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NATIONAL QUALITY BOARD

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REVIEW OF QUALITY IN THE NEW HEALTHCARE SYSTEM ARCHITECTURE

A note from the Secretariat

Summary

1. This covering paper seeks the Board's comments on and high level agreement to the first full draft of the NQB's phase two report on how quality will operate in the new system architecture, from April 2013 (Annex A). The report aims to clearly articulate:

- the nature and place of quality in the NHS in the new system architecture;
- the distinct roles and responsibilities for quality of the different parts of the system;
- a new model to facilitate the sharing of information and intelligence on quality between the different parts of the system and to ensure an aligned and coordinated system wide response in the event of a quality failure; and,
- the values and behaviours that all parts of the system will need to display in order to put the interests of patients and the public first and ahead of organisational interests.

2. It is proposed that the report should be published before the summer recess, in draft, ahead of a final version being published once the findings and recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry are known. The interval between publication in draft and the Inquiry reporting would be used to engage more widely with stakeholders across the health and care systems.

Recommendation

3. The Board is asked to:

- comment on the overall structure, tone and narrative of the report;
- agree the description of how the Board views quality, and the values and behaviours that each part of the system will need to demonstrate, as set out in **Chapters 2 and 3** respectively;
- note the distinct roles and responsibilities of the different parts of the system that are described in **Chapter 4**;
- agree the approach to how the system locally and regionally should work together to prevent, identify and respond to serious quality failure, as set out in **Chapter 5**; and
- comment on the actions that are described in **Chapter 6** of the report which would help to make the model set out in the NQB's report a reality.

Background and scope

4. In February 2010, the NQB published its *'Review of Early Warning Systems in the NHS'* report setting out how the system should identify, at an early stage, and respond to serious quality failures in the NHS. The Board had been commissioned to carry out that review and produce a report by the then Secretary of State for Health in response to the Healthcare Commission's report into serious failings at Mid Staffordshire NHS Foundation Trust.

5. Following the General Election and the proposed changes to the system set out in '*Equity and Excellence: Liberating the NHS'*, the NQB decided that it should look again at its 2010 report to ensure that it was relevant to the new system architecture.

6. The first phase of the NQB's review was completed in March 2011 when the Board published a report which explained and made recommendations

regarding how the NHS should safeguard quality during the transition[1]. The Board was clear that regardless of change across the system, a relentless focus on providing high quality care remained the primary purpose of all NHS funded services and all NHS organisations.

7. Since that report was published, and in light of the Health and Social Care Act receiving Royal Ascent, the ex-officio organisations represented on the Board have been working through the NQB Virtual Secretariat to complete phase two of its review and to update the 2010 report in full, taking account of the steers provided by the full Board. The report has also been informed by two Accelerated Solutions Events that brought together representatives from across the health and care system to test the model against various real life scenarios.

The report

8. The report is positioned as a joint statement from the NQB about how the new system will both drive continuous improvement and maintain the essential levels of quality and safety in the best interest of patients and the public. Rather than having a particular chapter on 'patients', the report seeks to weave throughout the importance of always putting the interests of patients and the public first and ahead of organisational interests.

9. The draft report follows the broad structure the NQB signed off at its April 2012 meeting. Chapter 1 provides the background and context to the NQB's review. Chapter 2 explains how the overall system will work in relation to improvement and failure but makes clear that the focus of the report is on failure, as it is absolutely essential that the system gets this right first time.

10. The main content of the document could be viewed as being contained in chapters 4 and 5, where distinct roles and responsibilities for quality and how the system will come together in the interests of quality are described.

[1] *'Maintaining and improving quality during the transition: safety, effectiveness, experience. Part One- 2011-12',* National Quality Board, March 2011

11. However, the report throughout, and in chapter 3 in particular, makes the point that clarity about roles and responsibilities, and having the right systems and processes in place, will not safeguard quality unless they are accompanied by individuals and organisations across the system exhibiting the right values and behaviours as part of a culture of open and honest cooperation. This reflects the top message of the NQB's 2010 report.

The Board is asked to:

- **Comment on the overall structure, tone and narrative in the report; and**
- **Agree the description of how the Board views quality, and the values and behaviours that each part of the system will need to demonstrate, as set out in chapters 2 and 3 respectively**

12. In chapter four, the report describes the distinct responsibilities of each part of the system with respect to quality. It talks briefly about each element's responsibilities or relationship to quality improvement, but focuses predominantly on their roles regarding failure, in line with the principal purpose of the report. It is proposed that for each of the national organisations or functions described in this chapter, the relevant Chair or Chief Executive would put their signature to the description in order to further ownership, responsibility and accountability.

The Board is asked to note the distinct roles and responsibilities of the different parts of the system that are described in chapter 4.

13. Chapter 5 sets out the approach that the NQB has previously considered for how the system should work together. The draft report goes further than the NQB's 2010 report did through setting out new processes to facilitate collaborative working. In particular, the chapter sets out how the system will need to:

- **proactively work together** to share information and intelligence about quality within provider organisations in order to spot potential problems early and manage risk through local and regional Quality Surveillance Groups, supported and facilitated by the NHS Commissioning Board; and

- **reactively work together** in the event of a potential or actual serious quality failure coming to light, to enable informed judgements about quality through Risk Summits.

Once a judgement has been made that there has been a quality failure, the relevant parts of the system should work together to ensure an aligned and coordinated response between those with performance, commissioning and regulatory responsibilities, without undermining or overriding individual accountabilities.

One organisation should ‘hold the ring’ to ensure that actions are coordinated and aligned, where appropriate, and to bring information and organisations together. To ensure maximum flexibility in responding to situations, the organisation should be determined according to the particular circumstances or type of provider. The Quality Surveillance Group is responsible for ensuring that one organisation is agreed quickly and that they have the legitimacy, capacity and capability to take on the role. To avoid unnecessary delay and confusion, if for some reason the parties cannot agree on who should ‘hold the ring’, the default should be that the NHS Commissioning Board takes on this role.

The Board is asked to agree the approach to how the system locally and regionally should work together to prevent, identify and respond to serious quality failure set out in chapter 5

Making it happen and next steps

14. The NQB's report will be a collective statement from the national organisations across the new health landscape as to how they will individually and collectively fulfil their roles and responsibilities and behave to ensure patients receive high quality care. It is not enough simply to write down and publish such a description. The system needs to collectively commit to enacting the model the report describes, and to living the values and behaviours that it has signed up to.

15. This chapter sets out what each individual organisation will do to make this approach a reality in how they operate, what organisations will do together, and where there are further questions which need resolving as part of ongoing national collective work.

The Board is asked to comment on the actions that are described in chapter 6 of the report which would help to make the model set out in the NQB's report a reality.

16. The draft report circulated to the NQB is not yet final – it requires some further refinement and checking for factual accuracy. Board members are asked to provide any drafting changes to the NQB Secretariat in correspondence. Further drafts of the report will be circulated to NQB members ahead of publication.

17. Publication is likely to take place before the summer recess to provide more clarity to the emerging system as organisations consider their new roles and how the new architecture will operate.

NQB Secretariat
June 2012

Annex A

Superseded by final published report, found at
http://www.england.nhs.uk/2013/01/24/nqb/