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Commissioning for performance improvement

This issue of ph.com is dedicated to patient safety and clinical quality. NHS Chief Knowledge Officer, Sir Muir Gray, reflects on maximising value and improving quality in today's NHS.

It is a sad fact of life that half of all services are below average. If all services performed at average levels, the resulting improvement in health and wellbeing would be very significant. Of course, if the average improves, namely if the whole population of services improves, the impact on health and wellbeing would be very significant.

Performance improvement is the term given to this aim and usually involves ensuring that all services improve and those with the furthest to travel are given the most 'help'. The word 'help' covering a multitude of interventions, which could include the removal of the Chief Executive. Because performance is assessed against quality standards as pre-set statements of goodness, the process is sometimes also called 'quality improvement'. Performance improvement is also of central importance in maximising value.

Maximising value
To maximise value, a number of questions have to be asked and the 10 questions are set out below.

1. How much money should we spend on healthcare?
2. How should money be distributed to different populations, e.g. the north and the south?
3. How much money should be top-sliced for management, IT and education?
4. How should money be distributed to different patient groups, e.g. cancer patients or mental health?

When resources have been allocated to a particular group of patients, two further questions have to be asked:

5. What interventions should be provided for this group of patients?
6. Which patients are most likely to benefit?

When all of the above questions have been answered;

7. How can the effectiveness of care be maximised?
8. How can the risks be minimised?
9. How can each patient's experience be enhanced to best effect?
10. How can clinicians be best helped to deliver high quality safe and patient-centred care?

Questions 1, 2 and 3 are out of the commissioner's scope, but questions 4-10 are core responsibilities if efficiency is to be maximised.

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Two types of efficiency

The term 'efficiency' is used in many different ways, if we define it as the relationship between the outcomes of healthcare and the resources invested; it is common to talk about two types of efficiency – allocative efficiency and technical efficiency.

Improving allocative efficiency

Allocative efficiency is the aspect of efficiency dealt with through the distribution of resources. The aim of every commissioner should be to distribute the resources until he/she reaches what is sometimes called the 'point of indifference'. Namely the distribution of resources which maximises benefit and minimises harm; the point at which no more health gain could be obtained or harm prevented, by shifting a pound from one budget to any other budget. Another responsibility of the commissioner is to allocate resources to add years to life and life to years, and to do this as fairly and openly as possible.

Programme budgeting and marginal analysis are skills required to carry out this task which does, however, involve value judgements as well as epidemiological. The importance of these skills is now widely recognised.

Improving technical efficiency

Increasing technical efficiency does offer the opportunity of cash-releasing savings, although there needs to be some return to the programme budget from which these savings were made, otherwise people will hide savings.

It is important at this stage to give some guidelines as to the sort of steps that need to be taken. Resources can be released by increasing productivity, for example by reducing the cost of goods procured, but commissioners should ask providers to demonstrate how they would release resources by changing clinical practice. For example, about £100 million a year is spent on blood testing of people with Type 2 diabetes, although there is no evidence of benefit and some evidence of harm.

Here are some questions that can be asked by commissioners to improve performance:

1. Within the present envelope of resources, is there a clear statement of policy, expressed through the 'Map of Medicine', that can be used to indicate what is required as the core standard?
2. Within the current amount of resources available, are there services delivering care of a standard that is unacceptable?
3. If a service is acceptable, it may still be below average or below the standard reached by the top quartile of services nationally, what can be done without investing additional resources to improve the service?
4. What are the variations, in either expenditure or service delivery, from other services to similar populations, and are these variations reflected by variations in outcome?

The Public Health Commissioning Network (PHCN)

Discussions about the NHS focus on PCTs, SHAs and Foundation Trusts and all the jargon of the current structure (the author's 22nd). However, these are no more the core businesses of the NHS than showrooms, service centres and factories are the core business of car manufacturing. Our core business consists of health problems such as cigarette smoking or headache or epilepsy. These should be the focus of commissioners. Last year the NHS spent over £500 million on asthma, an average of £6 million per PCT, but do we know what value was produced by that business?

The mission of the PHCN for England, which is supported by the 'NHS Institute for Innovation', 'World Class Commissioning' and 'Informing Healthier Choices', is to transform the focus of commissioning from primary and secondary care to these systems of care so that both allocative and technical efficiency can be maximised.

Sir Muir Gray
Chief Knowledge Officer
NHS

from the editor

The quality of healthcare is not strained…!

This issue of *ph.com* is dedicated to the intricately interwoven themes of clinical quality and patient safety, which are very dear to clinicians, the public and to public health, and which are now at the top of the NHS agenda thanks to Lord Darzi and his sentinel NHS document *High Quality Care for All*.

Sir Muir Gray's lead article emphasises the importance of commissioning for performance improvement, highlights efficiency as one of the enduring pillars of quality, and describes the pivotal role he envisages for the newly established Public Health Commissioning Network (PHCN) for England. Bernard Crump is the author of the first of two articles from the trail-blazing NHS Institute for Innovation and Improvement. Commissioning for social care quality sits along side an article from the Care Quality Commission. NICE writes about the impending reform of the Quality and Outcomes Framework (QOF) in primary care. Quality assurance for screening programmes gets a special mention.

Doncaster PCT shares its experience on 'Commissioning for Quality and Innovation (CQUIN)', as does the Wirral NHS Trust on the pioneering 'North West Pay for Quality Scheme'. 'Dancing with Wolves' brings out the unquestionable importance of public health proactively engaging with clinicians on the healthcare quality agenda. NHS Quality Observatories will play important roles in robustly interpreting contentious quality measures like hospital standardised mortality rates (HSMR).

Patient safety finds a prominent space in this newsletter. Articles from CEMACH, NPSA, NCAS and NCEPOD, all highlight the central role they play in the NHS in protecting and advancing patient safety of the highest order.

Scotland, Wales and Northern Ireland have all contributed sterling articles on quality and patient safety initiatives. Valuable lessons can be learnt from the achievements of NHS Quality Improvement Scotland, the 'Saving 1000 Lives' campaign in Wales and the development of service frameworks in Northern Ireland.

The eclectic range of articles in this newsletter demonstrates the widespread tentacles of public health across a multitude of healthcare quality and patient safety fields. Undoubtedly, public health needs to provide facilitative leadership and evidenced-based direction in symbiotic collaboration with the clinicians. Divorcing one from the other will spell disaster and strike a mortal blow to the long-term nurturing and sustenance of these hallowed concepts.

In conclusion, I am reminded of an immortal quotation from John Ruskin "Quality is never an accident. It is always the result of intelligent effort".

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One of the great joys of this job is, you often find yourself in the company of civil servants.

At dinner the other evening I had the pleasure of sitting next to someone high up in the Department of Health. Very high up. As the conversation weaved deftly around quality metrics, patient journeys and clinical dashboards, I was beginning to think he was trying to sell me a Porsche. When I ventured to mention the role of public health in all this, it became obvious that his idea of what we do was no more than promoting healthy lifestyles. “All those campaigns and stuff” he said. “We have to do it of course – the Minister likes it. But it doesn’t really work does it?”

When I’d recovered enough to retrieve my soup-spoon from his lap, I tried to explain that health promotion, aka health improvement, was just one of the three main domains of public health. There were also the crucially important areas of health protection and healthcare quality (I gave a few familiar examples) – not to mention health informatics and public health research.

All this was a complete eye-opener to him. He had no idea that public health skills and competencies extended across such a wide range of health and healthcare areas. He thought of PH people as well-meaning but ineffectual tree-huggers doing fluffy things in the community – a million miles away from cutting-edge hospital or primary care. He was simply not aware of the contribution that we can and do make to high quality, effective and safe healthcare. And this person was in charge of a large chunk of the NHS agenda! It was a profoundly depressing encounter.

Lesson: there’s an ever-present need to engage with, inform and educate our non-public health colleagues as to what we’re about. These key decision-makers, especially those in the clinical arena, need to know how we can help them do their job so much better, by applying a population perspective and providing PH skills and expertise.

That’s why we have themed this issue of *ph.com* on clinical quality and patient safety – and assembled a selection of useful insights, experiences and examples. Whichever part of the UK or overseas you work in, at whatever level, in whatever setting, the chances are you’ll be interacting with clinical quality in one form or another. From commissioning to service evaluation, from prevention in general practice to high-cost cases in tertiary services, and from breastfeeding in children’s centres to palliation in end-of-life care.

In England, the agenda is dominated by Darzi’s *High Quality Care for All* strategy and the many strands of work that flow from it. The key principle is that change should be evidence-based, patient-centred and clinically driven. Our strength here is around the evidence and epidemiology, and the assessment of need, appropriateness, acceptability and effectiveness. With all these things, we can do it better – and we should be in there proving our worth.

More and more of us already are often doubling as medical director, a role that carries very direct responsibility for quality and safety. Indeed, the post-Darzi programme involves employing medical directors at SHA, as well as trust and PCT level. Establishing a quality hierarchy from front-line services right up to the national medical director and a soon-to-be-established National Quality Board, will provide a kind of quality assurance of the quality function. The metrics feeding this whole process will be collated and analysed by a network of regional ‘quality observatories’ which (as I suggested to the very-high-up, soup-spattered civil servant) should be closely allied to (or better still, part of) our already well-established public health observatories. We shall see.

Changing the subject abruptly… You can’t have failed to notice the sudden omnipresence of Charles Darwin. The great man is everywhere, greater than ever. Once confined to a small area on the back of the £10 note, greater bearded Darwins have proliferated with such rapidity that they now outnumber Galapagos finches. Well adapted to almost any habitat – from TV documentary to magazine feature, and from radio play to pub quiz – the ubiquitous Darwin is a triumph of natural selection and niche marketing.

I wonder whether Health Secretary Alan Johnson might have been inspired by Darwin in launching his latest campaign, *Change4Life*. It’s all about tackling the obesity time-bomb, by creating a ‘people’s movement’ for healthy eating and active living. Families up and down the land, especially those with young children, are being blitzed with surveys, advice packs, quizzes, events, online networks and other assorted motivators in a three-year £75 million ultra-campaign. Commercial partners in this mammoth effort include Tesco, Co-op, Flora and… wait for it… Pepsico, so there’s little chance of escape.

If the flower of England’s youth can survive this onslaught, and if the government’s commitment to this initiative is matched by an even greater commitment to do something significant about our obesogenic environment, then I think *Change4Life* could just turn the tide. Let’s give it our support anyway and exploit the opportunity it creates for us.

Which brings us back to Darwin. As the great man himself might have said – survival is all about jumping on the bandwagon, and knowing when to jump off.

To comment on this editorial email Alan at **comments@fph.org.uk**

Pledge to help save the planet!

There is still time to add your ‘signature’ to the rapidly growing list of health professionals, who undertake to actively engage in tackling climate change and to advocate for an agreed global framework with redistribution of resources.

The Climate and Health Council is an international organisation and part of a registered charity, Knowledge into Action. Their aim is to mobilise health professionals across the world to take action to limit climate change, a serious threat to human health. Any health professional and any health or health care organisation can become a member.

Seems reasonable?

All you have to do is visit **www.climateandhealth.org** and click on the green ‘sign our pledge’ button

As you will see from the photograph London and the FPH were severely affected by the recent snow. Despite the difficulty for staff travelling to work, we only lost one day due to the weather! My thanks to the membership who understood the difficulties, and to the staff for their efforts to come into work.

We are now in a position to review performance during 2008. Having started the year with an agreed deficit budget we managed to bring the year to a close with a slight surplus. This has been achieved by careful and prudent management within the organisation. The Senior Management Team worked hard to ensure that costs are kept to a minimum, introduced cost-cutting measures and reduced waste. Each post as it has become vacant has been reviewed looking at the functions and needs of the organisation before deciding whether to recruit into the vacancy.

Whilst our investments have taken a hit from the downturn the FPH has not lost as much as other organisations. Working closely with our investment managers, the Risk Management, Audit and Finance Committee have reduced the impact as much as possible. We expect this current economic environment to continue for the foreseeable future so continued vigilance will be required throughout 2009.

As the economic climate continues to cause concern, these and other measures form part of the usual operating practices within the FPH. My thanks to officers and senior staff for their support and innovation in making 2008 both productive and cost-effective.

In February the FPH Board agreed to accept the resignations of the FPH's Lease Trustees. Both Sandy McCara and Jim Dunlop have acted in this capacity since the FPH moved into 4 St Andrews Place – taking legal and custodial custody of the building. Our sincere thanks to both Sandy and Jim for their wise and knowledgeable management of this important function.

The new Lease Trustees agreed by the Board are:

- Selena Gray
- Liz Scott
- Keith Williams

I am sure that these three Fellows will ensure that our building remains in safe hands once they take up their duties.

Finally please remember to book your place at this year's Annual Conference, to be held in Scarborough between 16 – 18 June. The programme promises to be one of our best to date.

Full details are available at **www.publichealthconferences.org.uk**. We look forward to seeing you there.

Leading for health

Evidence, policy and practice

Scarborough,
16-18 June
2009

The Faculty of Public Health's 2009 annual conference will focus on how we as public health professionals translate our knowledge, skills and expertise into leading-edge public health practice, and how we can shape the specialty to deliver health and wellbeing in the 21st century.

The conference will explore those big issues that cut across the full breadth of public health - from workforce and commissioning, to violence and the public health legacy of the Olympics. A wide range of top-level speakers are already confirmed, with further announcements to be made leading up to the conference.

So for your chance to shape the debate, and for further information on the conference including programme updates, registration, and exhibition and sponsorship opportunities visit our conference website at **www.publichealthconferences.org.uk.**

The Faculty of Public Health Annual Conference for public health professionals

Revalidation

Members will be aware that the General Medical Council (GMC) has begun its communication regarding revalidation and the licence to practice. We are currently working on our response to the GMC's regulations consultation (running from end January to end April). These regulations are vital to the options our medical members will have to both hold registration and re-licence with the GMC. The UKPHR has also indicated its wish to revalidate its registrants. The new regulatory framework is at the crux of our profession. We on the FPH Revalidation Working Group continue our work feeding into the Academy of Royal Colleges and the Revalidation Development Group. We will feedback our response on the consultation in the next issue.

Progress on the precise mechanisms for revalidation remains slow, due to the number and complexity of organisations required to feed into the process. Stakeholders include the Department of Health, the GMC and the Royal Colleges and Faculties, as well as agencies employed to run scoping consultations.

We have recently fed into an Information Management Scoping project from the DH and the DH's first draft indicators of the role and remit of the Local Responsible Officers (LROs).

FPH members' interests are well-served on the working groups of the Academy Revalidation Development Group (ARDG). We have submitted draft standards of public health practice to the Academy, and are pleased to report our specialty standards can be easily mapped across into the generic standards of the GMC framework. These encompass four domains: knowledge, skills and performance; safety and quality; communication and partnership; and teamwork. I chair the non-clinical working group of the ARDG, and administrative members of the Professional Affairs team are represented on the group exploring the technical implications of an e-portfolio. Finally, Dr Emilia Crighton represents FPH on the Directors of CPD group, responsible for setting baseline standards across all specialities in audit and credit requirements.

FPH's current CPD arrangements are robust for revalidation, but we have been awarded £50,000 by the Academy to scope our CPD further in 2009 and look into other technical solutions.

Our main priority is to ensure that the final model for revalidation, has provision for the diverse employment settings of our members and flexibility enough, when applying evaluation measures and processes, to recognise that public health consultants largely have no patient contact.

We will keep all members fully informed as revalidation develops this year. Our main message for members now though, is that CPD and enhanced appraisal systems will be central to whatever process emerges. We encourage all, whether from medical or other backgrounds, to engage fully with Personal Development Plans, CPD activities that map into them and assessment of their impact on public health practice.

Dr Steve George
Vice-President and Chair of FPH PH Standards and Knowledge Committee

CPD

Fulfilling your CPD obligations for revalidation should be straightforward for members enrolled with the FPH's CPD programme.

As we begin the CPD cycle for 2009, it is maybe just worth reminding members how appraisal, personal development plans (PDPs) and CPD should fit together for a coherent approach to professional development. Employers are increasingly building CPD activities into job plans with responsibility on both the employee and employer to ensure they are properly undertaken.

Your employment-based PDP should be agreed through your employment appraisal process. It should be signed by your appraiser and dated. The content of PDPs should reflect both your professional and job related development needs. These should cover three areas – your ability to do your job, your competence as a public health consultant and should also reflect any further career aspirations. Do bear in mind that the FPH CPD cycle is January to December so your CPD year may well be relating to two personal development plans.

When reflecting on your CPD needs, it is worth considering all learning opportunities, formal or informal. As well as courses and events, CPD can include 'on the job' learning, audit and reflection and also private study. The CPD section of the website identifies the different credits that are awarded.

The most important part of a CPD activity is what it achieves for you, rather than the summary of the learning event. These reflective notes are at the core of FPH's CPD programme. They need not be lengthy but should reflect on how the learning was relevant for you, and vitally, how it will now impact on your practice and any follow-up or additional needs or implications. Whether you choose to record your thoughts immediately or let it sink in depends on your personal way of working. The important thing is to ensure that the implications of your learning are carefully considered and physically recorded.

Dr Anne Mackie
CPD Director

Don't forget the deadline for 2008 CPD submissions is 31 March

Be active, be healthy

FPH warmly welcomes the Department of Health's new physical activity plan for England, Be active, be healthy. The plan aims to get two million more people active by the time by 2012, and focuses on everyday activities rather than sport.

Among its recommendations are the need to set up a 'world-class delivery infrastructure' for physical activity and a multi-agency, multi-sector Physical Activity Alliance to steer implementation of the plan.

FPH President, Dr Alan Maryon-Davis, commented: "This plan is good news. It gives us the basic route map and describes the necessary local infrastructure. But now we need real investment, from the commercial as well as statutory sectors, if we, as a nation, are going to take those first steps and keep going.'

Be active, be healthy establishes a new framework for the delivery of physical activity alongside sport for the period leading up to the London 2012 Olympic Games, Paralympic Games and beyond. Programmes outlined in the plan will contribute to Government's ambition to leave a lasting legacy from the Games.

Be active, be healthy also sets out new ideas for Local Authorities and PCT's to help determine and respond to the needs of their local populations, providing and encouraging more physical activity, which will benefit individuals and communities, as well as delivering overall cost savings.

More information can be found at **http://tinyurl.com/dd6596**

Care Quality Commission – what it could do to ensure quality in healthcare

The quality of healthcare is a complex business. It is always a challenge to define it while encompassing the needs and views of patients, professionals, managers, the public and any other stakeholders at the same time. The way quality is perceived by the patients and carers is at times different to the way it gets defined and measured by professionals.

Whichever way quality of healthcare is defined, the role of an independent regulator is paramount in safeguarding it. There have been some key developments in the regulatory landscape of the health and social care system in England recently.

A new integrated regulator for health and adult social care, the Care Quality Commission (CQC), was established on 1 October 2008. The CQC will takeover the role of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission from 1 April 2009.

The CQC may become the largest regulator responsible for the whole care sector in Europe, covering a population of 50 million, employing approximately 2.9 million people, spending over £100 billion of public money and delivering services through 30,000 organisations.

The CQC is currently deliberating on how to introduce some new approaches to deal with the quality challenge. These could include: establishing a mandatory registration system (based on minimum required standards) for all the service providers, developing a 'light touch', proportionate and risk-based approach using intelligent information, improving patients experience as the core of its regulatory activities, and regulating the public, private and voluntary services providers on the same standards. This should ensure that patients can, of their own wish, move easily between providers and different sectors without compromising the quality of their care within the health and adult social care system in England.

The first major challenge for the CQC will be to deal with those organisations with a poor Healthcare Associated Infection (HCAI) record. A new HCAI registration system will begin in April 09 to deal with that challenge.

The CQC is also endeavouring to assess the commissioners for their performance on assessment of population health outcomes for the first time. A complete picture of the state of population health or of a health/social care entity cannot easily be made without joining forces with other regulators and organisations on the ground. The CQC is keen to do this through a number of mechanisms e.g. Comprehensive Area Assessment, risk summits and gate-keeping.

It is important to remember that regulation is not the only way and CQC is the not the only organisation responsible for ensuring the quality and patient safety in healthcare. There are a number of other initiatives in the *High quality care for all: NHS Next Stage Review* report to deal with the quality chasm in the NHS. CQC needs to complement those initiatives through joined-up methodologies, whether it is about setting standards, measuring quality or acting decisively to deal with poorly performing organisations.

Finally, we should understand that quality is a co-production and the success only comes when everyone plays their part effectively, a lesson we could learn from other countries like Holland, Sweden and the USA.

Dr Mahmood Adil
Medical Director
Care Quality Commission
Establishment Team
Department of Health for England

NICE and the Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services contract in 2004. It was a pioneering approach to improving quality of care through a voluntary incentive scheme, rewarding GP practices for how well they care for their patients. The ultimate purpose of the QOF is to add years to life and life to years.

From the beginning there was almost universal participation of GP practices and high levels of achievement. The latest figures for the QOF show that practices have continued to deliver improvements in services for patients, with real progress being made in addressing health inequalities between affluent and more deprived areas.

The *NHS Next Stage Review* outlined the vision for primary and community care, which placed continuous quality improvement and an increased focus on preventing ill health at its heart. It described the intention for the QOF to continue to support GP practices in delivering outcomes for patients that are among the best in the world, and that it should be continuously reviewed to reflect up-to-date evidence of best practice.

The Department of Health (DH) has asked NICE to lead and manage a new independent, objective and transparent process. Its focus will be developing and reviewing QOF clinical and health improvement indicators from April 2009, as part of its role in providing guidance for the NHS based on evidence of clinical and cost effectiveness.

The process will involve NICE reviewing existing QOF indicators, prioritising areas for new indicators, and developing and recommending new indicators through the work of an external contractor. This will be informed by open consultation with stakeholders, including patients and professional groups. A national menu of indicators will be made available through the NICE website from which NHS Employers (on behalf of the DH) would negotiate with the British Medical Association on which should be applied nationally (or with the agreement of the devolved administrations, across the UK as a whole) and what the value of those indicators should be.

The DH has proposed that primary care trusts could potentially select indicators that reflect local priorities, using either resources devolved for this purpose or other local resources.

The aims and objectives of the new process are to:

- Ensure that all stakeholders have a clear opportunity to contribute to the development of indicators.
- Address topics of importance to patients, professionals and the health of the public, and help health professionals.
- Address health inequalities.
- Base indicators on evidence of clinical and cost effectiveness and make the best use of NHS resources.
- Ensure there is an objective and transparent system for setting the value of QOF indicators.
- Review existing indicators regularly.
- Test indicators through piloting to consider whether they are workable.
- Ensure all methods are inclusive, open, transparent and consistently applied.
- Ensure there are appropriate governance structures and working arrangements with other parties in place.

Work is underway at NICE to prepare for April 2009. NICE is currently recruiting for a variety of roles. For more information on the process or how to get involved, please visit the NICE website on **http://www.nice.org.uk**

Nicola Bent Associate Director
Implementation Systems
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Val Moore
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Quality Assurance (QA) in screening programmes

All screening programmes bring a mix of benefit and harm. Good ones bring more benefit than harm.

A screening programme takes an unsuspecting group of people and plants the seed of doubt in their minds by telling them they are at risk of something which they may (or most likely not) have been worrying about.

It then tests them for it, tells them that they may (or may not) be at greater or lesser risk of having the condition and then recommends further testing or treatment.

There will be people who would rather not have known, people who have been made anxious unnecessarily and those who are told they have a problem when in fact they don't and undergo unnecessary tests and treatments. And there will be people whose lives are saved, prolonged or made more comfortable by the programme.

This adds up to a moral requirement to make the screening programme deliver as much good and avoid as much harm as humanly possible. We know that once released from the research environment into the wild, the benefits promised by careful oversight of an idea and rigid adherence to protocols doesn't quite materialize in the real world that is the NHS.

Hence QA

QA has a long and distinguished history in industry and some of its principles have been applied in NHS screening programmes. These have been most obviously applied in cancer programmes. Peer reviewed articles showing evidence of benefit are few and far between, but those professionals involved in screening would agree the performance of cervical screening after QA was introduced, is hugely better than in pre QA days.

The National Screening Committee (NSC) recommends unselected populations be offered the opportunity to be screened for a series of conditions with the intention of reducing or managing the risk:

- Breast, cervix and bowel cancer
- Antenatal Down's syndrome
- Fetal anomalies detectable by ultrasound
- Antenatal hepatitis B, HIV, rubella susceptibility and syphilis
- Antenatal sickle cell and thalassaemia
- Newborn hearing
- Newborn bloodspot screening for phenylketonuria, congenital hypothyroidism, cystic fibrosis, medium chain acyl-coA dehydrogenase deficiency and sickle cell
- Newborn physical screening for congenital dislocation of the hip, heart disease, cataracts and undescended testes
- Diabetic retinal screening
- Abdominal aortic aneurysm (currently in the very first stages of roll out)

Only breast, cervix (in the near future bowel), hearing and diabetic retinopathy screening have formal funded QA activities at the moment.

The director of programmes of the NSC and regional directors of public health are jointly sponsoring a piece of work to address this gap and develop robust QA programmes for all screening activities.

Something else makes screening special

A screening programme is exactly that: *a programme*, not a test and while most clinical activities are also pathways, rarely are they treated quite so clearly. Most problems in screening are found where the pathways join. QA provides an insight into these issues and is a vital part of making the system work safely.

Dr Anne Mackie
Director of Programmes for the UK NSC

Commissioning for quality in social care

The recent winds of change in social care have brought about developments in the concept of commissioning for quality in social care, which is quite different from regulatory and legal requirements.

The 1980s introduced the inspection of nursing homes, with its emphasis on safety, continuity, respect, skills and prompt delivery. The NHS and Community Care Act 1990 introduced the externalisation of internal market controls on providers which gained momentum, leading to regulating standards and exacting inspections. Domiciliary care was regulated at the turn of this century, but today services still lack even voluntary standards.

Regulation and published standards, however, still did not guarantee quality. Some local authorities put in place voluntary star ratings, additional to existing standards. Residential homes could gain stars (and enhanced payments) on a voluntary basis. This was not universally accepted. Dissatisfied local authorities could not close rural services and disadvantage vulnerable people without any alternative service provision.

The registration of care staff, alongside minimum training and development requirements and a Criminal Records Bureau (CRB) check, have been introduced over the last eight years, but it is still incomplete. It allows for registration refusals and withdrawals but relies upon people getting caught. Robust whistle-blowing procedures need to be introduced as a safe-guarding measure.

These requirements, many of them legal, but all with additional costs, are routinely reflected in commissioning specifications. Commissioners may seek to increase existing specifications by adding specific caveats like minimum wage payment for staff, enhanced training and development, proper supervisory systems and improved policy frameworks for staff to work within.

Two challenging issues still present routinely: whose quality are we talking about and what is quality? In the first instance, some in the disability movement have found that the 'one size fits all' regulation has prevented them from making personal decisions. They would argue they do not require others to make decisions on their behalf. Why should they not be free to take risks like ordinary people? The question of restrictive accepted standards is now being debated along with issues of risk management and risk-taking.

It is difficult to answer precisely what quality is. The potentially restrictive nature of establishing hard and fast regulatory frameworks to impose a view not universally shared, is compounded by the problems of observing personal and often private practice and the burden of a financial framework that can only afford services which are societally undervalued and under-funded.

To counter these difficulties, commissioners are trying to focus specifically on allowing people to have defined budgets allocated to them. Making direct decisions regarding spend on service provision (known as Individual Budgets). Along with moving towards a new structure of commissioning for outcomes (results), rather than outputs (for example numbers of hours). This fundamental shift in thinking is still in its early stages, but is intended to produce greater satisfaction for individuals and better returns on investment for public money.

Traditional commissioning and block contracts in many areas of direct service provision will gradually give way to be replaced by pick and choose menus giving greater flexibility and choice to meet individual need.

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Dancing with wolves

Public health practice and its location have evolved in many ways since the origins of the FPH. It grew from the triumvirate of medical specialties of public health, medical administration and social and preventive medicine. Its placement has been subject to repeated re-organisation and in recent years has focussed rightly in many respects, on health inequalities and wider health determinants.

The role of public health in working with clinicians (the old medical administration function) has all but disappeared. However, the provision of healthcare remains an important part of the public's health, not least in the commissioning of affordable and cost-effective health care but in ensuring its quality, safety, and of course equity.

Darzi has emphasised the role clinicians should play in the quality agenda and this edition of *ph.com* covers centrally developed work, although often led by public health practitioners, but increasingly being directed by clinical specialists.

Some of my public health commissioning colleagues bemoan the loss of the links with clinicians and their networks and I quote – *"There is a reluctance to engage practising clinicians in commissioning – including specialist doctors – based on the assumption that clinicians are necessarily on the wrong side of the provider/commissioner split. Yet clinical expertise is crucial to effective service specification and evaluation. Action will be needed to overcome these barriers."*

"We are struggling to engage our interventional cardiologists in these discussions about treatment thresholds…."

How might we address this?
Those in commissioning environments can build these links, but clearly it is a challenge. I offer another route, to develop further the placement of public health practitioners in provider units. There is a small dedicated band of public health practitioners in Trusts, who all have established links with clinicians and clinical networks.

In the North West, for example, I have developed links in the field of hip fracture care, working closely with the National Falls and Fracture Audit, the National Hip Fracture Database (NHFD), the DH commissioning toolkit for falls and fractures and the Institute of Health Improvement on hip fracture care.

Furthermore, with local clinical leads, I have established a forum spanning parts of the North West involving different acute trusts and clinicians from all specialties (nurses, doctors and PAMS) involved in the frontline care of these patients.

We have carried out a serial region-wide audit of hip fracture care and will continue this programme with links into the NHFD. We have identified auditable quality criteria and standards that have been made available to commissioners and a draft document that is the basis of a future quality-led service level agreement.

We are working with the Greater Manchester Public Health Practice Unit to develop this agreement and establish a firmer commissioning footing with provider and clinician involvement.

Hip fracture is not a sexy subject but it is the major part of trauma care. It is an exemplar marker condition for assessing quality of providers. It is a focus of Dr Foster monitoring and of national interest. We have an enthusiastic band of clinical frontline staff who care about the quality of what they do and appreciate having the support of public health in this way. This is but one area and one model of influencing and working with clinicians and the new 'medical administrators' or medical directors and linking back into commissioning colleagues.

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The North West 'Pay for Quality' Scheme

October 2008 marked the beginning of the first full year of Advancing Quality, the North West's three-year healthcare improvement programme. The programme will give patients a better experience, a better quality of life and more influence in their healthcare. It aims to demonstrate that improvements can be made to the quality of patient care, whilst also reducing costs for hospitals.

Advancing Quality currently focuses on improving the quality of care in five key areas – heart attacks, community acquired pneumonia, heart failure, primary hip and knee replacements and heart bypass operations. It is based on a US system developed by Premier Inc. Each clinical area has a set of evidence-based measures, and data are collected showing whether the measures have been administered, monitored or carried out. So for heart attacks, for example, measures include aspirin on arrival and prescribed at discharge, fibrinolysis received within 30 minutes of arrival and smoking cessation advice given.

Patients will also have more influence, with their experiences of the care they received in hospital being taken into account, and acted on through patient experience and patient reported outcome measures. To begin with, there has been a focus on hip and knee replacement in line with the operating framework 09/10. This work is being co-ordinated by the Royal College of Surgeons. These measures will also count towards the hospital's results, due to be publicly reported in spring 2010.

Reinvestment in health services will be made to hospitals that do well. The programme is designed to reduce re-admission rates, length of stay, complications and deaths. All of which means extra resources for patient care, saving lives in the North West. It's estimated the programme will reduce costs for the NHS by up to £17million.

The systems to deliver Advancing Quality are different in every hospital and for each condition, so the impact on staff will vary. In Wirral, we decided to follow the US model and have as much pro-active audit as possible. For hip/knee replacements an audit form moves with the patient from the ward to theatre and back. For heart attacks, the Trust already resourced the MINAP audit, so the work flow has been altered to ensure patients receive these measures. For all conditions, there is a certain amount of data verification and retrospective audit that needs to occur. It is too soon to see real change, but our smoking cessation referral rates have risen four fold in three months.

The data on each of the measures is analysed and the verified information is about six months in arrears. However, the system we are using allows us to feed back unverified data to the clinical teams on a monthly basis for individual measures. This has been powerful in terms of improving compliance.

The Advancing Quality programme is a transparent and accessible measurement of quality that NHS staff, patients and the public can all understand. It will reward and acknowledge the skills and expertise of clinicians, enabling them to expand their skills through the sharing of learning and best practice.

Dr M J Maxwell FFPH
Director of Clinical Effectiveness
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Reporting and learning: an evolving paradigm

With the Reporting and Learning System at its heart, the National Reporting and Learning Service (NRLS) is the division of the National Patient Safety Agency (NPSA) given the task of analysing patient safety incidents and providing learning for the NHS.

Initially the underlying model was simple: if staff were encouraged to report incidents, without fear of blame, then they would willingly do so. Analysis of these incidents by the agency would identify solutions to these problems. These solutions could be given to the NHS, which would act on the advice and healthcare would be safer. With the reporting system now five years old, the NRLS is using this maturity to further develop the model, using the wisdom gained from its experience.

It has certainly proved to be the case that with little direct pressure from the agency, staff have been willing to report in increasing numbers. Reports now number over three million and the overall rate of reporting continues to increase. If success could be measured by volume, then the reporting arm of the service would be judged very favourably. However, there are some caveats.

Not all sectors report well. Primary care, for example, has very low reporting rates, with less than 0.5% of reports coming from this sector. Very little is known about patient safety incidents occurring in the sector where most healthcare is delivered. Nurses are good reporters, but consultants are very poor reporters. It is difficult to engage senior clinicians in a generic reporting system.

In order to overcome these problems, the NRLS has been undertaking two pilot projects aimed at improving reporting from general practice and anaesthesia. Working with the Royal College of Anaesthetists and the Royal College of General Practitioners, two bespoke reporting systems have been developed with input from senior clinicians. The anaesthetic pilot has been completed and shows that the bespoke system significantly improves the level of reporting from consultants.

Initially the NRLS produced detailed patient safety solutions that, when evaluated, proved difficult for organisations to implement. Over the last 18 months, simpler solutions have been developed using a one page format outlining the problems and describing possible actions to help prevent patients being harmed in the future. NHS organisations are also provided with supporting information outlining detailed data from the reporting system and advice on implementation. These rapid response reports cover a wide range of issues from resuscitation in mental health to the risks of amphotericin toxicity.

The challenges to improving patient safety in healthcare remain significant. The use of a reporting system as the basis for improvement has its critics. Voluntary reporting of incidents, especially those where patients suffer real harm, can be difficult to defend. Quantifying the improvement in safety is very difficult with reporting rates being too unreliable to use for this function.

The aim of the service is to develop the NHS into a high resilience organisation comparable to the aviation industry. Healthcare is now very complex and the changes are going to be incremental rather than dramatic.

Dr Kevin Cleary
Medical Director
National Patient Safety Agency

Dr Sukhmeet Panesar
Clinical Advisor
National Patient Safety Agency

The National Clinical Assessment Service – helping resolve performance concerns

The work of the National Clinical Assessment Service (NCAS), eight years on from its creation, is now a central part of governance and quality across the whole of healthcare in the UK. At present it focuses on individual doctors and dentists and their practice and from April 2009, its remit extends to pharmacists. To date it has received more than 6,000 referrals from employers and contracting organisations, as well as self-referrals from individual practitioners themselves.

Information on the size and scope of the problem of poor practitioner performance is limited, but for more than a decade, the international literature has shown a consistent figure in relation to hospital doctors. According to Donaldson's study in the northern region of the NHS, just over 1% of any population of hospital doctors each year get into enough difficulty to seek outside help to understand, address and resolve the concerns. Similar data for dentists, pharmacists and doctors practising in primary or community settings are not yet available. The true 'epidemiology' of poor clinical performance across a whole healthcare system remains unclear, but NCAS' experience and anecdotal evidence from colleagues around the world suggest that the figure quoted above is fairly consistent.

So, only a very small proportion of practitioners get into difficulties, but the impact of those difficulties can be great both for patients, their families and for the healthcare resources the consequent action consumes. NCAS' role is to respond to requests for advice, support and help in local responses to concerns about the performance of individual practitioners. The aim of that work is to clarify the concerns, to understand what might be contributing to them and shape recommendations on how they may be resolved.

When concerns arise about a practitioner's performance, their employer or contracting organisation is expected to seek advice from NCAS on how to address the problem. There is no general requirement to consult on all cases involving concerns. Where suspension or exclusion is being considered however, NHS bodies in England and Northern Ireland must seek NCAS' advice before proceeding to formal exclusion. All other healthcare bodies, including foundation trusts, are advised to do so.

To help resolve concerns about a practitioner's performance, NCAS offers:

- Advice from experts with backgrounds in clinical practice, healthcare management and human resources, signposting to other resources to help manage the concern.
- Specialist interventions including facilitation, mediation, performance assessment, action planning and back to work support.
- Shared learning, not only through publishing aggregated information from case experience, evaluation and research, but also through our education programme aimed at helping build local expertise.

A key insight into the place NCAS occupies in clinical governance structures arises from its statutory instrument and directions. These outline a prime directive – public protection – and set out a series of directions to service delivery, which are essentially developmental to local governance structures and developmental to practitioner performance.

More information on the services offered by NCAS and a helpful toolkit on managing performance concerns is available at **http://www.ncas.npsa.nhs.uk/toolkit/introduction**

Dr Peter Old
Associate Medical Director
National Clinical Assessment Service

Professor Alastair Scotland
Medical Director
National Clinical Assessment Service

CEMACH: the role of confidential enquiry in patient safety and clinical quality

The Confidential Enquiry into Maternal and Child Health (CEMACH) is one of three national confidential enquiries. It was established in April 2003 and amalgamated two previous organisations, the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) and the Confidential Enquiry into Maternal Deaths (CEMD). It operates across the UK and is funded by the health departments of all four UK nations. The lead commissioning role is provided by the National Patient Safety Agency (NPSA).

Confidential enquiry originated in the 1950s, when the medical profession sought to establish a system, to share the lessons learned from a maternal death with colleagues throughout the country, in an environment that did not seek to apportion blame. The remit of CEMACH now extends to mothers, babies and children and includes morbidity and well as mortality. Recently completed projects include diabetes in pregnancy and a review of children's deaths. Current projects include obesity in pregnancy and severe head injury in children. This is in addition to CEMACH's ongoing work on maternal and perinatal mortality.

Confidential enquiry makes a unique contribution within a wide range of research and audit techniques. It peer reviews adverse outcomes, often death, to identify avoidable factors associated with that outcome. During the review process the quality of care is assessed against evidence based standards, wherever possible, to help identify avoidable factors. Avoidable factors are then aggregated to identify lessons of wider relevance thus providing a mechanism for system-wide learning from individual events. Where applicable a case control approach is used to enhance the scientific robustness of the findings.

Confidential enquiry makes a unique contribution within a wide range of research and audit techniques. It peer reviews adverse outcomes, often death, to identify avoidable factors associated with that outcome.

Whether adverse outcomes in patient care can be avoided is fundamental to confidential enquiry. Whilst some adverse outcomes can clearly be avoided, in the vast majority of cases there are shades of grey and it is not possible to be certain. To this end CEMACH's most recently published study *Why Children Die: A Pilot Study* identified avoidable factors, rather than avoidable deaths. This study found that of the 119 deaths subjected to full enquiry, 26% involved avoidable factors. Particular issues identified were a failure to recognise illness, a lack of recognition of mental health problems in children who commit suicide, and a failure to follow up appointments in children who do not attend outpatient appointments.

In reality, this study only scratched the surface and the understanding of avoidable factors associated with child deaths remains poor. The dataset developed for it, has been used by the Department for Children, Schools and Families (DCSF) in developing their own dataset for national child death data collection in use from 1 April 2008.

It is now the remit of Local Safeguarding Children's Boards (LSCBs) to learn lessons from individual deaths and retain an overview of all deaths in their area and CEMACH has been working with a number of LSCBs in England to help them establish such mechanisms.

For further information please visit www.cemach.org.uk

Dr Shona Golightly
Director of Research and Development
The Confidential Enquiry into Maternal and Child Health (CEMACH)

NCEPOD – learning lessons

The quality of clinical care the medical profession might aspire to and the care which an individual patient might realistically expect to receive would, in an ideal world, be the same.

It is inevitable that despite best intentions, there will be instances where there will be gaps between the aspirations of the service and the reality of the delivery for some patients some of the time. The mission of the teams running and working with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is to find those gaps and to suggest ways to narrow them.

NCEPOD (colloquially known as n-c-pod) publishes two or three reports a year. In the last two years we have investigated four areas of high-volume, big-impact health care:

- Cancer patients who died within 30 days of receiving chemotherapy.
- Coronary surgery operations where the patient died postoperatively.
- Emergency medical patients who died or were managed in intensive care.
- Trauma victims with high injury scores.

In each example we are probing the gap between aspiration and reality.

The topics for study are selected by the Steering Group which has members from most of the medical specialties, nursing, the Royal Colleges and outside medicine. The topics are debated and selected in what can be very lively sessions, since they arise from pre-existing areas of concern.

It has been remarked that since we already know there is a problem, couldn't a group of experts simply write a report? Would not the recommendations be much the same?

“Primum non nocerum… First do no harm”

No one could argue with wanting our healthcare to be as safe as possible and to deliver the best quality care we can afford, so the logic of the NHS Next Steps review is unimpeachable. All quality improvement initiatives require good quality data, intelligently used to make a difference, hence the strong focus on metrics and measurement.

Perhaps the highest level indicator of secondary care quality is the Hospital Standardised Mortality Rate (HSMR) published by the NHS Trust as part of the Good Hospital Guide. Indicators are at their most useful if they lead to appropriate action and are more likely to do that if they meet basic criteria.

How does the HSMR do?
Hospitals where more people die than expected might be thought to be less safe than others with lower SMRs, but it is important to look at three aspects of the construction of the HSMR. The HSMR compares observed deaths in a trust with expected deaths applying national age and sex, deprivation, co-morbidity adjusted rates calculated from hospital episode statistics. It does not include all deaths in hospital, only those admissions where the primary diagnosis is one of a group of 56 which “contribute to 80% of all hospital deaths”. This requires that coding of primary diagnosis should be complete and accurate. Certainly in the past the proportion of potentially eligible deaths has varied widely between trusts due to poor coding, improving the apparent performance of some units.

Secondly, it is possible to identify catchment areas and populations for NHS trusts, and estimate the proportion of all deaths in that area which occur in hospital. On average about 50% of all deaths occur in hospital, but it varies widely from trust to trust from about 40% up to 65%.

Clearly the greater the proportion of these deaths which occur in hospital,the higher the HSMR. HSMRs are highly correlated with this proportion and adjusting for place of death can dramatically alter HSMR values. This may reflect a lack of access to nursing homes, hospices or sufficient support for death at home, or discharge policies, rather any direct hospital failings. A more robust indicator may be to look at case-fatality rates at 30 or 60 days, it may also indicate a sicker population. One way this is adjusted is using the Charlson index which scores co-morbidity and relies on secondary diagnoses in HES. It appears that the more secondary diagnoses are completed by the trust, the lower the HSMR.
Thirdly, fair comparison depends on appropriate risk adjustment, especially for case-mix. Ideally we would have a standard system, but coding differences mean that adjustment for case-mix may be incomplete. A recently identified problem is the constant risk fallacy. Essentially this says, it is false to assume that the underlying risks due to variations in case-mix are constant across all units, and that adjustment can introduce bias or worsen existing bias. This can have unpredictable effects on the HSMR.

What does it all mean? Although it is intuitively appealing to have a summary figure for hospital quality, the HSMR alone is inadequate and at best is indicative of something worthy of further investigation. It is highly likely that that something will initially be an investigation of the data rather than any launch into investigating quality. We should insist on seeing unadjusted SMRs, data relating to depth of coding and to catchment area deaths. Ideally we should have adjusted and unadjusted case-fatality rates.

More work is needed on the methods and necessity of case-mix adjustment. Finally, we do not distinguish avoidable from unavoidable hospital deaths. Recent investigations suggest that patients receiving palliative care in hospital are simply not being recognized and recorded in hospital episode statistics.

Ultimately, transparent reporting of healthcare quality is essential and this should go hand in hand with improving data quality, and improved methods for both indicator development and presentation.

Dr Julian Flowers
Director
ERPHO, Cambridge

from the dead

There is some truth in the premise – we go looking for trouble and we find it. That we know the conclusions already? It might look like that at times but it is not the truth. The process of collecting data even-handedly, scrutinising the records in peer review groups, quantifying and tabulating is the NCEPOD method. It is unquestionably laborious and arguably rigorous, but it is a research method ‘fit for purpose’.

We are very aware of the subjective nature of our conclusions. We do not and will not draw statistical inferences, so we do not litter the paper with p-values. Unlike a clinical trial, we are not seeking to answer a single research question in a defined sample with pre-specified outcomes. While we can illustrate our findings with ‘for instance’ vignettes, we cannot be sure of the denominator, so often cannot conclude that the outcomes would have been better if another course of action were followed.

Twenty years ago, using the example of what is now commonly called ‘the c-pod theatre’, it was observed that among the postoperative deaths there was a recurring pattern. In the small hours of the morning, trainee surgeons and anaesthetists were operating on some of the sickest patients who had come in on the previous days take. Many of these operations were being done at night, not because of extreme urgency, but because during the day the operating theatres were fully occupied by consultant surgeons and anaesthetists doing elective surgery. There are some things that need to be changed and it does not require a randomised control trial to prove it.

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Clinical Operational Research Unit (CORU),
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and Chairman NCEPOD

Quality intelligence

In June 2008 Lord Darzi published *High Quality Care for All: NHS next stage review*. He argued that the intelligent and appropriate use of information is paramount to achieving high quality, universal care, and tasked Strategic Health Authorities to establish quality observatories to enable:

- *"local benchmarking"*
- *"the development of metrics"*
- *"The identification of opportunities to help frontline staff innovate and improve the services they offer".*
  (Department of Health, 2008, p 53)

Additional impetus has since been provided by the 2008 *State of Healthcare Report* by the Healthcare Commission, highlighting significant improvements in the quality of healthcare to patients, but also emphasising a number of key areas where improvements are well overdue.

What should a quality observatory do?
Building on existing regional infrastructure, quality observatories should develop and provide intelligence to healthcare providers, commissioners and those responsible for performance to inform decisions and steer the system reforms necessary to ensure continued quality improvements. Additionally, through local, regional and national networks, they should provide a focus for the dialogue between the population and the NHS by providing information on healthy life-styles, informing patient choice and collating patient and public views on NHS services.

To quote Lord Darzi, *"we can only be sure to improve what we can actually measure."* (Department of Health, 2008). Therefore, quality observatories in partnership with each other, and local, regional and national stakeholders will define, develop and produce metrics which measure quality across the whole care pathway. This will include evaluating the limitations and reliability of the datasets and maintaining pressure on the system to improve their collection, availability and quality.

However, the quality agenda stretches far beyond metric development; it is about ensuring quality throughout the whole system. Quality observatory outputs will include not only the metrics, but reviews of the clinical effectiveness literature, national guidance, and information on patient safety, performance, patient experience and, where necessary, clinical audit and budgeting data.

These developments must focus not only on what is best for the individual, but also on an evaluation of equity in relation to the use of, access to, or uptake of services.

The role of quality observatories is therefore to monitor quality and provide an alert when there are variations in quality, deviations from standards and when these lead to inequalities. Their role also includes linking these concerns with the evidence base on how to improve quality.

Work programmes will be defined by regional and local strategic and clinical priorities, in consultation with patients, the public, clinicians, providers and commissioners. Because of this wide range of stakeholders, the independence of quality observatory must be respected by all parties.

The exact form quality observatories will take is yet to be decided, but whatever the solution, observation alone is not enough, it must lead to action.

Paul Brown
Deputy Director, South West Public Health Observatory

Dr Gabriel Scally
RDPH, South West England

Dr. Julia Verne
Director of SWPHO & Deputy Regional Director of Public Health

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Measurement for improvement, not judgement

Dr Jonathon Gray is a director on the '1000 Lives Campaign', an ambitious programme to improve patient safety and the quality of healthcare services throughout Wales. Its aims are bold – to prevent 1,000 unnecessary deaths and 50,000 causes of harm in Welsh healthcare over a two-year period.

Gray is adamant this is not another target-setting exercise, but a long-term plan to help deliver a first-class health service: "The '1000 Lives Campaign' is about measurement for improvement, not judgement. By acknowledging the issues surrounding unintentional harm in healthcare, we can be honest about the need to do something now."

Avoiding risks
"We know that healthcare in Wales, just like in other developed countries, has risks. It's sometimes unsafe and patients suffer unnecessary injury" says Gray. We also know that if we implement care well, we can avoid many of those risks. We have countless, marvellous examples of staff already working in those ways and this campaign is about building on this good work for the future."

Gray saw first hand how important and successful a campaign of this nature can be. While working with the Institute for Healthcare Improvement in the US, he witnessed the progress of the *100,000 Lives Campaign* which is the model on which the Welsh campaign is based.

"I was so inspired by the 'can do' spirit of the people who worked on the campaign in the States," says Gray. "I have to admit to being completely cynical at the start, but as I watched it unfold, I began to believe that anything was possible. In just three months, more than half of the hospitals in the USA had signed up to the campaign and had begun the process of saving lives. I suddenly thought, if they can do that in a country of their size, then we should be able to at least match it in Wales."

When Gray returned to the UK, he saw a window of opportunity to launch a similar campaign when he was involved in the Healthcare Quality Improvement Plan (QuIP), which set out clear actions to minimise avoidable death and harm.

Harm in the system
He soon realised, to put in place the necessary actions to bring about change and improvement, would mean taking an honest appraisal of the problems which currently exist in Welsh healthcare.

Confidence
Every NHS Trust and LHB in Wales has signed up to implement the Campaign and this enthusiastic response has given Gray confidence that significant improvements can be made.

"We are delighted that there has been such a high level of support" says Gray. "We know we need to capture the hearts and minds of our frontline staff to make this a success and we hope that the aims of the Campaign, which is to save lives, will remind staff of the reasons they joined the NHS."

For further information, visit **www.1000livescampaign.wales.nhs.uk**

Professor Jonathon Gray
Director of Healthcare Improvement
Wales Centre for Health

NHS Quality Improvement Scotland

NHS Quality Improvement Scotland (NHS QIS) was established as a special health board in 2003. It brought together a number of organisations including the Clinical Standards Board for Scotland, the Health Technology Board for Scotland, and in 2005 the Scottish Intercollegiate Guidelines Network (SIGN).

Since then, we have worked closely with healthcare professionals, researchers, decision-makers, patients and the public, to improve the quality of NHS care. This has been achieved through promoting best practice, knowledge management, patient safety and clinical governance.

The six dimensions of quality: safety, effectiveness, patient centeredness, timeliness, efficiency and equity, provide the framework for our approach. To deliver an integrated cycle of improvement, we provide advice and guidance on effective clinical practice (including national standards), drive and support implementation, assess NHS performance, and publish our reports in the public domain.

Improving safety
With the Institute for Healthcare Improvement as a partner, the Scottish Patient Safety Programme (SPSP) was launched in 2007. SPSP is unique worldwide as a national intervention, and uses evidence-based tools and techniques to improve the reliability and safety of everyday healthcare systems and processes through cultural change.

Initial goals relate to intensive care, medicines management, general wards and perioperative care, within an overarching theme of promoting safety leadership. This has been highly successful in engaging front-line teams in practical ways. We will continue to develop the work of SPSP in adult acute services, and will work towards involving primary care and paediatric services.

Reducing Healthcare Associated Infection (HAI) is a key national priority. We are translating the various national policy directives and initiatives into a framework, which includes new HAI Standards (with self-assessment tool), MRSA screening, prudent antimicrobial prescribing, and interventions linked to the SPSP programme. We are also setting up an HAI inspectorate to assess the effectiveness of the service's care practices, equipment, premises and organisational systems in preventing and controlling HAI.

Improving Quality
NHS QIS has developed clinical governance and risk management standards and we are about to embark on a second round of peer reviews of health boards. Other key programmes include cancer (including screening), heart disease and stroke, mental health, long-term conditions, primary care and nutritional care. Recent examples of other work include five SIGN guidelines on coronary heart disease.

Improving Health
We are focusing on three main areas: maternal and child health, alcohol misuse and sexual health. Standards development is carried out by a diverse range of stakeholders representing a wide range of service users, and includes the responsibilities of individuals in maintaining their own health and wellbeing.

We aim to develop a much stronger focus on support for implementation and improvement, and on knowledge management. There is a significant challenge in effecting quality improvement across a wide range of health services, and this requires the most up-to-date knowledge and best practice in quality improvement techniques within NHS QIS.

For more information visit **http://www.nhshealthquality.org**

Dr Peter Christie, Medical Adviser, Healthcare Associated Infection and CPHM, NHS Quality Improvement Scotland

Iain Wallace, Interim Medical Director, NHS Quality Improvement Scotland

Quality = Safety and Standards

Quality, like beauty, is in the eye of the beholder. The word seems to be everywhere in health and social care these days, not just here in Northern Ireland! But what does it mean? And does it mean the same thing to different people, patients or clients, policy makers, service providers, and carers?

The USA's Institute of Medicine (IOM) defines quality as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*

The IOM, went on to coin the term STEEEP, which defines that all health and social care should be Safe, Timely, Effective, Efficient, Equitable, and Patient-centred. In his review of the NHS in 2008, Lord Darzi highlighted three key components of quality: safety, patient experience and effectiveness (or standards) of care. The quality agenda for us is one focused on the patient/client, standards and safety.

The SQS Directorate in the Department of Health, Social Services and Public Safety (DHSSPS)
In 2007, the DHSSPS created the Safety, Quality and Standards Directorate (SQSD) in the Chief Medical Officer's group. This established a team of policy, administrative and professional people, tasked with ensuring a clearer and more proactive focus on quality, along three key dimensions – namely, patient/client focus, safety and standards.

One of the most innovative programmes of work to be led by the SQS Directorate concerns the development of service frameworks. The first wave of these service frameworks, deals with the most significant causes of ill-health and disability: cardiovascular health and wellbeing, respiratory health and wellbeing, cancer prevention, treatment and care, mental health and wellbeing, and learning disability.

Service frameworks will set out the evidence-based standard of care patients, clients and their carers can expect to receive and will be used by commissioners and providers to drive measurable improvements.

The future for quality
The future work programme for SQSD is varied and extensive. Clearly there is work needed in the future to ensure there are clear communication protocols with new Health & Social Care in Northern Ireland (HSC) bodies like the new HSC Board, Public Health Agency and Patient Client Council.

Most importantly, the Directorate will work closely with all HSC bodies to develop a 10 year strategy for service quality. That strategy will provide a clear vision for safety, quality and standards in the HSC to guide service design and development long-term.

Over the next two years we will restructure and enhance our adverse incident reporting and learning systems, introduce a new complaints procedure and further develop the service frameworks for children and older people's health and wellbeing.

A firm foundation for safety, quality and standards has been laid in recent years, providing a platform from which to venture forward. This will require sustained effort, clear vision and a focus on effective delivery, to ensure the Northern Ireland health and social care system really can claim to provide the highest quality service along all the quality dimensions for the benefit of its people. The SQS Directorate will seek to provide the leadership needed to make that aspiration a reality.

Dr Jim Livingstone, Director of Safety, Quality and Standards
Department of Health, Social Services and Public Safety, Northern Ireland

An NHS Institute Fellowship: discovering approaches to quality improvement

The NHS Institute's call for Fellowships applications came at the right time for me. In November 2007, I was coming up to five years as a director of public health, a fascinating role with many challenges. But it gave me much less time than I wanted to focus on improving health care – my primary interest in public health.

I had led on local hospital contracts on quality and safety – agreeing relevant measures and targets and wanted opportunities to take this further.

I knew relatively little about the NHS Institute before I applied, but the opportunity to develop the commissioner's role in quality and to update myself on quality improvement methods seemed too good to miss. In short, I started in Coventry four months later, alongside three other Fellows, all doctors, with a second in public health.

It rapidly became clear that as the policy agenda changed, more commissioners were focusing on quality. It was (thankfully) no longer a minority sport. In looking for a distinctive contribution, I was struck by the growth of information on quality, and the contrasting difficultly in understanding many reports on it.

Fortunately, many disciplines outside healthcare have taken significant steps in understanding and using data efficiently. Building on this, I spent much of my year working up two examples of efficient data presentation. The first – for commissioners of primary care epilepsy services the second – a hospital based project for using data on patient safety.

Firstly the implications of this work for presentation and use of any data are, to apply an understanding of visual perception and working memory. Using what we know about colour and pattern perception and our capacity to process information, can make a huge difference to the chance of being understood.

The second is the potential use of statistical process control (SPC) methods as part of our routine toolkit. Many already use funnel plots to explore differences in health status and service performance between places at a fixed point in time. Repeated measures over time allow insight into variation and potential methods for improvement. A brief summary of this is included in the recent *Good Indicators Guide*.

Alongside my own project, training opened new possibilities for me. I participated in a senior clinical leaders programme run by Intermountain Healthcare, a health care insurer and hospital provider in Utah, that has taken quality to its heart for more than a decade.

I've had almost a year back in my host PCTs – focused much more on levers for commissioners to improve quality and outcomes. This agenda is now moving to centre-stage.

The challenge is now to ensure this renewed interest, will mean better results from healthcare and better experiences of it by those who need it most. To be successful we will have to draw on existing public health values and skills, and be open to new approaches.

Dr Mark Lambert
Fellow of the NHS Institute, Consultant Epidemiologist
South of Tyne and Wear PCTs

Commissioning for quality: the Doncaster model

NHS Doncaster has used Lord Darzi's national reform agenda to drive forward a local change programme to improve the quality of healthcare. The PCT is committed to empowering clinicians to improving the quality of care, and has devised a local incentivised Quality Outcomes Framework scheme for acute, mental health and PCT provider arm services which will compliment the DH Quality and Innovation (CQUIN) payment framework. It was the result of a literature review of sanctions and rewards, discussions with Institutes of Higher Education and visits to explore the Boston 'Quality Model'.

We experienced a number of challenges familiar to DH in the development of the national CQUIN programme, namely the issues of improvement versus accountability, local ownership versus national bench-marking, and transparency versus competition.

The three Quality Outcomes Framework schemes are discreet areas of work, but take account of the individual organisation, the availability of local intelligence and data, and the priorities of our patients.

Our provider organisations can collect, collate and monitor a range of data and information, which is reflected in our quality indicator schedules.

We developed a model, based on the principles of improving access to services, targeting and reducing areas of local health inequality and improving the patient experience.

The indicators are either evidence based or intend to develop our local intelligence and are based on patient safety, clinical priorities and organisational measures. Signing up to the scheme is voluntary, and currently no financial penalties apply to the scheme.

A similar process was used for developing the different schedules in partnership with the individual providers.

Clinical engagement has been fundamental to the successful development of the indicators and we invited a range of managers and clinicians to a series of workshops and events in order to agree those areas where indicators would be developed.

Financial principles were agreed at the start of the process and we recognised that our providers needed support to engage in the development of the indicators.

Assurance frameworks are important and 2008/09 has been our 'pathfinder year' and we have agreed a range of monitoring tools including setting of trajectories, random sampling and audit.

There is incongruence between performance against national indicators and patient satisfaction and by triangulating national performance data and information, regional benchmarking and local patient experience, the PCT will hopefully develop a range of patient reported experience measures that will enhance the local assurance framework.

Discussions with the providers started in late 2007 and a range of 'aspirational indicators' have now been incorporated into the 2008/09 contracts and will be reviewed next year.

It's too early to demonstrate changes in behaviour and provide robust evidence of improved quality of care with better outcomes for patients. This has been a learning experience over the last year and developing the indicators has been about building relationships, breaking down barriers and effectively managing change. Board to ward commitment and grass-roots clinical engagement has been fundamental to our success.

Dee Sissons, Deputy Director of Quality and Clinical Assurance

Dr Rupert Suckling, Deputy Director of Public Health
Doncaster PCT

Measurement for quality improvement at a regional level – the South East Coast approach

South East Coast SHA is taking a transformational approach to improving the quality of care delivered to patients.

An overall vision for high quality care is outlined in *Healthier People, Excellent Care*, which sets out the pledges of the SHA for health and healthcare over the next 10 years. In order to deliver on this vision, the SHA has realigned its senior team and directorates to focus on the delivery and development of clinical leadership, led by a Medical Director and supported by a Director of Innovation and Technology.

A quality observatory and a quality board have been established, to drive forward work to improve quality. The quality observatory will provide data analysis, support organisations across the SHA with data monitoring, and support clinicians and managers with measurement and interpretation. The quality board will steer the *Healthier People, Excellent Care* programme, ensuring the delivery of its key pledges over the next decade.

South East Coast SHA are also actively pursuing the possibility of developing an Advancing Quality programme as pioneered by NHS North West.

Quality improvement at the local level – NHS East Sussex Downs and Weald & Hastings and Rother

A quality improvement and clinical outcomes group, chaired by the Director of Public Health and Medical Director, has been established to lead on the quality agenda and drive forward work to establish and monitor clinical outcomes.

The group's vision is to meet and surpass the expectations of patients for high quality services. A quality report is being developed to focus on around 15 indicators which have been selected, following consultation with stakeholders, for their impact on local patient care.

The PCT is developing a local commissioning for quality and innovation scheme which is likely to focus on the quality of maternity services, stroke services, clinical coding, discharge information and the patient experience. It has also been proposed to use the CQUIN scheme as a lever to promote the use of the WHO's surgical checklist and increase provision of single-sex accommodation.

The PCT is using a range of other mechanisms to drive up quality including a health status dashboard, the specification of quality measurement within SLAs, the development of clinical metrics within Community Services, and the establishment of a primary care balanced scorecard.

Diana Grice, Faculty of Public Health Board Member for the South East

Yvonne Doyle, Regional Director of Public Health South East Coast

Update on National Support Teams

The Infant Mortality National Support Team

Although infant mortality in England is at an all-time low and falling, significant inequalities persist. The Infant Mortality National Support Team (NST) was established in autumn 2008, to help local health economies meet the health inequalities infant mortality PSA target by:

- Helping them to reduce infant mortality in the routine and manual group and other disadvantaged populations and improve maternal and child health.
- Gathering and disseminating examples of good practice.

This is achieved through structured diagnostic visits and tailored support. The first pilot was held in December 2008, with roll out in 2009.

For more information about the Infant Mortality NST, please contact **IMNST@dh.gsi.gov.uk**

The Response to Sexual Violence National Support Team

Tackling violence is now a government priority. The National Support Team (NST) for Response to Sexual Violence, in partnership with other government departments was established in October 2008 to deliver the Cross Governmental Action Plan on Sexual Violence and Abuse (April 2007) to achieve the following:

- Establishment of a network of sustainable Sexual Assault Referral Centres (SARCs) across England and Wales.
- Support PCTs to work in collaboration with the Crime and Disorder Reduction Partnerships (CDRPs) to reduce and prevent sexual violence as in the NHS Operating Framework 2009/10.
- Develop guidelines and/or standards to ensure quality assurance and ensure the SARCs are 'fit for purpose'.

For more information about the Response to Sexual Violence NST, please contact **Rima.Chowdhury-Hawkins@dh.gsi.gov.uk**

Dr Marilena Korkodilos, Head of the Infant Mortality NST

Rima Chowdhury-Hawkins, National Delivery Manager Response to Sexual Violence NST

Quality and outcomes – feasibility

Quality, outcomes and commissioning along with actual feasibility are rightly very high on the public health agenda. Health Audit International (HAI) spent 2008 working on these issues, largely for the Welsh Assembly.

The Darzi report has subsequently raised the profile for quality and innovation. The latest Operating Framework for 2009/10 includes a Commissioning for Quality and Innovation (CQUIN) payment framework of 0.5% of central income.

UK purchasing remains largely cost and volume orientated. Most commissioners are reluctant to get involved in more problematic quality and outcome measures.

Purchasers want any such measures kept simple, to have minimal data collection costs and to know 'who' will produce the answers annually and interpret them. HAI experience showed considerable clinician interest ideally linked with existing local clinical audit. Many clinicians were willing to assist with annual reports. Some specialty outcome data is available from national data collection e.g. heart disease, cancers, burns.

Suggested standards are available from professional bodies, NICE and others, though ideal staffing levels should be avoided in favour of general principles. Local clinician involvement is vital for acceptance.

Cardiac rehabilitation and heart failure are two interesting areas rarely referenced in any purchasing documents or adequately undertaken locally. Cancer services are problematic in contractual terms with so many cancer sites, some of which need delivery sub-regionally. Cancer mortality is retrospective and usually population based so that individual clinician/hospital outcome monitoring is difficult, except with use of proxy service measures.

A key outcome from the above exercise was a clear need for greater public health medicine involvement in determination of measures, clinician liaison and interpretation of annual results for purchasers.

For further discussion or talks tailored to local issues visit **www.health-audit.com**

Dr Peter W. Briggs, Director, Health Audit International Ltd

Horizons in medicine
Volume 20

Updates on major clinical advances

Edited by Professor Peter Mathieson, Professor of Medicine and Dean of the Faculty of Medicine and Dentistry, University of Bristol

The *Horizons in Medicine* series provides physicians of all backgrounds and levels with an invaluable insight into these exciting times in the field of medicine and an opportunity to broaden their knowledge of other specialties.

Based on the 2008 Advanced Medicine Conference at the Royal College of Physicians, this volume brings together a series of articles representing state-of-the-art reviews written by acknowledged experts.

A diverse range of clinical and scientific topics in which there have been important recent advances is covered in this widely respected publication. Self-assessment questions provided at the end of each chapter enable the reader to consolidate their knowledge and further their continuing education.

Glimpses into the future are provided by articles on cartilage replacement, ischaemic conditioning as a possible therapy, and stem cells. The volume concludes with an article based on the Linacre Lecture by Helen McShane on a new vaccine for tuberculosis.

Reading these articles gives grounds for real excitement about the pace of medical advances and genuine optimism that the burden of human disease is being tackled as a direct result.

This appealing publication is essential reading for consultant physicians, general practitioners, or doctors in training, in the UK and overseas.

For more information and to purchase a copy please call 020 7935 1174 ext 358 or visit: **http://www.tinyurl.com/c5s3pp**

Putting public health intelligence to work

A new suite of training packages will support public health intelligence staff to develop their professional skills and knowledge. The packages, developed by Informing Healthier Choices, have been designed with a modular approach, so that anyone with an interest in the health of communities can access useful skills and knowledge.

The aim is to support local authorities, local commissioning teams, GPs and even providers of services such as the police or schools, to have the skills they need to use available public health intelligence to plan services and get the best value for money from them, based on robust evidence.

There are ten new e-learning modules, developed for the project by OnMedica; and 13 new training modules, developed by APHO, Rhema Group and Health Development Consulting. Between them, they cover all the public health competencies, up to and including Level 6 of the Public Health Skills and Career Framework for public health intelligence staff.

The project team have also produced model job descriptions and person specifications, to help align public health intelligence posts across the UK. They meet the Agenda for Change criteria and were developed using the Public Health Skills and Career Framework competencies.

Informing Healthier Choices
Informing Healthier Choices is a programme established by the Department of Health to improve the quality of health information and intelligence across England. Its aim is to make public health intelligence more accessible, timely, and to give people the tools, skills and knowledge they need to use it in their work.

Sir Muir Gray, Chief Knowledge Officer of the NHS, says: *"We want to support organisations like PCTs to use good quality intelligence to make their decisions – and this includes World Class Commissioning issues, exceptional treatments and all the challenges facing the NHS."*

"These training packages help them to do this but also are crucial for public health intelligence staff to work more effectively and have a clearer training structure. New people coming into public health can use them to build their expertise."

The e-learning modules are available on **www.healthknowledge.org.uk**, and the 13 training modules are in the form of PowerPoint Presentations and workbooks to download from the same place.

Conference on the WHO and the social determinants of health

In 2005, the World Health Organization set up a Commission for the social determinants of health. A panel of researchers and policy-makers chaired by Sir Michael Marmot, gathered evidence on the effects of social conditions on health. In its recently published report, *Closing the Gap in a Generation*, the Commission presents its findings and suggestions on how health inequalities within and between countries might be addressed.

In November a conference was hosted by University College London and the Wellcome Trust to discuss how the Commission's findings might be taken forward and translated into action. Over 20 speakers, including public health professionals, academics, government officials and medical sociologists, gathered and presented thought-provoking critiques of the report.

The general mood of the conference was one of reserved optimism. The report describes the need to address health inequalities as a "moral imperative" and a matter of "social justice", and this was repeatedly highly commended by speakers. The recommendations of the report were criticised by several delegates as vague and "politically appeasing".

The primary success of the report has been, to bring health inequities back on to the agenda. *Closing the Gap in a Generation* has the potential to become a political driver for action. But what we need now is political commitment and determination to ensure that good health is enjoyed by all, in rich and poor countries alike.

For further information on Commission for Social Determinantsof Health:
http://www.who.int/social_determinants/en/

Chief Medical Officer launches public health awards

Sir Liam Donaldson, Chief Medical Officer for England, has established awards dedicated to those working in public health, and is calling for entries

The Chief Medical Officer's Public Health Awards will recognise individuals, teams and services that have made an impact in public health in England. The awards will also help to raise the profile of public health.

Sir Liam said: "Public health in England has a long and proud history, and our current system is the envy of many other countries in the world. Yet those working to improve the health of our citizens do not always get the recognition they deserve. In establishing these awards I hope to shine a spotlight on public health and increase awareness of the exciting and innovative work taking place that will truly make a difference to the health of the nation."

The awards are open to anyone working in public health in England, regardless of job title or role. The closing date for entries is Wednesday 22 April 2009. Entries must demonstrate evidence of impact and sustainability of the initiative or project. Judges will also be looking for evidence that initiatives can be replicated to other settings or areas.

The winners of the gold, silver and bronze awards will be announced on 30 June 2009, at a ceremony at the Royal College of Physicians in London.

For more information about the awards, including entry guidance and submission forms, please go to **www.dh.gov.uk/cmo**

New directors at Health Protection Agency

The Health Protection Agency (HPA) has announced the appointment of Professor Maria Zambon as Director of its Centre for Infections and Professor Anthony Kessel as its Director of Public Health Strategy.

Since 1995, Prof Zambon has been Director of the World Health Organisation's National Influenza Centre and International SARS laboratory, based at the Centre for Infections, London and since 1999 has been Deputy Director of the Agency's Virus Reference Division.

The HPA hopes she will play a critical role in ensuring the Agency delivers the world class specialist public health and reference microbiology needed by its partners at local, regional, national and international levels.

As Director of Public Health at Camden PCT and an Executive Director member of the Board, Prof Kessel's particular interests are in improving health and reducing health inequalities, environmental health and health protection, and in developing research links between academic and service public health in the UK.

According to the HPA, Prof Kessel takes up the newly created post to ensure the continued development of the Agency's strategy for supporting health protection planning and delivery in the UK and internationally.

Prof Kessel said: "I am thrilled to have the opportunity to take on this exciting new role at the Health Protection Agency. I hope my diverse background in public health, primary care and academia will help the development of the Agency, ultimately leading to further improvements in the vital function of health protection."

New staff

Suvi Kingsley
Press and Information Officer

I'm the new Press and Information Officer in the FPH's Policy and Communications Department. My job is to raise the FPH's profile within print, broadcast and online media, and thereby to promote awareness of public health issues in general, through a range of media coverage.

Before joining the FPH I was a Press Officer at the British Library. Prior to the Library I worked as Public Affairs Executive at the Science Museum.

My first weeks here have been very enjoyable, and I very much look forward to working with you all and putting the FPH on the map!

Nic Donati
Training Administrator – Practitioner Development

Before working for the FPH, I worked with a children's charity, Action for Children in the payroll department.

In my current role in the Education and Training department, we look at practitioner engagement and regulation. As part of this work, the FPH are looking to expand its membership to practitioner level and put in place an assessment framework for public health professionals who wish to become registered as practitioners.

Sonia Malacarne
Training Administrator

I have been working at the FPH for five months and I am really enjoying my role as part of the Education & Training Department.

I deal with different areas of training, providing administrative support to the Training Programme Directors, being involved in developing and implementing new projects, and processing Out of Programme Experience and Article 14 applications.

Before joining the FPH I worked in a chemical company in Italy as a Training Administrator. I was the main contact for sales agents and used to organise their inductions and manage training process.

Iain Brown
Web & Communications Officer

Working within the Policy & Communications department, my responsibilities lay mainly with the FPH website and FPH publications. I am the in-house editor for *ph.com*, the monthly email bulletin, and the FPH and public health conferences websites.

Before joining the FPH, I was Web Manager at the Chartered Institute of Public Relations, developing their website and email communications strategy. What spare time I have is spent keeping up with current affairs, listening to music, watching sport and playing at utility-back for the Westminster Lobbyists Rugby Club.

Preventative Health 09

In June 2008 Lord Darzi's *NHS Next Stage Review* promised to create an "NHS that gives patients and the public more information and choice" and does more to "improve the prevention of ill health". But how much has been achieved so far?

GovNet Communications invites professionals from across the healthcare spectrum to discuss these issues at the Preventive Health 09 Conference, taking place on Thursday 25 June, 2009 at the QEII Conference Centre, Westminster.

Chaired by Professor Alan Maryon-Davis, President of the Faculty of Public Health. Preventive Health 09 will give delegates a chance to discuss in detail the key issues in relation to the prevention of serious illnesses, as well as the increased role of local care practitioners in the early diagnosis and treatment of illnesses. To view the conference programme please click here.

As a member of the Faculty of Public Health you can attend the Preventive Health 09 Conference with a 20% discount on your booking, this means you can attend for the following rates:

- Register one delegate for just ~~£249 + VAT~~ £199 + VAT
- Register two delegates for just ~~£225 + VAT~~ £180 + VAT
- Register three for just ~~£199 + VAT~~ £159 + VAT
- Register five delegates or more for £125 + VAT

For more information and to register your place please visit **www.govnet.co.uk/preventive**. Please quote promotional code 'FPH'

Fluoridation for Southampton!

Congratulations to the local PH teams and all those who successfully lobbied the South Central SHA to vote for fluoridation in Southampton and surrounding area. It's an important victory for oral public health and underlines the strength of evidence over prejudice. Let's hope it triggers a movement across the whole nation.

FPH Faces

With so many members, representing an impressive breadth of experience and specialisms, we thought it would be useful to put a 'face' to our members. Each issue, we'll profile a different member, asking how they got into public health, what they've achieved and where they think the industry is going. This month's 'face' of the region is Jean Chapple.

Name: Jean Chapple

Location: London, based at Westminster PCT

Current role: 3 days a week as consultant in perinatal epidemiology, leading on antenatal and child health screening and all things maternity and neonatal across London, 2 days a week as a public health training programme director for SW London, Surrey and Sussex

Number of years in public health
Who's counting?

Public health interests
Maternal and newborn health and screening

Career highlight to date
Starting an antenatal screening programme for Down's syndrome in North West Thames region several years before the national programme began. This involved one of the first tenders for laboratory services in the NHS. The programme means that women have equity of access to screening, properly trained and informed health professionals and choices. The programme is still going strong.

Most memorable public health achievement
Recruiting and directing the training of the next generation of public health consultants, I am always in awe of the enthusiasm and intellect of 'my' trainees.

How did you get into public health?
By default, I was going to go into community paediatrics, but there was no training scheme at the time. I applied for public health training in Liverpool so I could 'mark time' while training in paediatrics was sorted out and get a 'free' MSc, and never went back to paediatrics.

How would you describe your day-to-day job?
Very much day to day – there are never two days the same. I am constantly meeting and working with a wide variety of clinicians, commissioners, managers, charities and educators on a wide variety of topics. There is no such thing as a standard week in my life.

What is the best thing about working in public health?
The wide variety of issues that public health has to address mean that every day brings new learning and challenges – so there is never a dull moment (apart from chasing some process targets that do not directly improve health!).

Which public health professional do you most admire?
Sir Iain Chalmers, for bringing evidence based care to maternity services a decade before other specialities discovered it (with his help) and for questioning received wisdom and eminence-based care for the benefit of women and babies.

How long have you been a member of FPH for and what is the membership's main benefit for you?
I've been a member since the FPH was housed in a basement in Portland Place. The main benefit was becoming Chair of the Part I MFPH examination, which taught me more about public health theory than ever before. I also enjoyed being Assistant Registrar for five years.
I think members get from the FPH what they put in; the organisation is its members.

What is the biggest public health challenge in your region/area of work? How is it manifested? How are you tackling it?
The biggest challenge is maternal and child obesity, manifested by the strengthened delivery beds in London's maternity units and problems of ultrasound examination in pregnancy, as the sonographers cannot get past the fat. We need more preconception care to get women fit for pregnancy (national guidance and initiatives would help) and more midwives and health visitors trained to help women and their families to eat well and keep moving.

What do you think is the single biggest challenge facing public health professionals today? In your view, what is the most important action policy makers should take?
Obesity in all sections of society – we need policies to make fresh food available to everyone, education and incentives for cooking from scratch and family eating round the table rather in front of the TV, and clearer food labelling.

What is the best piece of career advice you've ever been given?
Think large for strategy, small for implementation and always communicate.

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to the Faculty between 18 November 2008 and 17 February 2009.

New diplomate members

Kakoli CHOUDHURY
Girija DABKE
Aileen KITCHING
Brendan O'BRIEN

New trainee members

Nicholas AIGBOGUN
Diane Frances Black BOLTON-MAGGS
Anna BRYDEN
Araceli BUSBY
Melisa CAMPBELL
Steven CASSON
Christopher John CHISWELL
Philip Daniel CONAGLEN
David CONRAD
Rebecca Claire COOPER
Jonathan COX
Osman DAR
Lucy DENVIR
Delanjathan DEVAKUMAR
Anna DHAR
Gayle Penelope DOLAN
David Stanley EDWARDS
Gracia Lisabeth FELLMETH
Irfan GHANI
Rosalind Mary-Jayne GRIFFITHS
Stephen GUNTHER
Christopher LITTLEJOHN
Kirsteen MACLEOD
Jeremiah James Muriithi NGONDI
Elizabeth ORTON
Virginia PAUL-EBHOHIMHEN
Sumantra RAY
Mohit SHARMA
Rachel SOKAL
Dana SUMILO
Anne SWIFT
Sara Ann THOMAS
Janine THOULASS
Sarah Philippa TICKNER
Philip Geoffrey VEAL
Michael WADE
Hannah WALL
Conall Hon WATSON
Sarah WHITE

New members

Ishraga AWAD
Tanja BRAUN
Bethan DAVIES
Abraham GEORGE
Katherine HAIRE
Sophie HAROON
Kulsum JANMOHAMED
Ros JERVIS
Siobhan JONES
Jeffrey LAKE
Maria LANG
Geraint LEWIS
Annette LUKER
Siu MA
Duncan MCCORMICK
Ashesh MODI
Ayoola OYINLOYE
Murad RUF
Anjila SHAH
Anandagiri SHANKAR
David SPENCE
Addisalem TAYE
Helen THOMAS
Joanna WILLIAMS
Dominik ZENNER

New fellows

Marie ARMITAGE
Paul BATCHELOR
Claire BRADFORD
Ivan BROWNE
Stuart CLARKE
David CLOUTING
Samuel CROWE
Rachel CROWTHER
Gabriel DOCHERTY
Lynn DONKIN
John FRANK
Sara GIBBS
Jenny HACKER
Therese HESKETH
Alan HIGGINS
Alistair HILL
Julie HIRST
Ronald HSU
Ciaran HUMPHREYS
Angela HUTCHINSON
Juliet JENSEN
Janet Elizabeth LAMBLEY
Antonio Ivan LAZZARINO
Helen LOWEY
Colmam MCGRATH
Ellaine MUSCROFT
Ian Gary NEEDLEMAN
Joanna NURSE
Eileen O'MEARA
Jose ORTEGA BENITO
Wendy RICHARDSON
Peter ROBINSON
Ruth RUGGLES
Julie SIN
Kenneth SNIDER
Martin TICKLE
Roberto VIVANCOS
Derek WARD
Mandy WARDLE
Barbara WATT
Susan WEBB
Julia WELDON

UK Public Health Register

The following have been admitted to the UK Public Health Register through portfolio assessment or training.

Through Generalist Specialist portfolio assessment

Ruth TWIGGINS
Lucy MACLEOD
Glenn TURNER
Susan LONGDEN
Diane STOCKTON
Ruth WOOLLEY
Wendy HATRICK
Frances HOWIE
Ann GOODWIN
Kirsty ROY
Kath CHILDS

Through the standard FPH Generalist Specialist training route

Paul SCOTT
Eva HROBONOVA

Deceased Members

The following members have sadly passed away:

Robert GREENBERG
John KILGOUR
Bevrley LITTLEPAGE
Francis MARTIN
Jean PRESTON
Valluri Rao

Watch this space!

The NHS has published its carbon reduction strategy for England. *Saving Carbon, Improving Health* will set the ambition for the NHS to drive change toward a low carbon society. The strategy is available from http://www.sdu.nhs.uk.
FPH will be launching its new guide supported by The SDU, on how to tackle climate change in the NHS in late March.

information

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Alison Hill

In-house Editor:
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In the next edition
If you would like to submit an article, please see guidance below.

Guidance for contributors to *ph.com*

◆◆ The editors reserve the right to edit and amend copy. ◆◆ When submitting an article, remember to include your name, job title, employer and contact details. ◆◆ Send articles in Word via email to the Policy & Communications Department at FPH. Handwritten copy cannot be considered. ◆◆ Avoid abbreviations, acronyms and jargon. ◆◆ Keep sentences and paragraphs short. ◆◆ Always attribute other people's work. ◆◆ Declare any conflict of interest. ◆◆ Avoid automatic formatting of articles and using the footnote function. ◆◆ Illustrations and photos can be accepted in Tif/jpg format only. ◆◆

SUBMISSIONS FOR THE JUNE EDITION TO REACH US BY FRIDAY 8 MAY

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The views expressed in this publication do not necessarily reflect those of either the editors or the Faculty of Public Health.

Moving?
If you have recently moved, please notify the Faculty of your new contact details to ensure you will still receive FPH communications.

Improving quality and safety

The NHS is improving and bears comparison with other systems internationally. Nonetheless it needs to improve further in at least four respects.

Firstly, the variations experienced by patients in the clinical care they receive, exceed the variations in their needs and preferences. Secondly, care is not as safe as it could and should be. Thirdly, the cost of care is rising at an unsustainable rate. Fourthly and finally, patient experience, while improving, is still not what we would wish for our own families. To make an impact on these four dimensions of quality of healthcare requires the development of interventions built around a series of prerequisites.

The first of these concerns *leadership*. We need leaders at all levels in the NHS to accept, that the improvement of quality is a fundamental responsibility and that it is possible. This means going beyond the stereotypes,

I have worked with clinicians across the spectrum of interest in quality, and with managers who were as passionate about patient care as their clinical colleagues. Equally, I have encountered a sense of nihilism which can and should be challenged. Rapid and profound improvement has occurred in the programmes where leaders get the quality agenda and are helped to communicate their ambition to transform care for patients in partnership with clinical colleagues.

We know that is the case because of the second prerequisite appropriate use of measurement. As public health practitioners we have a lot to offer here, though I confess, I only learned the tools of measurement for improvement (Statistical process control and the use of run charts for example), when I took an active interest as a CEO. Choosing metrics, using them to inform decisions, finding ways that people can understand them and interpreting information, are our stock in trade, or should be.

The third prerequisite is: we have the tools of quality improvement to make care better for patients and to improve health. I believe there is a scientific approach to managing improvement and change. It is a relatively new science and there are a number of promising approaches. It is probably more important that any one organisation decides on the approach it favours and follows it, than to argue one approach is superior to all others. So whether it be the 'Theory of Constraints' or 'Lean Thinking' or 'Six Sigma' or 'Clinical Microsystems'. It is important to have a group of people who have used an approach successfully and can show the improvements that have resulted. Our website can be a useful starting place if you want to learn more. **http://www.institute.nhs.uk/**

The final prerequisite is appropriate internal and external relationships. Firstly, the ability to establish functional and respectful teams, in which the inspiration and motivation that comes form good leadership, is converted into the energy which is the fuel of improvement. As John Kotter says "People change what they do less because they are given *analysis* that shifts their *thinking* than because they are *shown* a truth that influences their *feelings*."

Effective respectful relationships need also to extend beyond the organisation to partners in other parts of the system. At times I encounter a sense that the elements of the NHS, at least in England, have been set up to show their independence and to succeed at the expense of one another. I usually encourage people displaying these views to search online for 'co-opetition'. An inelegant word which describes the ways in which highly competitive organisations co-operate when they realise it is in their interest to do so, with a whole corpus of management practice which describes how to do this successfully.

These four prerequisites inform our programme at the NHS Institute, if you want to learn more we would be delighted to see you.

Bernard Crump
Chief Executive Officer, NHS Institute for Innovation and Improvement