

Maintaining and improving quality during the transition: *safety, effectiveness, experience*
Part One- 2011-12

National Quality Board



March 2011

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Foreword



Over the next four years, the NHS will need to rise to some of the greatest challenges in its history. Despite the relatively strong financial settlement afforded by the spending review, rising demand, demographic changes and the cost of new drugs and technologies mean the NHS will need to deliver efficiency savings of up to £20 billion over this period if it is to improve the quality of the comprehensive service on offer to patients.

Meeting this challenge - the Quality Innovation Productivity and Prevention (QIPP) challenge - is about achieving the highest possible value from the resources allocated to the NHS. It is about improving quality whilst reducing cost by improving productivity and redesigning services wherever possible. The scale of the challenge means that the NHS will only succeed if it acts confidently, collectively and boldly.

At the same time as rising to this challenge, subject to Parliamentary approval, the NHS will also be making a complex transition to the new system architecture, set out in the Government's White Paper, *Equity and excellence: Liberating the NHS*. The reforms aim to improve quality (effectiveness, safety, experience) through a combination of policies aimed at freeing the NHS from central control, introducing greater competition and choice, enhancing clinical leadership and introducing a system of accountability based on the outcomes achieved for patients. These modernisation plans will leave few parts of the current system untouched and past experience and lessons from elsewhere shows that any period of structural change can put quality and safety at risk. It is therefore critical that steps to mitigate these risks are taken before any failures in quality and safety are allowed to emerge.

Quality is a systemic issue where success or failure is determined by a complex set of interactions between individuals and organisations. It is precisely because of this that the National Quality Board (NQB), which brings together all parts of the national system, has come together to consider how best to maintain and improve quality during this period of substantial change. Throughout the transition, quality must remain our guiding principle and should act as the glue that binds organisations - existing, emerging and new - together.

This first report focuses on 2011/12, the first full year of the transition. This is because, despite significant paving activity being set in train throughout 2011/12, the current system structure and its underpinning performance and regulatory regime remains in place and unchanged next year. This report builds on, rather than replaces, the NQB's February 2010 *Review of Early Warning Systems in the NHS* and should be read in conjunction with it. Later this year we will publish a second report setting out our collective view on how quality will be stitched into the fabric of the new system architecture.

In this report, we take the opportunity to restate how healthcare professionals working at the front line are ultimately responsible for ensuring patients receive high quality care and how it is their professional duty to speak up if they have concerns. We also restate that the overall system of assurance and support that runs throughout the NHS must give primacy to quality. In doing so, NHS organisations should ensure that an open and honest culture, where all staff feel empowered to make improvements and feel able to raise concerns, prevails.

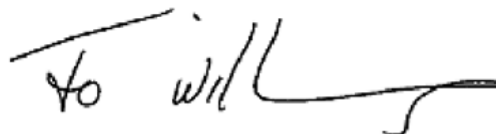
The vision set out in the Government’s White Paper requires a significant de-layering of management across the system. As this is implemented, we must remember that the knowledge and corporate memory of an organisation’s employees is a rich resource that needs to be preserved in order to maintain the continuity of services and, more importantly, improve the quality of care provided to patients. Chapter 3 of this report therefore sets out how, starting in 2011/12 with Strategic Health Authorities and Primary Care Trusts, we will strengthen and formalise handovers between old and new organisations so that our corporate memory for quality is not lost.

Whilst the period ahead will undoubtedly be very challenging, we are confident that an unwavering focus on purpose - delivering high quality care - and the values that unite and drive all those working in and for the NHS will result in a successful transition. Success will, however, require a culture of open and honest cooperation at every level of the system and should be judged not just in terms of business maintenance, but also in terms of whether quality, including safety, is maintained and improved.

On behalf of the National Quality Board, we commend this report to the service.



Sir David Nicholson KCB CBE
NHS Chief Executive and
Chair, National Quality Board



Dame Jo Williams DBE
Chair, Care Quality Commission and
National Quality Board member



David Bennett
Chair and Interim Chief Executive,
Monitor and National Quality
Board member



Ian Cumming OBE
Chief Executive, NHS West Midlands and
Chair, National Quality Board Subgroup

Chapter 1:

Introduction and approach



The Challenge

1.1 The Government's July 2010 White Paper, *Equity and excellence: Liberating the NHS*¹, set out an ambitious and far reaching programme of change for the NHS aimed at:

- putting patients at the heart of all NHS care;
- delivering improved healthcare outcomes; and
- empowering local organisations and professionals to improve quality.

1.2 Over the next four years the NHS will make the transition to the new system architecture described in the White Paper resulting in **major structural changes to how the NHS is organised and run**. Subject to the passage of legislation, by April 2014:

- An independent NHS Commissioning Board will have been established, with responsibility for overseeing the commissioning of NHS services and the allocation of the NHS budget (April 2012).
- Strategic Health Authorities and Primary Care Trusts will have been abolished (April 2012 and April 2013 respectively).
- GP Consortia will have been established, with responsibility for commissioning the majority of local health services for their populations.
- Monitor will have become the new Economic Regulator for the NHS (April 2013).
- All NHS Trusts will have become Foundation Trusts, free from central direction or control but subject to a new system of economic regulation (April 2014).
- A new champion for patient voice will have been created with the establishment of HealthWatch (April 2012).
- A number of arms length bodies will have been abolished, including the National Patient Safety Agency (NPSA) and the NHS Institute of Innovation and Improvement (the NHS Institute) with their roles and functions transferring elsewhere.

¹ *Equity and excellence: Liberating the NHS* can be downloaded here:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf The Government's response to the consultation is available here:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122707.pdf

1.3 In order to ensure quality is safeguarded during the first year of transition the service must be familiar with timetable, the emerging structures and the roles and responsibilities they should be delivering.

1.4 In addition to these structural changes, a number of new policies will also build upon existing mechanisms for the provision of NHS services. For example, the introduction of 'any willing provider' and the 'right to request / provide social enterprise schemes' may see many more services being provided by non-NHS organisations.

1.5 Managing a smooth transition to the new system whilst ensuring the quality of services provided to patients is maintained and improved represents a highly complex challenge. It is also a challenge that must be delivered at a time when the NHS will be under huge financial pressures. The Quality, Innovation, Productivity and Prevention (QIPP) challenge requires the NHS to find up to £20 billion of efficiency savings by 2014/15 in order to respond to demographic changes, rising demand and the cost of new drugs and technologies.

1.6 In response to this complex and interconnected set of challenges, **the NHS Chief Executive, Sir David Nicholson, asked the National Quality Board to advise on how best to maintain and improve quality including safety during the transition** and once the new system architecture is in place.

Role of the National Quality Board

1.7 Quality is, first and foremost, the responsibility of the individual. However, it is also a systemic issue where success or failure is determined by a complex set of interactions between individuals and organisations. In recognition of this, the National Quality Board (NQB) was established in 2009 to bring about greater alignment for quality between the national bodies responsible for the overall health system. Through bringing together the Department of Health, the Care Quality Commission (CQC), Monitor, the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) the Board is uniquely placed to look at the risks and opportunities for quality and safety across the whole system, both during the transition and once the new system architecture is fully operational.

1.8 The NQB established a small subgroup, chaired by Ian Cumming, Chief Executive of NHS West Midlands, to take this review forward, full membership is listed in the box below.

NQB Subgroup – Maintaining Quality during the Transition

Chaired by: Ian Cumming, NQB Member and Chief Executive of NHS West Midlands

- Sally Brearley, NQB lay member
- Steve Bundred / Adrian Masters representing Monitor
- Hilary Chapman, NQB expert member and Chief Nurse / Chief Operating Officer, Sheffield Teaching Hospitals NHS Foundation Trust
- David Haslam, NQB expert member and National Clinical Advisor, CQC
- Bruce Keogh, NQB ex-officio member and NHS Medical Director, DH
- Jo Williams / Cynthia Bower representing CQC
- Suzette Woodward representing NPSA
- Ian Dalton (Managing Director of Provider Development, DH)
- Barbara Hakin (National Managing Director of Commissioning Development, DH)

1.9 In taking forward this review, the Board has built on its earlier **Review of Early Warning Systems in the NHS report, published in February 2010²**. That report was commissioned by the previous Secretary of State for Health following publication of the Healthcare Commission's report into the serious failures in quality identified at Mid Staffordshire NHS Foundation Trust, which is now the subject of a full Public Inquiry. That report described how the overall system for preventing, identifying and responding to serious failings in quality should work.

Scope of the review and approach

1.10 The review is being taken forward in two parts and the following guide terms of reference were agreed by the Board at its September 2010 meeting.

Guide terms of reference:

Part One (to report by February 2011)

To review whether the NQB's February 2010 report *Review of Early Warning Systems in the NHS* remains fit for purpose during the transition to the new system architecture set out in *Equity and excellence: Liberating the NHS*; and to make recommendations as to what changes or additional measures should be taken to strengthen quality resilience during this period.

Part Two (to report Summer 2011)

Building on part one, to describe and make recommendations about the operation of the early warning system for identifying and responding to serious failures in quality once the new system architecture set out in *Equity and excellence: Liberating the NHS* is in place.

² A copy of the report can be found here:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113021.pdf

1.11 The work has been split into two parts in order to ensure the provision of comprehensive advice to the service that both addresses the unique issues facing the system during the first full year of transition in 2011/12, and those facing the service once the new architecture formally begins to emerge from April 2012. Since agreeing the above terms of reference, the Board has decided to broaden out the second phase of its work to look at how quality improvement will be driven by the new system in addition to how a system wide approach to identifying and responding to serious failures in quality will work in practice.

1.12 This report marks the conclusion of part one of the review. A report covering part two will be published during summer 2011.

1.13 The NQB agreed five key principles that should underpin both phases of the review:

- any advice should be, wherever possible, evidence based;
- the beneficiaries of the advice should be the patients who use NHS services;
- any advice given should be proportionate, and seek to avoid duplication and complexity;
- flexibility and learning should be built into the advice where possible; and
- the advice given should be evaluated / monitored so that we might learn the lessons for future transitions.

1.14 Although our approach has been to start with the delivery of care to patients and the safeguarding of quality, the report, by its very nature, looks to provide support to healthcare professionals and NHS staff and acknowledge the pressures on staff as we move forward into a period of extended change.

Audience

1.15 This report is aimed primarily at the boards of NHS organisations. However, we would expect each board to ensure that the key messages contained within it as well as the NQB's original *Review of Early Warning Systems in the NHS* report are cascaded and understood throughout their organisations.

Evidence on the impact of structural change

1.16 The period of change that we are going through in the NHS is unprecedented. We will see not just the mergers of existing organisations, but also the complete removal of bodies such as PCTs and SHAs, with some of their functions being passed to new bodies such as GP Consortia. In order to manage the period of change ahead, we need to learn from within the NHS and other industries what managerial strategies can be applied to reduce and mitigate any risks to quality. A literature review of what we can learn from previous re-organisations or mergers within the NHS produced the following findings:

Evidence on the impact of change:

- Mergers have a negative effect on delivery of services because of a loss of managerial focus on services' (**Fulop et al 2002, study of London Trusts**).
- Greatest lull in productivity following a merger occurs during the first few months, and can take one-two years for a full recovery (**Pritchett et al 1997**)
- Mergers have negative effect on staff: high levels of stress, anxiety, staff turn over, lower job satisfaction (**Marshall & Olphert 2008**)
- One of key risk factors for **serious service failure** is a recent history of mergers or major structural change (**CHI, lessons from CHI Investigations 2000-2003**)

1.17 This review revealed that there is currently relatively little evidence on the impact of extensive organisational change on the quality of NHS care. There are however, parallels that can be drawn from change in other areas. Specifically, we can learn much from clinical practice at the micro level, where, for some time, it has been recognised that the most risky time is the handover between one set of clinical staff and another.

There is evidence that the most risky time in clinical care is handover:

- "As a result of perceived clinical handovers, the doctor/ED and patient were affected adversely in 8.8% and 4.7% of cases respectively"
Emergency Medicine Australia (2007) 19, 433-441
- "... [medication errors] were often attributable to poor signovers between cross-covering teams of house officers" **Focus on Patient Safety; Vol 7, Issue 2; 2004**
- "A 59-year-old man presented to the emergency department (ED) with the chief complaint of "panic attacks." In total, he was evaluated by 14 faculty physicians, 2 fellows, and 16 residents from emergency medicine, cardiology, neurology, psychiatry, and internal medicine. These multiple transitions were responsible, in part, for the perpetuation of a failure to accurately diagnose the patient's underlying medical illness. The case illustrates the discontinuity of care that occurs at transitions, which may threaten the safety and quality of patient care."
Academic Emergency Medicine 2003; 10; 364-7

1.18 In response to these known clinical risks at a micro level, the following mitigating strategies have been recommended. Whilst the parallels between a handover at a micro level and a significant series of changes at a system level are not exact, they offer some useful learning points for the wider NHS as to how mitigating interventions can help to ensure a quality service during periods of transition.

There are some mitigating actions we can take:

- Face to face verbal updates between incoming and outgoing teams with interactive questioning
- Read-back to ensure that information is correctly received
- Outgoing team writes summary before handover
- Incoming team assesses current status
- Incoming team reviews historical data before handover
- Outgoing team shares knowledge from previous handover
- Outgoing teams declares stance toward planned changes
- Unambiguous transfer of responsibility
- Delay the transfer of responsibility when concerned about status / stability of process

Selected strategies summaries from; Handoff strategies in settings with high consequence for failure: lessons for health care operators International Journal for Quality in Healthcare; Vol 16, No 2; 125-132

1.19 Drawing on this evidence, and conversations with senior managers and clinicians with extensive experience of change in the NHS, we have produced this report to help mitigate any risks during this period of transition.

Chapter 2:

Understanding and capitalising on the constants



2.1 During any period of change, it is important to understand what remains constant - whether it is values, organisations, roles and responsibilities or people - and to think about how to build on the points of stability in order to maintain a strong focus on quality. This chapter explores some of the important constants during 2011/12 and beyond which include:

- the *NHS Constitution*;
- the NQB's *Review of Early Warning Systems in the NHS* (February 2010):
 - *Quality at the heart of everything we do*
 - *Values and behaviours that put patients first*
 - *Roles and responsibilities throughout the system*
- the role that staff and patients can play in protecting and improving quality; and
- the organisations that will endure throughout the transition.

The NHS Constitution

2.2 The *NHS Constitution*³ establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities for the public, patients and staff. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the *NHS Constitution* in their decisions and actions. As such, the *NHS Constitution* represents an important constant during this period of transition. The Department of Health has recently reminded the NHS that local commissioners should hold providers to the rights set out in the *NHS Constitution*, including those around maximum waiting times, in order to maintain and improve quality for patients.⁴

Review of Early Warning Systems in the NHS - February 2010 Report

2.3 Although 2011/12 represents a significant year of change for the NHS as preparations are made for the formal implementation of the new system from April 2012, the current

³ Available on the NHS Choices website:

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/nhs-constitution-interactive-version-march-2010.pdf>

⁴ See David Nicholson's letter of 17 February 2011, *Equity and Excellence: Liberating the NHS – Managing the Transition* p2:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124479.pdf

system structure and its underpinning performance and regulatory regime remains in place and unchanged throughout next year.

2.4 This is crucially important to remember as existing roles, responsibilities and statutory duties must be discharged fully and effectively throughout this period. It is also important because it means that **the NQB's February 2010 report *Review of Early Warning Systems in the NHS* holds true throughout 2011/12. All parts of the system need to have read and understood this report.**

Quality at the heart of everything we do

2.5 **The most important constant that needs to bind the system together through the period of change ahead is the continued focus on quality as the primary purpose or 'organising principle' of everything the NHS does.** What we mean by quality – effectiveness, safety and patient experience - also remains constant and, indeed, has been drafted onto the face of the Health and Social Care Bill currently before Parliament. Importantly, quality is only achieved if all three of these domains are present – delivering on just one or two is not enough.

Putting patients first - extract from NQB February 2010 report

“Patients, users and carers are the reason for the NHS existing... and as such must be at the centre of all that the NHS and its staff do.”

“...the quality of care provided to patients should never be compromised by the ambitions or management pressures of the organisations commissioning or providing the services”

2.6 The NQB recognises that the pressures on staff working right across the system will be significant during 2011/12. Throughout this period, it will therefore be critical to make sure that a focus on quality guides every move and decision made.

Values and behaviours that put patients first

2.7 **Throughout the transition, the values and behaviours of all those working in the NHS need to remain squarely focussed on putting patients first.** As the NQB's previous report set out, an organisation that is truly putting patients first will be one that embraces and nurtures a culture of open and honest cooperation.

What does a culture of open and honest cooperation look like or mean for the NHS?

- **Healthcare professionals and all NHS frontline staff** feel able to raise concerns about the quality of care at an early stage.
- **Clinical teams** understanding the quality of service they are providing to patients through routinely measuring and benchmarking their performance with peers across the three dimensions of quality – safety, effectiveness, patient experience
- **Provider boards** see their fundamental role as ensuring high quality care for patients
- **System managers (PCTs and SHAs) and regulators (CQC and Monitor)** work together to share information and intelligence on risk; be seen as a source of advice and support in the event of concerns being raised; and visibly work together to support improvement where potential or actual failures in the quality of care being provided to patients are identified
- **All parts of the system** are actively listening to and proactively engaging with patients and the public to understand concerns

Roles and responsibilities throughout the system

2.8 2011/12 will see significant activity across the NHS in readiness for the statutory changes to the system that will commence, subject to legislation, from April 2012. Despite this preparatory work, the statutory functions, responsibilities and accountabilities of existing organisations remain firmly in place throughout 2011/12. This means that the roles and responsibilities of organisations set out in the NQB's last report, and summarised below, hold true and must be fully and effectively discharged during 2011/12. For example, PCTs will need to have put in place clustering arrangements by June 2011 in order to enhance resilience during this period. Although they will increasingly be working alongside the emerging GP Consortia whilst remaining responsible and ultimately accountable for ensuring their statutory and non-statutory roles and responsibilities with regards to quality are maintained.

2.9 In addition to meeting these roles and responsibilities, all NHS organisations must meet the duties within the Equality Act 2010 and public sector duties (set out in section 149 of the Act). The aim of the Equality Duty is to embed equality considerations into the day to day work of public authorities, so that they tackle discrimination and inequality. The equality duty covers the following protected characteristics:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex; and
- sexual orientation.

Overview of roles and responsibilities – extract from NQB February 2010 report

| | |
|------------------------------|---|
| NHS staff and clinical teams | “...NHS staff and clinical teams are the first line of defence in preventing serious failure in the NHS. It is their responsibility and duty to speak up when they have a concern, as well as striving to deliver continuous improvements in the quality of care they provide” |
| Provider Organisations | “...ultimate responsibility for safeguarding the quality of care provided to patients rests with the provider organisation through its board. Boards should be ensuring that their organisation meets the essential levels of quality and safety as set out by the new system of registration...and continuously striving for quality improvement.” |
| PCT Commissioners | “secure provision of services to meet the needs of local populations by commissioning from registered providers. They then assure themselves that providers are meeting their contractual obligations, through contract management, soft intelligence and other information. They have a statutory duty to secure continuous improvement in the care that they commission.” |
| Strategic Health Authorities | “are accountable to the Secretary of State for the operation of the NHS in their region. They do this by assuring themselves that PCTs are commissioning high quality services that meet the needs of the population and that they are holding all providers to account for performing against their contracts. They also directly manage the performance of NHS trusts (non FTs)” In the event of a serious failure, the SHA is responsible for holding the ring and ensuring that “the management and regulatory responses remain aligned and coordinated at all times.” |
| Care Quality Commission | “is the independent regulator for health and adult social care in England. It registers all providers of health and adult social care against registration requirements (essential levels of quality and safety), and attaches conditions to registration where appropriate. It then monitors ongoing compliance against these requirements and takes enforcement action where necessary” |
| Monitor | “is the independent regulator of NHS Foundation Trusts. It determines whether NHS trusts are ready to become, FTs authorising those that meet certain pre-determined criteria...Monitor sets the regulatory and reporting framework for all FTs via its Compliance Framework, which it uses to monitor whether or not NHS foundation trusts are complying with their terms of authorisation. As part of this Compliance Framework, all foundation trusts must comply with CQC’s registration requirements...Monitor looks to CQC for judgements as to whether an NHS foundation trust is complying with their registration requirements...” |
| Department of Health | “is accountable to Parliament for the provision of health services to the population of England. It designs the health system, including setting registration requirements in legislation, setting out national priorities through the NHS Operating Framework, and delegating responsibility to regional and local levels. It is the responsibility of the Department of Health to ensure that there are effective flows of information on emerging concerns and risks throughout the system” |

Mobilising staff and patients to protect and improve quality

2.10 Whilst the overall structure of the health system will be changing, with many organisations set to be abolished and new statutory bodies to be established, **staff and patients will remain a critical constant throughout this period. The NHS needs to understand how to harness the knowledge and expertise of staff and patients in order to protect and improve quality** through what will be an extremely turbulent time, with the additional risks brought by organisational change.

2.11 Although the NQB's previous report emphasised the critical importance of listening to staff and patients about the quality of services and care provided by the NHS, we feel that it underplays the central role these two groups now need to play during the transition period. **The system now needs to think creatively about how it can better mobilise and empower staff and patients to help protect and improve quality.**

2.12 There are formal mechanisms for involving patients such as Local Involvement Networks (LINKS). As Health and Wellbeing boards are established in shadow form, they will also provide a useful mechanism for partnership working. In addition to these formal mechanisms, boards need to think about other opportunities for mobilising staff and patients.

2.13 **Some examples of initiatives that are seeking to mobilise staff and patients to improve quality are set out below:**

- The Care Quality Commission is developing a programme of unannounced inspections of the care that older people receive. A senior nurse will form part of the inspection team to observe the quality of nursing care. An 'expert by experience' – a patient who has received care – will also be part of the inspection team.
- The Patient Safety First⁵ campaign, sponsored by NPSA, the NHS Institute and the Health Foundation, was developed as a locally owned campaign, rather than a centrally driven initiative, and reached thousands of staff through a series of focused activities such as Patient Safety First Week, as well as provided simple practical steps to support local action. It increased understanding about the difficult art of implementation and what it takes to spread and sustain improvement in patient safety. Although the campaign itself is not set to continue, the resources and the learning stemming from it can still be accessed by all those working in the NHS, via the Patient Safety First website.
- Real-time feedback, gathered through SMS texting, comment cards, hand-held devices and similar, is being used effectively by several providers. Usually led by local providers at the point of care level, it can provide swift local feedback, typically along the service or ward lines and gives clinicians and managers a detailed insight into patient experience of care at the point

⁵ For further details visit <http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/>

of delivery. The information is used directly by staff to improve services at or near the time care is provided and action taken is fed back to patients in a variety of formats ranging from ward board displays to internet feedback and Quality Accounts.⁶

- The NHS Staff Survey continues to play an important role in the transition. It provides a structured, evidence-based way for employers to engage with their staff and to gather information about important areas relating to staff experience including where staff can see potential and actual risks. In particular, the survey provides information on staff assessment of the quality of care and this is an important indicator of potential problems / outcomes for patients.
- The NHS Institute has an online Patient Experience Network (PEN) that identifies models of gathering patient experience feedback that NHS organisations can use.⁷
- St George's Hospital has employed a 'One Team' programme that brings together groups of non-clinical staff to examine how patients were treated in the hospital. The programme established working groups to discuss key issues around staff and patient experience; to identify responses and solutions to any issues; and to develop a culture of improvement. As part of the programme, participants were encouraged to visit and learn from other organisations such as retail companies and public sector bodies.⁸

2.14 Another important group of staff that should be mobilised is trainees. For example, as they move between organisations at regular intervals, trainee doctors can provide unique insights into the relative quality of different organisations. As a minimum, we would advise boards to engage with the results of the GMC National Trainee Survey.⁹ As part of understanding the views of trainees, SHA Medical Directors can seek views from Deaneries on the quality of training, given that this can be an indicator of the service that is being provided. Deaneries are well placed to share information with SHA medical directors, providing an opportunity to share any concerns.

⁶ More details and case studies can be found on the NHS Institute website

http://www.institute.nhs.uk/share_and_network/pen/add_your_experience_programme_story.html

⁷ The PEN website can be found here: http://www.institute.nhs.uk/share_and_network/pen/welcome.html

⁸ Further information on staff engagement is available here (more details of the St George's Hospital scheme can be found on p5):

<http://www.nhsemployers.org/Aboutus/Publications/Documents/Staff%20engagement%20in%20the%20NHS%20some%20local%20experience.pdf>

⁹ Formerly the Postgraduate Medical Education and Training Board (PMETB) survey

Enduring organisations as the champions for quality

2.15 Of course, **despite the significant change to the current system there will still be a number of organisations that will remain constant, or relatively stable, throughout the transition.** These organisations include, but are not limited to:

- the majority of NHS provider organisations
- General Practices
- the Care Quality Commission
- National Institute for Health and Clinical Excellence (NICE)
- Royal Colleges and Professional Associations
- Professional Regulators
- Trade Unions and the Social Partnership Forum
- NHS Employers
- The NHS Litigation Authority
- Local authorities

2.16 Whilst maintaining and improving quality is everyone's business, **these organisations need to recognise that their relative stability means that they need to step up during the transition period and become the champions for quality.** For example, we are delighted that the Academy of Medical Royal Colleges has agreed to work with the NQB in phase two of this review to consider how Royal Colleges and other professional associations can better support the early identification of quality failures in order to support the new system to take swift remedial action. Equally, **any new organisations that are established as a result of the reforms will need to actively listen to and engage these linchpins of quality in order to ensure quality is maintained throughout the transition period.**

Chapter 3:

Enhancing resilience for quality in 2011/12



3.1 The previous chapter highlighted those parts of the current system that will remain constant during 2011/12 and, in some cases, beyond. Whilst it is important to recognise and capitalise on these constants, **all NHS organisations should be looking to put in place additional measures to enhance their resilience for quality and the resilience of the new system as, subject to Parliamentary approval, it emerges over the next four years.** Focusing on 2011/12 this chapter explores three key areas:

- firstly, some of the practical steps that can be taken to safeguard quality during the transition;
- secondly, how existing and new processes need to be harnessed in order to enhance resilience for quality; and
- thirdly, what those organisations that will be winding down in 2011/12 should be doing in order to enhance resilience for quality.

Practical steps to safeguard quality during the transition

3.2 As the service looks to manage the delivery of high quality care to patients throughout 2011/12, it is important that all parts of the system are familiar with some of the more practical steps that can be taken and tools that can be deployed to enhance resilience for quality.

Raising concerns

3.3 As well as being frontline champions for quality, staff should be a powerful tool in alerting an organisation to issues of care and identifying where quality can be improved. For example, we know that the 2006 NHS staff survey revealed that, at Mid Staffordshire NHS Foundation Trust only 27% of staff said they would be happy to be cared for by the Trust compared to a significantly higher national average.

3.4 Staff voice and opinion must be seen as a valuable indicator of the quality of care within a Trust and should provide boards and managers with insight into the standards of care being delivered to patients. Staff voice offers an alternative perspective straight from the frontline of day to day delivery and as such can offer organisations the opportunity to identify how they can improve quality of care and address any issues of concern before they become serious failures.

3.5 It is therefore critically important that the boards and leaders within an organisation, as well as the staff themselves, take responsibility for ensuring that:

- staff voice is heard and that there is the culture and environment to support staff in speaking up;
- there are appropriate structures and processes in place to facilitate staff in raising concerns; and
- there is a cultural expectation that appropriate action will be taken in response to any concerns that may be raised.

3.6 All staff working in the NHS have a responsibility to speak up should they have genuine concerns about patient safety and the NHS organisations in which they work have a responsibility to listen to and act upon these concerns.

3.7 It is important that organisations promote employee engagement, both to spur quality improvement and provide opportunities for staff to raise concerns. Healthcare professionals should raise any concerns they may have about the quality of care to patients with their team leader or manager in the first instance. Other routes for raising concerns can include team meetings that senior operational managers hold with frontline staff. Staff can also raise concerns through their professional representative bodies and through staff partnership structures/organisations.

3.8 There may be instances where action cannot be or is not taken at team level. In which case, individuals or team leaders should look to the appropriate member of the trust senior management or board.

3.9 Bringing about a culture in which all staff feel able to raise concerns requires strong leadership. To demonstrate our commitment to bringing about this culture and to support implementation of this report **we will provide a leaflet for staff encouraging staff to think about what they can do to improve quality and reminding them of their responsibilities to speak up if they have any concerns. Importantly, we will be looking to the boards of organisations to endorse this leaflet, to make it widely available to staff throughout their organisations and to tailor it with local information.**

3.10 Of course, it is important to remember that all healthcare professionals are subject to professional obligations in relation to quality and safety. All regulated healthcare professionals must abide by standards of professional practice, conduct and ethics set by their regulatory bodies. These professional standards require clinicians to make the care of their patients their first concern and to protect and promote the health of patients and the public in all they do. This includes an obligation on registered healthcare professionals to raise concerns about patient and public safety. For further information on professional codes of conduct, please access the website for the relevant body.

3.11 If the right culture exists within an organisation then staff should feel comfortable in raising concerns and confident that any concerns they do raise will be listened to and investigated. However, in order to provide protection when raising concerns, healthcare professionals and all NHS staff are entitled to protection in the instance of 'whistleblowing'

under provisions in the Public Interest Disclosure Act 1998. In order to further support employees, the Social Partnership Forum produced guidance for the NHS on best practice for whistleblowing procedures¹⁰.

3.12 Negotiations with NHS trade unions are looking to amend the terms and conditions of service for NHS staff to include a contractual right to raise concerns. Additionally, the NHS council has recently reached agreement to change the NHS handbook on terms and conditions of service to provide staff with a contractual right and duty to raise concerns. This agreement was published on the NHS Employers website on 13 September 2010.¹¹

3.13 Proposed amendments to the *NHS Constitution* were published in October 2010 to:

- insert an expectation that NHS staff will raise concerns as early as possible;
- insert an NHS pledge to support all staff in raising concerns; and
- highlight in the *NHS Constitution* the existing staff legal right to raise concerns.

3.14 'Whistleblowing' protects the rights of staff in raising genuine concerns over the quality of care being offered to patients. However, it should act as a final resort in ensuring concerns are heard. **Organisations should work to ensure that they foster an open and honest culture where all staff feel empowered to make improvements and be able to raise concerns.**

Feedback from the public and patients

3.15 **All organisations should utilise all the available and relevant sources of information on patient and public feedback and complaints.** These are key sources in providing insight into the delivery of care at an organisation, and in identifying issues before they become serious failures.

3.16 There is no one ideal system for seeking feedback from patients and the public to inform service improvement and it is important that organisations use a variety of approaches. This includes the use of nationally coordinated surveys to produce quantitative comparable data, complaints data, bespoke locally designed systems to collect feedback and ratings at the point of care, and a range of initiatives to capture a qualitatively rich and detailed insight into the experience of patients and service users.

3.17 All these forms of feedback are needed and, when analysed together, will provide boards, as well as local clinicians and managers, with vital intelligence on the quality of services being provided. Therefore, **organisations should be taking steps to actively seek and act upon public and patient feedback. Complaints data makes up an especially important**

¹⁰ A copy of this guide can be downloaded here:

<http://www.socialpartnershipforum.org/SiteCollectionDocuments/Speak%20up%20report%20%28final%20%29%20bkmk.pdf>

¹¹ Terms and Conditions of Service Handbook:

<http://www.nhsemployers.org/PayAndContracts/AgendaForChange/TermsAndConditionsOfServiceHandbook/Pages/Afc-Handbookr.aspx>

part of feedback and when analysed appropriately at trust level, can be used to spot patterns and trends, and hence potential problem areas.

3.18 The Health Service Ombudsman (HSO) conducts independent investigations into complaints of injustice or hardship resulting from maladministration or poor service in the NHS. It also publishes reports and complaints that provider organisations can learn from and use to improve the quality of services provided.

3.19 The HSO works with CQC and Monitor, sharing information gathered during its investigations, any recommendations made, and subsequent implementation plans that arise. This information is further used in CQC Quality and Risk Profiles.

Good Governance for Quality

3.20 **The boards of provider organisations are ultimately accountable for the quality of care provided across all service lines.** Therefore, they must ensure that they have appropriate governance arrangements in place for ensuring quality within their organisation. Effective quality governance resonates throughout an organisation and fosters an environment where quality of care delivered to patients is the main priority.

3.21 In order to support provider boards in achieving this, **the NQB has published guidance on what good governance for quality looks like alongside this report.** *The Quality Governance Guide – a guide for provider boards, identifies a core framework for ensuring quality governance in an organisation and provides guidance on how to practically enable this from board to ward.* The guide is being published alongside this report as a supporting tool and responds directly to a recommendation made in the 2010 *Review of Early Warning Systems in the NHS* that “trust boards be given further guidance on how best to govern for quality” following the breakdown in the structures of governance at Mid Staffordshire NHS Foundation Trust.

3.22 Building on the quality governance good practice introduced by Monitor as part of its Quality Governance Framework and assessment process for aspirant Foundation Trusts, the guide sets out a definition of quality governance and is structured around four key pillars:

- strategy
- capability and culture
- processes and structures
- measurement

3.23 These are the key areas provider boards should look at when thinking about their governance structures and in order to ensure a focus on continuous quality improvement. The guide takes each pillar and outlines in more detail its definition before underpinning it with practical examples and links to supporting material. **Provider boards are urged to read and discuss this guidance with a view to considering how governance for quality might be enhanced within their organisation.**

3.24 People often ask whether there is a core set of quality indicators that all organisations should look at in order to help them to understand how healthy their organisation is in terms of quality. Our view is that there are significant risks in doing this, as organisations will have a tendency to focus only on those indicators set out in the list at the expense of looking at quality in each and every service line. No matter how good any of the indicators may be individually, boards need to take overall judgements about their organisation and a fixed set of indicators can and will only ever provide a false assurance. That said there are a number of operational indicators that can be helpful to look at on a regular basis in order to build up a picture of how healthy an organisation is. These include, but are not limited to:

- staff turnover rates
- sickness absence rates
- percentage of staff as agency/locum or temporary (up to 12 months) contracts
- number of staff reported minor incidents (errors that do not create a complaint but where staff have noticed the system has not worked well) as well as monitoring those events should never happen (i.e., ‘never events’)
- the relationship between overall incident reporting rate and levels of severity (the total would be expected to increase as the number of incidents of severe harm and death decrease).

3.25 **In addition, there are a range of tools that organisations can use to evaluate their organisational culture and its approach to quality and safety. One such tool is the Manchester Patient Safety Framework (MaPSaF) which was developed by the University of Manchester in partnership with the NPSA.¹²** Phase 2 of this review will consider whether there are additional prompts and tools that boards may find helpful in assessing the overall ‘temperature’ of their organisations.

CQC Quality & Risk Profiles

3.26 In order to support registration and compliance monitoring, the CQC has developed Quality and Risk Profiles (QRPs), to provide a picture of the quality of the care provided by an organisation and the level of risk attached to it. At the time that the NQB’s 2010 Early Warnings review was published, we were only able to discuss QRPs in theoretical terms, as they had not then been launched into the system. QRPs are now live within the system and organisations are encouraged to become familiar with their content and structure and interact with them as real time quality assurance processes. The QRP is updated monthly, with new data being added as soon as it becomes available. CQC is constantly looking for new sources of data that can be used to assess risk, so as to improve the risk analysis that the QRP provides. The effect of this is that risk of non-compliance with essential standards of care is being constantly and pro-actively monitored.

3.27 Crucially, QRPs are not a judgement in themselves. They are a prompt or guide to assist CQC's operational staff in their day-to-day work of monitoring compliance, and are used to help plan inspection activity.

¹² Further details of the MaPSaF can be found on the NPSA website at:
<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59796>

3.28 However, QRPs can also allow organisations to track their performance and identify where there may be quality failings. They are, therefore, a good source of information and in looking to maintain a grip on quality throughout the transition, **organisations throughout the system are encouraged to become familiar with the structure of QRPs and the way the CQC manage them.** More detailed guidance on how to use QRPs can be found at the reference below.¹³

3.29 It is recommended that all trusts interact with the data and information provided by the CQC and utilise this information as an added assurance process that will provide a further view on the delivery of care at an organisation.

3.30 The content of QRPs is regularly updated, with refreshes typically taking place on a monthly basis. However, this may be a shorter or longer cycle depending on the type and source of data. Currently an updated version of the QRP with new risk calculations is made available to providers and commissioners each month.

Other useful sources of information on quality

3.31 There is a wealth of data, information and guidance on quality available which all NHS organisations can draw on to understand both their own quality performance and also how they can go about making improvements. Sources of information include, but are not limited to:

Useful sources of information on quality

Click to load the relevant websites for more information

- [Health Service Ombudsman](#)
- [National Patient Safety Agency](#)
- [National Reporting and Learning Service](#)
- [GMC National Trainee Survey](#)
- [CQC Quality & Risk Profiles](#)
- [Quality Observatories](#)
- [Indicators for Quality Improvement](#)
- [Hospital Episode Statistics](#)
- [NHS Evidence](#)
- [Patient Safety First](#)
- [Patient Reported Outcome Measures](#)
- [Clinical dashboards](#)
- [National Clinical Audits](#)
- [Local Clinical Audits](#)
- National Registries
- [Patient experience surveys](#)
- [NHS Staff Survey](#)
- [Quality Accounts](#)
- [Organisations for Economic Cooperation and Development](#)
- [Public health observatories](#)
- [NHS Information Centre](#)
- [National Institute for Health and Clinical Excellence](#)

* There is no central website for national registries

¹³ Information on using QRPs:

http://www.cqc.org.uk/db/documents/20100921_QRP_v1_NHS_How_to_Use_Guidance_FINAL.pdf

Harnessing existing processes to enhance resilience for quality

3.32 Throughout the NHS there are numerous processes aimed at safeguarding quality. During the transition, these processes need to be used to maximum effect and strengthened where appropriate in order to enhance resilience for quality. Some of the important national level processes already in place are highlighted below, as well as the proposed authorisation process for GP Consortia that will need to be developed over the course of 2011/12.

The authorisation process for Foundation Trusts:

3.33 Subject to Parliamentary approval, all NHS Trusts will need to have achieved Foundation Trust (FT) status by 2014. The application and authorisation process for becoming an FT therefore provides a powerful lever for ensuring a focus on quality is maintained in those organisations that are not yet FTs. **Quality must remain at the heart of this process and all FT applicants should look to harness the authorisation process as a means of strengthening governance arrangements and resilience for quality. It should not be seen as simply a one off hoop to jump through.**

3.34 **The statutory responsibilities of Monitor do not change during 2011/12 and their role, as described in detail in the 2010 review, remains the same. Therefore, as the independent regulator of NHS Foundation Trusts, Monitor will continue to assess all applicants for FT status during 2011/12.** Monitor's quality governance framework¹⁴, developed to provide clear guidance and assessment criteria to trusts, requires that all FT applicants demonstrate how boards manage their organisations for quality. Monitor also requires applicants to be in good standing with the Care Quality Commission and to continue to satisfy the requirements set by the NHS Medical Director, as described below. In addition to this, Monitor is currently consulting on introducing a framework for quality governance into the compliance framework for existing FTs that would further assure the levels of care being delivered by all FTs.

3.35 Following the events at Mid Staffordshire, we welcome the part that the NHS Medical Director and his team of SHA Medical Directors who meet monthly, play in advising on the quality aspects of the FT applications. Following a collective consideration of an application at these meetings, the NHS Medical Director provides advice on the appropriateness of the application for proceeding to the final stage of assessment. The NHS Medical Director must support an application before advice is given to ministers to support an application and enable the final assessment with Monitor to commence. **It will be important that the Secretary of State can continue to receive clinical advice on the quality aspects of FT applications from April 2012 onwards. As part of phase two of our review, we will advise on how and by whom this important function should continue.**

3.36 **Monitor's quality governance framework forms the basis of the *Quality Governance Guide*¹⁵. It is recommended that all FTs and aspirant FTs remind themselves of the content of Monitor's quality governance framework and look to continually improve against the**

¹⁴ Details of this can be found in *Applying for NHS Foundation Trust Status: Guide for Applicants* available here: <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-applicants/applying-nhs-foundation-trust-status-guide>

¹⁵ Published alongside this report

specific criteria outlined in the authorisation process. This will both help to ensure preservation of quality throughout 2011/12 and lay the foundations for the NHS White Paper vision that all trusts will be FT status by March 2014. Detailed guidance on Monitor's authorisation process can be found in *Applying for NHS Foundation Trust Status: Guide for Applicants*.¹⁶

Contract Monitoring

3.37 Primary Care Trusts are responsible for managing the contracts that they hold with providers and the routine contract monitoring process, if done well, will provide an important mechanism for assuring quality during the transition. Robust contract monitoring should include agreeing clear performance measurement and reporting cycles; fit-for-purpose data monitoring systems; and holding regular contract performance meetings with providers.

3.38 Through robust contract monitoring and the appropriate use of soft intelligence, PCTs will continue during 2011/12 to have access to the most up-to-date information and intelligence about providers and therefore continue to play a vital role in detecting and preventing serious failures at an early stage. While it is for the CQC to make judgements on whether a provider is compliant with registration requirements, PCTs should be able to spot signs of non-compliance at an early stage and should inform the providers and the CQC as appropriate.

GP Consortia & the Authorisation Process

3.39 Subject to Parliamentary approval, from April 2013, GP consortia will formally take over commissioning functions from PCTs. All holders of primary medical services contracts will be required to be a member of a consortium.

3.40 Both the NHS Commissioning Board and GP consortia will be under statutory obligation to reduce inequalities in healthcare provision. The Health and Social Care Bill also includes a duty for the NHS Commissioning Board and GP consortia to carry out their functions with a view to securing continuous improvements in the quality of the services provided to patients, with particular regard to clinical effectiveness, safety and patient experience. Each consortium will be responsible for the quality of the care that they commission. **The NHS Commissioning Board will be responsible for authorising the establishment of GP consortia.** This will be an important element of ensuring that consortia are ready to take on their responsibilities, **the NQB will therefore provide further advice as part of phase two of the review on how to ensure that quality is placed at the heart of the authorisation process for GP consortia.**

3.41 Similarly, as the provider landscape changes over the coming months and years, qualification processes for new providers should be designed to ensure that maintaining and improving quality is a core objective.

¹⁶ *Applying for Foundation Trust Status: Guide for Applicants*: <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-applicants/applying-nhs-foundation-trust-status-guide>

Quality Accounts

3.42 The boards of provider organisations are ultimately responsible for the quality of care provided across all service lines. The primary purpose of a Quality Account, therefore, is to spur boards and leaders of healthcare organisations to assess quality across the entire range of their healthcare services, with an eye to continuous quality improvement. As boards lead organisations through the challenges ahead and make the transition to the new system architecture set out in the NHS White Paper, Quality Accounts must be seen as a key mechanism by which they can demonstrate that a relentless focus on improving service quality is being maintained.

Reporting of Patient Safety Incidents

3.43 Patient safety incident reporting is a crucial mechanism for identifying downward trends in the quality of care, identifying failure and facilitating learning. Since April 2010, it has been mandatory for NHS trusts in England to report all serious patient safety incidents to the CQC as part of its registration process. In order to fulfil this requirement it is ultimately the responsibility of healthcare professionals in the first instance to flag up and report incidents when they happen. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the National Reporting and Learning System (NRLS) and the NPSA will then report them to the CQC.

Ensuring resilience as organisations wind down during 2011/12

3.44 Some organisations including PCTs and SHAs are currently going through a period of transition. As they begin to approach the date at which they cease to exercise statutory responsibilities (i.e. SHAs April 2012), and/or as they begin to delegate some of their statutory functions to other transition bodies (i.e. PCTs to clusters until the end of 2012/13), they will need to pay particular attention to both their resilience for quality and their handover to successor bodies.

Strategic Health Authorities and Primary Care Trusts

I. Ensuring the NHS continues to deliver in 2011/12

3.45 *The Operating Framework for the NHS in England 2011/12*¹⁷ set out the priorities that the NHS will be expected to deliver during the next financial year. Each SHA must submit an integrated plan by 25 March 2011 to the Department of Health, bringing together all the key requirements across quality, resources and reform. A transition assurance process will take place in each region from March to June 2011, where each SHA will be visited by the NHS leadership team to provide assurance on its agenda for quality, productivity and reform. As set out in *The Operating Framework for the NHS in England 2011/12*, NHS organisations will need to have in place strategies for managing the risks associated with organisational change. **Each board will be expected to be able to assure itself that they have robust plans in place to ensure resilience for quality during a period of change, including:**

¹⁷ <http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Planningframework/index.htm>

- having a plan in place to deal with the potential loss of managerial and clinical talent so as to maintain capacity and capability for quality throughout transition, both within and between organisations;
- each Cluster must ensure they identify an unambiguous (clinical) lead responsible for holding the ring on quality across their area, with a clear succession plan in place. There should be appropriate arrangements in place with PCTs to ensure they can fulfil their accountabilities;
- SHAs should ensure that as they approach 2012 they have succession plans in place to ensure that they continue to have a clear lead for the quality and safety agenda;
- maintaining the ability to ensure that the voice of patients, as a vital element of the early warning system, remains heard at all times and is not drowned out by other organisational or transitional noise;
- bringing key partner organisations together to consider collectively risks to quality both in relation to specific services or provider organisations and, more broadly, across whole health economies;
- delivering a robust and effective handover to successor organisations, part of which involves production of a 'Legacy Document', described below;
- identifying and tackling any long-standing and intractable quality issues before handing over responsibilities to successor bodies;
- that integrated plans can be delivered whilst also delivering all statutory responsibilities with regard to quality;
- that board and governance arrangements – particularly where accountabilities may be delegated – are robust enough for boards to provide challenge and oversight with regard to quality and to assess the impact of any proposed changes effectively;
- that arrangements are put in place to ensure prompt and effective information sharing between different parties and organisations with regard to the quality of services; and
- that each board understands their responsibilities as set out in the NQB's previous report, *Review of Early Warning Systems in the NHS*, and that there is clarity locally about who is responsible for what during the transition period.

II. Effective handovers: capturing organisational memory

3.46 The NHS employs over 1 million people and relies heavily on the professional and organisational knowledge and corporate memory of its employees. The vision set out in the NHS White Paper however represents a major system redesign, and requires a significant de-layering, whereby whole tiers of management will be taken out of the system.

3.47 The knowledge and corporate memory of an organisation's employees is a rich resource that needs to be preserved in order to maintain the continuity of services and, more importantly, to maintain and even improve the quality of care provided. It cannot be left to individual managers or clinicians to pass on informal intelligence or views about services, nor should it be left to new bodies or individuals to discover for themselves afresh, longstanding

problems that exist within their local health service. **The scale of the change means that the NHS now needs to enhance the robustness of its handover arrangements.**

3.48 In order to ensure that the new bodies can ‘hit the ground running’ and start reaping the benefits of the new system, whilst reducing the risk of transition, **there needs to be a robust system of handover that effectively captures and transfers organisational memory.** Although modelled on the practice of due diligence, this transfer of hard and soft intelligence will be the responsibility of both the outgoing and the incoming organisations.

3.49 Each outgoing organisation (i.e. PCT/SHA) will be required to produce documentation that captures the knowledge that has been accumulated through managerial and clinical interactions over the years. This should form the basis of a ‘Legacy Document’, from the departing organisation to the new. We recommend that the NHS Commissioning Board provide a template for the SHA level Legacy Document by June 2011. PCT Cluster Chief Executives should agree with each of their constituent PCTs the precise content required for each of their Legacy Documents. As a minimum, all Legacy Documents (PCT/PCT Cluster and SHA) should include:

- information on all services provided to the local population, including primary care services;
- ‘Pen Portrait’ of the patch to include the key facts and figures on population, geographical boundaries and so forth;
- current state of play with regard to quality, finance, performance, capacity, and people; recognising that this will be a snap shot in time;
- relevant organisational memory – in each of the above categories, For example if a Trust is currently in surplus but actually has had many years of deficit and brokerage, or has seen 5 changes in leadership in 5 years, or has a long standing reconfiguration issue;
- future challenges/risks - a formal risk register to capture each of the above issues with proposed mitigating actions;
- library of knowledge/skills – a depository of all useful resources such as strategy documents, consultancy reports, so that incoming teams are not required to re-discover problems and/or re-invent answers; and
- directory of services and skills – to help people navigate their way round the various information sources/skills available regionally, including contact details for people who have corporate memory.

3.50 The transition has been designed to minimise the impact on the services delivered and so sees the gradual transferral of powers from PCTs and SHAs. **The Legacy Documents will be vital for maintaining safety at several key stages of the transition and so will need to be maintained as living documents over a sustained period.**

3.51 **Figure 1** provides an overview of the Legacy Document approach to retaining corporate memory on quality during the transition. In summary:

PCT/PCT Cluster Level

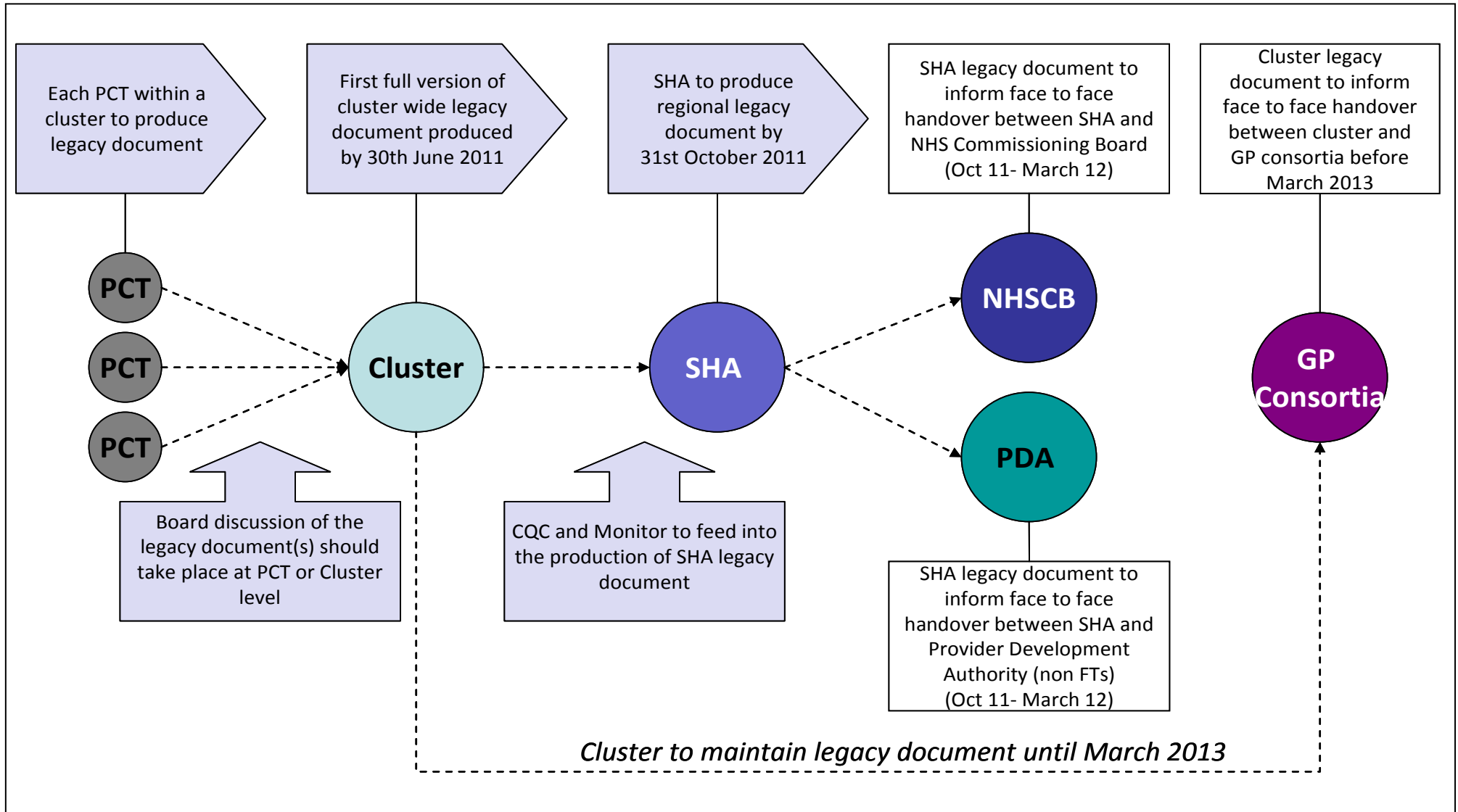
- Each PCT within a Cluster to produce a legacy document.
- PCT Clusters will be responsible for producing a first full version of a cluster wide legacy document by 30 June 2011. These will provide essential information for SHAs as they begin to develop their own Legacy Document by October 2011.
- PCT Cluster Legacy Documents should provide an overview of quality across its geographical reach and should include the individual legacy documents of each constituent PCT.
- PCT Clusters should ensure that the cluster-wide documents are maintained up until the abolition of PCTs in March 2013. This is so that they can form part of the PCT handover process to GP Consortia.

SHA Level

- SHAs should complete their first full Legacy Document by 31 October 2011 to dovetail with the establishment of the shadow NHS Commissioning Board.
- These should draw on the Legacy Documents produced by PCT Clusters.
- The SHA documents will be used to ensure a robust handover between the SHAs and the NHS Commissioning Board.
- For those remaining non-FTs, the Legacy Document should be used to inform the handover between the SHAs and the Provider Development Authority (PDA).
- SHAs will need to maintain their Legacy Document as a living document until March 2012.

3.52 At both PCT/PCT Cluster and SHA level, all legacy documents should be subject to a (public) board level discussion for assurance purposes. We also recommend that these documents are available publicly to enhance and ensure their vigour. PCTs and SHAs should consider how they could involve LINKs, Overview and Scrutiny Committees (OSCs) and other local bodies and draw on them to support the production and maintenance of the documents. Additionally, we recommend that CQC and Monitor should have sight of the Legacy Documents to provide them with the opportunity to flag any concerns they have and that should be included in the documents.

Figure 1: Approach to retaining corporate memory on quality during the transition



3.53 Ensuring resilience for quality as organisations wind down will require active participation by both old and new organisations in a robust handover process. Whilst it is imperative that PCTs and SHAs produce thorough Legacy Documents, the onus will be on the new organisations (the NHS Commissioning Board and GP consortia) to satisfy themselves that they understand the whole quality picture of the providers they are taking responsibility for.

3.54 Written documents are an important part of the handover process however, to ensure they are effective, the evidence shows that face-to-face processes are essential. In addition to written documentation, we would expect as a minimum:

- each departing CEO to have a face-to-face handover to discuss the above issues; and
- each manager/clinician to ensure either an effective handover or a record of their work as part of their public sector duty.

National Patient Safety Agency

3.55 **With the abolition of the NPSA timetabled for the end of 2011/12, it is vital that the service and regulators identify how the NPSA's functions will be absorbed into the new architecture, and where organisations should go to continue to report serious safety incidents.** This is a key mechanism in enhancing resilience for quality, and the service must take seriously, and recognise where responsibilities will fall when the NPSA no longer exists.

3.56 **Since** 1 April 2010, it has been a legal requirement for NHS trusts in England to report all serious patient safety incidents to CQC as part of the CQC registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm are reported to the National Reporting Learning System (NRLS), who then pass on the reports to the CQC.

3.57 **From** April 2011, the NPSA will reduce its provision of general patient safety advice, and support, focussing only on the production of the most urgent advice. In 2012, it will cease to exist in its entirety. The legal requirement to report serious incidents and the wider expectation that trusts will report less serious safety incidents will both continue however, and the service must be familiar with the arrangements in place for re-homing the NPSA's incident reporting functions.

3.58 **The key message to focus on during the transition year is that organisations should continue to report safety incidents to the NRLS and these reports will continue to be analysed,** the responsibility for securing the functions of the NRLS will rest with the NHS Commissioning Board. To ensure continuity of this important function, priority must be given to placing the NRLS and the responsibility for action that flows from analysis, in an appropriate organisational setting with accountability to the NHS Commissioning Board. The central alerting system that issues patient safety alerts will continue to function and trusts will still be expected to take any actions specified in those alerts to ensure safety issues are dealt with.

Chapter 4:

Next steps



4.1 This report completes the first stage of our review. It provides clarity regarding existing roles and responsibilities during this period of transition, and advice and guidance to support clinicians and managers in ensuring that we do not lose focus on quality, and continue to build on the significant gains we have made in recent years.

4.2 **Beyond 2012 there will be significant changes to the quality landscape.** SHAs, who currently are expected to hold the ring on system management will no longer exist, and PCTs will cease to function from 2013. GP consortia will be in the driving seat, operating in a much more plural environment on behalf of more informed patients. **In order to articulate clearly who is responsible for identifying and responding to early warnings in the new system, we will need clarity as to both the overall operating model for quality and the respective roles and responsibilities of different players within it** (subject to further parliamentary debate and scrutiny).

4.3 This will be the focus of the second phase of our report. Through a combination of seminars, research and scenario planning, we will seek to clearly describe the overall architecture for quality, making clear who has responsibility for what within the different domains of:

- Delivering for quality
- Assuring for quality
- Commissioning for quality
- Regulating for quality
- Identifying and responding to quality failures
- Holding the ring on system wide failures
- Driving continual quality improvement

4.4 Within this overall framework we will then build upon Phase 1, to describe and make recommendations about the operation of the early warning system for identifying and responding to serious failures in quality once the new system architecture is in place.

4.5 The NQB is ideally placed to take these issues forward, as it uniquely brings together the different perspectives and powers within the health care system, including patients, providers, commissioners, regulators, academics and the Department of Health, to pool intelligence and sovereignty to ensure that quality remains at the heart of all that we do.

Appendix A: 2011/12 Checklist for NHS organisations



Below is a checklist outlining some key tasks and responsibilities organisations are required to fulfil and action during 2011/12. These tasks are about enhancing resilience for quality and are aimed at ensuring that quality remains at the heart of care and service delivery during 2011/12. The tasks outlined are in addition to business as usual roles, responsibilities, and requirements, and it is not an exhaustive list - the checklist looks to identify key quality tasks and requirements that must be actioned throughout 2011/12 to ensure quality is provided and protected.

Checklist for 2011/12

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| <p>Providers:</p> | <ul style="list-style-type: none"> • All providers to read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, all providers to ensure key messages from both reports are disseminated throughout the organisation • All providers to consider the robustness of their arrangements for quality governance, building on the NQB's <i>Quality Governance Guide</i> • Non FT's to read and become familiar with Monitor's <i>Guide for Applicants</i> to prepare for FT authorisation process • Non FTs to work as appropriate to achieve FT status having clearly understood quality governance requirements of the <i>Guide for Applicants</i> • Subject to consultation, all FTs to ensure compliance with the quality governance mechanisms in the <i>Compliance Framework 2011-12</i> • All providers to consider how to mobilise staff and patients to improve and protect quality • All providers to continue to develop and implement QIPP plans • All providers to engage on the new system of provider regulation and preparing for transition to this system (for more information http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm) |
| <p>Clusters/PCTs:</p> | <ul style="list-style-type: none"> • Read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, ensure key messages from both reports are disseminated throughout the organisation. • Continue to deliver against all current statutory and non-statutory roles and responsibilities as described in the NQB's 2010 review • Each PCT within a cluster to produce a legacy document, as set out in chapter 3 of this report, to inform the production of a cluster wide legacy document by 30 June • First full version of cluster wide legacy document produced by 30th June 2011, as set out in chapter 3 of this report • Each cluster/PCT to hold a board level discussion on legacy document(s) • All clusters/PCTs to develop and support the emerging GP Consortia |

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| SHAs: | <ul style="list-style-type: none"> • Read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, ensure key messages from both reports are disseminated throughout the organisation. • Continue to deliver against all current statutory and non-statutory roles and responsibilities as described in the NQB's 2010 review • Produce regional legacy document, as described in Chapter 3 of this report, building on the information provided by the cluster legacy document by October 2011, and ensuring Monitor and CQC are given the opportunity to input. • Ensure collective board level discussion and sign off of regional legacy document • Formally submit regional legacy document to NHSCB and PDA to inform face to face handovers. |
| Shadow NHS Commissioning Board (NHSCB): | <ul style="list-style-type: none"> • Read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, ensure key messages from both reports are disseminated throughout the organisation. • Hold face to face handovers with each of the ten SHAs drawing on the legacy documents • Develop own capability and capacity and oversee the development of GP consortia |
| CQC: | <ul style="list-style-type: none"> • Read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, ensure key messages from both reports are disseminated throughout the organisation. • Continue to deliver against statutory and non-statutory roles and responsibilities as described in the NQB's review • Provide input to the SHA legacy documents |
| Monitor: | <ul style="list-style-type: none"> • Read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, ensure key messages from both reports are disseminated throughout the organisation. • Continue to deliver against statutory roles and responsibilities as described in the NQB's 2010 review • Ensure that quality remains at the heart of the FT authorisation process • Subject to consultation, publish the quality governance requirements for existing FTs as part of the Compliance Framework 2011-12 |
| Provider Development Authority (PDA): | <ul style="list-style-type: none"> • Read, understand, and hold a board level discussion on this report and the NQB's 2010 <i>Review of Early Warning Systems</i>. Following board discussion, ensure key messages from both reports are disseminated throughout the organisation. • Provide governance and performance management to NHS Trusts until they become Foundation Trusts. • Hold face to face handovers with each of the 10 SHAs drawing on the legacy documents in relation to non-FTS |