NQB(12)(01)(01)

NATIONAL QUALITY BOARD

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QUALITY DURING AND POST TRANSITION

A note from the Managing Director for Quality During Transition

SUMMARY

1. This paper provides an update on the work of the National Quality Team, led by Ian Cumming, which was established to support the NQB in driving forward its work programme on quality both during the transition period and its place in the new system architecture. In particular, the paper:

   i) provides the Board with an update on progress made by the National Quality Team against the five work streams it was set;
   ii) sets out details of the scenario testing event taking place on 1 March in support of the NQB's Phase Two report on how quality will operate in the new system architecture from April 2013; and
   iii) sets out the key, broader policy issues that the Phase Two report should seek to tackle.

RECOMMENDATION

2. The Board is asked to:

   - note the progress made on the five work streams led by the National Quality Team;
   - note the plans for a scenario testing event on 1 March; and
   - consider and agree the key broader policy questions that should be addressed as part of the Phase Two report.

BACKGROUND

3. In August 2011, David Nicholson appointed Ian Cumming as Managing Director for Quality during Transition, and asked that he lead, with the support of the National Quality Team and the DH Quality Team, on the five following areas of work:

- Implement the NQB's Phase One report, *'Maintaining and improving quality during the transition'* - in particular, the Board's recommendation to introduce a robust handover and legacy process for quality between the old and new parts of the system;

- Develop a single quality and safety operating model for the SHA Clusters;

- Specify a standardised set of quality metrics that feed through into the NHS Operations Board dashboard;

- Continue to support the NQB's Phase Two work to identify the quality architecture for the new healthcare structure and develop a robust early warning system; and

- Take forward the NHS response to the Mid Staffs Public Inquiry

PROGRESS

Maintaining Quality During Transition - implementing the Phase One Report

4. The NQB report, *Maintaining and improving quality during the transition*, set out a number of requirements on the NHS to ensure formal written and verbal handover processes to support a safe and successful transition to

the new system architecture from April 2013. It was agreed that each SHA Cluster would undergo an assurance process, in order to:

- provide a degree of confidence/assurance that a robust process of handover has taken place between PCTs and PCT Clusters, between PCT Clusters and SHAs, and between SHAs and SHA Clusters, in line with national requirements and expectations;
- provide assurance that the SHA Cluster has a process to identify appropriate actions to address the greatest risks, and has the capacity to implement them;
- identify areas of best practice with regard to quality and safety, to help design the national quality and safety operating model for PCT and SHA Clusters; and
- identify learning from the handover process to feed into the legacy process between SHA Clusters and the NHS CB, when PCTs and SHAs will formally be abolished.

5. The handover assurance process consisted of four one-day visits to each of the SHA Clusters and SHA London, with a small panel led by Ian Cumming and Sir Bruce Keogh. Each visit was preceded by a desk top review of existing documents.

6. All four assurance visits have now been completed and high-level feedback will be provided at the meeting. In light of the assurance process, the intention is to produce a 'how to' guide for the system, possibly including an update of the NQB Phase One report *Maintaining and improving quality during the transition: safety, effectiveness, experience (March 2011)*.

The Board is asked to i) note the findings from the assurance process and progress being made in developing a robust quality assurance process for the transition; and ii) note the intention to publish an NQB branded 'How to' guide to support SHA Clusters, possibly including a refreshed version of the NQB Phase One report.

Develop a single quality and safety operating model

7. As part of the SHA Cluster Handover Assurance Process, the National Quality Team has sought to understand from each region their current operating model for quality and safety, with a view to identifying the most appropriate model going forward. There is a live question as to the footprint that such a quality model should operate at (PCT or SHA), which will be influenced by the current debate about transition milestones.

The Board is asked to note progress made.

Develop a standardised set of quality metrics

8. Good progress has been made in this area, working closely with DH and the four SHA Clusters to ensure alignment with the existing dashboard as set out in the Operating Framework and to review the ten existing dashboards and best practice elsewhere. A mock-up of the dashboard will be shared with the NQB.

9. In terms of reviewing quality as a regular part of the Operations Executive, the National Quality Team is leading the revision of the current Never Events framework in liaison with Bruce Keogh's Directorate in DH. The Operations Executive Board has agreed to look each month at Never Events, and to add a further metric each month so that by March 2012 there will be a small basket of indicators that will allow Board members to scrutinise quality from a national perspective in the same way as is done with other operational data.

10. Looking ahead more work needs to be carried out to ensure alignment with the design of the Patient Experience and Information work stream of the NHS Commissioning Board, which is in hand. Progress made on this will be shared with the NQB at the next meeting.

The Board is asked to note progress made.

Identify the quality architecture for the new healthcare system - Phase Two Report

11. The NQB's work on quality in the new system architecture seeks to provide an update of the NQB's *Review of Early Warning Systems* that was published in February 2010 as a response to the events at Mid Staffordshire NHS Foundation Trust. The second phase of the report needs to reflect what the system will look like from April 2013, and be responsive to any recommendations from the Francis Inquiry.

12. The process for developing the report was launched with an Accelerated Solutions Event on 18 November, at which several Board members were present. Discussions at this event informed a paper that the Board considered at their December meeting (NQB(11)(06)(01)).

13. That paper presented an emerging 'strawman' for quality in the new system architecture. In addition to starting to outline roles and responsibilities of different organisations in the new system, this paper also proposed a system of quality assurance and surveillance groups a reminder of which is set out at **Annex A**. The intention is to provide a forum for different organisations to share information proactively and regularly.

14. The next stage is to test this emerging thinking. Therefore, a number of NHS, social care and patient / user group representatives, including representatives from the NQB, will be taking part in an Accelerated Solutions Event on 1 March. This event will use a number of scenarios to test out the 'strawman'- particularly, the proposed quality surveillance and assurance model (Annex A).

15. In the morning session, the event will consider in detail a failure in an acute setting (the exercise will consider issues arising if this was either a NHS Trust or a Foundation Trust). As part of the exercise groups will be provided with data and set a number of questions to test for example: what their agreed course of action is; why; and their assumptions about what others in the system should or should not be doing.

16. In the afternoon session, having learnt any lessons from detailed testing against an Acute Trust failure, small groups will then consider how well the quality surveillance and assurance model stands up to a number of other types of quality failure with a view to understanding if and how it might need to be adapted to suit differing circumstances and settings. The proposed scenarios are :

- A primary care setting
- Independent providers
- A reconfiguration project
- Children's / adult safeguarding
- Multiple commissioners of NHS care
- A voluntary sector / social partnership failure
- The social care sector and failure in a care home

17. A summary of the event will be provided to the Board at the April meeting.

The Board is asked to note plans for the scenario testing event.

18. In further developing the quality 'strawman' and following discussions at the December meeting of the NQB a number of broader policy questions have come to light. Further consideration of these will enable the Phase Two report to not only provide clarity about how the new system will work

in relation to quality but also describe how the picture presented might / needs to be improved in the medium to longer term.

19. The broader policy questions identified are:

- Do providers have sufficient clarity about what constitutes the 'essential requirements for quality and safety'?
- How can we better align quality regulation (at organisational level) with professional regulation?
- What is the strategy for shifting the minimum quality bar to the right of the quality curve?
- What expectations should we place on CCGs with regards to their role in assuring the minimum quality bar is maintained, and how can we make sure this compliments rather than duplicates the role of CQC?
- How far should / can the review extend into social care?
- Do we need to instigate specific training for leaders at the various levels of the new system to help prepare them to manage quality?
- How can we best involve patients and carers in the design and delivery of the new system?

Does the NQB agree with the key policy questions that have been selected for focusing on at this stage?

20. Continuing engagement with stakeholders and policy colleagues is taking place in helping to address these questions. These issues will also form some degree of focus at the scenario testing event on 1 March. An update of the progress made with then be given at the April meeting of the NQB.

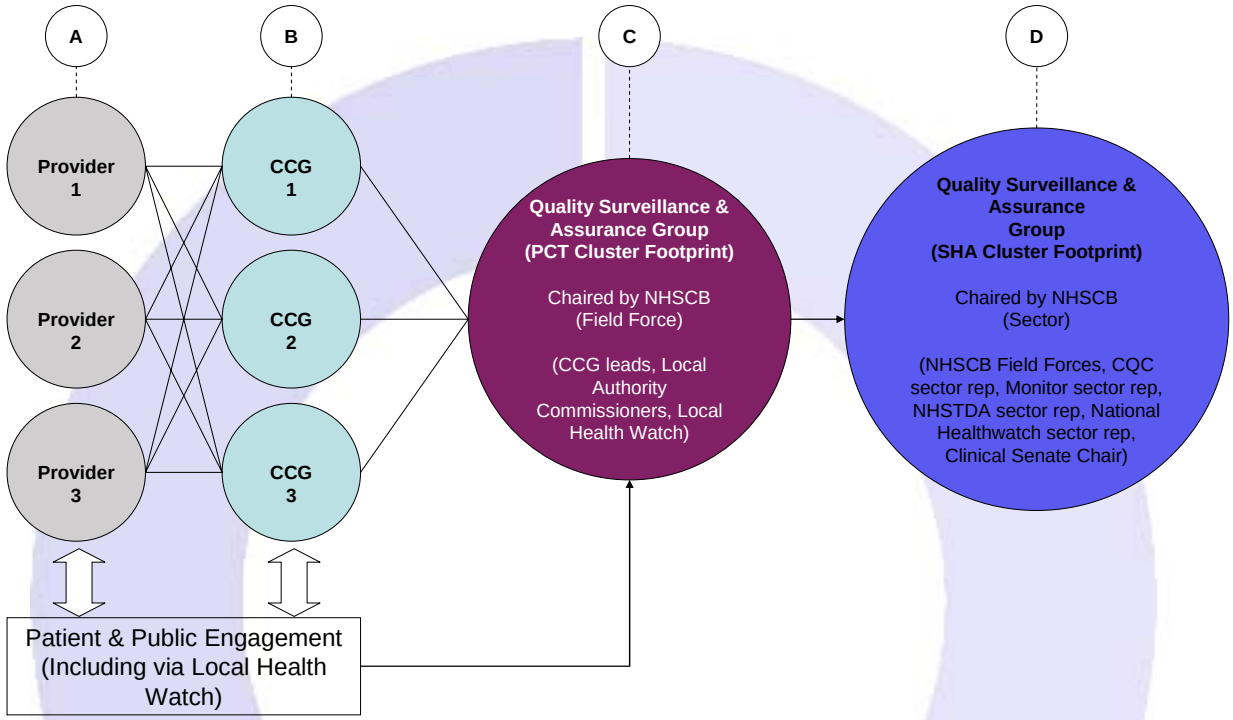
Take forward implementation of Mid Staffs recommendations

21. Ian Cumming is continuing to work alongside Una O'Brien, DH Permanent Secretary, to ensure that the NHS is ready to receive the final recommendations of the Public Inquiry, and to implement any necessary changes, to make certain that real changes and improvements occur as a result.

Ian Cumming
February 2012

Annex A

Quality Surveillance and Assurance Groups



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 governance arrangements are key and, as part of this, quality monitoring and patient, public and staff engagement must take place on a continuous basis. The introduction of revalidation for doctors from late 2012, the expansion and greater transparency of clinical audits, and the continued development of Quality Accounts will all strengthen provider level focus on quality and the early warning system and will need to be described in the final phase two report.

B Clinical Commissioning Groups should be monitoring the contracts that they hold with providers on an ongoing basis and constantly engaging with and seeking the feedback of the patients and the public they are commissioning services on behalf of. In doing so and because of their proximity to the provider organisation, clinical commissioning groups are better placed than other parts of the system to spot the early signs of quality failure.

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Because a number of clinical commissioning groups may commissioning services from the same provider, it makes sense to put in place 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 and assurance group is formed on the PCT Cluster footprint, led by the NHSCB's local field force unit with membership including CCG leads and local healthwatch representatives amongst others. This group might meet on a monthly basis.

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It is proposed that a further quality surveillance and assurance group is formed on the SHA Cluster footprint (NHSCB sector). These four groups would be led by the NHSCB and would provide an important formal and planned mechanism for triangulating the information and intelligence held by commissioners with that held by system regulators (CQC and Monitor) and performance managers (NHSTDA). It may make sense for this group to also include sector level representation from National Healthwatch as well as representation from relevant clinical senates. This group might meet on a quarterly basis and consider a standard set of quality information along the lines of the discussion in the main paper.