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Barry McCormick

Pathway peer review to improve quality

In this thought paper, Professor Barry McCormick explores a novel approach to improving quality. He argues that pathway peer review offers a high-quality and complementary addition to the market regulation of the NHS. It utilises the benefits of professional insight and self-regulation in what is argued to be a cost-effective way.

At the Health Foundation, the drive to find new ways of doing things that will improve the delivery of healthcare is central to our work. We are interested in solutions that have the potential to make lasting and widespread improvement to health services. Many of these emphasise the

importance of internal motivators (for example, professionalism, organisational development and leadership), alongside external ones (for example, regulation, economic incentives and performance management).

Health Foundation thought papers present the authors' own views. We would like to thank Professor McCormick for his work, which we hope will stimulate ideas, reflection and discussion.

A research report, entitled 'Quality of NHS care and external pathway peer review', accompanies this paper. Available from:
www.chseo.org.uk/papers.html

About the author

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He has published extensively in journals including *Economic Journal* and *Journal of Public Economics*. He co-authored *Immigration Policy and the Welfare System* (Oxford University Press, 2002), and his reports for the Department of Health include *Explaining NHS Deficits, 2003/04-2005/06* and *Hospital Organisation, Specialty Mix, and MRSA*.

He received his degrees from Manchester University and Massachusetts Institute of Technology (MIT), where he was a Harkness Fellow. His research interests include healthcare system reform and quality improvement, health sector productivity, emergency care, the funding of clinical education and healthcare for deprived communities and the homeless.

Foreword by Sir Donald Irvine CBE

Peer review has a long and honourable history in the medical profession. My first encounter with it, soon after I qualified in 1958, was witnessing its powerful and positive effect on four distinguished ear, nose and throat (ENT) surgeons who meticulously examined and learned from each other's practices through their 'travelling club'. They knew that this habit helped them keep their surgery at the leading edge. Thirty years later I took part in the first UK national study of standard-setting and performance review in general practice carried out by GP trainers and paediatricians in the Northern Region. Some 110 doctors volunteered to set optimal standards for five common conditions in childhood. Clinical and patient experience data were analysed independently, then fed back to the trainers who worked together in groups to compare results and see where their personal practice should be changed. In both these examples what was remarkable was the amount of effort everyone put into the work and the improvements made to personal practice.

These examples, and more, have taught me four things. First, seeking to improve one's practice by comparing it with others can be strongly motivating, thus adding to the enjoyment, as well as the effectiveness, of practice. Second, and perhaps as a direct result, doctors who have willingly engaged in good peer review come to see it as an inseparable part of their professionalism, of their identity as clinicians seeking excellence for the benefit of their patients beyond the imposed essentials of external regulation.

Third is the power of data in bringing objectivity and rigour to the process. Without the discipline that reliable data bring, peer review can so easily slip into the realm of subjective discussion and opinion, thus limiting its usefulness. Finally, on the downside, it was, and still is, a minority activity largely limited to volunteers in the medical profession; the patients of doctors and other health professionals who show no interest in peer review are therefore disadvantaged.

In this thoughtful paper, and the report which supports it, Barry McCormick invites us to think more ambitiously about peer review in the NHS. He has some interesting ideas which I think are well worth exploring further. He would like to see the NHS and its staff develop and adopt a culture of sustained self-improvement to foster consistent good quality and to minimise that selective poor performance to which healthcare is susceptible. He proposes a method – pathway peer review. He envisages this as a multidisciplinary process that would embrace the whole of the patient's journey through primary and secondary care. It is peer review seen very much 'through the patient's eyes', rather than the conventional monospecialty perspective, and would therefore embody both clinical outcomes and performance, and the results of patients' experience of their care. He asks us to look in particular at the mid-range of performance, to consider peer review as a practical method for moving most of practice more towards the optimal end of the performance scale. After all, he infers, every sensible person wants a good doctor, nurse, hospital and

general practice rather than one which just passes regulatory muster. External regulation would continue to provide the floor with which all should comply to ensure basic standards. But regulation unleavened by self-regulating professionalism can inhibit aspiration, and with it the motivation to do the best we can rather than settle for the least we can get away with.

Some of the royal colleges and specialist societies are moving in this direction. They recognise that they have a distinct leadership role to play in developing modern peer review, supporting their members in practical ways to achieve optimal practice and to deal with poor performance when it is identified. Modern peer review includes setting standards and developing the supporting infrastructure needed to measure and monitor those standards, as well as devising the methodology for defining acceptable and non-acceptable variance from such standards. It embraces the need to work with others to investigate performance where outcomes or other valid measures of clinical practice are not 'as expected', and the need to make judgements following investigations into performance. The Society for Cardiothoracic Surgery of Great Britain and Ireland has given us a fine example of what can be achieved by a responsible, forward-looking, peer-led organisation. They have shown that, for both doctors and patients, transparent outcomes and performance results are surely the best expression of patient-centred professionalism, and should become the essential underpinning of revalidation.

Management has a vital part to play in facilitating modern peer review. The fundamental purpose and priority of hospital (and general practice) management, from the board down, should be the nurturing of a professional and organisational culture which unequivocally puts the needs of patients first, expects optimal outcomes, performance and patient experience, and publishes the results in the most accessible way possible for the public. Good management will support clinicians who perform well and protect them from unjustified threats of legal action. Equally, it will act promptly to deal with and, where necessary, remove poor performers, to protect patients and its own reputation for only providing good healthcare. The provision of the electronic patient record, easily accessible by the patient, is a crucial element for accurate, economical data recording and data abstraction for analysis and review.

In the UK, the NHS has a patchy track record on quality. We all know that there is plenty of good care, but Mid Staffs is just the latest reminder that there are patients and segments of the public who get a very raw deal. The record shows that the NHS and successive governments have not made the most of the opportunities they could to achieve consistent quality, everywhere. Barry McCormick is challenging us all to try harder, to think and act more boldly, by presenting the case for pathway peer review as one example of what could be done. I agree.

Donald Irvine
Chairman of Picker Institute, Europe
Former President of the General Medical Council

Summary

This paper explores why and how external peer review can address the vexed question of how best to reinforce existing policy in the pursuit of high-quality care in the NHS. It argues that the development of external peer review provides a broad and flexible policy response capable of addressing the challenges raised by both the appalling standards of hospital care revealed at the Mid Staffordshire NHS Foundation Trust (Mid Staffs), and the slow progress towards integrated care pathways.

The long-term underperformance at Mid Staffs, despite receiving Foundation Trust status and satisfying regulatory requirements, highlights the concern that policy to prioritise quality of care is not yet satisfactory. An explanation is required of how a culture can develop, and survive regulation, while providing a mix of both acceptable and very poor elements of care.

The hypothesis here is that policies that rely on specific metrics relating to quality can lead competing providers to override clinical intuition and focus effort on improving the **measured** elements of quality. While this shortcoming is recognised in discussions of national ‘targets’, it also arises when regulators or patients use specific quality metrics to monitor organisations. This problem is commonplace in public services but may be more amenable in healthcare, where a strong cross-provider professional ethic may counterbalance distorted organisational incentives. Policy to correct this problem aims to reduce emphasis on ‘ticking boxes’ and encourage **balanced** patient-sensitive care.

This paper discusses why systematic external peer review can address the major task of incentivising organisations to provide care across a wider range of quality elements, which may clash with their financial objectives.

While peer review is valued in the NHS, it is sparingly applied: self-regulation is by a single speciality, and used by invitation, either to provide remedial insight or to share clinical data and methods. Peer review is not proactive and does not address the care pathways at the interface of hospital specialities, or between primary and secondary care.

It is argued here that the form of peer review should develop to address patient pathways, thereby helping build integrated care and self-improving cultures with the relevant self-regulation. As well as providing external ‘ballast’ to counterbalance organisational pressures to narrow the scorecard along complex pathways (or not to offer certain services), the reports from pathway peer review can also increase the quality of pathway information available to trusts, patients, regulators and commissioners and hence reinforce choice in these ‘markets’. This paper also discusses whether peer review can offer good value for money.

If the implementation of peer review in England is to be successful, it should be mindful of lessons from international experience. For example, it should address clinical decision taking and patient outcomes rather than clinician ‘knowledge, skills and attitude’ or management processes, as with the notable Dutch ‘*visitatie*’ model.¹

It should also aim to be transparent and, by building upon the successful remediation programmes of the royal colleges, provide quality assurance from the collaborative context of quality development.

It is proposed that peers are used on a regular cycle to review hospital clinical standards, encompassing pathways between, as well as within, clinical specialties. This would be extended

to review certain pathways between primary and secondary care. This may be particularly relevant for 'mid-table' trusts insofar as incentives to raise quality have perhaps been least strong there.

Peer review offers a potentially cost-effective way of developing and assuring the quality of integrated care, and mitigating the adverse effects of incomplete measurement with the balancing contribution of professional insight.

Introduction

The public inquiry into ‘commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust’ will address the weaknesses in policy that resulted in an NHS Foundation Trust failing to meet minimum standards of care for a prolonged period. Regulated health markets, introduced a decade ago with the primary aim of more effectively pursuing high-quality care, not thought possible in a ‘block grant’ model, will be given a ‘report card’ that may again demonstrate the influence of ‘events, dear boy, events’.

One view of the crisis at Mid Staffs is that such cases are rare and that policy to drive quality improvement is effective: new policy might strengthen regulatory detection. A more searching interpretation of the underlying policy weakness is that hospitals give quality improvement a selective and low priority against other, often pressing, organisational objectives; in a few cases this becomes extreme. This paper considers how policy might address this second diagnosis, arguing that an appealing way to strengthen balanced quality improvement is to develop peer review, and to do so in a way that enables peer review to help resolve the complex challenges to building high-quality patient pathways.

The view that hospitals insufficiently prioritise balanced quality improvement is consistent with:

- the lengthy delay in uncovering poor care at Mid Staffs
- evaluations explaining the modest national impact of clinical audit^{2,3}

- evaluations of leading quality initiatives⁴
- continuing comparatively weak patient outcomes for major conditions relative to European Union (EU) comparators
- the slow progress to compile patient outcome data.

It suggests that at least a few other hospitals are wrestling with problems not very different to those at Mid Staffs and that policy should address the prioritisation of not merely the measured, but also the more informally recognised dimensions of quality.

But how should policy move forward in a way consistent with an over-arching approach of quality being driven by choice and contestability in regulated markets? A conventional way of addressing the prioritisation of quality of care would be to widen the activities of the healthcare regulator, adding new metrics, inspections and methodologies. The danger with this approach, quite apart from any simple cost–benefit consideration, is that pursuing the added metrics may be of modest incremental patient value relative to either existing or unmeasured metrics. Hence, by attracting the organisation’s resources, it may potentially have an adverse overall effect on patient outcomes. Attaching financial incentives to a few more quality dimensions is vulnerable to a similar critique. For this reason, and given the weight of resources currently directed towards monitoring the minimum threshold, an alternative approach is suggested here. This alternative is directly aimed at increasing quality of care in a way that balances the quality ‘scorecard’ by incentivising attention to all informally observed unmeasured quality elements.

This paper explores how a systematic approach to external peer review can complement current policy towards quality improvement, and also support Care Quality Commission (CQC) quality assurance. Peer review can incentivise both clinical and non-clinical professionals to prioritise a wide range of quality elements, including some not formally measured, against other organisational objectives. This is because non-measured dimensions of quality that lie outside contracting may be considered and reported by senior peers using their ‘authority’ to judge the value of ‘soft’ or privately viewed performance information. In this way, organisations are incentivised to provide balanced patient care despite healthcare contracts necessarily omitting many dimensions of quality.

As the population ages and the burden of long-term, chronic conditions increases, there is a shift towards treatments requiring several stages and more care in the community. Consequently, as more care is provided in the community, funding shifts from hospitals to the community and the process of assessing quality must also move in that direction. It follows that reviewers must not only assess team performance, but performance across patient pathways. Since the ‘professional ethic’ – for both clinicians and managers – remains the most important influence on whether high-quality care is delivered seamlessly, across the lines of clinical and financial accountability that make integrated care problematic, by strengthening this ethic peer review is of particular relevance to building integrated care. This paper discusses some of the challenges this significant step brings.

This paper begins by setting out how peer review is currently used in healthcare, what pathway peer review is, why its adoption could enhance quality, and whether it might offer a cost-effective route to assuring continuous quality improvement within and between teams and organisations.*

Peer review: the current picture

Peer review is the professional assessment, against standards, of the organisation of healthcare processes and quality of work, with the objective of facilitating its improvement.

Peer review is concerned with ensuring the highest levels of professional conduct and is a notable part of healthcare in England. It incentivises clinical and non-clinical professionals to prioritise high-quality care, and reinforces this effort with external ‘authority’ to lever organisational change.

It is interesting to first look at why, given the value placed on professional autonomy in clinical decisions, it is beneficial to potentially constrain individual decisions via peer review. The modern interpretation of professional autonomy is of a freedom, given by trusting patients, that is earned by a profession demonstrably practising within its standards, protocols and guidelines – which themselves evolve over time. This recognises the value of moderating individual clinician autonomy towards the standards set in the profession. The development and application of standards for complex patient pathways has also led to the development of self-regulation to

* A research report accompanies this paper, giving supporting analysis for the arguments set out here, and a discussion of the key implementation issues, underpinned by contributions from health sector leaders.

The report, entitled ‘Quality of NHS care and external pathway peer review’, is available online at: www.chseo.org.uk/papers.html

meet these growing areas. The contribution of peers to individual clinician quality is therefore already recognised and its continuing development is a critical component of self-regulation.

However, there is currently no consistent strategy in place in England for the use of external assessment to improve and assure standards, and there has hitherto been no evaluation of its potential as a system-wide approach to high-quality care.⁵ The current use of peers comprises a patchwork of schemes, some of which are unfunded and short lived. In addition, not all specialties use extensive outcome data, address the role of multi-professional teams, or look at how care pathways between primary and secondary care can be improved.

The main ways in which peer review is currently used in England are:

- individual remediation and team reviews
- sharing of information and good practice
- accreditation.

Medical royal colleges use peer review in remediation work for individual doctors and, more commonly, in service or team reviews. These reviews are voluntary and invited by providers, although some colleges are considering more proactive involvement.

However, the nature and scale of the work varies, as some institutions have no experience in this area, while others have dedicated teams working on individual and service development. Most colleges average two department service reviews or less per annum. Two of the busier colleges average 15 to 20 reviews over a five-year period and the Royal College of Surgeons has between

15 and 20 reviews a year. The reviewers are typically independent experts with specific training in peer review and remediation. Outcomes range from an individual or service action plan to referral to the General Medical Council or the CQC.

Many professional societies, regional teams and royal colleges have developed voluntary peer review programmes which, unlike remediation, look to raise standards by sharing information and good practice, rather than address a specific local problem. The aim of these schemes is to disseminate data, patient pathway information and professional experience, and a review team usually draws up an assessment. The Society for Cardiothoracic Surgery has an advanced system for collecting patient outcome metrics, using peer assessment and site visits, mostly in invited remediation work. Separately led by the National Cancer Action Team, the National Cancer Peer Review Programme has strongly encouraged involvement and now has almost 100% participation.

These royal college and professional society schemes vary in structure and degree of development. Evaluations of these review schemes are generally supportive and suggest that their strengths include:

- the improved setting of organisational priorities within relevant managerial contexts
- improvements in the quality and standardisation of services, with reviews acting as catalysts for change
- raising the information levels of commissioners with peer assessment
- helping to remove inter-professional barriers.

A number of colleges describe the importance of bespoke peer review, rather than formulaic assessment, by emphasising the importance of having expert peers to identify problems and offer recommendations.

Accreditation and peer review

Accreditation is the granting of recognition to hospitals which have high standards, with the aim of incentivising improvements elsewhere. It was initiated in 1918 by the American College of Surgeons. Major schemes in the UK include:

- those for clinical pathology
- several being managed by the Royal College of Psychiatrists
- stroke services accreditation being developed by the Royal College of Physicians
- primary medical care provider accreditation that has been piloted by the Royal College of General Practitioners.

In each scheme, an assessment is made against specific standards and an externally assessed accreditation decision with a development plan is provided following a site visit.

It is beyond the scope of this paper to explore the fine line between the preceding models of peer review and accreditation, but the most critical point is that peer review has its roots, development and application in the professions, not in a private body assuring standards agreed with professionals. Although assurance from an independent private body is in principle appealing, international experience of

accreditation has been for professionals to seek assurance that clinical decisions will only be reviewed insofar as this is acceptable to their professional organisations. This has resulted in accreditation assessments being located less close to 'actual clinical performance in terms of structure and process as well as outcome'⁶ than review by senior peers.

A systematic review⁷ examining the effectiveness of accreditation in the health sector found that it provided consistently positive findings in relation to prompting change and professional development. However, there were inconsistent findings in the areas of organisational impact, financial impact and quality metrics.

'The failure of accreditation systems to engage clinicians is not a function of accreditation per se, but appears to have more to do with a reluctance on the part of clinicians to engage with nationally set qualitative standards which impact on medical administration and clinically relevant organisational processes and may also be a function of how quality assurance programmes are organised with hospitals.' E Scrivens, 2008.⁸

In England, the examples of accreditation models for psychiatry and stroke have been shaped by royal colleges seeking to assure the application of specific critical technologies. Accreditation is well regarded in this role. However, the broader challenge is to establish a model in which assessment and quality improvement covers not only certain treatments and organisational processes, but a wide range of clinical

decisions and patient outcomes. This aim would appear to be more consistent with a peer review model, incorporating the insight of senior clinicians to assess clinical decision taking and building on royal college reviews, than an accreditation one. Peer review also grants peer esteem to those meeting the objectives of self-regulation, which may be of considerable motivational value.

Developing peer review

In market models, choice and contestability are expected to incentivise quality improvement by enabling patients to choose to be treated by high-quality providers, and thereby reward high-quality organisations with increases in volumes and revenue. Although the NHS has taken great steps to collect and provide information about quality, only certain dimensions of quality are measured and rewarded. This can lead to an unbalanced assessment of the quality of a hospital's services and an incentive for providers to focus on measured elements: an 'unbalanced scorecard'. Moreover, this incentive may have been increased by the introduction of regulated markets and a tariff in place of a 'block' grant. Healthcare, among other complex industries, is vulnerable to the limits of measurement and 'selective poor performance'.

One approach to addressing this problem is to combine the use of hard data with 'soft', more informal information – from local clinicians, managers, other employees and patients – to widen the range of quality under consideration, and for a conventional regulator to manage

this work.⁹ External peer review differs by combining hard and soft information in the context of senior peers leading quality assessment and development. This has several advantages for both improving the quality of provider services and enabling patients to choose high-quality providers. Firstly, peer review has a direct impact on quality that adds to the impact of patient choice: senior peers help design balanced quality improvement and lever change against inertia. Secondly, in acquiring soft information to build a development plan, senior peers nominated by the royal colleges and professional societies are more likely to identify problems in clinical decision taking than the arm of a traditional regulator – even if the latter has clinical agents. Provided the scheme is carefully implemented, this allows peer review to provide patients with better information, enabling choice of higher-quality providers. Thirdly, review by senior peers nominated by the colleges and societies is more able to bestow or withdraw esteem on those reviewed, and thereby motivate continuing self-improvement. An assurance process organised by a regulator is unlikely to carry the support and standing of a development process that provides assurance, led by a separate body governed by, among others, the colleges and professional societies.

To be effective, the peer review process would need to be based in the management and clinical structures of the hospital and CCG, and contain proposals for continuing self-improvement and quality development, to which the hospital chief executive would publish a response and follow-up plan.

The organisation of the peer review cycle, the ensuing follow-up work and any subsequent interactions with the reviewers, would all be undertaken by a new central body. The most basic extension of current external peer reviews would be to review all hospital clinical specialties on a four-to-six-year cycle.

A step further would be to recognise that many unresolved problems critical for patient welfare lie at the interface of the clinical specialties, and specialty peer reviews are unlikely to fully address these issues. Measurement of the integration of treatment along pathways that cut across hospital departments would be needed. The effectiveness of hospital organisation structures and processes that support clinical care, and the capacity of shared infrastructure would be reviewed once each cycle, and not partially by each specialty review. This would imply review teams containing an appropriate range of clinical and non-clinical professionals. This approach would be a starting point, with pathway peer review being developed from this base. The positioning of this work within the NHS organisation structure is discussed in the accompanying technical report, in which the establishment of an independent Peer Review Commission is proposed.*

The case for pathway peer review
Pathway peer review would provide a systematic, external process that is aligned to patient pathways, rather than individual clinicians, specialties or hospitals. The benefits of introducing a system of pathway peer review into the existing NHS

architecture extend beyond that of helping to overcome the unbalanced scorecard by widening the range of qualities being incentivised, to include the following.

Self-regulation aligned to patient pathways

Self-regulation in the NHS does not currently take into account multi-specialty teams or the increasingly important patient pathways between both primary and secondary care and clinical specialties within hospitals. The use of pathway peer review could be highly beneficial when developing and assessing standards, protocols and guidelines for patients with complex care needs or long-term, chronic conditions.

From a patient perspective, those with long-term conditions are more concerned about quality across their whole experience of care, rather than that provided by any one organisation. Furthermore, guidelines from the National Institute for Health and Clinical Excellence (NICE) are increasingly setting standards for care across patient pathways. Peer reviews that assess against such standards will need to assess pathway performance.

Advances are being made in the measurement of integrated care¹⁰ and the development of patient experience metrics across the care pathway. The Department of Health (DH) has recently responded to these developments by issuing interim guidance¹¹ on measuring patient experience of integration in the NHS. This includes the identification of seven core questions, included in current patient surveys, to

* The report, entitled 'Quality of NHS care and external pathway peer review', is available online at: www.chseo.org.uk/papers.html

develop a sense of how patients feel about integration.

A range of methods for measuring integration have been identified in the literature, including:¹²

- questionnaire survey data, for example patient experience surveys, which have been the focus of DH policy officials in responding to calls from the NHS Future Forum¹³ and the King's Fund/Nuffield Trust¹⁴
- automated register data, for example the number of skilled nursing care beds within hospitals and the number of home health visits;¹⁵ emergency hospital admissions and discharges from hospital directly to residential or nursing care¹⁶
- mixed data sources, for example the indicators used in Hebert and Veil's¹⁷ mixed measurement tool.

Encouraging integrated care

Conducting peer review along patient pathways may help those working across the health and social care sectors to build relationships and reduce organisational barriers. There might nonetheless need to be a shift in the attitudes of some staff to accept constructive criticism from peers across the health and social care sector. This could be particularly important in circumstances where colleagues (as peers) review each other's work. However, this type of review may also foster joint responsibility for the whole pathway of care, and provide both an incentive and an opportunity for clinicians in different sectors working across patient pathways to challenge each other's practice.

Given the different systems of performance management in general practice, community healthcare, hospitals and social care, each sector is at a different stage of accepting constructive criticism from colleagues in other parts of the health and social care system. Although primary care trusts (and clinical commissioning groups in the new system) use contracts with hospitals to performance-manage them, there is no tool that hospitals might use to performance-manage GPs. Hospitals are therefore likely to be more used to being performance-managed by other players in the system. Agreeing terms of reference for the peer reviews is also likely to be difficult when each organisation working along the patient pathway must agree the terms and priorities.

However, these obligations to work together may themselves be a benefit of pathway peer review in terms of forcing different sectors to work together and encouraging integrated care.

Provision of high-quality information

Pathway peer review can provide high-quality information that supports patient decisions and helps organisation leaders to establish priorities and identify and justify change.

NHS policy emphasises the importance of there being transparency about the quality of services provided. Information about patient outcomes is positioned as the key tool for informing patient choice, shaping managerial decisions and raising quality of care. However, there are difficulties in measuring providers' performance¹⁸⁻²¹ and in users interpreting this information to

make informed decisions.²² Furthermore, in specialist clinical areas, hard data and inspection information may not be sufficient to accurately assess quality of care.

The review of performance information by informed, expert clinicians provides an objective assessment of performance data which takes into account the usefulness of the given dimensions of quality. This gives patients a rich information base to support choice, and can reduce misunderstandings arising from information overload and shortcomings. It adds 'softer' information from local clinicians, managers, other employees and patients. This might include, for example, analysis of patient complaints data. It may also provide information that enables host organisations to make better decisions and lever action.

By providing a long-term quality improvement plan for the organisation, pathway peer reviews can also encourage quality to become a regular item for trust boards, and help give items such as employment policy a long-term emphasis, rather than a short-term one.

Targeting of poor performers

Pathway peer review will require selective investigation, given the many pathways being used, and could be targeted at the poor performers within a pathway, with prioritisation driven by the CQC or commissioners. And, as national clinical audits for long-term conditions are increasingly focusing on patients rather than organisations (therefore incorporating data on, for example, general practice and social care), it might soon be possible to

drill down in the audit data to see where there might be weak areas of performance along the patient pathway.

Providing incentives to 'mid-table' performers

At present, resources supporting quality change are largely directed towards high- and low-performing institutions. Peer review may add most to the 'mid-table' performers, where further development is desirable and not exceptionally challenging to define, but also where the problems raised by minimum thresholds of performance do not require statutory levers.

Addressing reservations about self-regulation

Self-regulation has a long history and has been widely applied in many industries. However, it has also been the target of extensive criticism, and awareness of this is valuable in the design of NHS policy.

Lawyers view self-regulation as giving power to groups that are not politically accountable and, given the centrality of the quality of the NHS to politics in England, it is important that any major extension of self-regulation operates in a context that gives democratic legitimacy.

Economists emphasise how self-regulation may potentially limit competition by erecting barriers to entry and encouraging the development of standards that create benefits to suppliers, rather than consumers/patients.²³ However, more recent analysis has looked to identify circumstances in which self-regulation may contribute to efficiency, relative to direct government regulation.^{24,25}

The comparative efficiency gains from self-regulation arise in contexts where professionals have superior knowledge of the matters to be regulated. These potential gains must be set against any losses incurred because regulated professionals may pursue their interests by influencing the regulatory process.

The models of peer review discussed below have a public-private mix and are not, strictly speaking, self-regulation: the framework is given by an arm of government, but is made concrete, and applied, by professionals. The risk that certain professionals pursue self-interest is reduced by the specific nature of the delegated regulation and by appointing senior reviewers who are named by professional societies and royal colleges, and not employed by competing providers. Other facets of implementation can also help reduce the risks.

Towards pathway peer review

Although there is a strong case for introducing pathway peer review, there is perhaps little sense of how this might actually be done. This is because current NHS quality assessment programmes are limited to evaluating a single institution or specialty. The greatest value from pathway peer review can be gained by extending it from specialties and/or hospitals through patient pathways to assess the integration with primary care and the quality of that care.

Although probably still based in the management and clinical structures of the hospital and its partner providers, the peer review assessment would move beyond

the current focus on single specialties or organisations. It would consider quality along pathways that cut across hospital departments, general practice and other professionals delivering integrated care. The focus would be on patient outcomes and experience, and it would require the development of more clinical specialty outcome data, evidence of the quality of the chronic care pathways and an assessment of the degree of integration.

Peer review of clinical specialty teams already exists in some areas of the NHS. However, there are lessons from the analysis of pathway peer review that can help make specialty peer review more effective, even if the organisation is not ready or equipped to move to a pathway model just yet.

The focus of regular, in-depth quality assessment of specialties should be on clinical decision making, patient outcomes and experience. The review team should be fully briefed to inform its understanding of outcomes and experience. In certain specialties, reviews will require the development of more patient outcome data. The approach would resemble that of the royal college team reviews referred to earlier, but would include relevant non-medical professionals and patient representatives.

There is currently a shortage of relevant, conventional metrics for the quality of care along that pathway. One strategic approach that may help overcome this is to collect the perceptions of senior participants on the degree of cooperation and local pathway care quality. The results would be analysed and benchmarked, along with the available hard evidence, to provide a basis for a peer review.

Can peer review be cost-effective?

Peer review is clearly not a costless activity. It requires resources – largely staff time – which would otherwise have an alternative use. This time can be valued using wage rates, taking into account the time of the staff being reviewed, as well as for the staff conducting the review itself. Depending on the scheme's design, this may include time for reviewing data, for conducting peer review visits, and for providing subsequent written reports or feedback.

The most common criticism made against peer review schemes is their expense. They must be demonstrably cost-effective, justifying their cost through a mix of improved patient outcomes and greater efficiency.

Despite its importance, value for money has not been a focus of existing research on peer review. However, estimates of the costs and benefits of a recent peer review scheme on chronic obstructive pulmonary disease (COPD), drawing upon a randomised controlled trial, indicate significant net benefit that is well above the NICE threshold for accepting a new intervention.²⁶ By combining the staff time required with standard unit costs,²⁷ the cost of each peer review visit was estimated to be approximately £12,000. However, the peer review scheme was associated with increased use of three particular interventions, yielding a benefit of 2.4 patient life years per hospital per year, alongside some additional resource savings. The cost per life year of this peer review scheme compares favourably with

alternative healthcare interventions and the NICE benchmark of £30,000 per year. Indeed, the benefits exceed the costs if the life years are valued at just £2,750 each. While these results concern only COPD, the return is sufficiently high to be promising for other areas.

While the COPD scheme gives evidence on value, further assumptions are needed to estimate the likely cost of a peer review scheme covering all specialties. A rheumatology peer review scheme²⁸ also provides evidence on staff time, covering preparation, subsequent reporting and the peer review visit. Under plausible assumptions, staff costs are similar to the COPD scheme. If extrapolated across all secondary care specialties and spread over a six-year cycle, as with the rheumatology scheme, the total annual cost of a national scheme would be about £40m, before allowing for any cost savings that the new ways of working would permit, or savings from the current peer review work. This figure is the full 'opportunity cost', and exceeds the set-up cost by, for example, the cost of employee time already purchased by providers.

By way of comparison with a major peer review programme (albeit not from health), the Research Assessment Exercise (RAE) for university research (now the Research Excellence Framework (REF)) is part of the process used to allocate research funding and takes place every five to seven years. Considering both the costs to those assessed, as well as running costs, the scheme cost just under £60m, spread over seven years.^{29,30} This is

equivalent to 0.5% of the total funds that the RAE allocated over the same period. Extrapolating the cost of the rheumatology scheme to the rest of the NHS suggests it would cost 0.15% of funds allocated.

If the public purse is prepared to adopt a peer review scheme to quality assure academic pursuits that cost 0.5% of the total education budget, surely there is scope for the NHS to adopt a similar scheme, especially when it would come in at 0.15% of health funds.

Observations

Pathway peer review is a development that could not only address the profound challenge to patient care that arises from the many important but poorly-measured components of quality, but should be formed to also meet the growing need to assess quality across the patient pathway and address the integration of care.

Some overarching observations regarding the implementation and policy implications of such a scheme are as follows.

- Long-term and serious quality failings at a hospital are understood by investigating the failure of that hospital to prioritise quality of care, rather than the failure of the regulatory body to detect the problem. But to ask a public inquiry why a hospital has not prioritised the quality of care is highly political because it asks about the very centrepiece of the past decade's health reforms, advocated by successive governments and widely popular with patients: the introduction of regulated markets with the purpose of increasing quality to the highest levels. The evidence concerning Mid Staffs and the neglect of what is not well-measured suggests that establishing balanced high-quality care requires an incisive policy that would complement regulated markets. This policy would address how to protect and prioritise the balanced delivery of patient care in circumstances when other organisational interests may intervene to inhibit the provision of unmeasured elements of care.
- The proposal here is that the English system of regulated markets may benefit from systematic external professional self-regulation to promote improvements in the quality of care, and to help assure quality by increasing the influence of the professional ethic to protect the balance of care. Thus the assurance of high-quality outcomes would be partly provided on the basis of a judgement by senior professionals given the freedom to identify problems. Pathway peer review offers the prospect of mitigating the adverse effects of the powerful but coarse policies of regulated markets, with the balancing contribution of professional insight.
- In order to manage the scale and diversity of chronic care where patients have a number of co-morbidities, pathway peer review should not be focused on clinical specialties (at least not in all cases), but instead on broad categories of aspects of care, for example for older people, children or those with end-of-life needs.

- Peer review may have been considered too expensive to take forward. The analysis here, and in the accompanying report,* suggests that this is unlikely to be the case, and that it represents a potentially highly worthwhile investment to help pursue not only balanced high-quality care, but also a staff invigorated by the reinforced role and standing of the professional ethic.

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