**NQB(12)(02)(04)**

**NATIONAL QUALITY BOARD**

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# REVIEW OF QUALITY IN THE NEW HEALTHCARE SYSTEM ARCHITECTURE

***A note from the Managing Director for Quality During Transition***

## Summary


1. This paper provides an update on the NQB work programme reviewing quality in the new healthcare system architecture, led by Ian Cumming. At its December meeting, the NQB heard about an emerging quality surveillance and assurance model from April 2013 which will form the focus of this paper. This paper seeks to:

   i) outline the purpose of the review and what it will aim to achieve;
   ii) update the Board on the testing of the emerging model via an Accelerated Solutions Event;
   iii) highlight some key issues for discussion with the NQB; and
   iv) set out proposed next steps.


## Recommendation

2. The Board is asked to:

   - note the testing of and subsequent outcomes to, the emerging model;
   - agree the proactive and reactive approaches developed to ensure the early spotting and responding to possible quality failure;
   - discuss the key issues to be worked through;
   - consider and agree the report outline for the review; and
   - note next steps.

## Background

3. The review has three main aims:

- Clarify roles and responsibilities with regard to quality of individual organisations, bilateral responsibilities and across the system;
- Propose a model for quality assurance and response to failure in the new system; and
- Signal wider policy issues that need to be tackled in the longer term (eg alignment of professional and system regulation).

4. The quality surveillance and assurance, and response to failure model presented at the December NQB meeting had 2 components:

- **A proactive element** - to share and triangulate intelligence across the system. This is important because each individual organisation will have bilateral relationships with a provider. There is nowhere where information can be shared on a routine basis. The proposed 'Quality Surveillance and Assurance Group' (QSAG) provides such a forum, allowing multiple organisations, all of whom will have a unique relationship with a provider organisation, to come together. The proposal is that this part of the model should operate at two levels: NHSCB local office footprint and NHSCB sector level footprint.

- **A reactive element** - promoting a risk summit model as a way of aligning and coordinating swift action to deal with failure.

5. Further detail is set out at **Annex A**.

## Progress

### Testing the model

6. Since the last NQB meeting, an Accelerated Solutions Event has been held with over 60 senior representatives from across the health and care system. The model was tested through a number of fictional scenarios including:

- Spotting signs of failure at an acute hospital.
- Problems at a social partnership offering hospice service.
- An out of hours service that was providing poor service and attracting media interest.
- An independent healthcare provider offering mainly private IVF, experiencing a problem with supply of incorrectly labelled foreign drugs.
- Reconfiguration of surgical services ( deterioration in clinical risk management since the former SHA handed over the project)
- Child safeguarding – rising referral rates, thresholds, lack of services.
- A care home where the GP was spotting concerns.
- Serious incidents at an independent sector specialist hospital for people with learning disabilities.

**Summary of feedback**

7. There was unanimous support for using a risk summit model. There was broad support for the proactive element (QSAG). Although there was some concern at the beginning of the day as to whether this felt overly bureaucratic, as the day went on, many realised its potential value. The proactive element of the model proved to be particularly useful in the acute failure scenario and most people felt it was a sensible mechanism for having the required conversations and considering issues and agreeing actions. However, in some other scenarios there was a feeling that the QSAG would not be sensitive enough to spot issues of low-level concern that are in fact indicative of broader problems.

8. There was general agreement – with a minority querying – that the NHS Commissioning Board should chair the QSAG and risk summits as long as it was clear that this role did not mean the Board could direct any other statutory body as to how they should discharge their specific duties. The group should be chaired by the NHSCB because it is responsible for commissioning care for the population on behalf of the taxpayer and for the quality of care they commission. It would be inappropriate for the regulator to chair, because it is independent and may need to take action against a provider at any point.

***The Board is asked to note the testing that has taken place, and conclusions drawn from this.***

**Key issues arising**

9. There are a number of issues which need further consideration as the report is developed. These include:

- For this model to work healthy relationships are a pre-requisite. This might be the value of the QSAG. The right behaviours will be key.

- Clarity will be needed about roles and relationships, including how this fits with the wider governance architecture. QSAGs will also need to be clear on thresholds, for example, when should a risk summit be triggered, and what data should the group consider? Finally, there will need to be thought given as to what issues are best dealt with at a local/sector/national level.

- Capacity and support for leaders will be needed. Commissioning leaders and others will need training in understanding the data and making tough judgement calls, managing relationships etc.

- Mandate: some delegates at the ASE felt that for the QSAG to be effective then someone would need to mandate compliance from the relevant parties to avoid it just being a 'talking shop'.

- Patients need to be the focus of the model, not the interests of participating organisations.

- Is the triggering of a risk summit a sign of a failing or healthy health care system? Is the risk summit a supportive or punitive act? In other words, is it there to support the trust to exercise its responsibilities in improving their services or does it effectively take it off them?

- Further thinking is also needed about membership of the two groups. For example, would they include representation from professional regulators or LETBs?

***The Board is i) invited to discuss the key issues arising; ii) confirm these are the key issues that will need to be tackled; and iii) consider ways in which they could be addressed.***

10. In many cases there will also be specific bilateral issues to be worked through – eg the role of the NTDA, relationship between CQC and Monitor etc.

**Next Steps**

11. Next steps will include:

- Ongoing engagement to build wider support for the model:
    - Taken to Future Systems Executive Board meeting 10th April
    - Engage with the Departmental Board

- Starting to develop detailed descriptions of roles and responsibilities across the system.

- Further refining the QSAG and response to failure model.

**The Report**

12. The intention is to draft a report for the end of May. A suggested outline structure for the report is at **Annex B**. The Board will also need to give thought promoting implementation of the report.

13. The next NQB meeting is not until 11th June so much of the sharing of drafts and input from NQB members will be via correspondence and meetings with colleagues representative of some member organisations eg. CQC and Monitor.

***The Board is asked to consider the proposed outline structure for the report.***

**Ian Cumming**
**April 2012**

**Annex A**

## A proposed model for quality surveillance and assurance

### Introduction

1. Quality is a systemic issue. It is not the responsibility of any one organisation but a collective effort requiring collaboration and alignment at every level of the system. It is therefore vital that all organisations are very clear about their own roles and responsibilities for quality as well those of others.

2. However, this on its own is not enough. There needs to be clear structures and processes in place to support organisations across the system in:

    i) **proactively working together** to share information and intelligence about quality within provider organisations in order to spot potential problems early and manage risk; and,

    ii) **reactively working together** in the event of a serious quality failure coming to light, to ensure a swift, aligned and coordinated response.

3. The NQB believes this is necessary because different organisations currently have and will have in the future, specific relationships with healthcare providers. Consequently, different intelligence (hard and soft) about quality within provider organisations will be held in different parts of the system.

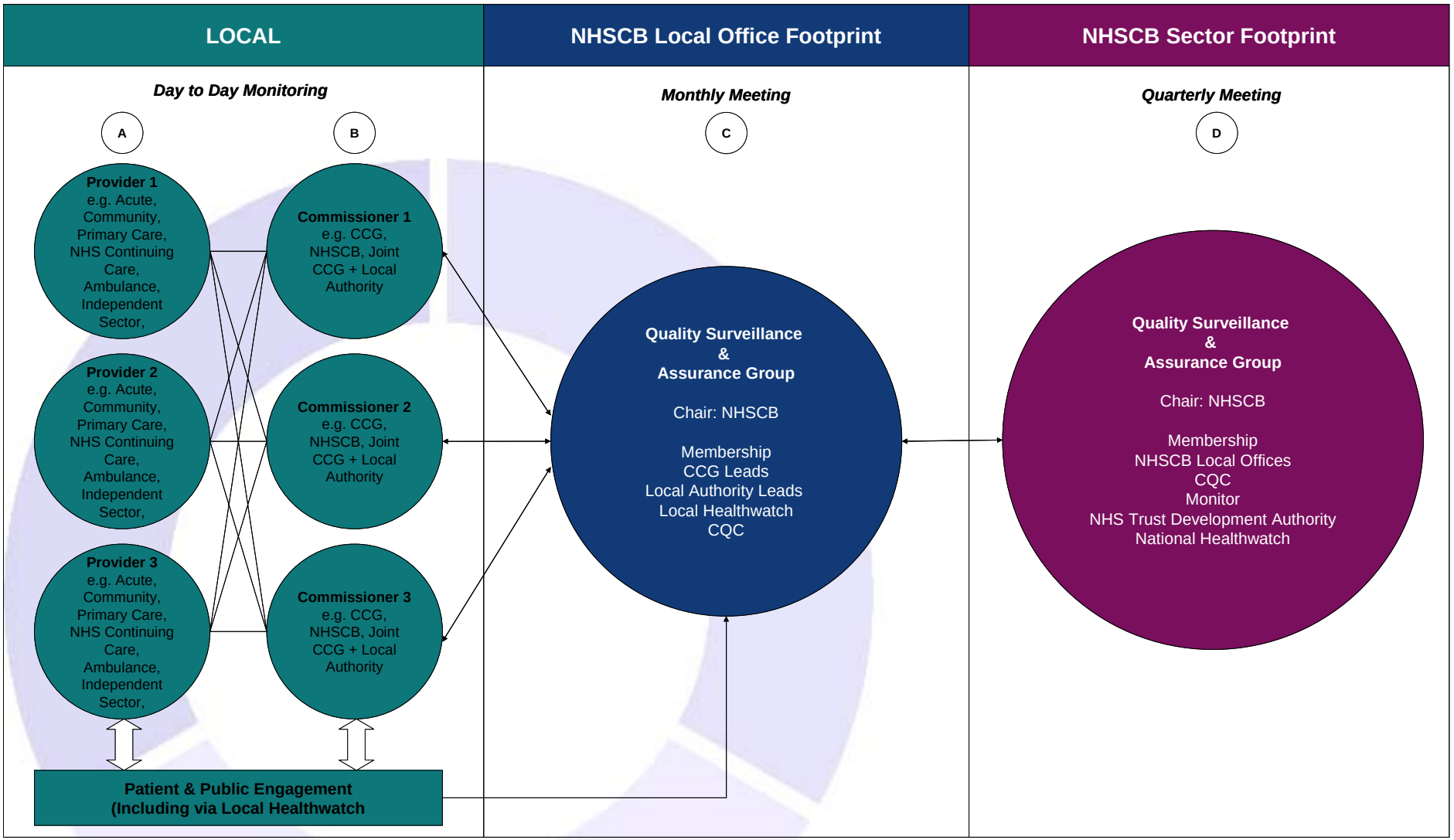
4. The remainder of this note therefore sets out a proposed quality surveillance and assurance model with a proactive element and a reactive element. Although strong bilateral arrangements between organisations will be very important, the model is intended to supplement these by supporting the triangulation of information and intelligence across the system and by providing a mechanism for coordinating and aligning action in the event of a quality failure being identified.

5. The scenario testing event will help inform the development of this proposed model.

### Proactive Element – Quality Surveillance and Assurance Groups

6. In terms of putting in place arrangements for the proactive sharing of information and intelligence across the system, **Figure 1** presents a model for Quality Surveillance and Assurance Groups on i) the footprint of the NHS Commissioning Board's local offices (currently, the PCT Cluster footprint); and, ii) the footprint of the NHS Commissioning Board's Sectors (currently, the SHA Cluster footprint). A brief commentary on the model is also included.

## Figure 1: Quality Surveillance & Assurance Groups



*Commentary on Figure 1*

**A)** The early warning system starts within the organisation providing care. Healthcare professionals and clinical teams are the first line of defence and the board (or equivalent) must ultimately take final responsibility for quality across each and every service line it provides. Robust clinical / quality governance arrangements are key and, as part of this, quality monitoring and patient, public and user engagement must take place on a continuous basis.

**B)** Commissioners- clinical commissioning groups (CCGs), the NHS Commissioning Board (for primary care and certain specialised services) and joint commissioners (CCGs and local authorities)- are responsible for the quality of care that they have commissioned. They should monitor the contracts that they hold with their providers on an ongoing basis and be constantly engaging with and seeking the feedback of the patients and the public on whose behalf they commission services.

**C)** Because a number of local commissioners will be commissioning services from a common provider, there needs to be a formal mechanism that allows these different commissioners to come together to share information and intelligence about quality in a regular and planned way. It is therefore proposed that a Quality Surveillance & Assurance Group is formed on the footprint of the NHS Commissioning Board's local offices (currently the PCT Cluster footprint). It is proposed that this group should be Chaired by the NHS Commissioning Board, would meet monthly and its membership would include all local commissioners in the area - CCGs and local authorities -, Local Healthwatch representatives and representation from the Care Quality Commission.

**D)** It is proposed that a further Quality Surveillance & Assurance Group is formed on the footprint of the NHS Commissioning Board Sectors (currently the SHA Cluster footprint). There would be four of these groups in total covering the whole country. It is proposed that these groups should be Chaired by the NHS Commissioning Board and would provide an important formal and planned mechanism for triangulating the information and intelligence held by local commissioners with that held by system regulators (CQC and Monitor), performance managers (the NHS Trust Development Authority) and National Healthwatch. It is proposed that these groups meet on a quarterly basis.

## Reactive Element- Risk Summits

7. If any statutory organisation - local, regional or national - has concerns that there may be a serious quality failure, or the potential for there to be a serious quality failure within a provider organisation, it is proposed that they should be able to trigger a Risk Summit.

8. The decision to convene a Risk Summit might be as a result of the sharing of information and intelligence at the planned Quality Surveillance & Assurance Groups or as a result of new intelligence coming to light outside of these planned meetings for example, from a 'whistleblower, a patient, an undercover reporter or dramatic local or national media exposure.

9. Because of the importance of a single organisation 'holding the ring' in such a situation, it is proposed that the Risk Summit should be convened and Chaired by the NHS Commissioning Board and normally within 24/48 hours of the request. The purpose of the Risk Summit would be to support rapid judgements to be taken about quality within the provider organisation in question and to agree the subsequent response which should:

    - rapidly seek to safeguard patients;
    - ensure the continued provision of services to the population; and,
    - begin the process of securing improvements at the provider organisation

10. It is proposed that the relevant members of the sector level Quality Surveillance & Assurance Group should form the core participants in the Risk Summit, with other interested parties being invited as appropriate e.g. local commissioners, other local government agencies, professional regulators.

11. The proposed role for the NHS Commissioning Board in 'holding the ring' does not mean that the Board would, in any way, direct the regulators or other parts of the system who are free to act within their statutory frameworks. Rather, its role would be to ensure an aligned and coordinated system wide response. However, the scenario testing event will need to consider whether the NHS Commissioning Board is always the most appropriate organisation to take on this role or whether, in particular circumstances, another organisation should have responsibility for 'holding the ring'.

**Annex B**

## A suggested outline structure for the report

Foreword

Chapter 1: What do we mean by Quality – what are we trying to achieve?

Chapter 2: Collaboration and Integration – putting patients, users and populations first

Chapter 3: The overarching framework for quality

Chapter 4: A single model of change

Chapter 5: Roles and responsibilities for quality across the system

Chapter 6: Working together to improve quality

Chapter 7: Working together to safeguard patients – spotting the early signs of failure

Chapter 8: Working together to safeguard patients – responding when things go wrong

Chapter 9: Embedding the right cultures and behaviours throughout the system

Chapter 10: Further issues and next steps

NB. Patient voice will be a feature throughout the report referenced in every chapter