NQB(13)(03)(01)

NATIONAL QUALITY BOARD

_____

The role and work programme of the National Quality Board 2013/14 – 2014/15

A paper by the Secretariat

Purpose

1. At the NQB meeting in May 2013, there was a discussion about the role, scope and work programme of the NQB. The Board asked the Secretariat to set out for the next meeting the role and scope of the NQB to date, details of the work it has taken forward so far and a summary of the conclusions the NQB has reached over recent meetings as to how it should operate in future.

2. This paper seeks to do that, with a view to clarifying the role, scope and work programme of the NQB for 2013/14 and 2014/15

Background

3. The NQB was established in 2009 following the NHS Next Stage Review and the publication of '*High Quality Care for All'.*

4. The Board's own 'statement of purpose' said:

> *"The National Quality Board has been established to provide strategic oversight and leadership for quality across the NHS system and in joining up health and social care. It will do so by:*
> - ***aligning the national system*** *around a single definition of success: creating shared goals for improving quality;*

- ***advising on priority areas*** *for improving quality and the development of tools to support clinical teams achieve improvements; and,*
- ***providing leadership and support*** *to the service in driving forward improvements in quality."*

5. The NQB was established with three constituent parts: ex-officio members (the statutory organisations with responsibility for quality of health services); expert members (to provide professional, managerial and clinical challenge); and lay members (to provide challenge from the perspective of patients, carers and the public).

NQB work to date

6. Over the last four years, the NQB has taken forward numerous pieces of work in line with its purpose, including:

As part of aligning the national system

- Conducting and publishing a report of the ***'Review of Early Warning Systems in the NHS'*** *(February 2010)* which for the first time defined the roles and responsibilities of different parts of the system for quality, and set out how they should work together in a culture of open and honest cooperation. It introduced the concept of **Risk Summits** as a mechanism for collective and collaborative responses to potential or actual quality failures, which are now commonly used across the NHS. Taken forward by the Mid Staffs Sub-group, chaired by Una O'Brien.

- This work was kept under review following the announcement of changes to the health system. In March 2011, the NQB published the guidance ***'Maintaining and improving quality during the transition'*** (March 2011) which set out how NHS organisations should be maintaining a grip on quality during the transition years. It then updated its 2010 report in 2012/13 to reflect the new system, and published ***'Quality in the new health system: maintaining and improving quality from April 2013'*** (January 2013). This report clarified roles and responsibilities of existing and new organisations in

respect of quality, and introduced the concept of **Quality Surveillance Groups** (QSGs) as a way of routinely triangulating information about quality locally and regionally across organisations. ***'How to establish a Quality Surveillance Group'*** (Jan 2013) was published to support the system in rolling out QSGs by 1 April. QSGs are now in operation in every area and region of England. Taken forward by the QSG Steering Group on behalf of the NQB, chaired by Paul Watson (NHS England).

- Leading a programme of work to explore how through aligning different parts of the system, quality improvement can be driven more effectively. The NQB looked at this in four areas, bringing all different parts of the system and leading experts together to develop a set of recommendations as to how organisations could support the implementation of the first four NICE Quality Standards on **Venous Thromboembolism, Dementia, Stroke, and Neo-natal care.** Taken forward during 2010 by four System Alignment Subgroups, chaired by Bruce Keogh, David Behan, Margaret Goose, and Christine Beasley (former Chief Nursing Officer and ex-officio member) respectively.

As part of advising on priority areas

- Overseeing the development of the concept and process for producing **NICE Quality Standards, and** prioritising the clinical topics which would make up the library of 180 over 5 years**.** Prioritisation was taken forward by the Prioritisation Committee during 2009/2010 chaired by Bruce Keogh.

- Steering the development of the concept, shape and roll out of **Quality Accounts**, which are now produced annually by every provider of NHS funded services (ongoing).

- Guiding the compilation of the assured menu of **Indicators for Quality Improvement (IQI)** which provides a library of indicators available on the HSC Information Centre's website for use by clinicians and commissioners in measuring quality (ongoing).

- Advising the Advisory Committee on **Clinical Excellence Awards** as to how the awards could best be used to incentivise improvement in quality (ongoing).

- Developing a new **MRSA Objective** for the system, based on clinical evidence and endorsed by statutory organisations across the system. Taken forward by the MRSA Sub-group in 2009 chaired by Paul Lelliott (former expert member).

- Providing advice on the development of the **Patient Led Assessments of the Care Environment** (PLACE). Lay members represented NQB views on the PLACE Steering Group during 2012 and the NQB signed off the overall approach and guidance on the methodology for assessments in December 2012.

- Developing a **core model for clinical service accreditation** in partnership with the Academy of Medical Royal Colleges, to support the alignment and standardisation of approaches to accreditation across the professions. Led by Paul Lelliott (former expert member) on behalf of the NQB

- The **Quality Information Committee**, chaired by David Haslam, has been leading work to align the information architecture in the NHS to best support quality improvement. It produced a report on '***Information on the Quality of Services'*** (May 2010), which fed into the DH's Information Strategy in 2011. Subsequently, the Quality Information Committee has produced the first **National Data Quality Report** (March 2013) which sets out how the information architecture around measuring quality needs to improve.

As part of providing leadership and support

- Producing guidance to NHS providers on ***'Quality Governance in the NHS - a guide for provider boards'*** (March 2011). This helped providers understand what good governance for quality looks like and how they can achieve it, including getting clinical governance right. Taken forward by the Quality Governance Subgroup, chaired by Hilary Chapman.

– Producing the guidance ***'How to prepare for handover'*** (May 2012) which set out what sender and receiver organisations should do to properly handover during the transition period to ensure that intelligence on quality in areas and regions. The handover process described was implemented between PCTs, SHAs and NHS England across the country and underwent an assurance process.

– Developed a range of other **'How to guides'** which provide advice to commissioners on how they can best maintain and improve quality, e.g. running risk summits, conducting rapid responsive reviews, and quality impact assessing cost improvement programmes (published during 2012). Taken forward by the National Quality Team on behalf of the NQB.

– **Developing a patient experience framework.** Taken forward by the Patient Experience Subgroup, chaired by Don Brereton.

The role of the NQB from 2013/14

7. The Health and Social Care Act 2012 is transforming how services are commissioned, how providers are regulated, and the distinct responsibilities for quality of existing and new organisations:

- New organisations have entered the system e.g. NHS England, Public Health England, Health Education England, NHS Trust Development Authority, HealthWatch England.
- There is no longer a 'system manager' function in the NHS.
- There are separate accountability and delivery systems for the NHS, Social Care and Public Health.
- The national arm's length bodies more clearly become the delivery agents of the Department. But the Secretary of State retains ultimate accountability for the overall system.

8. However, the focus on outcomes across all sectors through the outcomes frameworks demands strong collaboration and integration of services across sectors. And the systemic nature of quality remains. It is not the responsibility of any one organisation. It is a collective responsibility requiring aligned effort across the system.

9. At its meetings in June and September 2012, the NQB considered its role, scope, composition and purpose. David Nicholson concluded these discussion in a letter to all NQB members of 21 November 2012 (Annex A – attached separately) setting out that:

> "fundamentally, the role of the NQB should be about **driving greater alignment for and sharpening the focus on quality right across the system at every level.** Our success or otherwise in achieving this does not rest in any executive powers held by the Board - it has none. Rather, it is dependent on how we behave and how we choose to align and deploy the various powers, tools and levers that the organisations represented on the Board individually hold."

10. Given the changes resulting from the Health and Social Care Act, and the duties placed on many of the statutory bodies represented on the NQB cooperate with each other in the interests of patients, the NQB concluded that its benefit lies in providing the system with an important mechanism for supporting and nurturing cooperation and collaboration at the highest and most strategic level.

The scope of the NQB from 2013/14

11. The membership of the NQB has already been extended to include the new organisations that have been established from April 2013: NHS England, Public Health England, Health Education England, NHS Trust Development Authority, HealthWatch England. Reflecting the system-wide nature of quality, and their desire to play their part in that system, the main professional regulators, the

General Medical Council and Nursing and Midwifery Council, and the Health Ombudsman for England, are also now ex-officio NQB members.

12. The NQB has at various points considered whether its scope should extend to cover all issues relating to quality in social care and public health, in addition to its current areas of focus in the NHS. Its consistent conclusion has been that to sets its sights so broadly would mean a dilution of focus so that it would be unable to effectively address issues relating to quality in any sector. Simply put, all three sectors would be too much for one body to look at.

13. However, the NQB has been clear that it has not lived up to its commitment in its 2009 statement of purpose (see para 4 above) in respect of considering issues concerning quality at the boundaries of health and social care, such as how there can be greater integration of services to deliver higher quality care for users of both the health and social care sectors, how information can be shared between sectors and how outcomes can be aligned.

14. Given that there are similar opportunities to improve quality and outcomes by considering where public health and NHS services should work together, the NQB also felt that it should have a similar remit in respect of public health, and PHE are now members of the board.

15. David Nicholson's letter of 21 November 2012 concluded these discussions by setting out that, over and above the NQB's primary focus on the quality of NHS-funded services:

> *"Our remit should extend to* ***any area where we believe greater alignment between the three statutory sectors - NHS, public health and social care - would lead to improved quality and outcomes*** *for patients, service users and the population of England."*

16. To ensure that the NQB is suitably constituted, the membership will need to be extended further to include a local government representative (the secretariat is discussing this with the Local Government Association) and ideally, the frontline

commissioning perspective (in recruiting to the two expert member vacancies, we will seek to recruit a CCG representative).

Ways of working

17. As has always been the case, statutory organisations are represented on the NQB at Chief Executive / Chair level. While organisations remain independent, the NQB provides an opportunity to ensure that their actions and the way in which they exercise their functions are aligned, with a view to making sure that the overall system pulls in the same direction. It provides support and challenge for individual organisations in playing their parts in driving quality improvement.

18. The focus of the full NQB meetings, which take place six times per year, is therefore on strategic alignment, with the aim of providing a facilitative, permissive framework in which work can be taken forward on behalf of the NQB and reported back at key stages. Work takes place on the whole through a range of sub-groups and committees which include NQB member organisations, NQB expert and lay members with an interest and other organisations and individuals with expertise or a role to play in taking action. Where there are sub-groups or committees of the NQB, these are chaired by an NQB member who reports back to the Board on progress. The NQB will agree to actions / recommendations that are developed on its behalf, which constituent organisations then taking forward those actions.

19. In addition, each national statutory organisation can be represented on the NQB's virtual secretariat which agrees NQB agendas and papers, and oversees progress, ensuring that organisations are working together effectively.

Work Programme for 2013/14-2014/15

20. The NQB has had discussions in December 2012, March and May as to where it should focus going forward. Decisions have been complicated by the uncertainty as to a) how the Health and Social Care Act would be implemented and b) the implications of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

21. In May, the NQB considered various issues on which it was proposed that the Board should have an on-going interest. Since the last meeting, discussions have been taking place between statutory organisations in these areas, which could be brought together and taken forward under the auspices of the NQB as follows in the table overleaf:

	Theme	NQB focus	Method for taking forward
1	Aligning the overall quality architecture	Determining where elements of the quality architecture require alignment, including where the health, social care and public health architecture need to align; Working collectively across the national statutory organisations to determine how they should be aligned, including with the social care landscape; and Making recommendations for the NQB to agree, which statutory organisations would implement, and would be reflected in an updated 'Quality in the new health system' document, and revised 'How to' guides.	A quadripartite group is already in place to identify issues in relation to the NHS. This should be brought under the NQB as a time-limited sub-group which would include: • CQC - chair • Monitor • NHS TDA • NHS England Revised *'Quality in the new health system'* document, and 'How to' guides would be published before the end of 2013. This will particularly need to reflect on how the roles of the new Chief Inspectors (of hospitals, primary care and social care) relate to the system and to the NQB. On aligning the quality architecture between the NHS, social care and public health the NQB subgroup described above could work with PHE, and with social care (e.g. via the Think Local, Act Personal (TLAP) partnership and working with DH social care policy).
2	Patient Safety	a) Continuing to provide oversight, coordination and leadership for the embedding of human factors awareness and understanding across the NHS, including developing a	There is currently a NQB subgroup focussed on Human Factors. Current membership is as follows: • CQC, NHS England, NICE, HEE, NMC, GMC, NTDA, HEE • Health Foundation • NHS Leadership Academy

		joint statement / concordat which would form part of the system's response to the Berwick Review b) Providing a mechanism to take forward any relevant system-wide recommendations from the Berwick review, as determined by the organisations that sit on the NQB	• John Oldham, Margaret Goose • Human Factors Experts This should be expanded to include: • Monitor • SCIE • HealthWatch England • NHS Improving Quality • Academy of Medical Royal Colleges Depending on the content of the Berwick report, the above group could be expanded, or a similar NQB sub-group could be created, if there is consensus on the need for a system-wide perspective on patient safety. It could be chaired by NHS England who are likely to be leading the implementation of the Berwick recommendations across the healthcare system. This is however dependant on the findings of the review which are not yet known. Membership of the subgroup would be determined by the specific activity the NQB is undertaking
3	Patient Experience	Providing a mechanism for gaining cross system commitment to the common purpose of improving patient experience, and to align statutory organisations' actions to drive improvement in patient experience of care. This should include where interactions between public	The NQB's Patient Experience Sub-group previously worked to develop a 'patient experience framework' to guide organisations' understanding and actions in relation to improving patient experience. This sub-group has been inactive since July 2011. This sub-group should be reconstituted to take forward cross system aligned action on improving patient experience. NQB members who were on the sub-group include: Don Brereton, Stephen Thornton, Sally Brearley, Margaret Goose and Hilary Chapman Other statutory members should include: CQC, Monitor, NHS England, HealthWatch

		health and social care services impact on patients' experience of healthcare and how this can be improved.	England, NHS TDA, NICE, SCIE, and the Health Service Ombudsman Social Care representatives (e.g. through TLAP, working with DH social care policy) should be included / engaged to reflect the impact of transition between health and social care services
4	Clinical Effectiveness	Providing an opportunity for the system collectively to consider how data on quality can be best used by commissioners and providers (leadership and clinicians) to drive improvement and transformation in quality and outcomes, over and above being used for assurance. This would apply to NHS funded services as well as to where health, public health and social care services need to integrate.	This theme would complement the work of the NHS TDA in supporting NHS trusts to improve to gain FT status, of Monitor in supporting FTs to improve their governance for quality, NHS England in supporting commissioners to drive improvement in quality with their providers, as well as various other organisations. A sub-group / committee of the NQB would be the most effective vehicle to take this work forward. It would need to include representatives from NHS England, NHS TDA, CQC, Monitor, HEE, NICE, the HSC Information Centre amongst others. Should the NQB wish to take forward this work on using data to drive improvement, the NQB's Quality Information Committee (QIC) could be tasked with taking it forward. It would need to be refocused to ensure its membership and support arrangements enable it to the address issues. There are discussions on-going regarding the future place of QIC. QIC has recently been focussing on the quality of data, which led to its National Data Quality Report. There is an argument that delivering this report sits better with the Information Standards Commissioning Group (ISCG), rather than the NQB. There is therefore an option that QIC could report into both the NQB and the ISCG on different issues. ISCG are considering this in advance of the NQB meeting, and the NQB will receive an oral update on their conclusions.

22. Some themes are inevitably more developed in scope than others. In terms of developing further specific issues to be considered and taken forward under each theme, national statutory organisations should be tasked with identifying issues they would like to work through the NQB to resolve collectively. This will involve considering current issues organisations are dealing with, as well as horizon scanning for future potential issues.

23. The NQB is asked to comment on each of the proposed themes for 2013/14 – 2014/15, including membership of the proposed subgroups and chairing arrangements. As David Nicholson set out in his letter of 21 November, once the Board has agreed its work programme, it should then write to the Secretary of State for Health to set this out, including exactly how it intends to measure its impact and report progress.

24. This work programme will also be used to inform candidates and guide the recruitment process to fill the lay (x3) and expert (x2) member vacancies which the Board has been carrying since Stephen Duckworth, Victor Adebowale, Tim Kelsey and Paul Lelliott stepped down, and David Haslam became an ex-officio member.

Summary

25. In summary, this paper sets out that the NQB's role, scope and work programme for 2013/14 and 2014/15 should be as follows:

Role – The NQB's role is to drive greater alignment for and sharpening the focus on quality across the health system at every level.

Scope – Focussing primarily on NHS services, the NQB's remit extends to any area where greater alignment between the three statutory sectors - NHS, public health and social care - would lead to improved quality and outcomes for patients, service users and the population of England.

Work Programme – The NQB in 2013/14 and 2014/15 will focus on four themes:

- providing collective leadership and system alignment to drive improvements in **patient safety;**
- providing collective leadership and system alignment to drive improvements in **patient experience;**
- providing collective leadership and system alignment to drive improvements in **clinical effectiveness; and**
- ensuring the **overall quality architecture** (safety, effectiveness, experience) is coherent, aligned and operationally robust.

The NQB is asked to reflect, comment on and agree the role, scope and work programme of the National Quality Board for 2013/14 – 2014/15.

Next Steps

26. Subject to the NQB's agreement, the suggested next steps include:

- the NQB Secretariat finalising membership of the various sub-groups, and there work will continue / commence;
- David Nicholson as chair writing to the Secretary of State to set out the NQB's areas of focus, and clarifying its role and scope; and
- national statutory members identifying issues on which they would value working collaboratively through the NQB to resolve.

NQB Secretariat

11 July 2013

Annex A

Attached separately as PDF (NQB(13)(03)(01)Annex A)