The UK: your partner for global healthcare solutions

Improving the quality and safety of patient care

HEALTHCARE IS GREAT
BRITAIN & NORTHERN IRELAND

HealthcareUK

A vital partner in global healthcare

The UK is internationally renowned for delivering excellent healthcare. Our National Health Service (NHS) is the world's largest integrated health system. It has provided high-quality services for nearly 70 years, supported by the top academic institutions in the world, as well as innovative commercial healthcare companies.

All of these combine to offer a breadth and depth of expertise that no other country can match.

Healthcare UK is your route to access this expertise

Whatever type of health facility, service or training programme you are planning, we can bring together the right UK organisations to meet your needs. Our position in government gives us an excellent platform to support and promote international collaborations, working with the United Kingdom Trade and Investment's international network of offices in 107 markets around the world.

To find out how you can draw on UK expertise to extend, improve and transform healthcare provision in your country, contact Healthcare UK:

Call: +44(0) 20 7215 5000
Email: healthcare.uk@ukti.gsi.gov.uk
Visit: www.gov.uk/healthcareuk

UK Trade & Investment

Department of Health

NHS

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Foreword

In 2014, the Commonwealth Fund named the NHS the number one healthcare service for safe care, ahead of Australia, Germany and the United States. While this is an amazing achievement, I believe what makes the NHS stronger than any other health service is that we know how important it is to be constantly improving.

We also know that there is nothing more vital to improvement than getting the culture right. In the NHS we recognise that blame is a barrier, and always encourage our staff to be open and honest about mistakes. This allows us to learn, improve, and prevent errors from being repeated.

As part of this, over a decade ago we launched the National Reporting and Learning System, which today receives more than 1.7 million reports a year. These reports provide vital insight into what is happening on the NHS frontline, and help us further our knowledge in the measuring and monitoring of patient safety. More importantly, the reports make it possible for us to quickly identify and raise awareness of emerging or under-recognised risks, which in turn helps us prevent them.

We are also developing a brand-new reporting system, which will provide further depth to our incident reporting, analysis and learning strategies. Furthermore, to help our staff better understand avoidable harm, we will soon roll out new best-practice guidelines for retrospective case reviews that deal with deaths in acute hospitals.

The NHS is now more open and transparent than ever before. Patients can access public information about their local healthcare providers, enabling them to make informed decisions about their care based on an organisation's safety record. They can also give their feedback, which we know helps us improve further.

Going forward, our focus will be on facilitating collaborative work between individuals and organisations in order to improve frontline services, while at a national level we'll continue to develop innovative programmes that tackle the underlying causes of risk in healthcare.

We understand that there is plenty of hard work ahead, but we're dedicated to building on the momentum we have, and remain committed to making patient safety in the NHS the envy of the world.

Dr Mike Durkin

National Director of Patient Safety, NHS England

> **"The NHS was named the number one healthcare service for safe care"**

Withdrawn on 19 November 2020

The UK
Your partner for patient safety, quality and care

Over the last 50 years, healthcare in the UK has been transformed from a world where high-quality healthcare was merely assumed, to one of accountability and transparency.

Patient safety is now recognised to be something that every healthcare professional must hold at the very heart of what they do.

This has progressively improved outcomes for patients and, crucially, reduced variation between different hospitals and doctors. This consistency across the NHS gives patients the confidence that whichever doctor they see, in whichever organisation, they can be sure to receive the highest standard of care, delivered in a safe manner.

But it is not possible to be too safe. That's why we aim for a future where avoidable harm is prevented, where 100% of patients achieve the shortest, most uneventful hospital admissions, and where everyone achieves the best possible outcome.

This brochure outlines some of the initiatives the UK is currently pursuing, and the organisations which are leading the way in standards of safety. The different sections also provide information on the partners who can best help you achieve your goal of safer, better healthcare.

"It is not possible to be too safe"

Withdrawn on 19 November 2020

Section one
Setting the standards

1 Healthcare guidelines

National Institute for Health and Care Excellence (NICE)

Since it was founded in 1999, NICE has been an integral part of the NHS. It sets evidence-based, best-practice standards for healthcare professionals, on topics that range from preventing specific conditions, managing medicines in different settings, providing social care to adults and children, to broader services that seek to improve the health of communities.

In order to meet international demand for more cost-effective healthcare delivery, NICE International was established to offer advice and support on a not-for-profit, fee-for-service basis.

In the UK, we have professional bodies who define the standards that patients can expect from healthcare organisations and staff.

These standards cover everything from medical tests and care pathways to treatments for particular medical conditions. These standards fit within four main areas:

1. Healthcare guidelines
2. Medical competence
3. IT systems
4. Developing quality infrastructures

For each of these areas, we will outline the main organisation whose responsibility it is to set the standards, as well as case studies demonstrating the work they do.

Case study 1: NICE International

Developing clinical pathways in rural China

This joint programme by NICE International and the China National Health Development Research Centre aimed to improve health services for China's rural population of nearly 800 million people.

NICE International worked with senior practising NHS and Chinese clinicians to pilot best clinical pathways at hospitals in the Shaanxi and Chongqing provinces. Their aim was to find alternatives to existing failing interventions, such as elective caesarean section and pharmacological management of hypertension.

After a successful pilot the new approach is now being scaled up to include more than 40 counties across China.

www.nice.org.uk

Case study 2: Evidence Based Networks (EBN)

Creating a national medicines formulary in Kazakhstan

A national medicines formulary contributes to good decision-making on the frontline of patient care, giving all healthcare professionals access to the same information about medicines.

When the Kazakhstan government decided to invest in creating a national formulary, they chose to work with the UK's Evidence Based Networks (EBN).

Working from guidelines put in place by NICE and the World Health Organisation, EBN was able to create the Kazakh National Medicines Formulary in just six months.

www.evidencenetworks.com

Withdrawn on 19 November 2020

3 IT systems

Whether it's hardware, software, or a combination of the two, IT in healthcare can deliver significant benefits. However, failure or unintended use of IT systems have the potential to cause serious hazards, possibly leading to patient harm.

It is therefore essential that IT systems be carefully monitored and stringent safety standards put in place.

Case study 4:
Health and Social Care Information Centre (HSCIC)

Clinical risk management for healthcare IT systems

The Health and Social Care Information Centre has established an IT safety management framework, which is rolled out across NHS England. They have published two safety standards, one for IT system development and another for health organisations implementing and running IT systems. These standards address the clinical risk of IT systems by encouraging a culture of safety, as do the additional services they offer:

Clinical safety services
Train staff in the clinical and technical risks inherent in IT healthcare systems

Executive management services
Explain the regulatory and contractual requirements of the HSCIC standards, and offer an assessment of liability within the healthcare IT environment

Clinical safety incident management
Teaches effective risk management through the careful and considered analysis and assessment of clinical safety incidents related to IT healthcare systems

www.hscic.gov.uk

2 Medical competence

The UK's Royal Colleges

The UK has 14 Royal Colleges that set and monitor the standards of postgraduate medical training, ensuring that every doctor – whatever field they specialise in – has been trained to operate to the highest possible standard.

Case study 3:
Royal College of Obstetrics and Gynaecology (RCOG)

Developing a Global Health Toolkit for women

Founded in 1929, the Royal College of Obstetrics and Gynaecology now has over 12,500 members worldwide, working to improve the standard of care delivered to women, encourage the study of obstetrics and gynaecology (O&G), and advance the science and practice of O&G.

The RCOG's Global Health Toolkit provides a practical guide to help different countries develop the protocols, care pathways, standard operating procedures and clinical practice standards that are best suited to their country.

The RCOG also offers three types of review, each designed to help employers, commissioners and managers provide safe and sustainable services:

Service review
The RCOG team will visit with the clinical team, managers and other stakeholders, and report on the safety and quality of their current service

Individual performance review
This review is an examination of the clinical practice of an individual doctor who is causing concern, and can include case-note reviews and independent second opinions

Configuration review
This is carried out when commissioners and healthcare organisations need clinical assurance of proposals for significant changes to local O&G services

www.rcog.org.uk

4 Developing quality infrastructures

The UK has well-established and highly regarded institutions charged with setting standards to achieve effective, efficient systems and processes that reduce risk and promote quality services.

Case study 5: United Kingdom Accreditation Service (UKAS)

Accrediting medical laboratories in Dubai, United Arab Emirates

UKAS' international accreditation provides an independent assurance of safety, quality of care, and a commitment to continually improving patient experience.

It also ensures that the awarded facility's results are accepted as equivalent to those from a UK-accredited laboratory, meaning they will be accepted in over 60 countries around the world.

Clinical Pathology Services (CPS) is a UAE-based company with a purpose built, privately owned medical laboratory for clinical laboratory testing. Since 2009, CPS has been accredited as one of the highest quality clinical pathology services in the region.

It is accredited to carry out testing in the areas of blood transfusion, clinical biochemistry, haematology and microbiology. Accreditation has enabled the laboratory to win new business, such as workplace alcohol and drug screening of aviation employees at UAE airports.

www.ukas.com

Section two
Regulations and licensing

Once standards have been set, it's important to make sure they are adhered to. If standards are not met, then the license to practice or operate can be revoked. This ensures patients can be confident of the quality of care they receive.

Government regulation provides a set of rules against which to assess the standards that are set for NHS organisations, facilities and staff. The government bodies charged with regulating healthcare are divided into three main areas, based on who or what they regulate:

1. Healthcare professionals
2. Healthcare organisations
3. Specialist areas of medicine

1 Healthcare professionals

The Professional Standards Authority for Health and Social Care

There are nine separate regulatory bodies that focus on different healthcare professions, such as midwives, dentists and opticians. Overseeing these bodies is the Professional Standards Authority. They monitor performance, conduct audits, scrutinise the decisions taken by these regulatory bodies and report to Parliament.

They also set standards for organisations holding voluntary registers for health and social care occupations and accredit those that meet the standards.

Case study 1:
The Professional Standards Authority

Regulation for support workers in Ontario, Canada

The Authority works in the UK and with colleagues around the world to analyse strengths and weaknesses in mandatory and voluntary regulation, improve regulatory performance, advise on regulation policies and support both individual regulators and governments. All with a view to improving patient safety.

The Ministry of Health and Long Term Care in Ontario, Canada, is committed to improving the quality of care and safety of older people and adults with long-term conditions or disabilities, who receive help from personal support workers.

In 2015, they chose the Authority to review the Ontario Personal Support Workers Registry, conduct a gap analysis and make recommendations for future improvements. Over a four-month period, the Authority was able to analyse the gaps in the existing arrangements, interview and involve many local stakeholders, conduct a review of alternative models and make practical recommendations for improvements and change. The Ministry said that the review provided valuable guidance and insights for their overall strategy.

2 Healthcare organisations

The Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator for quality in health and social care in England, covering both the NHS and private providers. It registers and inspects hospitals, care homes, GP surgeries, dental practices and other health and care services and facilities. If services are not meeting the required standard of quality, care and safety, the CQC has the power to issue warnings, restrict the service, issue a fixed penalty notice, suspend or cancel registration, or prosecute the provider.

The questions the CQC asks of each facility are:

• Is it safe?
• Is it effective?
• Is it caring?
• Is it responsive?
• Is it well led?

Case study 2:
Guy's and St Thomas' NHS Foundation Trust

Quality Accreditation for British military healthcare in Germany

Over the last 20 years, Guy's and St Thomas' (GSTT) have worked in partnership with SSAFA, the Armed Forces charity, to provide high-quality healthcare to British Armed Forces personnel based in Germany through a network of hospitals accredited to GSTT standards.

Five hospitals were selected to provide services. Each is formally accredited using a peer review quality assurance model which includes an assurance protocol, risk management, data review, as well as reviews of safety and quality evidence.

The approach makes use of a comprehensive assessment tool developed by GSTT, which is used during on-site visits by senior GSTT clinicians and hosted by the local clinical directors. Together, the British and German teams agree assurance reports with commendations and recommendations to improve services.

The approach is rooted in two-way learning, mutual respect and collaboration and has resulted in longstanding, strong relationships between the clinical teams, leading to improvements in the quality and safety of clinical care.

www.gsttcommercialservices.co.uk/international-services

Case study 3:
Verita

Governance framework for patient safety, Shining Towers Clinic, Abu Dhabi, UAE

Verita is a leading UK independent healthcare consultancy, which has developed a range of tools designed to identify the conditions that are known to be unsafe for patients.

In 2014 Verita supported the opening of King's College Hospital NHS Foundation Trust's Shining Towers Clinic in Abu Dhabi. As part of King's goal to give patients at Shining Towers an experience comparable to those in London, Verita worked to embed a strong governance framework that was properly communicated and rigorously implemented.

The project involved taking policies and procedures used in London and applying them in Abu Dhabi, ensuring that they were culturally and legally acceptable.

Verita tested the newly developed governance arrangements to ensure their practical application met the needs of the population in the UAE, and worked in conjunction with King's management so that all staff were aware of how the framework affected them in the day-to-day running of the clinic, establishing a rigorous safety culture.

www.verita.net

Case study 4:
Fieldfisher LLP

Patient safety regulations in a Gulf free zone

In all areas of healthcare there are legal procedures that it is important to get right. These legal complexities differ from country to country, which is why the UK has a number of highly regarded law firms that specialise in all areas of healthcare law.

Fieldfisher is a full-service law firm with a specialist team focused on healthcare regulatory frameworks. They work alongside many of the UK's regulators of healthcare professionals, providers, medical products, devices, tissues, embryos and cells, helping create appropriate regulation to ensure that safety is at the heart of every service.

Fieldfisher drafted a framework for a Gulf free zone covering healthcare liability and claims, with documents from a Ruler's decree through to procedural regulations. They helped advise on patient contracts and consent forms, as well as a complaints procedure that put patient safety at the core. The providers of healthcare services were able to better understand and predict how complaints and concerns would be addressed and patients could be confident about the quality of service they could expect.

www.fieldfisher.com

3 Specialist areas of medicine

The UK's healthcare regulatory bodies extend to those that focus on very specific areas of healthcare, often dealing with innovative areas of medical practice.

Case study 5:
The Human Fertilisation and Embryology Authority (HFEA)

Established in 1991, the Human Fertilisation and Embryology Authority was the world's first regulator of assisted reproduction and human embryo research. The HFEA have since helped the UK establish a peerless reputation for innovation and safety in this fast-moving field of medicine.

The HFEA's regulatory requirements have evolved over time, and are incorporated into the HFEA Code of Practice. This Code of Practice combines risk-based assessment tools, patient safety reports and inspections of all clinics. These regular inspections identify concerns relating to laboratory practices, the impact of drug courses provided to patients, patient consent, and understanding the patient experience at each clinic.

The HFEA can provide a wide range of help and assistance to clinics or governments looking to develop their assisted reproduction services:

- Implementation of the HFEA Code of Practice
- Inspection methodology and tools to promote patient safety
- Establishing a national patient safety reporting system
- A methodology for undertaking root-cause analyses of incidents to extract the maximum learnings
- The preparation and publication of a national report of incidents to promote learning and improvement

www.hfea.gov.uk

"High-quality care for people affected by assisted reproduction"
The HFEA mission

Section three

Measuring the quality of safety and care

National Reporting and Learning Service (NRLS)

Set up specifically to help learning and improvement, the National Reporting and Learning Service is a database of patient safety incidents submitted by organisations across the NHS. Acute hospitals, mental health services, community trusts, ambulance services, primary care organisations - they all report incidents to the NRLS.

National patient safety experts then study the incidents in order to spot trends, emerging risks to patient safety and any specific areas for concern.

The NHS then use the experts' reports to identify and prevent emerging patterns from becoming nationwide problems.

The NHS Safety Thermometer

The NHS Safety Thermometer was developed by the Innovation and Improvement Science Centre (Haelo), in partnership with Salford Royal NHS Foundation Trust and NHS England. The objective was to create a tool that would allow NHS Trusts across the country to improve their patient safety using a simple measuring tool.

In 2015 the National report from the Safety Thermometer included data from surveys of 6.6 million people, across 1,156 organisations. This information has not only promoted awareness and prompted frontline action to reduce pressure ulcers, falls, urinary tract infections and venous thrombosis, but has also shaped a new era of measurement in the NHS, where measurement greatly increases an organisation's ability to understand change over time.

www.haelo.org.uk

It is not possible to guarantee that a healthcare system is safe for patients unless policy-makers and funders are aware of what is going on across that system.

It is therefore vital that we record as much information as possible about our healthcare systems, in order to draw key insights that can be reviewed and actioned.

In the UK, we make sure to get a fully rounded view of the safety and care in our healthcare systems by using information collected and analysed in the NHS, as well as by independent companies.

Withdrawn on 19 November 2020

Case study 1:
Salford Royal NHS Foundation Trust

The impact of quality improvement

A prime example of patient safety excellence, Salford Royal NHS Foundation Trust has not rested on the laurels of their 'outstanding' rating from the CQC. They have worked very hard to underpin this, striving to become the safest organisation in the NHS. Since 2008, fundamental improvements in the quality of care have resulted in outstanding outcomes, including:

- Top 10% in the country for risk adjusted mortality
- 51% reduction in cardiac arrests
- Over 365 days without a grade 3/4 pressure ulcer
- 79% reduction in grade 2 pressure ulcers
- Consistently rated in the top 3 for patient and staff satisfaction

Salford Royal, a teaching hospital with extensive, new-build training facilities, now works with the University of Manchester and University of Salford to deliver world-class healthcare and leadership education. They work nationally and internationally supporting clients, strategic partners and leaders to deliver the very best in quality care and patient safety.

www.srft.nhs.uk

"Outstanding"
The Care Quality Commission (CQC)

Case study 2:
Dr Foster

International hospital benchmarking: Global Comparators

Global Comparators is a member-led collaborative set up by Dr Foster. It provides its 40+ member hospitals with the ability to benchmark key indicators for outcomes such as mortality, length of stay, readmissions and complications of care against peers from 11 countries from Europe, America, Asia-Pacific and the Middle East.

The dataset, formed from the administrative data for all Global Comparators members, is the foundation for researching the causes of variations in outcomes of care, seen within and between countries, as well as examining the health economics.

Peer-reviewed publications are a core output, and the ability to network with colleagues on pertinent topics leads to sharing of best practice and improvement in quality and efficiency of care, the world over.

www.drfoster.com

The Dr Foster Quality Investigator

Dr Foster is a trusted partner of over half of all hospitals in England, its Quality Investigator tool allowing them to monitor and manage clinical quality and patient safety.

Making sense of valuable data, it allows hospitals to measure, benchmark and analyse mortality rates and other indicators of quality, including length-of-stay and readmission rates.

Section four
Education, learning and development
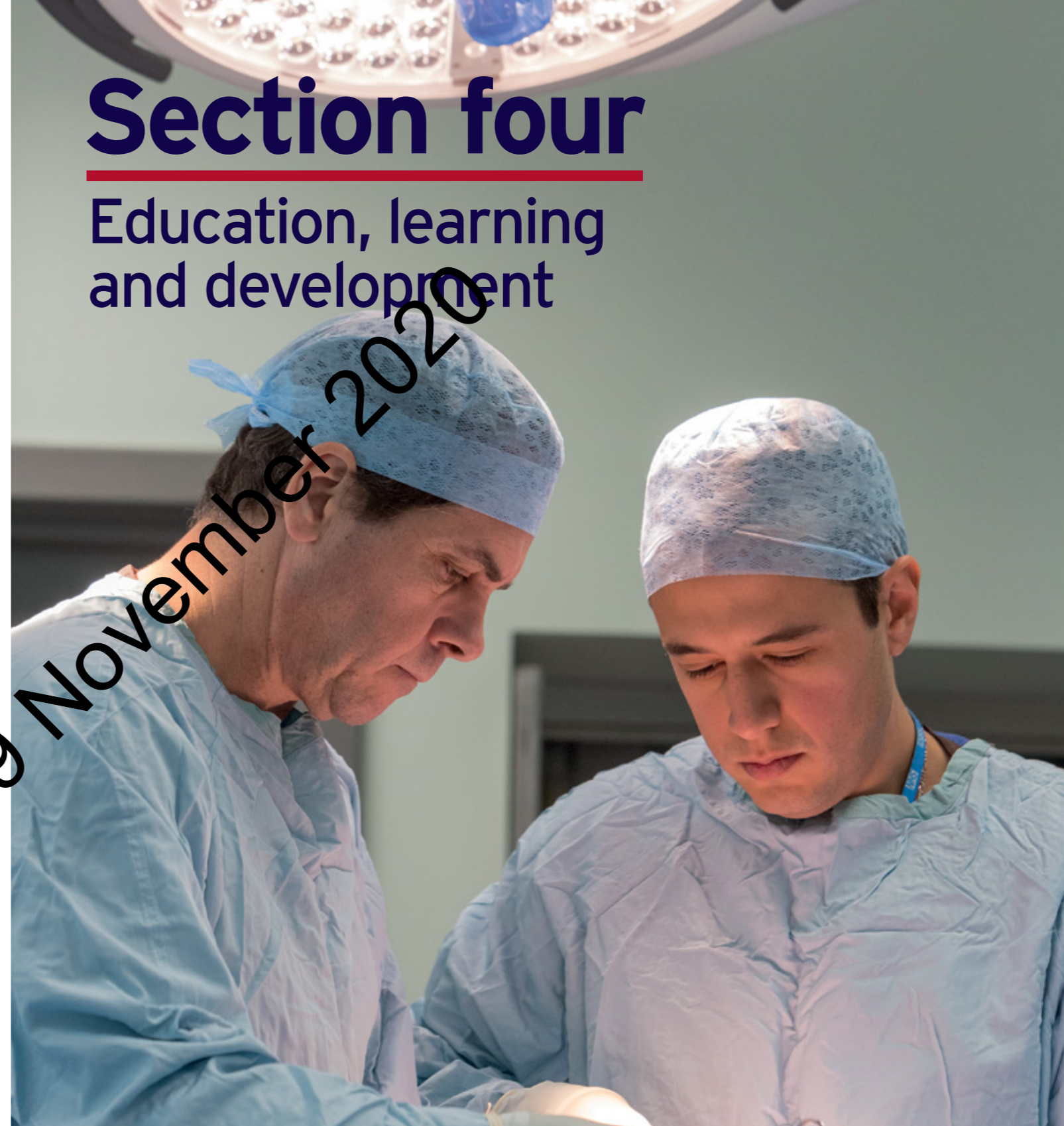
Within the UK, a focus on patient safety is embedded in all levels of education and training for healthcare professionals.

This can be broken down into three key areas:

1. Undergraduate and postgraduate training
2. Continuous improvement
3. Staff development

1 Undergraduate and postgraduate training

Case study 1: University of Dundee and Ninewells Hospital

The Improvement Academy at Dundee's Ninewells Hospital provides a centre of excellence for further education and development. The Academy's comprehensive curriculum addresses the ever-increasing worldwide emphasis on quality and safety, offering a wide range of programmes including a distance-learning MSc in Quality Improvement, delivered in partnership with the NHS Tayside. This course equips health professionals with the skills to influence and lead quality improvements in practice.

The University of Dundee and NHS Tayside, working under the Academic Health Science Partnership in Tayside, are also committed to developing bespoke Master Class Courses aimed at supporting Continued Professional Development (CPD) in overseas markets.

The University's undergraduate curriculum includes the module Recognising Acute Deterioration: Active Response (RADAR). This course provides an innovative approach for healthcare students to practise patient safety in the protected environment of simulated scenarios with simulated patients.

www.ahspartnership.org.uk/ quality-and-safety

Case study 2: Master's degrees in Patient Safety and Health Policy, Imperial College London

Imperial College London is a world-class research and education institute, consistently acknowledged for excellence in scientific, engineering and medical research.

Underpinned by the latest research in patient safety and strong links with global-health thought leaders, ICL's Master's degrees in Patient Safety and Health Policy are helping shape the next generation of health policy makers.

The Master's degree programmes are designed with the aim of equipping students with dual theoretical understanding and practical knowledge of pertinent issues in patient safety and health policy. Most importantly, students are linked with the necessary resources to influence future positive change.

International students, in particular, benefit tremendously from and contribute to the richness of the learning experience. Upon returning to their home countries, students are able to apply newly acquired knowledge to their local patient safety challenges.

www.imperial.ac.uk/medicine

2 Continuous improvement

3 Staff development

Case study 3:
NHS Improving Quality (NHSIQ) Patient Safety Collaboratives

NHS Improving Quality (NHSIQ) coordinate a network of 15 Patient Safety Collaboratives, to help support continuous improvement in quality and safety of the NHS for patients.

These collaboratives, led by England's Academic Health Sciences Networks (AHSNs) make up the largest and most comprehensive network of its kind in the world.

The collaboratives tackle the leading causes of avoidable harm to patients. They empower local patients and healthcare staff to work together to identify safety priorities and develop solutions. These are then implemented and tested within local healthcare organisations before being shared nationally with the other collaboratives.

www.nhsiq.nhs.uk

UCL Partners

As one of the 15 Patient Safety Collaboratives, UCL Partners has a strong focus on improving patient safety and on developing the improvement capabilities among front-line staff. This is essential to improving safety, outcomes and patient experience for a population of over six million people.

Currently, UCL Partners is working on two processes aimed at improving the identification and treatment of sepsis and acute kidney injury (AKI).

www.uclpartners.com

Case study 4:
Yorkshire & Humber Improvement Academy (YHIA)

Part of the Yorkshire and Humber AHSN, the YHIA has been supporting organisations across Yorkshire to improve their patient safety standards with several new initiatives:

Reducing Hospital Falls
YHIA designed an effective, multi-component intervention to support frontline hospital teams in reducing patient falls. The intervention has supported more than 50 frontline teams across Yorkshire to deliver impressive results, demonstrating a return on investment of 400%. This has contributed widely to a cultural shift away from accepting patient falls as inevitable, towards a proactive approach of prevention.

Mortality Review Programme
Hospitals need effective methods of learning from deaths in order to improve quality and safety of hospital care. The YHIA's standardised, evidence-based review is quick and easy to carry out, integrates easily with other hospital quality programmes, and allows learnings to be drawn from every case – including feedback from good practice.

Achieving Behaviour Change (ABC) for Patient Safety
YHIA has developed an effective programme to make theories of behaviour change more accessible to healthcare professionals and managers who are responsible for generating change. Over the past two years YHIA has supported teams across the region to apply these methods successfully to change staff behaviour towards safer practice.

Case study 5:
The Sign up to Safety Campaign: NHS England

NHS England launched this national safety campaign in 2014, with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The campaign aims to reduce avoidable harm by 50% and save 6,000 lives in the process.

The campaign encourages all organisations and individuals within NHS England to commit to 5 pledges:

- to put safety first
- to continually learn
- to be honest
- to collaborate
- to be supportive

Organisations turn their actions into locally led, bespoke safety improvement plans that set out what the organisations will do over the next 3-5 years to reduce avoidable harm and save lives within their organisation.

Withdrawn on 19 November 2020

The UK's proud history of patient safety

Today, NHS patients can expect the highest standard of care. This is because every individual and every organisation across UK healthcare puts patient safety at the heart of what they do. These high standards are the result of decades of work by the NHS along with local and national government.

2014 NHS England launched "Sign up to Safety", a national patient safety campaign.

2014 NHS England and NHS Improving Quality establish 15 Patient Safety Collaboratives, led by England's Academic Health Sciences Networks (AHSNs).

2013 The National Advisory Group on the Safety of Patients in the UK, led by Professor Don Berwick, publishes their report.

2012 Medical revalidation comes into force across the NHS in England.

2011 97% of NHS Trusts participate in the "Matching Michigan" improvement programme, led by the NPSA.

2013 NHS England announces that it will publish outcome data on individual surgeons across ten specialities.

2013 Imperial College London proposes a new framework for measuring and monitoring safety in healthcare.

2009 The adapted World Health Organisation surgical checklist rolled out across the NHS.

2009 List of Never Events published by Department of Health.

2005 NHS Tayside introduces a dedicated patient safety improvement programme, leading to the Scottish National Patient Safety Programme.

2004 Launch of the Health Foundation's "Safer Patients Initiative."

2001 The National Patient Safety Agency (NSPA) and National Reporting and Learning System (NRLS) established.

2008 "Patient Safety First" campaign launched in England.

2004 NPSA publishes *7 Steps for Patient Safety*.

2001 The *Dr Foster Good Hospital Guide* is published.

2000 The first influential report on patient safety, *An Organisation with a Memory*, published.

1963 The Committee on Safety of Drugs established. It evolves into the Medicines and Healthcare Products Regulatory Agency (MHRA).

1973 Office of the Health Service Ombudsman set up.

1999 National Institute for Health and Care Excellence (NICE) established.

1969 NHS Hospital Advisory Service established, the first NHS inspectorate.

1995 NHS Litigation Authority established.

1999 Commission for Health Improvement established. Its functions are now carried out by the Care Quality Commission (CQC).

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Healthcare UK is your route to access all of the expertise within the UK's healthcare sector. Whatever type of health facility, service or training programme you are planning, we can bring together the right UK organisations to meet your needs.

To find out how you can draw on UK expertise to extend, improve and transform healthcare provision in your country, contact Healthcare UK:

Call: +44(0) 20 7215 5000
Email: healthcare.uk@ukti.gsi.gov.uk
Visit: www.gov.uk/healthcareuk

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