service delivery initiatives, and were constantly evaluated over a 10-year time period, sometimes with different or contradictory conclusions. While this makes it difficult to assess impact on quality overall, multiple evaluations allowed evidence-based formative evaluation of the initiatives which helped avoid unintended consequences.

Table 20: Volume of evidence identified

Lever	Initiatives examined	Number of studies
Supporting self-management	Year of Care (YOC) Expert Patient Programme Personal health budgets (PHBs)	29
Creating and developing roles for quality	Emergency care practitioners (ECPs) Modern matrons Clinical Nurse Specialists (CNSs) Community matrons	84
Use of guidelines	NICE clinical guidelines	29
Inspection	Commission for Health Improvement (CHI) Healthcare Commission (HCC) Care Quality Commission (CQC) CQC provider ratings	25
Standard setting	National service frameworks (NSFs) and national strategies including: - NSF Mental Health - NSF Coronary Heart Disease - NSF Older People - NSF Diabetes - NHS Cancer Plan	73
Performance reporting	Consultant Outcomes Publication (COP) MyNHS Quality accounts	22
Target setting	Reducing health care associated infections (HCAI) Cancer waiting time standards Four hour A&E standard Ambulance response times Elective care waiting time standards	80
Adjusting access	NHS Direct NHS 111 Nurse-led walk-in centres (WICs) GP-led health centres GP extended hours (Direct Enhanced Services) GP extended hours (GP access fund) Pharmacy-based minor ailments schemes	81

Many initiatives were at different stages in their evolution: some were established, had been seen through to completion and could be more fully evaluated (eg NSFs, various targets). Others were more recent, not fully embedded and only pilots or the early stages had been evaluated (eg NICE quality standards, NHS 111). For some levers, initiatives had altered over time (or ceased), but this was not always in response to evaluation of their effectiveness.

All of the initiatives were nationally driven, by definition, but were planned and implemented in a range of settings and to varying degrees. For a number of initiatives, local implementation and uptake varied, meaning impact on quality was uneven. We were also aware that it was hard to determine whether impact was driven centrally or locally.

Findings on the domains of quality

We used the IOM domains of quality¹ as a framework for analysing the impact of initiatives, though the volume and quality of evidence varied across the different domains. The initiatives we examined were not designed to achieve impact in all the domains of quality and so where they did not, they are not necessarily a failure. Evidence of impact on safety, timeliness and equity was frequently identified. Impact on patient-centredness was more difficult to quantify objectively and often relied on reported levels of patient satisfaction. Measuring effectiveness and efficiency was also complex: evidence on outcomes and cost-effectiveness were identifiable but infrequent and often difficult to attribute to the policy initiative.

Summary observations about the evidence: what is available and what is needed

Evidence was strongest when an initiative was focused on direct, front-line impact. This was typically the case for person-focused interventions, as they tended to be influenced by fewer variables than system-level initiatives. Evidence was also strongest when the intended effect of a policy lever was clearly directed at a single domain of quality, such as supporting self-management (patient-centred care) or time-based targets (timeliness).

Evidence was more ambiguous when the initiative operated at a national, rather than local, level – typically regulatory and system-management interventions. For this type of initiative the impact could be very challenging to isolate because of the number of variables or differences in local implementation. A time lag is often needed for implementation to be effective and to measure impact, but often not given enough consideration by policymakers desiring outcomes immediately. Unintended and unmeasured effects arising from the influence of the wider context can negate positive impact in other areas. For example, it is challenging to define the overall impact of initiatives if patient satisfaction is reported as high but evidence on clinical outcomes is mixed or contradictory.

Although we have not conducted a systematic review and would not present this work as a comprehensive catalogue of evidence, it is a preliminary interpretation of the evidence available on impact of policy and related initiatives in the NHS in England. The findings were used to develop an illustrative list of ‘best bets’: initiatives that are most promising in enhancing quality of care in England. These are listed here and highlighted as green or amber according to our judgement on the strength of evidence of impact.

People-focused interventions



Supporting self-management

The evidence shows these initiatives result in improvements in wellbeing, self-efficacy, confidence and motivation of individual patients. It also suggests that health outcomes are improved and costs are neutral. The YOC model stands out and is acknowledged as best practice.



Creating and developing new roles in the workforce to improve quality

There was evidence of better use of resources, cost-effectiveness and cost savings in other areas with positive gains in patient experience and safety. Some improvements in health outcomes were noted. We highlight community matrons, CNSs and ECPs for their positive impact on quality.

System-focused interventions



Performance reporting to improve provider performance

We found limited evidence on the impact of performance reporting on quality in the NHS in England. International evidence shows that performance reporting appears to have an effect on the behaviour of provider organisations but less of an effect on patient choice. We found one report of an association between improved mortality and publishing of surgeons' outcomes.



Setting standards and clinical engagement

The NSFs and related activity to implement them positively affected quality, particularly when specialty-focused, for example by improving mortality rates, access, length of stay and patient experience. The NSF CHD stands out as exemplary. NHS Cancer Plan and NSF Mental Health also improved quality. Continuous evaluation, clear implementation strategies and clinical engagement are associated with success.



Target setting when used appropriately

Most initiatives reviewed in this area were found to improve safety and patient experience, though there was significant variation in local practice in response to targets. The HCAI targets impacted positively on quality.



Inspection is necessary but must be balanced by initiatives to support improvement

We identified reports showing inspections had led to greater patient safety and an increased focus of resources on improvement, as well as evidence that recommendations are followed up by organisations. However, we also identified evidence that inspection creates a burden for providers.



Guidelines with implementation strategies

While we identified evidence of the positive impact of the use of guidelines in clinical practice, a link with improved outcomes is complex and harder to demonstrate. Adherence to guidelines is also demonstrably inconsistent, which would reduce their impact. NICE now includes cost impact assessments to published guidance which may improve their impact on quality.



Adjusting access

We found evidence that some initiatives to create new routes of access to health care had generally led to the provision of safe and effective care, but were less likely to meet policy objectives to reduce pressure on other services. The Pharmacy Minor Ailment Scheme stood out on a number of aspects of quality and there was some positive evidence on the impact of NHS Direct and nurse-led walk-in centres.

3. Conclusions and next steps

Conclusions

The government's ambition is to maintain the English NHS as a world-class health system, while meeting other high profile commitments to eliminate the fiscal deficit and achieve a surplus in the public finances.²⁸⁸ Maximising the quality of care that can be delivered within finite resources is a challenge common to every health system, and the fundamental purpose of a quality strategy is to articulate how this will be achieved.²⁸⁹ The economic, political and policy implications of the recent vote for the UK to leave the EU will also add to an increasingly uncertain and complex outlook for the health and care system.

The knowledge and skills – of patients, carers and health professionals – and technology that can be applied to improve the delivery of health services have all advanced more rapidly than the capacity of nations to resource and deliver consistently high quality care for all. All health systems must seek to balance these opportunities against what is feasible within limited resources. Ways this can be done differ between countries: priorities may be set explicitly or implicitly at different levels of the system, with resource limits determined through central planning or as the product of thousands of individual decisions by patients, clinicians or payers. But all health systems can, and should, develop a systemic and strategic approach for delivering high quality health services within finite resources.

Establishing an explicit quality strategy is increasingly common among developed countries, many of which have far more distributed health systems than the English NHS. And, in nations with greater adverse circumstances – such as significant funding and resource deficits, natural disasters or armed conflict – health care leadership is increasingly demonstrating commitment to establishing a strategic approach to quality.

Even after the extensive restructuring undertaken in the last parliament, the national tier of the NHS remains more unified than in many other health systems internationally. Working collectively, policymakers retain the scope to set national priorities, align resources, develop consistent standards of care, implement multi-level quality measurement, ensure maturity of data collection across the whole population, and refine policy. Policymakers can also draw on evidence from the last two decades of substantial investment in quality initiatives and their evaluation to guide decisions. There is clear potential for England to be a world leader in creating an environment that supports significant improvements in health system performance.

As a result of the Health and Social Care Act 2012, a national tier of arm's-length bodies (ALBs) is now operating outside of, but clearly accountable to, the DH. While still in an early stage of organisational development – certainly collectively and in many cases individually – these 'system stewards' together cover most of the main elements of what should be in a quality strategy.* There is now a huge opportunity and responsibility for

* A key element is overall workforce planning, which is influenced by a complex set of institutions, where the Department of Health is responsible for setting strategy and coordination. See the Health Foundation report *Fit for purpose? Workforce policy in the English NHS*.

these national bodies to build a coherent, balanced and compelling near- and longer-term road for the NHS towards greater quality care, and articulate this to the service and others as the primary *raison d'être* for current and future reforms.

Quality must include efficiency. This explicitly tandem approach could motivate staff and patients more than the increasingly prevailing message of 'save money', or reforms obviously stemming from a political vision as to the future of the NHS. This would need to be backed up with the necessary planning, investment and collaboration. Clearly such a strategy needs to accommodate the priorities set out in the Mandate to NHS England by the government of the day, as well as short-term issues that arise. However, it should not be driven by short-term tactical, operational and/or necessarily political considerations, as many key elements need long lead times to develop properly.

The *Five year forward view* (Forward View) is an exemplar for how the national bodies can unite behind a shared vision. The opportunity to build on these foundations to create a well-defined, high functioning national approach to quality – rooted in evidence – not only remains within reach, but is also positively enviable. The work in this report is an example of a structured way of developing such a strategy.

Key points from our analysis

Overall we were struck by the marked consensus that exists among senior leaders as to the diagnosis of issues at national level that block progress towards higher quality care.

Improving quality remains a stated priority, but implementation is weak

The Juran trilogy (see figure 1) holds that achieving high quality within any system requires a framework that balances three equally important core functions: planning, improvement and control.

Following the second Francis Inquiry, strengthening control functions became an understandable and necessary priority. This included substantial changes to how the CQC inspects and regulates providers of health and adult social care services,²⁹⁰ and the creation of a new special measures regime for NHS providers assessed as failing on quality.²⁹¹

But there has not been a concomitant effort devoted to strengthening planning and improvement. The overall effect is that the planning and improvement functions are now underdeveloped and the overall approach to quality is unbalanced, as noted in *Constructive comfort*.²⁹² This points to a need to develop planning and improvement to support providers to make changes (described most recently in The King's Fund report *Improving quality in the English NHS*²⁹³).

Bringing together Monitor and the NHS Trust Development Agency (TDA) under a single executive team to form NHS Improvement from 1 April 2016 has been welcomed as an encouraging development. NHS Improvement's intentions to balance its roles as regulator and performance manager, with genuine support for improvement for NHS trusts, offer

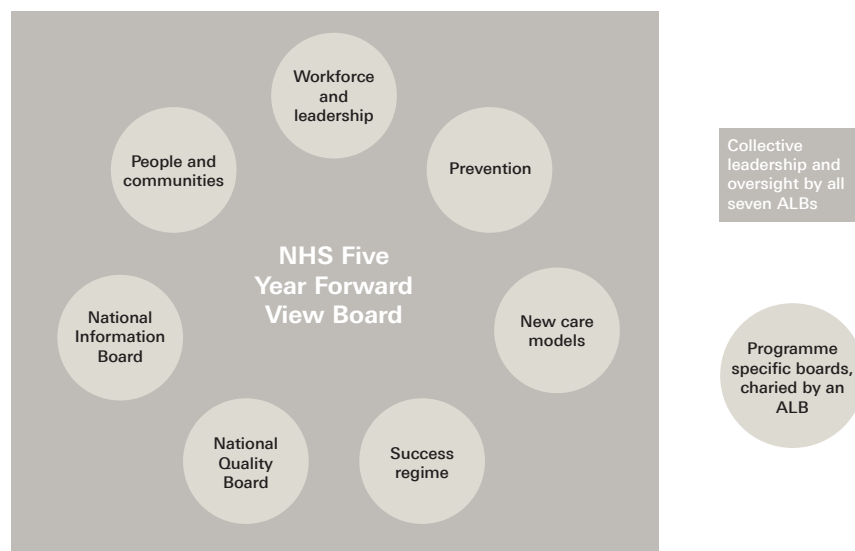
grounds for optimism.²⁹⁴ But this must be weighed against daunting objectives, set out in the Mandate, that in 2016/17 the provider sector will achieve financial balance, secure considerable efficiency savings and recover performance against key national targets.

The remit of NHS Improvement does not extend to proactive support beyond provider trusts. NHS England retains an important role in developing clinical commissioning groups (CCGs) and, through its role in direct commissioning, driving improvements in primary care. The recently announced programme of improvement support for strengthening and redesigning general practice should be a substantial step forward in this area, but financial and workforce issues mean delivering on this will be especially challenging. Designing a coherent short and long term strategy for ‘improvement’, focusing on the objective of accelerating change through supporting front-line staff, is a daunting one for any industry, especially the NHS which is the largest and most complex industry in the UK. But this is now the task at hand. The limits of not doing this are already well known.

National leadership issues

Responsibility for quality is distributed between the national NHS bodies, with no individual or organisation having authority to lead the quality agenda on behalf of the system. Pursuit of a common agenda therefore depends heavily on the nature of the relationships between the national bodies. Following the NHS Next Stage Review, the National Quality Board (NQB) was established to bring the leaders of the national organisations together to promote collective decision making and alignment of plans and actions. As of 1 July 2016 the NQB is now co-chaired by Professor Sir Bruce Keogh (Medical Director at NHS England) and Professor Sir Mike Richards (Chief Inspector of Hospitals at CQC), and the membership includes a number of impressive and highly respected individuals. However, there are concerns that the now primarily clinical membership leaves the NQB with insufficient influence over all of the organisations it represents to make the necessary changes happen. The chief executives of the national bodies instead now sit on the new Five Year Forward View Board (Forward View Board), with the NQB as one of seven subcommittees, as shown in figure 5.²⁹⁵

Figure 5: Governance arrangements for delivering the Forward View



Our analysis found a perceived lack of clarity about the roles and responsibilities of different national bodies in relation to quality. This is not a new issue, but the reforms undertaken in the last parliament appear to have exacerbated the situation. Organisations working on quality issues at national level – including patient organisations, royal colleges and professional regulators – expressed understandable frustration about the difficulties encountered in trying to navigate the system and engage with the national bodies.

‘Since the 2012 Act the system is so fragmented, we now talk to three organisations whereas it was just one organisation before. It’s all become terribly complicated.’

Our analysis focused on national policy in England, and so we did not consider local leadership or governance issues (eg within NHS trusts, across CCGs or Health and Wellbeing Boards or devolved areas in England) to develop the quality of care. There is, of course, a role for national policy in supporting the development of local leadership and governance, as well as creating an environment that allows local organisations to pursue innovative ideas and solutions that have potential to improve quality; for example, the appointment of a chief quality officer to trust boards to provide oversight and leadership on quality.²⁹⁶

Opportunity costs from the surfeit of objectives and requirements

The past few years have seen many policy initiatives in the wake of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, which made 290 recommendations. In response, the government commissioned six independent reviews to examine particular issues highlighted by the Inquiry, each of which made further recommendations. In less than three years, the government published three formal responses to the Francis Inquiry, plus a combined response to the recommendations of the Freedom to Speak Up consultation, the Public Administration Select Committee report, *Investigating clinical incidents in the NHS*, and the Morecambe Bay Investigation. In total, 179 distinct quality related policy initiatives – almost one a week from June 2011 to December 2015 – were announced by government and almost all were explicitly or implicitly assigned to one or more of the national bodies. Nearly 70% (125) of these measures were focused on improving safety, rather than other aspects of quality. With limited headspace to implement them, ‘priority thickets’ may lead organisations to resort to defensive, compliance-based approaches to meeting externally imposed demands, at the expense of internally motivated efforts to improve quality.²⁹⁷

Identifying the opportunity costs of these initiatives was not the purpose of our analysis but they were repeatedly pointed out by the people we interviewed and surveyed.

An unfocused approach to building capability

There are a number of specific national programmes to support the development of new models of care. The Integrated Care Pioneers and Vanguard programmes both offer a central mandate to try out new ways of working, with advice and support from national bodies, alongside access to national expertise and modest funding for cross-programme networking and shared learning. Such programmes are complex and innovative, so realising their potential will require sustained central support, as well as protection from pressure to demonstrate results in the short term.²⁹⁸ Beyond such initiatives, too little

emphasis has been attached to building capability in the essential operational, analytical and change management skills needed to make sustained improvements in quality. These skills will be critical, not only for supporting improvements in quality but also in addressing the issues raised by Lord Carter of Coles in his recent review of productivity and efficiency.²⁹⁹ Case studies demonstrate how local leadership – rather than national support – has been a major factor where providers have been able to build and sustain improvement capability at scale.³⁰⁰ Health Education England (HEE) is already working to include essential quality improvement skills in education and training curricula for front-line clinical staff. The Smith review has also highlighted the need for action on improvement and leadership development,³⁰¹ and NHS Improvement is working to develop its role in this area, including through its partnership with the Health Foundation to develop the Q initiative, a community of people with experience and understanding of improvement from across the UK. * The creation of a new national leadership and development board to lead work in this area is an encouraging development, but one that will need long-term commitment to ensure its efforts are not crowded out by the current focus on short-term priorities and performance. The strategic approaches taken in Scotland and Wales to skilling up the workforce in tried and tested skills for quality improvement would be worth examining further.

Inconsistent arrangements for local accountability

The Forward View acknowledges that the various frameworks used by NHS England, Monitor, NHS TDA and CQC for overseeing the performance of CCGs, foundation trusts (FTs), NHS trusts and primary care contain a number of differences in how national priorities are translated into local action. This is also reflected at regional level, where there are differences of approach between national bodies operating within the same locality, as well as how each body operates in different localities. Few people we spoke to called for the restoration of the Strategic Health Authorities, but a considerable number highlighted that a strong, unified regional tier will be a prerequisite for the development of actionable Sustainability and Transformation Plans (STP) for local health and care systems which progress the quality of care. The devolution deal for Greater Manchester and the ‘success’ regimes for failing health economies were considered by some interviewees to be the potential means for providing regional cohesion, but these remain in early stages of their development.

Asymmetries in measurement and reporting

A large volume of data relating to quality is collected and published by national bodies, but substantial gaps remain in important areas (such as community services and children’s services) while there is considerable duplication in others (such as having multiple channels for public reporting of quality metrics in general practice).³⁰² Information on the quality of NHS services was an area where the previous incarnation of the NQB had undertaken work to construct a roadmap for development of data and metrics,³⁰³ but limited progress appears to have been made on addressing its recommendations. The Health and Social Care Information Centre (HSCIC – renamed NHS Digital from July 2016) could assume a

* For more information about Q, see www.health.org.uk/q

more prominent role in this area. A number of the people we spoke to also highlighted the continuing need for national work on evolving quality measurement and reporting to have greater meaningfulness and utility with NHS providers.

Availability and quality of evidence

Even for the selected analysis undertaken in this report, we found it difficult to find evidence on the progress and impact of many recent initiatives. This is not surprising as the field of evaluating quality related interventions is still relatively new and beset by methodological issues, such as the attribution of impact to discrete interventions when there is almost always a constellation of policy and practice-oriented activities taking place simultaneously. However, England is one of only a small set of countries globally who have invested consistently and considerably in quality related programmes across the past 20 years and does have evidence to help identify what is known, unknown and unknowable. This is a massive undertaking to gather, sort and analyse the admittedly uneven evidence base, and we have made only a preliminary start. With that caveat, we have identified some 'best bets' that should be considered. We have also prioritised where additional evidence analysis can be conducted and where the most important gaps exist.

Next steps

What is needed

The first step is to develop a shared vision of how quality will be improved in the short to long term, and to identify a road with practical steps to be implemented.

As we have noted, the policy and legal changes undertaken since the publication of *High quality care for all* in 2008 offer new opportunities to shape a stronger, more effective strategy for improving the quality achieved by the NHS within the available financial resources.

Establishing a stronger quality strategy to take account of these changes need not be a burdensome and bureaucratic exercise that results in a one-off plan which gathers dust on a shelf. It can be an iterative ‘living’ approach based on a shared understanding of a strategy leading to a clear ‘road’ ahead. Clearly this ‘road’ can build on history, shared understandings, current capabilities and existing infrastructure to become a practical strategy for action. In the first instance, it could form the means to making explicit – and implementing – current priorities on quality. In the medium term, however, it could become fully embedded as a strategic framework for driving improvements in quality across the health service, in a balanced and coherent way.

There is a clear and compelling case for developing a stronger quality strategy, but the question of who should lead its development is less straightforward. Quality is rightly described as ‘everyone’s responsibility’,³⁰⁴ but those responsibilities have been distributed between a greater number of national arm’s length bodies (ALBs). No one officeholder or organisation is solely responsible for quality, with the mechanisms for supporting coordination and collaboration still emergent and immature.

The DH is now the only national organisation with a remit across health, health care and adult social care. The DH retains important functions in supporting ministers to develop government policy for health and care, fulfil their statutory duties – including a duty to improve the quality of NHS services – and discharge their accountability to parliament and the public. However, the DH’s former responsibilities for implementing NHS policy were effectively transferred to the national bodies when the 2012 Act was brought into force in April 2013. This was a major shift in the national governance of the NHS – as highlighted by the recent Organisation for Economic Co-operation and Development (OECD) review of quality in health care in the UK³⁰⁵ – that leaves the DH with a markedly different role to those of the majority of health ministries around the world. Under the current arrangements, the DH should agree the respective operating plans of the national bodies and ensure that these present a coherent, comprehensive and mutually reinforcing set of objectives for the national tier of the NHS. The DH should also hold them to account, individually and collectively, for their performance against these plans.

Responsibility for establishing and embedding a coherent quality strategy for the NHS should therefore fall to the national bodies, working within the current policy and legal framework. The central emphasis should be on how to achieve implementation of quality priorities through a focus on statutory roles, accountabilities and collaborative relationships, rather than structures. A demonstrable sense of shared purpose, collective leadership and alignment of action among the national bodies can mitigate many of the weaknesses in the system, and the Forward View is an exemplar for how the national bodies should – and can – unite behind a shared vision. Recent planning guidance emphasises the need for local organisations to set aside institutional interests and work together as local systems. The national bodies should aim to take a lead in showing how this can be done at national level. This requires coordinated action by the national bodies – acting through the Forward View Board – in a number of areas:

- **Identify a shared view of quality and the ‘road’ ahead:** This should be done along with identifying the priorities for progress and the practical steps forward to achieve them over the short and longer term. This should be done with key stakeholders, including but not limited to national bodies representing clinicians and patients.
- **Articulate a single set of quality goals and a common definition of quality:** The NHS does not lack for priorities and objectives for quality. The national bodies should take the various priorities, actions, objectives and standards set out in a range of documents, and publish a consolidated and balanced set of quality priorities with explicit, measureable goals for improvement. The national bodies should agree a definition of quality to provide a shared conceptual framework and a common language for quality. Various definitions have been developed for different purposes, but none is fundamentally superior to the others. While the Darzi definition commands widespread recognition within the NHS, there is a strong case for broadening the definition beyond safe, effective and experience to include an efficiency dimension, explicitly linking quality to cost, and equity of access to care – especially in the current climate. The five questions used by the Care Quality Commission (CQC) in its inspections of care services is a reasonable option, given their link back to Lord Darzi’s quality definition of safety, effectiveness and experience, their salience with providers, and the role the regulator will take in assessing use of resources.
- **Provide unified national leadership for quality:** The Forward View Board currently provides a unified focus for action across the national bodies at the highest level. The chief executives of the national bodies, who sit on the Board, have the authority to agree to actions on behalf of their organisations and ensure these are followed up. As such, for pragmatic reasons, it should become the main national committee for making decisions about quality. It should be supported in this role by advice from the NQB, acting as the conscience and the intelligence of the system on quality. There should be no expectation that a re-chartered NQB will be an executive committee responsible for overseeing the delivery of particular objectives or plans. Instead, it should act as an expert advisory group with a formal mandate to proactively develop and advance a national agenda for quality for agreement

by the Forward View Board, as well as being commissioned to provide advice to the Board on specific issues. The NQB would also benefit from an expanded membership to include a wider range of organisations operating at national level, such as Healthwatch England and representation from professional organisations and regulators, to secure a greater range of professional and public involvement. As a minimum, the terms of reference for the re-chartered NQB should be to advise the Forward View Board on how best to align plans, actions and resources to support quality. It could also take on a more substantial role in understanding the evidence base on quality interventions, choosing metrics and advising on policy levers, as well as reporting to the public on the state of quality.

- **Build on experience and evidence:** The NHS is a complex adaptive system: national policies do not always achieve the impact intended by policymakers, and may have unintended consequences. Our evidence review concluded that research on the impact of policy on quality provides few definitive answers, but that sensitive use of the available evidence can guide policymakers towards a number of ‘best bets’ that are more likely to have a meaningful impact and more prudently employ limited resources. Important components in a balanced approach to improving quality seem to be:
 - setting evidence-based national standards
 - the creation of National Service Frameworks, involving strong clinical leadership and professional engagement in setting standards across a pathway
 - the focused use of inspection and performance targets
 - well-designed decision support tools for patients and providers.
 - developing new roles – such as community matrons and emergency care practitioners (ECPs) – and building the capability of the NHS workforce
 - exploring and boosting the available evidence base, and actively working to fill the gaps that exist, forming part of a stronger national quality strategy.
- **Update a set of core quality metrics:** Based on advice from the re-chartered NQB, the Forward View Board should co-produce a unified set of core quality measures for the NHS to be used as the basis of performance measurement by all national bodies. The development of the new CCG scorecard, along with a small set of sentinel metrics for GP practices, may provide a useful starting point. Work in this area will require meaningful engagement with a diverse range of stakeholders, but it should be possible to achieve a consensus on a small set of indicators that can be piloted in a small number of local health economies.³⁰⁶
- **Articulate a shared understanding of how improvements in quality and costs are linked and pursue both in tandem:** The national bodies also need to develop a more sophisticated and granular view of the relationship between quality and resources. The conventional wisdom that improving quality will result in lower costs is attractive, but the reality is likely to be more complex. Improving quality can reduce costs in some settings but can also sometimes cost more than

it ultimately saves:³⁰⁷ the goal is to spend where investment matters. Even where investing in quality has the potential to generate savings, upfront investment may be required, benefits can take time to realise and any cash-releasing savings may not automatically accrue to the NHS organisations that made the initial investment. Being explicit where investment and disinvestment may occur, with what intended effects and risk mitigation, would provide a transparent basis for addressing quality within a seriously resource-constrained NHS.

- **Provide unified regional leadership for quality:** The Forward View Board should also consider taking further steps to bring together their various regional and local presences to share information, develop joint working arrangements and streamline requests for information from commissioners and providers. This already happens to some extent, for example through quality surveillance groups, but there is clear potential for achieving much greater alignment.
- **Inform the future quality agenda:** In the previous sections we outline that there are in effect twin tracks to a comprehensive quality strategy. The first is strategy development that is seen across many international health systems to ensure sustainability and progress in quality of care. The second is short-term legitimate government priorities to operationally improve quality. The critical issue at stake now is to tend to both, ensuring that the effort between these twin tracks is right, the approaches are coherent, and also that the balance between planning, control and improvement (the Juran trilogy) is healthy. Under the 2012 Act, this task now falls to the national bodies, which collectively have the autonomy necessary to take this agenda forward. Given the financial stress the NHS is under – and against a backdrop of economic, political and policy upheaval in the wake of the recent vote for the UK to leave the EU – the temptation in practice will be to concentrate on immediate operational and financial issues at hand, rather than the steady approach to maintaining an intelligent strategy to improve quality that is needed.

This report sets out a practical and feasible set of actions for an implementation strategy to safeguard and improve quality within the current priorities, as well as to support the development of the NHS for years to come. The time to act is now.

Appendices and references

Appendix A: How the seven steps were modified

‘Setting direction and priorities’ is added as a new step in response to our qualitative analysis and mapping of the roles of national bodies described above, both of which indicated a significant gap. Some organisations have a perceived role in setting quality priorities for the system (eg Department of Health (DH) via the Mandate). This was not fully captured in the original ‘seven steps’.

‘Measure and publish quality’ was a combination of two of the original ‘seven steps’.² This was done because the organisations who were collating data on quality were often responsible for publishing it. Additionally, in the current context there is a drive to create a more transparent NHS.²¹⁵ As such, measurement and publishing are complementary.

‘Raise standards’ was renamed ‘Build capability’ and retained as a step but updated to incorporate improvement science and capacity building as a mechanism for raising standards as well as the original focus on clinical leadership and management.

‘Stay ahead’ was also retained as a step but expanded to include forward planning by the system as well as research and innovation.

Examples of organisations represented by interviewees

Government and ALBs	Number of Interviews
Department of Health (DH)	27
NHS England	
Care Quality Commission (CQC)	
NHS Improvement (Trust Development Agency [TDA]/Monitor)	
National Institute for Health and Care Excellence (NICE)	
Health Education England (HEE)	
National Voices, General Medical Council (GMC), Nursing and Midwifery Council (NMC), Healthcare Quality Improvement Partnership (HQIP), Patient’s Association, NHS Clinical Commissioners, NHS Confederation, NHS Providers, Faculty of Medical Leadership and Management, Key leaders from trusts and foundation trusts (FTs), Royal Colleges	15

Please note: to protect anonymity, this table is not an exhaustive list.

Appendix B: Analytic framework for evaluating quality enhancing initiatives' impact on quality

IOM domain of quality	Measures of improvement in quality				
Safety	Reduced mortality	Reduced avoidable harm			
Effectiveness	Improved health outcomes	Improved treatment and diagnosis	Improved clinical decision making		
Patient-centredness	Patient satisfaction	Involvement in decision making	Supporting self-management	Improved communications	Reflecting patient voice or rights
Timeliness	Shorter waiting times	Reduced delays			
Efficiency	Cost-effectiveness	Service improvements	Workforce development	Greater strategic focus	Disease prevention
Equity	Reduced inequalities for treatment	Reduced variation in services	Reduced variation in access		

Definitions for Institute of Medicine domains of quality¹

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Decision-making and service provision based on clinical and scientific evidence and knowledge, as well as refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centred:** Providing care that centres on the patient, respecting and responding to individual patient preferences, needs and values and ensuring the patient is in control.
- **Timely:** Reducing waits and delays for both those who receive and those who give care.
- **Efficient:** Providing care that is cost-effective and avoids waste.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

Appendix C: Taxonomy

Table 1: Illustration of contextualisation of Quality Enhancing Initiatives Framework³² to NHS

QEI	NHS	Modifications
Patient-focused interventions	Patient- and public-focused interventions	<p>Interventions to improve access were moved to health care delivery focused interventions as policy initiatives in the NHS in England that aimed to improve access were focused generally on how, where and who delivered the health care rather than access initiatives targeting specific groups of patients.</p> <p>Self-care (self-management) and shared decision making were grouped as a new focus: patient empowerment, which also includes patient activation.</p> <p>Interventions to improve safety were moved to Improvement.</p> <p>Interventions to improve health literacy were changed to health promotion and prevention which also includes prevention programmes and health Promotion.</p> <p>Patient experience was removed as category as we used the Institute of Medicine's (IOM's) domains of quality to analyse the impact of the policy initiatives so patient experience is captured as an outcome. Also, it appears to be a theme that runs throughout the policy initiatives explored, rather than standing alone as an individual group of initiatives.</p>
	Workforce focused interventions	<p>New focus as so many national initiatives focused on workforce planning, workforce engagement, creating and developing new roles, and education and training of workforce. In other health care systems workforce focused interventions tend to be more locally driven and led. There is usually a labour market in other health systems but in the NHS there is a significant national strategic element to workforce focused interventions, and workforce in the NHS is used as a mechanism to drive quality improvement.</p>
Regulatory interventions	Regulatory focused interventions	<p>Increased focus on patient protection including initiatives establishing accountability or statutory declaration and protection of patients' rights.</p> <p>Market regulation removed and initiatives that regarded capacity and supply, including commissioning, and choice and competition, as levers to drive improvement in management of resources were grouped under system management.</p> <p>Management of resources was a focus for national policy initiatives in the NHS in England, whereas in other contexts this appeared to be a more regional or local focus, so the 'market' in the NHS was shaped and overseen in broader ways than market regulation seen in other countries.</p>

QEI	NHS	Modifications
Incentives	System management focused interventions	Incentives were included in the broader focus of 'system management' where initiatives regarded the day-to-day functions of the whole NHS as a system, for example: performance and reporting, targets and standards, incentives, capacity and supply.
Data-driven and IT-based interventions		Many of the initiatives found included data and IT as a part of the broader initiative so this was not included as a specific focus. Public reporting and performance monitoring was moved to system management.
Organisational interventions	Improvement-focused interventions	Organisational interventions were renamed as improvement-focused interventions as many of the initiatives included in this focus were about driving innovation and improvement and aspiring to high quality health care. This focus regarded initiatives that aimed to improve the day-to-day functions of the NHS, to build on the initiatives of the system management focus. Professional behaviour change was moved from here to workforce focused interventions.
Health-care delivery models	Health care delivery focused interventions	As opposed to initiatives that regarded specific areas of health care, eg acute or primary care, or specific specialties, initiatives included here focus on the daily delivery of health care through interactions of patients with the NHS, for example, adjusting access, reducing variation, specialisation or localisation of health care delivery. Health promotion and prevention was moved to patient focused interventions.

Taxonomy with examples of initiatives

Patient and public focused interventions

Category	Lever	Initiative examples
Health promotion and prevention	Health promotion	FAST (stroke) campaign
		Catch it, bin it, kill it
	Prevention programmes	NHS Health Check Programme
		NHS Breast Screening Programme
		NHS Flu Immunisation Programme
		Healthy Child Programme
	Improving health literacy	NHS Choices
		Patient Online
Patient empowerment	Patient activation	NHS Choices
		Ask 3 Questions
		Patient activation measure pilot
	Shared decision making	Decision aids
		National Institute for Health and Care Excellence (NICE) guidance on medicines optimisation
		Right care decision aids
	Supporting self-management	Expert Patient Programme (EPP)
		Year of Care (YOC)
Patient and public involvement	Patient and Public Involvement	Integrated Personalised Commissioning
		Patient participation groups
		Healthwatch

Workforce focused interventions

Category	Lever	Initiative examples
Workforce planning	Workforce architecture	European Working Time Directive for doctors
		NICE safe staffing
		Graduate primary care workers (increase in workforce to meet demands of National Service Frameworks (NSFs))
	Creating and developing roles	Modern matrons
		Community matrons (specialist nurses to offer case management support)
		Further expansion of paramedic role (specialist, advanced consultant)
		Clinical nurse specialists (CNSs)
	Developing workforce	Professional competencies 2015
		Local Education and Training Boards
Workforce engagement	Staff involvement	Annual NHS Staff Survey
		Connecting initiative
	Culture change	Learning not blaming
		Freedom to speak up report
	Workplace health	£5m initiative to improve staff health

Health care delivery focused interventions

Category	Lever	Initiative examples
Developing access	Improved access	National Defibrillator Programme
		Commuter walk-in centres
	Adjusting access	NHS Direct
		NHS 111
		Minor Injury Units
		See and Treat
Service delivery	Integration	Polyclinics in Primary care and Community Strategy 2009
		Integration Pioneer Program
	Localisation	Devolution in Manchester
		Intermediate care
	Specialisation	GPs with special interests
		Cancer networks
		Rapid access chest pain clinics
Capacity planning	Capacity management	NHS-funded nursing care in care homes
		Independent sector treatment centres
		Day surgery

System management focused interventions

Category	Lever	Initiative examples
Managing supply	Commissioning	Clinical commissioning groups (CCGs)
		PCTs
		Cancer Drugs Fund
		Alternative provider medical services contract (APMS)
	Choice and competition	Patient choice of hospital
		Hospital competition
		National booked admissions programme 1999 / Choose and Book
Incentivising	Financial incentives	Quality Outcomes Framework (QOF)
		Payment by results
		NHS Contract penalties
	Patient incentives	Reverse incentives, eg charging for missed appointments
		Vouchers for mothers who breastfeed
	Earned autonomy	Foundation Trust (FT) status
	Enhance reputation	Care Quality Commission (CQC) rating

Category	Lever	Initiative examples
Increasing transparency	Patient feedback	NHS inpatient survey
		Friends and Family Test
		Patient Reported Outcome Measures
	System reporting	CCG outcome indicators
		National Clinical Audits
		Provider ratings
	Provider reporting	Consultants Outcomes Publication
		Quality accounts
Targets and standards setting	Standard setting	NSFs
		NHS Cancer Plan (2000)
		Clinical guidelines
	Target setting	National target to reduce health care associated infections (HCAIs)
		18-week referral to treatment times
		Health care inequalities targets

Regulatory focused interventions

Category	Lever	Initiative examples
Institutional regulation	Accreditation	
	Inspection	Care Quality Commission (CQC)
		Healthcare Commission (HCC) Annual Health Check
		Monitor
		NHS Trust Development Agency (TDA)
	Statutory standards	Fundamental Standards 2014
		Registration
		Licensing
		NHS Outcomes Framework
Patient protections	Patient protection and rights	PALS
		Mandated access to medical records
		Duty of Candour
		NHS Constitution
Professional Regulation	Certification	Care certificates for health care assistants
		CCT-certified completion of training for doctors to become consultants
		Fit and Proper Persons Test
		Disclosure and barring services (CRB)
	Credentialing	
	Registration and licensing	Paramedic, GP, nursing, etc registration
		Licensing
		Revalidation

Improvement focused interventions

Category	Lever	Initiative examples
Reducing variation	Assuring quality	NICE quality standards
		National Peer Review Programme (quality assurance programme that aims to review services and clinical teams to determine compliance with national measures)
		Assurance frameworks for CCGs
	Increasing accountability	Named accountable GP 2014
		Name Above the Bed
		Duty of Candour
	Managing safety and risk	Cleanyourhands campaign
		Surgical checklists
		Independent Patient Safety Investigations Service
		NHS Safety Thermometer
Capacity building	Strengthening leadership and improvement skills	Executive Fast Track Programme, 2013
		Leadership programmes (eg Elizabeth Garrett Anderson Scheme)
		NHS Institute for Innovation and Improvement
	Embedding learning	The Technology Programme (2008) including the Rapid Review Panel (2004)
		National Reporting and Learning System
		Innovate UK 2015 – Businesses to develop health for older people
	Planning/partnering for improvement	Special measures
		Patient Safety Collaboratives
		Sign up to safety
	Sharing knowledge and best practice	Academic Health Science networks (AHSNs)
		Clinical reference groups
		Vanguard sites

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The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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