High quality care for all
NHS Next Stage Review – final report

July 3rd 2008

Northgate Information Solutions' initial response

Summary

The quality of the quality system established within the NHS rests on the ability to transform data into useful information which can measure and improve performance and public satisfaction.

Northgate believes that information has an integral part to play, not only in supporting and improving performance and choice but also in transforming our approach to healthcare, giving people and professionals more control over the direction of healthcare and shifting the central emphasis to one of well-being and improving the health of our communities.

If the emphasis is going to increasingly move away from quantity to the high quality of care, it is essential that clinicians and NHS staff are involved and engaged, and that services are built around individual need, rather than organisational functionality.

Whilst we support a minimum of nationally driven quality standards, locally implemented, a critical factor will be the need to ensure locally robust systems which reward the right things.

Difference in communities, their place and their profile must be respected when responding to local needs and reaching out to the most disadvantaged not only to meet their clinical needs but their human needs for dignity and respect.

Quality measures will need to draw on the disparate information sources that already exist to provide objective data about clinical care, combined with the development of people related outcome measurements.

We welcome an emphasis that moves from treating the sick, to promoting community well being. This requires collaborative partnerships within localities, not always easy to develop on the ground. The sharing of quality information is crucial to develop successful collaborations.

Screening programmes can be an invaluable public health service through facilitating early diagnosis of serious health conditions and in improving and increasing personalised provision. NHS resources can be targeted more accurately and appropriately through early identification and planning. In our experience, screening programmes must be robustly tested, rigorously evaluated and continuously improved to respond to changing needs and opportunities for innovation.

We agree wholeheartedly and believe that tackling health inequalities is a crucial task for all who wish to see radical improvements in the health of the nation. This requires accepting that many of the factors which give rise to health inequalities lie outside the control of the NHS and developing innovative partnerships which promote well-being and prevent ill health. Strategies for improving health inequalities by early interventions, such as screening programmes, should be fully integrated with broader strategies focused on tackling disadvantage.

The public has a right to expect timely information concerning healthcare performance. The information available should reflect the day-to-day healthcare experience of the public. Where possible, information should be publicly available in as timely a fashion as possible, as part of an annual cycle of review.

Whilst ultimately we believe that information should be made available to the public about individual clinical performance, it is critical that clinicians are involved in the process of developing the quality clinical comparators. They must be confident that the systems are robust enough to ensure that clinicians themselves wish to share such information with the public to demonstrate the high quality of care on offer and the mechanisms by which quality systems can identify poor performance and maintain a safe system for patients.

Exploring the reasons for outliers will help to develop better healthcare models. Northgate believes that this should become a regular part of healthcare analysis. Once detected, a clear action plan for acting upon the identification of outliers could be developed in a timely and appropriate fashion and lead to improved healthcare outcomes.

We are concerned that the development of quality indicators should take place at both the acute level and the community level, and whilst there is a commitment to put in place the first set of quality indicators by December 2008, no such commitment has been given for community services.

Given the current extent of the data available, we believe that there are arguments for rapidly developing quality measurement systems through proof of concept models at local or regional level. These could be used to test a number of different methodologies within particular areas. This could assist all NHS healthcare providers to develop strategies in time to publish quality accounts in April 2010.

We believe there are strong arguments for supporting a 'right to bid' as outlined in a recent speech by the Secretary of State for Work and Pensions. This right to bid would help to ensure that the move towards integrated and comprehensive quality systems within the NHS could advance at a pace consistent with national, regional and local need.

If the duty to innovate is to be realised and if the NHS is to foster a culture of innovation and enterprise within the NHS, it is essential that employees and clinicians are able to witness rapid implementation of their good ideas. Just as the NHS may benefit from the right to bid, enabling it to draw on external sources for ideas, so it may benefit from an 'invitation to implement'. Here external organisations could be encouraged to enter into partnerships arrangements or joint ventures to implement ideas at a local level and scale up best of class practice on a regional or national basis to help provide change more rapidly.

Sustainable performance partnerships, involving external organisations working alongside the organisation's leadership and employees and using knowledge and skills transfer as an integral part of performance improvement, offer the NHS a new and innovative way of working, with more flexible framework contracts and fees linked to performance improvement.

In this way external organisations could assist by helping to ensure that good ideas benefit from great implementation.

1 Introduction

1. Northgate welcomes the publication of the NHS Next Stage Review final report and particularly its emphasis on placing quality at the heart of the NHS as part of the process of continuous improvement of the service.

2. Northgate is a strong supporter of the ethos of the NHS. As a partner organisation that works with local and regional healthcare professionals and runs national programmes on behalf of the Department of Health, the Medical Research Council and The Information Centre for health and social care, we wholeheartedly support the aim of creating an NHS that gives patients and the public more information and choice and one that works in partnership to support quality services.

3. Whilst improvements have been made in recent years, for far too long our healthcare services have been data rich but information poor. We are delighted that the central role that information has to play in providing patients with informed choice, and in measuring and improving performance, has been recognised throughout the review process and in the final report.

4. Quality that is defined as clinically effective, personal and safe, can only be delivered by a combination of clinician-led quality development supported by people-reported outcome measurements. But there are real challenges ahead, the quality of the quality system established within the NHS rests on the ability to transform data into useful information which can measure and improve performance and public satisfaction.

5. We believe that information has an integral part to play, not only in supporting and improving performance and choice but also in transforming our approach to healthcare, giving people and professionals more control over the direction of healthcare and shifting the central emphasis to one of well-being and improving the health of our communities.

6. Northgate has prepared this response as a contribution to the debate. Our views have been developed from our experience of working with the NHS, local government, the police and emergency services in developing performance partnerships. These help to strengthen and sustain the public sector, which in turn, can build new and innovative relationships with external organisations aiding the speedy implementation of sustainable change.

2 Change –locally-led, patient-centred and clinically driven

7. At the heart of the review, is the view that change must be implemented locally, it must be clinically led and patient or people-centred. We wholeheartedly support such a view. If the emphasis is going to increasingly move away from quantity to the high quality of care, it is essential that clinicians and NHS staff are involved and engaged, and that services are built around individual need, rather than organisational functionality.

8. We believe that the same is true for the development of quality standards. Whilst we support a minimum of nationally driven standards, locally implemented, a critical factor will be the need to ensure locally robust systems which reward the right things. Difference in communities, their place and their profile must be respected when responding to local needs and reaching out to the most disadvantaged not only to meet their clinical needs but their human needs for dignity and respect.

9. Building services around the personal needs of people, requires greater emphasis on identifying people's needs and measuring outcomes. However, quality measures will need to draw on the disparate information sources that already exist to provide objective data about clinical care, combined with the development of people related outcome measurements. For example, the National Joint Registry is seeking to combine quantitative data drawn from a range of official sources and combine this with patient reported outcome measures, only when these two are combined can a real assessment of the patient's experience be made.

10. Innovation and developing a rapid pace to change, has to be balanced against the need to ensure quality of the systems for measuring quality. To ensure that the good ideas of NHS employees can be harnessed and implemented efficiently and effectively, the public sector could consider new ways of engaging with external organisations to build long term capacity and capability and to develop new mechanisms for speedy implementation. Performance partnerships are one way of achieving this.

3 The challenges

11. With quality placed firmly at the heart of the NHS, the key challenge in relation to its measurement is to ensure a robust methodology. One which supports national minimum standards, whilst ensuring that NHS clinicians and employees have the headroom, the capacity and capabilities to develop local quality systems which are responsive to people, relevant to professionals and measure the rights things in the right way.

12. The quality of the information system rests on the quality of the data. There is a wealth of data held in disparate sources which could be more effectively utilised in measuring quality.

13. We do not think that the complexity of this process should be under-estimated. The challenge is to identify the most useful sources of information and to reduce the level of data collected, where it is duplicated or serves no particular use.

14. Any effective quality system must be continuously reviewed to ensure that it is not diverting activity in a detrimental way which ironically may affect the quality of the overall service. It also needs to be built on a spirit of co-operation and collaboration, inclusion and involvement. This may run counter to a culture which rewards and fosters competition within the NHS such as the Foundation Trusts.

4 ‘High quality care for patients and the public’

Prevention

15. We welcome an emphasis that moves from treating the sick, to promoting community well being. This requires collaborative partnerships within localities, not always easy to develop on the ground. The sharing of quality information is crucial to develop successful collaborations.

16. We believe that information has an integral part to play, not only in supporting and improving performance and choice, but also in transforming our approach to healthcare, giving people and professionals more control over the direction of healthcare, and shifting the central emphasis to one of well-being and improving the health of our communities

Screening

17. We welcome the fact that the review accepts the importance of screening, and that government will strive to accept and implement every recommendation for screening and vaccination programmes that the relevant national expert committees make (3:9).

18. Helping people make better choices about their health is at the heart of giving people more control, enabling them to take responsibility for their health, for preventing ill health, and promoting well-being.

19. Screening programmes can be an invaluable public health service through facilitating early diagnosis of serious health conditions and in improving and increasing personalised provision. NHS resources can be targeted more accurately and appropriately through early identification and planning.

20. In our experience, screening programmes must be robustly tested, rigorously evaluated and continuously improved to respond to changing needs and opportunities for innovation.

21. Below, we set out the lessons learnt from our involvement in the Newborn Hearing Screening Programme (NHSP), and propose a framework for delivering high-performance screening programmes that can demonstrate success and enjoy the continuing support of the public and health professionals alike.

22. To ensure screening fully meets the needs of policy makers, the public and healthcare professionals, Northgate believes that the following five priority actions must underpin all current and future programmes:

    - measure and report on performance
    - prioritise training
    - manage risk
    - ensure integration, and
    - review and improve.

Learning the lessons
Newborn Hearing Screening Programme

Introduction

It is widely acknowledged that early identification of hearing impairment or deafness is important for the development of the baby. Late identification can lead to a lifetime of underachievement for the individual and prevent children from reaching their full potential.

Recognised as the most advanced hearing screening programme in the world, over two million babies in England have had their hearing screened through NHSP. The programme has been rolling out since 2001, and from March 2006 every parent in England has been given the chance to have their baby's hearing screened shortly after birth.

More than 3,400 babies have been identified as having some level of permanent hearing impairment. This has enabled a range of proactive services to be delivered, including earlier provision of amplification and early advice and support for families.

The success of screening programmes such as NHSP lies not only in the test itself, but also in the way that the information is used to identify inequalities, trends and quality in healthcare.

Clinician led

All of the partners involved in developing, using and supporting NHSP have recognised since its inception that this was not simply a technology programme. This is a major reason for its success. It is an integral part of the business of delivering more effective and efficient screening services and must be guided and led by the clinicians involved.

Patient choice

Patient choice is at the heart of the government's vision for improved health services. It is important that choice is considered from the outset, including whether or not to participate in any screening process.

NHSP gives parents the option to have their baby's hearing tested. Parents who themselves are deaf may prefer that their child does not participate in the test, and this must be respected if the programme is to retain the trust of all patients.

Communication

Effective communication is key. People must have easy access to information on the aims of any screening programme, the condition being screened for, and the process involved. Using information collated as part of the performance management framework the success – or otherwise – of any screening programme must be reported to clinicians and the public.

Performance measurement

Strong performance monitoring and evaluation must be built into the screening process to make certain that there is equity in service delivery, ensuring that some of those most vulnerable in society – who may be most likely to benefit from screening – actually participate.

The problem with a number of screening programmes is that they can be data rich but information poor. Whilst extensive data may be collated, it might only be accessible locally and in ways that will not meet the future needs of clinicians and the public.

The Newborn Hearing Screening Programme is an exception.

The use of information to manage performance and guarantee quality is an integral part of its success. The national clinical IT system eSP (eScreener Plus) is recognised as one of the most successful electronic screening systems in the NHS.

NHSP is a fully managed service consisting of a national dataset with secure hosting at a data centre which provides a national online information and performance management system to the programme. This includes fully automated notification of babies newly born, enabling clinicians to effectively manage screening and follow-up services.

eScreener Plus is used by every local hearing screening service in England for management and audit purposes. It handles approximately 600,000 babies a year and already contains over two million total records, increasing at 1,700 per day. It has over 1,500 active users and was the first national clinical system to be rolled out over the secure N3 network, as well as the first to link to the NN4B (NHS Numbers for Babies) service.

The interface between the NN4B and eSP systems was developed and went live in August 2003. Birth notifications are now received by eSP within six seconds of an NHS number being generated, usually within 2-3 hours of birth. This saves screeners a great deal of time in entering baby demographics whilst ensuring accurate data and high coverage.

Data collected by eSP is reported, analysed and used to support quality assurance and quality improvement. It provides feedback to local services which are provided with regular information about their progress, in particular towards meeting the NHSP quality standards. This ensures all services are working to achieve the same high standards across the whole of England.

eScreener Plus is being developed and enhanced as part of a process of continuous improvement. One of the latest enhancements is to enable data to be fed directly to the eSP from the 2,400 pieces of hearing test equipment located at 182 NHS trusts. This removes the need for manual importing or duplicate entry which, in turn, leads to improved data quality and much less chance of a baby with a hearing loss being missed.

Training

Training is integral to the success of NHSP. Technology training was integrated into the general training of screeners. This helped to ensure screeners recognised that the use of technology to assist in managing performance and providing quality assurance was part and parcel of delivering the

service.

Most recently, NHSP has concentrated on developing e-learning opportunities, launching its first module in March 2007. The aim is to provide training for newly recruited NHSP screeners and a resource for trained NHSP screeners to support continuous development of their skills in line with the evolution of new technologies, evidence and practice.

Managing risk

The UK National Screening Committee (NSC) has been tasked by the Prime Minister with advising on additional screening procedures that would be "genuinely useful" in assessing other conditions. The NSC assesses proposed new screening programmes against a range of criteria, such as the condition itself, the screening test, any treatment options, and the acceptability of the screening programme. Its mission is to ensure that "screening does more good than harm at a reasonable cost".

As the NSC acknowledges, it is also important that the public has a realistic expectation of what screening programmes can deliver. There is a risk that participation in the screening process itself may offer people false reassurance or, indeed, cause unnecessary anxiety.

The NHSP is governed by a risk management framework and quality assurance programme that operates in partnership with other services in healthcare, education, social care, public health and the private and voluntary sectors. As part of the process for introducing NHSP, issues of maternal anxiety were considered and the risk assessed. The way the screening process is explained and any referrals handled was found to be critical to avoiding this anxiety, and NHSP has developed training programmes to ensure the best possible parent-screener interaction.

Review and improvement

It is essential that screening programmes are kept under review to ensure that innovation can be rolled out or that outdated processes are removed. The NHSP itself was a replacement of the previous infant distraction test that was identified as needing improvement.

There is also huge potential to use existing screening data to identify areas of inequality and trends in performance. For example, this data could also be linked with other data held on secondary and primary healthcare, such as HES (hospital episode statistics) and NHS Comparators. In this way, a holistic view of patient treatment and healthcare delivery could be achieved, irrespective of whether treatment is received within primary or secondary healthcare.

Conclusion

Screening programmes have a vital part to play in improving health services and engaging people in their healthcare. To operate effectively they must secure and maintain high levels of trust among policy makers and opinion formers, clinicians and the public.

This requires a strong focus on quality assurance and a framework that prioritises performance measurement and reporting, training, risk management, integration with existing systems, and continual review and improvement. Only through this process will meaningful information be provided on which long-term healthcare decisions can be made.

Our responsibility to our employees

23. Northgate fully supports the view that the private sector has a role to play in promoting well-being among its employees. Our people are our most valuable asset. Promoting well-being is an integral part of our corporate responsibility policy and human resources policy. We therefore welcome the announcement of the launch of the Coalition for Better Health, which seeks to establish a new set of voluntary agreements between government, private and third sector organisations, focused on the action each needs to take to achieve better health outcomes for the nation (3.15).

Tackling health inequalities

24. The report makes clear that the root causes of "ill health lie heavily in people's life circumstances" (3.16). We agree wholeheartedly and believe that tackling health inequalities is a crucial task for all who wish to see radical improvements in the health of the nation. This requires accepting that many of the factors which give rise to health inequalities lie outside the control of the NHS and developing innovative partnerships which promote well-being and prevent ill health.

25. Education, housing, the quality of the local environment, jobs and income and social relations have a strong influence on the mental and physical health of individuals and the health and quality of life of local communities.

26. We believe that eliminating health inequalities requires increased investment and prioritising resources to support comprehensive public health programmes. Broader social policy interventions engaging a wider group of agencies are needed, along with using technology to transform data into information which can be used as the evidence base for making change that improves service delivery.

27. Strategies for improving health inequalities by early interventions, such as screening programmes, should be fully integrated with broader strategies focused on tackling disadvantage.

28. Currently there are no figures maintained on public health expenditure. If public health service delivery is to be evaluated effectively there must be a means of accessing information about the resources allocated and to what effect they have been used. Without such figures it is difficult to make any judgement on the effectiveness of policy in this area.

Empowering patients

29. Information can empower patients, not only in informing choice but also in taking greater control of their own healthcare and in solving their healthcare problems.

30. At both a national and local level, the structure of public services has traditionally placed organisational functionality above personal need. The challenge is to meet citizens' demands for services that are proactive and responsive to individual need, and that keep pace with changing expectations.

31. There is no 'one size fits all' approach to public service delivery. People may choose to access services in different ways, but it is crucial that all services are easily and equally accessible.

32. The public has a right to expect timely information concerning healthcare performance. The information available should reflect the day-to-day healthcare experience of the public. Where possible, information should be publicly available in as timely a fashion as possible, as part of an annual cycle of review.

33. As we have said above, at a national and local level there is a need to explore how data residing in disparate systems and with different organisations can be transformed into linked information which assists the delivery of personalised services, and presented to inform patient choice.

34. Northgate currently supports primary care professionals in delivering effective practice-based commissioning through NHS Comparators, designed on behalf of the Information Centre and Connecting for Health. This has been developed, implemented and rolled out by Northgate across SHAs, PCTs and GP practices. By becoming more informed about local patterns of care, primary care clinicians are able to make better commissioning decisions to support people's local health needs.

35. NHS Comparators uses nationally collected data to provide comparative information about local commissioning and healthcare outcomes for patients at GP practice and activity level. Comparisons can be made locally with peers, at primary care trust (PCT) level, at strategic health authority (SHA) level, and nationally. It is also a dynamic model with information and performance enhancements being added in a phased approach. It not only helps GPs to assess performance against key criteria which can then be compared with similar organisations locally and nationally, but it also maps patient referrals. This information could easily be made available to patients relatively quickly.

36. A particular area of concern for clinicians is how far clinical comparators should be made available to the public. Clinical comparators are being gradually introduced within the NHS so that clinicians can compare practice on a mandatory and a voluntary basis. Whilst ultimately we believe that information should be made available to the public about individual clinical performance, it is critical that clinicians are involved in the process of developing the quality clinical comparators. They must be confident that the systems are robust enough to ensure that clinicians themselves wish to share such information with the public to demonstrate the high quality of care on offer and the mechanisms by which quality systems can identify poor performance and maintain a safe system for patients.

37. At the heart of what the patient wants are constantly improving quality services, and we warmly welcome the introduction of the commissioning for quality and innovation scheme (CQUIN)(3.41).

38. Supporting world-class commissioning is crucial to developing sustainable healthcare services. GPs, nurses and other healthcare professionals working in the primary care sector are often in the best position to understand the needs and wants of their local population. Practice-based commissioning supports enhanced service delivery, but access to accurate and real time information is critical for making informed and quality decisions, as too is consistent information across local healthcare commissioners.

Keeping patients safe

39. We welcome the review's emphasis on patient safety.

40. Poor performance is rarely deliberate or premeditated and may also be a cause of anguish and anxiety to the professionals. They need to have enough confidence in the system to raise concerns about their own performance.

41. Professional assessment needs to take account of local information and issues facing the professionals in their day-to-day work. They will have little faith in a system if they perceive that the quality of the information collected is poor because it fails to take local issues into account.

42. This requires constant refinement of the kinds of information collected to ensure that they are consistent with the development of healthcare and adequately reflect the quality of care delivered. It also requires the ability to pull together information from disparate sources and bodies of statistics to identify adverse patterns and trends.

43. In improving the quality of care and providing for a safer NHS, Northgate believes that information technology can assist in the process of providing objective evidence to inform judgements on the quality of healthcare being provided.

44. In particular, greater use could be made of the early identification of 'outliers' or unusual data values to enable the healthcare system to investigate poor performance and improve health. This is something currently being developed through the National Joint Registry.

45. Once data errors have been omitted, the earlier identification of patterns and trends could help to promote efficiency and effectiveness in the delivery of the healthcare service, and enable the sharing of best practice.

46. Earlier analysis of outliers would help to prevent abuse within the healthcare system and reduce the risk of high-profile scandals, and could help to identify possible sources of high levels of infection caused, for example, by MRSA.

47. Exploring the reasons for outliers will help to develop better healthcare models. Northgate believes that this should become a regular part of healthcare analysis. Once detected, a clear action plan for acting upon the identification of outliers could be developed in a timely and appropriate fashion and lead to improved healthcare outcomes.

5 'Quality at the heart of everything we do'

48. We welcome the fact that the final review places enhanced emphasis on quality measurement and performance improvement.

49. The challenge is to ensure that quality is neither an add-on nor a bureaucratic burden, but is integral to performance improvement, is clinician- and public-led, and is carried out and

organised in a systematic and comprehensive fashion which balances the need for national standards against the importance of ensuring local control.

50. Some of these difficulties and challenges have been recognised by the review such as the need for clarity and we welcome the role of NICE in establishing national quality standards. But there is a danger, as we have said above, that the complexities of establishing a comprehensive and national system have been overlooked and that the mechanisms for achieving this have been under-explored.

51. We are concerned that the development of quality indicators should take place at both the acute level and the community level, and whilst there is a commitment to put in place the first set of quality indicators by December 2008, no such commitment has been given for community services (4.10).

52. Community initiatives which could help to further build up public trust may not be accorded the priority they deserve. Given that an increasing amount of involvement between patients and community services is anticipated it is, in our view, essential that locally-led organisations establish timetables for implementation and that they should be required to do this.

53. We strongly recommended in our response to the interim report of the review that patient-reported outcome measures form a stronger part of the approach to measuring clinical quality, and the development of these would need to be integrated into the timetables above.

54. Given the current extent of the data available, we believe that there are arguments for rapidly developing quality measurement systems through proof of concept models at local or regional level. These could be used to test a number of different methodologies within particular areas. This could assist all NHS healthcare providers to develop strategies in time to publish quality accounts in April 2010 (4.17).

55. We support the proposal that there should be incentives for implementing quality improvement (4.20). We believe that it is critical that quality systems are sufficiently robust to ensure that improvement is correctly related to the quality of the service rather than simply adhering to the measurement system in a way which is detrimental to the overall quality of service received by people.

56. We welcome the proposal for a National Quality Board (4.33) and the proposal that this should be led by the NHS chief executive. Leadership from the top is essential if the complexities of the challenge ahead are to be met.

57. Whilst it is currently not disclosed how the board may relate to private sector quality partnerships, we believe there are strong arguments for supporting a ‘right to bid’ as outlined in a recent speech by the Secretary of State for Work and Pensions. This right to bid would help to ensure that the move towards integrated and comprehensive quality systems within the NHS could advance at a pace consistent with national, regional and local need.

58. We welcome the emphasis on the need to encourage innovation and quality in healthcare. However, we are concerned that the review has not considered the need to ensure the need for

performance measurement in this area so that quality outcomes in innovation can be identified more readily and adopted more widely and more rapidly within the service.

59. If the duty to innovate is to be realised and if the NHS is to foster a culture of innovation and enterprise within the NHS, it is essential that employees and clinicians are able to witness rapid implementation of their good ideas.

60. Just as the NHS may benefit from a right to bid, enabling it to draw on external sources for ideas, so it may benefit from an 'invitation to implement'. Here external organisations could be encouraged to enter into partnerships arrangements or joint ventures to implement ideas at a local level and scale up best of class practice on a regional or national basis to help provide change more rapidly.

61. Sustainable performance partnerships, involving external organisations working alongside the organisation's leadership and employees and using knowledge and skills transfer as an integral part of performance improvement, offer the NHS a new and innovative way of working, with more flexible framework contracts and fees linked to performance improvement.

62. Performance partnerships guarantee financial outcomes and substantial and measurable outcomes in improved organisational and operational performance through the delivery of in-house partnership solutions.

63. Through encouraging new forms of service provision, new methods of sharing risk, and new ways of collaboration, 'best in class' services could then become something equally owned by the centre and by local providers, working in partnership with external practitioners with a practical knowledge of quality systems and information.

6 'Freedom to focus on quality'

64. We welcome the approach laid out in the review that healthcare transformation must be clinician and public led.

65. As we have emphasised throughout this response, our experience of success and failure is that projects that both treat clinicians as partners and have clinicians as leaders are more likely to guarantee clinician involvement at a practitioner level and enjoy greater success. Services built around the needs of individuals are more likely to generate public trust and satisfaction.

7 Quality and technology

66. The final report makes little mention of the use of technology in delivering quality.

67. Northgate's experience is that although IT projects may be delivered successfully, all too often they fail because of poor overall change management. Too little consideration is given to joining up systems and considering the impact of new technology on employees, members of the public and users of the services.

68. Prior to new systems being introduced, professionals need to be consulted and prepared, the impact on services analysed and planned for, and pre-emptive measures put in place to meet new demand. There must be adequate measures to deal with change management, with key partners involved as members of a partnership board working on the basis of mutual trust.

69. Effective delivery is based on establishing an open learning environment where people can experiment with new ideas, learn from chance experiences, assess individual needs, share information and reach conclusions from all these experiences to drive through a programme of continuous improvement and create public value.

70. This is particularly important in the health service, where clinicians and other healthcare professionals are often in the best position to develop services which meet the needs of patients most effectively. Engaging and listening to their needs, and demonstrating the relationship between technology, information and continuous improvement in service delivery, is critical to successful transformation work.

8 Conclusion

71. We welcome the final report of the review and the emphasis that it places on quality. We believe that there are considerable challenges ahead to ensure that the quality agenda retains its relevance and its resonance with both clinicians and the public.

72. Innovation in developing quality performance partnerships is critical to ensuring its success. So, too, is the need for speedy and efficient delivery.

73. External organisations could play a new supportive role in assisting innovation in this important area of public service work, through helping to build capacity and capability within the NHS in the development of quality systems and in ensuring that good ideas benefit from great implementation.

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About Northgate

Northgate Information Solutions is a leading provider of innovative services to the public sector and utilities markets. It is committed to high quality public services and understands the public sector. That knowledge is core to its business. Northgate's task is to enhance public value through the intelligent use of people and technology, and to share in the economic and social benefits that this brings.

In the UK, the company works with four out of five local authorities and every police force. Northgate supports public service transformation through sustainable performance partnerships. Its services are used in the administration of more than £12 billion of revenues and benefits; in electoral administration systems covering 18 million people; to support the national system for reporting police performance; and in the management of over three million local authority and housing association properties worldwide. Founded in 1969, the company has over 6,500 employees.

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