NQB(13)(02)(04)

NATIONAL QUALITY BOARD

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Quality architecture post-Francis

A paper from Professor Sir Bruce Keogh

Summary

1. Over the past 12 months, the NQB has introduced a number of new mechanisms to strengthen the overall system's focus on quality, underpinned by a range of tools and guidance. There is a need to consolidate this work but also consider how it aligns with various new policies and initiatives following publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry report. In this context, NQB members are asked to consider the next steps on aligning the system wide architecture for quality.

Recommendation

2. That the NQB:
    a. reflects on the breadth of activity it has already led to strengthen the system's overall focus on quality and the new policies and initiatives relating to the quality architecture announced in recent months; and
    b. provides views as to where further steps to align the system are necessary according to the suggestions set out in the table at **Annex A**.

Background

3. Ever since the Healthcare Commission published its original report into the failings at Mid Staffordshire NHS Foundation Trust, the National Quality Board has dedicated a significant part of its work programme to considering how to strengthen the system wide architecture for quality. This work has brought greater clarity to roles and responsibilities for quality across the system (*Review of Early Warning Systems in the NHS, Feb 2010* and *Quality in the New Health System, Jan 2013*) and has resulted in the adoption of new mechanisms to

enhance the system's ability to detect and respond to quality problems at an early stage, such as Quality Surveillance Groups and Risk Summits:

a. **Quality Surveillance Groups** (QSGs) – QSGs were introduced through the NQBs *Quality in the New Health System* report, and have been rolled out across every area and region in England on the footprint of the NHS England offices. They were all in operation in advance of the new system going live on 1 April 2013. QSGs bring together commissioners, regulators and other parts of the system who have information and intelligence on the quality of care being provided to the local community. They provide a proactive mechanism for allowing organisations to share information and concerns they may have and to determine further action.

b. **Risk Summits** – Risk Summits were introduced through the NQBs *Review of Early Warning Systems* report published in *t* 2010. They bring together commissioners, regulators and other parts of the local health economy with information about a specific provider where there may be concerns about quality. Risk Summits can be called by a QSG following a discussion or by any statutory QSG member. They enable the organisations to take a collective view on the risks to quality and to patients and to coordinate actions in the best interests of patients. Risk Summits are widely used across the country, and have been called regularly following QSG discussions. They are also being used as key part of Bruce Keogh's on-going Mortality Outliers Review which is looking at the quality of care and treatment being provided by 14 trusts in England

4. With the support of the National Quality Team, which was established to strengthen the focus on quality during the transition and led by Ian Cumming, The NQB has also overseen the production of various supporting tools and guidance, including the National Quality Dashboard and a series of *'How to Guides'*:

a. **The National Quality Dashboard** – brings together a set of indicators based on information from various sources including HES, safety

information, CQC enforcement activity etc. to provide a single view of quality in acute providers. It is accessible by different parts of the system and has been underpinning discussions at Quality Surveillance Group meetings. This dashboard is currently being transitioned into NHS England's Integrated Intelligence Tool where there is scope to further develop and refine it.

b. **'How to' guides** – the following table provides an update on the suite of 'How to' guides which formed part of the National Quality Team's portfolio of activity:

Title	Status
How to organise and run a Risk Summit	Published – July 2012 Is being updated to reflect abolition of SHAs. Question whether delay until can reflect Mortality Outliers Review lessons learned
How to assess the quality impact of a provider CIP	Published – July 2012 Is being updated to reflect abolition of SHAs.
How to carry out a Rapid Responsive Review	Published – July 2012 Is being updated to reflect abolition of SHAs. Question whether delay until can reflect Mortality Outliers Review lessons learned
How to establish a Quality Surveillance Group	Published – January 2013 Will be reviewed in the summer and a revised guide (How to make your QSG effective) is due to be published in the autumn
How to Handover for Quality	Published – March 2011
How to use the Quality Dashboard	Draft being road tested
How to do a Case Note Review	Ready to be published

How to Investigate Serious Incidents	Ready to be published – question whether need for this has been superseded by Serious Incidents Framework
How to understand and respond to Mortality statistics (in partnership with Public Health Observatories)	Draft has been prepared. Need a decision as to whether it should be published and when. Could follow lessons learned from Mortality Outliers Review

5. The range of activities were initiated and in many cases delivered, in advance of the Mid Staffordshire NHS Foundation Trust Public Inquiry report was published. Now that the Inquiry has reported it is necessary to think about how this work can complement and align with new policy and initiatives which were committed to in the Government's response in March 2013[1], and more that may follow once a further response and implementation plan is published in the autumn. Such policies and initiatives include:

    a. **New approach to standards** (fundamental, enhanced, developmental) – the Care Quality Commission, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall. There will be a zero tolerance approach to breaches of these standards. They will form part of registration requirements for all providers registered with CQC.

    The fundamental standards will be complemented by enhanced and developmental standards. To implement this approach, NICE will extend the scope of its quality standard programme to provide guidance on known good practice in providing excellent care.

    b. **Chief Inspector of Hospitals** – the Care Quality Commission will appoint a Chief Inspector of Hospitals later this year. Armed with a sophisticated

[1] *Patients First and Foremost - The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry,* Department of Health, 26 March 2013

battery of information about hospitals from across the system, but, crucially, informed by expert judgements of inspectors, the Chief Inspector will make an assessment of every NHS hospital's performance, drawing on the views of commissioners, local patients and the public. The Care Quality Commission will be supported by local Quality Surveillance Groups, encompassing all the key players in the system, so that there are effective arrangements in place to identify rapidly those hospitals where there is a risk or reality of poor patient care. A Chief Inspector General Practice and a Chief Inspector for Social Care will also be appointed.

c. **Hospitals ratings system** – there will be a single version of the truth about how hospitals are performing, not just on finance and targets, but on a single assessment that fully reflects what matters to patients, including quality. The assessment of quality (including the triggers for the new single failure regime), will be based on a consistent approach and data set agreed across organisations. Based upon this agreed common approach, the final judgement of a hospital's quality will be delivered by the new Chief Inspector. This will ensure that there is a single shared view of quality, covering a continuum from excellent, good and average, and ultimately, to unacceptable, where the new single failure regime will operate.

d. **Single failure regime** – a new time-limited three stage failure regime, encompassing not just finance, but for the first time quality, will ensure that where fundamental standards of care are being breached, firm action is taken until they are properly and promptly resolved. See **Annex B** for details on the three stage process.

e. **Mortality Outlier Review** – commissioned by the Prime Minister, this discrete review is being led by Bruce Keogh and is investigating 14 trusts that have been outliers for the last two consecutive years on either the Hospital Standardised Mortality Ratio or the Summary Hospital-level Mortality Index. The Review is following a three stage process. Stage 1

involves gathering and analysing all the information and intelligence held across the system about each of the 14 trusts to develop key lines of enquiry. Stage 2 involves Rapid Responsive Review Teams conducting site visits, based on the NQB's guide on *How to Run a Rapid Responsive Review*. Stage 3 involves convening a formal Risk Summit where the system comes together to consider the findings of the review team and agree what, if any, system-wide action and support should be put in place to support improvement. A lessons learned report will be produced following the conclusions of the review, to feed into the development of other aspects of the quality architecture.

6. There are various interactions and interdependencies between the above new policies and initiatives, and the existing quality architecture. Many will not become evident, or will not be able to be addressed until these new elements of the system are more fully developed in concept, and/or are implemented in practice. However, at the design stage, there are various issues which can be addressed in advance to ensure as far as possible that the interaction between the elements on the ground is as aligned and simplified as possible. The table at **Annex A** sets out various such issues which could be addressed by the NQB and its member organisations.

7. **The NQB is asked to:**
   a. **reflect on the breadth of activity it has already led to strengthen the system's overall focus on quality and the new policies and initiatives relating to the quality architecture announced in recent months; and**
   b. **provide views as to where further steps to align the system are necessary according to the suggestions set out in the table at paragraph.**

ANNEX A **Areas within the Quality Architecture for Consolidation and Alignment**

	Description	Current planned next steps	Alignment issues / opportunities
Quality in the new health system	NQB Report, January 2013 Sets out roles and responsibilities of different organisations across the new health system for quality	No current plans to update in the public domain.	Should this guide be updated to reflect: • new approach to standards • Chief Inspector role • single failure regime • hospital ratings system?
Quality Surveillance Groups	Bring together , commissioners regulators and other parts of the system to share information and intelligence on the quality of care being provided to the local community	Model to be reviewed over the summer. Guidance to be updated based on the review and to include good practice in the autumn	Guidance should reflect the new elements of the system Should we delay updating the guidance until the new elements are more clear?
Risk Summits	Bring together , commissioners regulators and other parts of the system to take a collective view on the risks to quality and to patients and to coordinate actions in the best interests of patients	*How to Organise and Run a Risk Summit* guide has been updated and is ready to be published, to take account of the abolition of SHAs	Risk Summit guide has been used in the Mortality Outliers Review to determine action following the rapid responsive review. Should we delay updating the guide until lessons learned have been brought together from the mortality outliers review?
National Quality	A tool for different parts of the	Needs more development as it includes	Need to consider the future purpose and

Dashboard	system to view indicators of quality from a range of sources Is being used as one source of information by QSGs	a mix of indicators (provider and commissioner) which do not give the full picture on quality. There is an opportunity to do this as it is integrated into NHS England's Intelligence Tool	development of the dashboard in the context of the Intelligence Framework that CQC are looking to develop to provide the information that various organisations require to support the single failure regime. But it will need significant joint working and development to get to this point. Is this something the NQB wishes to explore?
New approach to standards	Fundamental standards will be developed to set out the absolute basics of care below which standards should never fall. They will be part of a rationalised set of registration requirements and supported by enhanced and developmental standards	Work is underway to determine the fundamental standards, supported by NICE who are looking to underpin them with evidence. The CQC will consult on the principles underpinning fundamental standards in June. Further It is not clear what enhanced and developmental standards will look like or what role they will have	How will the new standards impact on the operation of QSGs? The relationship between enhanced and developmental standards needs to be determined, including how they relate to NICE Quality Standards.
Mortality Review	Discrete review into the quality of care and treatment provided by 14 trusts that have been persistent outliers on mortality statistics.	Following completion of the individual reviews, an overarching summary and lessons learned report will be published before 19th July.	How can this review inform: • the role of the Chief Inspector of Hospitals • new CQC intelligence framework • commissioner led reviews (should it be necessary to develop guidance / a methodology) • operation of QSGs and Risk Summits • development of National Quality

			Dashboard? Should we delay updating the *How to organise and Run a Rapid Responsive Review* guide until lessons learned have been brought together from the mortality outliers review?
Chief Inspector of Hospitals	The Chief Inspector will be appointed by the CQC, to make an assessment of every NHS hospital's performance and report it publicly, informed by data from across the system	The CQC will be consulting on this role in June The role will be advertised and appointed to this year	How will the Chief Inspector of Hospitals provide 'a single version of the truth'? The CQC are seeking to develop an 'Intelligence Framework'. What information will they need, in what form, through what mechanism? Is this a further developed National Quality Dashboard?

Annex B Three stages of the single failure regime

From 'Patients First and Foremost - The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry'

In the first stage, the Chief Inspector will require the hospital board to work with its commissioners to improve, within a fixed time period, but the Care Quality Commission will not be responsible for making improvement happen. That will first be a task for the Board of the hospital, working with its commissioners.

In the second stage, if the hospital with commissioners is unable to resolve its own problems, then the Care Quality Commission would call in Monitor or the NHS Trust Development Authority to take action.

In the final stage, where fundamental problems in the hospital mean that its problems have not been resolved, the Chief Inspector will initiate a failure regime, in which the Board could be suspended or the hospital put into administration, whilst ensuring continuity of care.

The Care Quality Commission, the NHS Commissioning Board, Monitor and the NHS Trust Development Authority will be required to agree together the data and methodology for assessing hospitals. This will ensure a single set of expectations on hospitals of what is required of them which are aligned with the way in which commissioners, led by clinicians and guided by the views of local patients, ensure high quality care in the hospitals for which they are responsible. Providers will demonstrate, through annual Quality Accounts, how well they are meeting that single set of expectations.