NQB(12)(05)(04)

NATIONAL QUALITY BOARD

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General Update

A note from the Secretariat

Annexes

A – Quality Accounts: List of mandated quality indicators for 2012/13

B – 'Quality in the new health system': summary of responses

C – Establishing Quality Surveillance Groups: Steering Group membership

Summary

1. This note provides the NQB within an update on progress on the following areas of their work programme:

   A. Quality Accounts - mandated indicators for 2012/13;
   B. Clinical Human Factors Sub-group;
   C. finalising the NQB's report, 'Quality in the new health system'; and
   D. establishing Quality Surveillance Groups.

A. Quality Accounts - mandated indicators for 2012/13

2. Quality Accounts were introduced by the Health Act 2009 to strengthen provider board-level accountability for quality and place quality reporting on an equal footing with financial reporting.

3. The legal duty to publish a Quality Account applies to all providers of NHS-funded healthcare services (whether NHS, independent or voluntary sector), including

mental health and ambulance services. Providers of primary care services and NHS continuing care are currently exempt under the regulations.

4. To date, the considerable local flexibility in the content of Quality Accounts has fostered strong local ownership as Quality Accounts are developed, allowing them to reflect local priorities and local circumstances. Some providers have chosen to incorporate comparative information in their Quality Accounts as a means of setting their performance in context. However, without such comparative information, readers of Quality Accounts may struggle to understand whether a particular number represents good or poor performance.

5. From the 2012/13 reporting period (Quality Accounts published in June 2013), trusts will be required to report on a common set of quality indicators (Annex A), following advice from the NQB. The Department of Health wrote to trusts earlier this year setting out the planned changes to Quality Accounts and giving trusts the opportunity to include these indicators in the report they published in June 2012. Of the Quality Accounts reviewed this year, most trusts reported on one or two of the indicators in the list. The list of quality indicators has since been strengthened to include three indicators relating to the quality of mental health services. The list for 2012/13 Quality Accounts is attached at **Annex A.** Some of the indicators are not relevant to all trusts - for instance, ambulance response times. Following NQB advice, the set of indicators will clearly indicate which groups of trusts they apply to.

6. It is important to note that this is the first step towards the mandation of specific indicators in Quality Accounts and what we can include in future Quality Accounts is somewhat limited because the indicators need to be readily available and already reported nationally. In future years, the development of new quality indicators to support the delivery of the NHS Outcomes Framework, should be aligned with other element of the quality improvement architecture such as Quality Standards, clinical audit and Quality Accounts.

The NQB is asked to note these developments on Quality Accounts and the list of mandated indicators for 2012/13

B. Clinical Human Factors Sub-group

7. At the NQB's September meeting, the Board heard from Sir Stephen Moss, Prof. Jane Reid and Prof. Bryn Baxendale about clinical human factors and their potential impact on quality and efficiency in the NHS. The Board was keen to pursue this important agenda, and agreed to establish a subgroup to focus on the issues.

8. Sir Mike Rawlins agreed to chair that Subgroup on behalf of the NQB. The subgroup has now been established and met for the first time on 26 November. Its membership includes:
    - John Oldham
    - David Haslam
    - Margaret Goose
    - HEE – Lisa Bayliss-Pratt
    - CQC – Philip King
    - NHS Commissioning Board – Mike Durkin
    - NICE - Gillian Leng
    - NHS TDA - Peter Blythin
    - GMC – Martin Hart
    - NMC – Emma Westcott
    - DH Human Factors Reference Group – Stephen Moss and Jane Reid

9. The Subgroup has been tasked with considering how the functions of statutory organisations represented on the NQB could be better utilised to reflect the impact of human factors on quality; and collectively determining and coordinating action, agreeing a set of actions that various organisations would take to pursue this agenda.

10. The subgroup agreed that this coordinated action should take the form of a System-wide statement that would:

- acknowledge that there is a problem with a lack of recognition of human factors across the NHS, a large part of which stems from issues concerning culture;
- demonstrate that the NQB is willing to provide leadership in this area;
- set out that individual organisations can play a part in bringing about the cultural changes that will be needed; and
- define what each organisation is committing to do to make these changes happen, and how their actions will be measured.

11. The publication of this statement could form part of the system's response to the Mid Staffordshire Public Inquiry. The first step in its development will be a workshop in the New Year with key organisations, experts, clinicians, academics and other interested parties. The aim of the subgroup is to have a draft statement to bring back to the NQB for consideration at a meeting in the first half of 2013.

The NQB is asked to comment on and endorse the Subgroup's approach

C. Finalising the NQB's report, 'Quality in the new health system'

12. The NQB's report 'Quality in the new health system' was published in draft in August. It was widely distributed and signposted through NHS bulletins, trade press and through other NQB members' channels. The NQB requested views on the system they described in their report by 30 September. 27 responses were received in total, including from Royal Colleges, the Parliamentary and Health Service Ombudsman, the Kings Fund, and the Foundation Trust Network. **Annex B** provides a summary of responses and a list of those who responded.

13. The task now is to take these points on board, as well as incorporating views raised by the NQB and others, in an updated version and publishing the report in its final form. The original intention had been to publish the final report following the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry. However this is now unlikely to be published until February and so the NQB needs to strike a balance between ensuring that there is clarity as to roles and

responsibilities when the new system goes live on 1 April, and being able to reflect Robert Francis' findings and recommendations.

14. On balance, we recommend that the NQB's final report should be published in mid-January, before the Inquiry reports to ensure that there is clarity in good time before 1 April 2013. Alongside the NQB's final report, several other documents would be published:

    - a patient-friendly version of the report;
    - guidance from the NHS Commissioning Board to CCGs on their role and responsibilities around quality, in the context of the NQB's report; and
    - guidance on establishing Quality Surveillance Groups.

Does the NQB support this approach and timing regarding publication of their final report?

15. If the NQB accepts this timetable, it will mean that there will not be an opportunity for the final report itself to be formally discussed at a NQB meeting (the next NQB meeting is on 22 January).

Is the NQB content to sign off the final report via correspondence?

D. Establishing Quality Surveillance Groups.

16. As part of the NQB's report 'Quality in the new health system', it set out that a new network of Quality Surveillance Groups should be established across the country, to bring together different parts of the local and regional health economies to share information and intelligence on the quality of care being provided to their communities. The network would act as a proactive early warning system for potential or actual quality failures.

17. The NQB were keen that the network was in place from 1 April 2013, when Strategic Health Authorities would no longer be in existence to provide this system oversight role. Since the last NQB meeting, a Steering Group has been

set up to oversee the establishment of QSGs – **Annex C** provides a list of members. It is overseeing a programme of work that includes:

- piloting the approach and practicalities of QSGs both locally and regionally;
- using learning from the pilots to develop the model in more detail and produce guidance to the system on how to establish QSGs;
- developing and overseeing an assurance process to ensure that QSGs are in place and fit for purpose in advance of 1 April 2013;
- ensuring the QSGs have the right information feeds to enable them to share information and intelligence; and
- communicating across the system and with the public on the role and function of QSGs in the new system.

18. QSGs are being piloted in Essex and in Hertfordshire and South Midlands at a local level, and in the Midlands and East at a regional level. Paul Watson, Regional Director, Midlands and East, NHS Commissioning Board, is leading on behalf of the NHS Commissioning Board and is chairing the Steering Group, and regional QSG. Each pilot has now met once, with further local meetings planned on a monthly basis and regional meetings every two months.

19. An outline of the guidance to the system on establishing QSGs has been developed, and a first draft will be produced in coming weeks. The intention is to publish the guidance, possibly alongside the NQB's final report, 'Quality in the new health system', in January. The guidance will be issued as a NQB document, developed by the whole system for the whole system. Due to the need to get the guidance out as soon as possible to support the system, it will not be possible to wait until the next NQB meeting on 22 January to clear the document. It will therefore be necessary to clear through correspondence.

The NQB is asked to note the progress in establishing QSGs to date.
Is the NQB content to clear the guidance to the system on establishing QSGs by correspondence?

NQB Secretariat

27 November 2012

Annex A Mandatory Quality Indicator Set for 2012/13 Quality Accounts

Prescribed Information		***Related NHS Outcomes Framework Domain & who will report on them***
12.	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to— (a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. **(part B is included as a contextual indicator to the SHMI indicator response)**	1: Preventing People from dying prematurely **All trusts**
13	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	1: Preventing People from dying prematurely **All trusts providing mental health services**
14	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.	1: Preventing People from dying prematurely **Ambulance trusts**
14.1	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.	1: Preventing People from dying prematurely **Ambulance trusts**
15	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.	1: Preventing People from dying prematurely 3: Helping people to recover from episodes of ill health or following injury **Ambulance trusts**
16	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	1: Preventing People from dying prematurely 3: Helping people to recover from episodes of

Prescribed Information		*Related NHS Outcomes Framework Domain & who will report on them*
		ill health or following injury **Ambulance trusts**
17	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	2: Enhancing quality of life for people with long-term conditions **All trusts providing mental health services**
18	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.	3: Helping people to recover from episodes of ill health or following injury **All trusts**
19	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged— (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	3: Helping people to recover from episodes of ill health or following injury **All trusts**
20	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's Commissioning for Quality and Innovation indicator score with regard to its responsiveness to the personal needs of its patients during the reporting period.	4: Ensuring that people have a positive experience of care **All trusts**
21	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	4: Ensuring that people have a positive experience of care **All trusts**
22	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting	4: Ensuring that people have a positive experience of care

Prescribed Information		***Related NHS Outcomes Framework Domain & who will report on them***
	period.	**All trusts providing mental health services**
23	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **All acute trusts**
24	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **All acute trusts**
25	The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents that occurred within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **All trusts**
26	Where the necessary data is made available to the trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust (as applicable) in items 12 to 25 with— (a) the national average for the same; and (b) with those National Health Service trusts and NHS foundation trusts with the highest and lowest of the same, for the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **All trusts**

Annex B

Summary of Responses to draft NQB report
'Quality in the new Health System – Maintaining and Improving Quality from April 2013'

General Comments and Main Themes

On the whole there was support for the report, in particular what people recognised as its good intentions around quality and the aim of putting patients and their care at the centre of everything. Most felt that roles and responsibilities in the system were clearly laid out and that the vision for how they would work together to promote quality and tackle failure was commendable, although may be at times slightly aspirational. Many responded positively to the culture of openness and transparency and welcomed the direction of sharing information but suggested that this needed to be more clearly spelt out by documenting where information such as clinical audits and other quality metrics should be kept, how it could be accessed and the routes through which it would be signposted.

Some responses suggested that there was perhaps too much emphasis on prevention and tackling failure, rather than designing quality into the system and constantly driving up standards and promoting innovation. As the Royal College of Radiologists said, "the norms of care of the present will be the unacceptable levels of care of the future". The importance of maintaining quality throughout transition was also highlighted in a number of responses.

Several groups and individuals welcomed the engagement with staff at all levels, acknowledged the difficulty in changing culture within the NHS and accepted it would take time and concerted effort to make this happen. There were a number of references, in particular, to the failure to address the difficulty of whistleblowing, suggesting the need for clarity and consistency around whistleblowing guidance and rules and changing the culture around it to make it a more acceptable and recognised method of raising concerns.

Whilst many responses recognised and agreed that quality was systemic and everyone's business, some concerns were raised around the number of organisations involved and so no one organisation being solely responsible. A few were worried that this may create complexity and a danger of "over-the-fence management", with nobody taking responsibility, issues being lost in the gaps, and everyone thinking that someone else is doing something. Concerns were also raised that it was not clear where the primary responsibility lay at the interface of service providers and who would be responsible to the local population.

There were some comments on funding, in particular, the recognition that financial pressures can often negatively impact on the ability to drive improvement and make changes, the need for a robust financial architecture to be able to support any proposed changes in the system and also the need to move away from reliance on financial incentives. Quality should be part of day-to-day practice, designed into the system, rather than seen as a target by which to achieve financial reward.

Membership and Inclusion within the Report

There were a number of comments around what was felt to be minimal reference to Royal Colleges, Professional Bodies and Trade Unions throughout the report, as these are often the first groups to see emerging problems within a healthcare economy. It was therefore suggested that they should be included in any forums that were concerned with quality issues. Royal Colleges, in particular, were seen to play a key role in quality by way of setting minimum professional standards, some Colleges providing accreditation scheme, setting aspirational aims for quality improvement and embedding quality improvement and safety into education and training. The Royal College of Radiologists cited their Imaging Services Accreditation Scheme (ISAS) as an example of how delivering quality in the new health system can potentially be realised.

A couple of the responses mentioned the apparent lack of input to the report from any quality or safety professionals or their regulatory bodies and the failure to mention any independent organisations who play a role in the delivery of quality in the health system. In particular, the United Kingdom Accreditation Service (UKAS) noted that "UKAS is the only UK accreditation body recognized by Government to operate to the international standard for accreditation" and were "somewhat disappointed that there is no recognition in the report of the role that independent organisations, such as UKAS, can plan in ensuring the quality of healthcare provision".

There was concern expressed in some responses about how this report would relate to social care and highlighted the need to focus on how this system should also prevent, identify and respond to serious failures in quality in that sector. It was suggested that the report should consider the health and social care system together, not just NHS trusts but social care registered providers who also provide NHS services. The English Community Care Association commented that the NHS and social care visions of quality do not fully align, since the latter is based on wellbeing, which can be confusing for people working in both sectors, and that the report needed to be "absolutely clear on its definition of NHS funded care". They also commented on the "constant reference to patients and wards and not people/individuals".

Many groups and individuals welcomed the inclusion of patients, carers and service users in the work to maintain and improve quality. However, there was frequent reference to the lack of clarity around how service users would be recruited and involved, to what extent this relatively small number of people would be able to represent such a large service user group and exactly what they would be expected to undertake as part of their role. It was suggested that the section on HealthWatch should be expanded to include more details on this. There was also concern expressed around service users being equipped with the necessary skills, knowledge, experience and confidence to be able to contribute fully and meaningfully to any discussions and actions. It was suggested that work should be done to ensure that service user representatives, and also to some extent Healthwatch representatives, felt empowered and were offered training, guidance and support in their roles as patient champions. Action against Medical Accidents (AvMA) offered assistance in this area and "would be pleased to be a strategic partner of Healthwatch, the QSGs and the National Quality Board in supporting lay people in monitoring and surveillance of quality and safety in the NHS".

On a related issue, it was noted that commissioners, leaders and monitors of the system are left without training or regulation in their particular function and one individual (Jim E. Swain, BBCEL Quality Engineer) raised the question "who trains and regulates the regulators?"

There were some groups who felt their particular area had been overlooked and/or not mentioned or acknowledged enough within the report. These included:

- The Parliamentary Health Service Ombudsman were concerned by their lack of mention in the report and failure to recognise their ability to provide "a unique perspective on 'patient experience' and identify emerging patterns and trends"
- The area of mental health as a whole (raised by Prof Woody Caan)
- The Supervision of Midwives, a statutory function which is seen as "good practice and one that other professions could learn from" (raised by the Royal College of Midwives)
- The significant amount of evidence available in support of the provision of 24/7 obstetric cover (raised by Liverpool Women's NHS FT)
- The lack of detail and explicit consideration of quality in specialised services and those which are directly commissioned by the NHS CB (raised by Specialised Healthcare Alliance)
- The British Geriatrics Society felt that "care of older people should be prioritised"

- The Federation of Irish Societies thought there was "no reference to the specific cultural needs of vulnerable people" and to specific service delivery areas.
- Community pharmacy is not currently regulated by either CQC or Monitor, the Royal Pharmaceutical Society would like "some clarity as to how the new quality system will relate to [pharmacies and pharmacists] and the services they provide", as well as how the National Clinical Assessment Service fits into the new NHS.

Quality Surveillance Groups (QSGs)

Many of the more specific comments were directly in relation to QSGs, in particular their membership:

- It was suggested they should include adequately trained and informed Healthwatch and patient representatives in order to establish transparency, credibility and confidence.
- As the first line of defence, it was widely felt that professional bodies and colleges should be included, the Royal College of Midwives suggested they could attend "quarterly regional meeting and be co-opted to attend risk summits, when appropriate".
- Some suggested the need for neutral observers in order to ensure justice and fairness.
- Several commented that providers should be included and also be informed if they were to be the subject of discussion at any QSG meetings.
- There was a strong feeling that membership and area coverage should be determined locally in order not to duplicate or override current arrangements and relationships.

Several responses made the point that information on QSGs was, at this point, quite vague and undefined. Further clarity would be welcomed on areas such as their role and status, what information they would use and share and how they would work geographically, particularly across borders.

Offers of further advice and discussion

The following groups/organisations offered to assist with issues as set out in the report and/or speak to the NQB further about the points they raise. These include:

- Pharmacy Northamptonshire are "very interested to know how we can work with the NQB to ensure the experience and knowledge of Community Pharmacy, both professional and community based, can be taken into consideration in maintaining and improving quality and safety of the new health system and ensuring patients receive the best care possible."
- Anna Dixon (King's Fund) said the King's Fund "would be happy to come and discuss…any other issues raised in our paper with the Board or individual members or organisations"
- The Independent Healthcare Advisory Services IHAS felt that the Independent Sector should have a representative both on the National Quality Board and on Quality Surveillance Groups and "would like the opportunity to discuss how this can be facilitated"
- The Chartered Quality Institute (CQI) have worked with various industries to "develop sector specific documents and guides" around quality and "would welcome the opportunity to develop a similar guidance with you for healthcare. Moreover, we would welcome the opportunity to contribute to the advice that the National Quality Board provides DoH on quality. We would also like to ask for the opportunity to meet with you to discuss our comments further. We would be delighted to meet with you and other National Quality Board members following the consultation process".
- The United Kingdom Accreditation Service (UKAS) "would very much welcome the opportunity to explain to the National Quality Board in more detail how UKAS can contribute to policy in this area and we would be very happy to meet with you if you think this would help".

Responses were received from:

Individuals
Professor Woody Caan FRSPH AcSS FHEA MICR
Suzan Collins, SPC Consultancy & Training
Patricia Fagan
David Martin, Patient Representative on a NICE sub-group that monitors implementation of NICE guidance within the healthcare community of a London Borough
Mr Tobias Payne
Jim E. Swain BA MSc (Dist) MCQI CQP, BBCEL Quality Engineer

Groups/Organisations
Action against Medical Accidents
British Geriatrics Society
Cambridge University Hospitals NHS Foundation Trust
Chartered Quality Institute's Healthcare Special Interest Group
Council of the Royal College of Anaesthetists
English Community Care Association
Federation of Irish Societies
Foundation Trust Network
Good Governance Institute
Independent Healthcare Advisory Services
The King's Fund
Liverpool Women's NHS Foundation Trust
Parliamentary and Health Service Ombudsman
Pharmacy Northamptonshire
Royal College of Midwives
Royal College of Radiologists
Royal Pharmaceutical Society
Southampton, Hampshire, Isle of Wight and Portsmouth PCT Cluster
Specialised Healthcare Alliance
Tameside Hospital NHS Foundation Trust
United Kingdom Accreditation Service

Annex C

Establishing Quality Surveillance Groups
Steering Group membership

Paul Watson (Chair)

Ruth May, John Stewart, Lyn Simpson (NHSCB)

Adam Cayley (Monitor)

Ian Biggs, Andrea Gordon (CQC)

Peter Blythin (NHS TDA)

Susan Robinson (Healthwatch transition team)

Jo Lenaghan (HEE)

Sally Burlington (LGA)

Philippa Mellish (SOLACE)

Sandie Keene (Leeds City Council, representing ADASS)

James Johnstone (PHSO)

Ben Jones (GMC)

Eve Seall (HCPC)

David Dalton (Provider Representatives – Salford Royal NHS FT)