Paper 2

NQB'S Quality Strategy Workstream

Discussion Document

National Quality Board
16 September 2015

Contents

Purpose

The purpose of this paper is to provide an update on the Quality Strategy workstream, including:

- an update on the scope and aims of each of the four sub-streams: defining quality, measuring quality, prioritisations, roles & responsibilities;
- an overview ('baseline') of existing models and approaches, roles and responsibilities; and
- key issues for discussion and further consideration.

Papers on quality in **social care** and **public health**, and the interface with NQB's work, will be discussed in October, and the quality strategy will need to be updated accordingly.

In the meantime, NQB is asked to consider the discussion points outlined in each section, ***in particular***:

- How we should integrate 'value' into our definition of quality?
- Should NQB take a lead on developing a 'measurement strategy' for health and care?
- How does NQB want to position itself with regard to setting – and delivering - the priorities for quality?
- Should the quality strategy describe all roles and responsibilities across the system, or just those of NQB members?
- What are the opportunities for externally commissioned support or partnerships?

What are we trying to achieve ?

The document “Five Year Forward View: Time to Deliver” set out the following as an objective:

> ***“Narrowing the gap between the best and the struggling***
>
> *We know from the CQC’s inspections and other national and international reports that there is still too much variation in the NHS. 65% of services across health and social care deliver good or outstanding care, but that means that about 1 in 3 services still require improvement, and they require this improvement now.* ***Under the leadership of the National Quality Board, we will further align our understanding of quality in the NHS, how we measure it, and set common priorities for quality improvement.*** *“*

Does the NQB feel that this captures what we are trying to achieve ?

What are we trying to achieve ?

Our understanding is that the both the success and impact of the National Quality Board will be measured on how well it is perceived to be contributing to 'closing the quality gap'.

Unlike the "finance gap" which is clearly defined in the 5YFV, the "quality gap" is, as yet, not clearly defined.

This has highlighted the importance and urgency of progress in relation to two elements of the Quality Strategy workstream:

- defining quality; and
- measuring the "quality gap".

What is in the NQB Quality Strategy Workstream?

1. Defining quality

- develop a common definition for quality in the context of the 5YFV – this will provide the context and scope for the 'quality gap' and will consider how it relates to and can impact on the health and wellbeing, and finance and efficiency gaps.
- seek to consolidate definitions organisations are using where possible, and explain where variances lie

2. Measuring quality

- identify a core set of metrics to the 'quality gap'. I.e. the distance between high quality care for all, and current quality of care across the system. The basket of measures will draw from existing data sources, in particular the outcomes frameworks and CQC ratings, to be relevant from a range of perspectives, e.g. provider/commissioner; patient/population; health/care; primary/secondary
- coordinate activities to support the system in using measurement to drive quality improvement, working with the improvement architecture
- oversee the development of comparable measures of quality across all major pathways of care by 2020

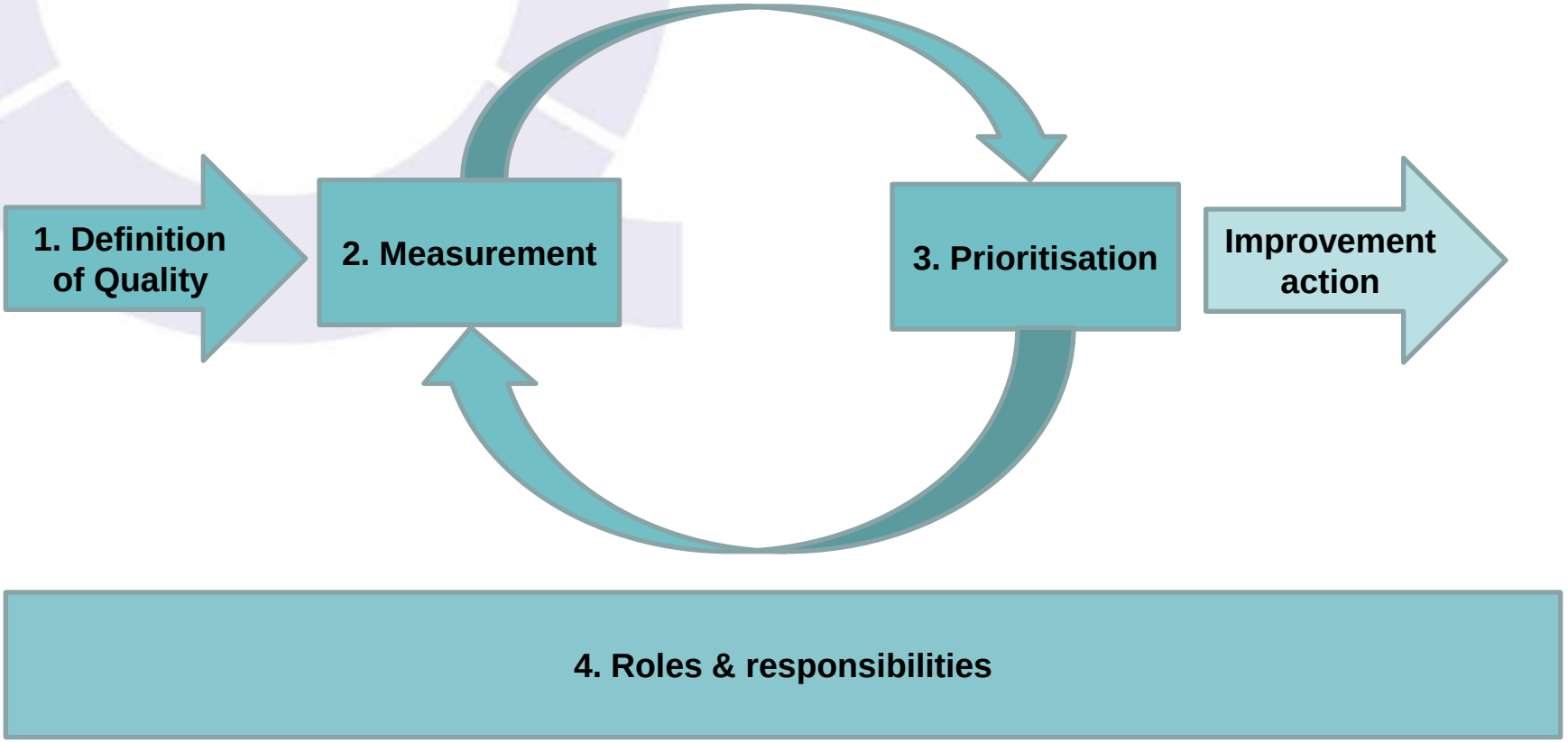
3. Prioritisation

- develop a methodology for identifying and selecting quality priorities e.g. population groups, service types, providers, aspects of quality
- use this to determine longer term priorities for quality improvement beyond our current set of priorities

4. Roles and responsibilities

- clarify our individual & collective roles & responsibilities, setting out our shared framework for quality and how we work together.
- this will include how we will drive quality improvement, making links to the architecture and improvement strategy coming out of the Smith Review, and focussing on where we will align our tools and levers, for example:
  - ✓ Incentives on individuals such as revalidation and appraisal, clinical excellence awards
  - ✓ Supporting the utility and implementation of NICE guidelines and Quality Standards
  - ✓ Measurement tools and levers, such as national clinical audit, intelligent monitoring and other quality indicators

How do the Quality Strategy “sub-streams” relate to each other ?

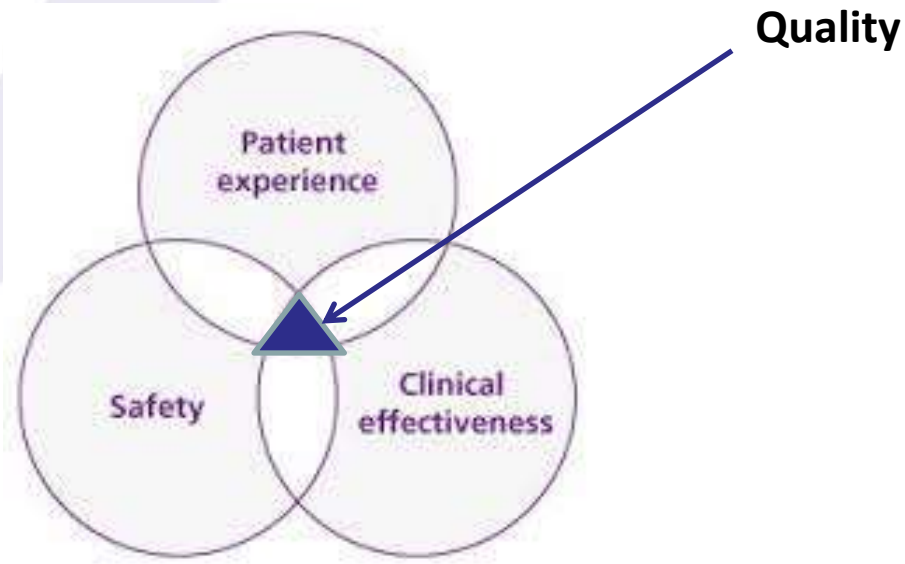


Defining Quality

Darzi's definition of "Quality"

- A single national definition of what we mean by 'quality' was first introduced following Lord Darzi's review of the NHS in 2008/09 - care that is safe, clinically effective, and that provides as positive an experience for patients as possible.

- All three dimensions must be present to deliver a high quality service:



- *High Quality Care For All* (2008) stated that quality should be the organising principle of the NHS.
- The definition is now enshrined in legislation in the Health and Social Care Act 2012
- Organisations across the NHS use this as the basis for their understanding of quality

"Well-led"

In April 2015, Care Quality Commission (CQC), Monitor and the NHS Trust Development Authority (TDA) set out an aligned view of a well-led organisation, aimed at supporting NHS providers to improve, and therefore benefiting the broader NHS and its patients.

"Well-led" means that the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture.

The characteristics of a well-led organisation, as defined by CQC, Monitor and TDA, are now identical. There is a common understanding of what a good organisation looks like and what it should be able to demonstrate, creating coherence, consistency and transparency across our regulatory activities.

This aligned view of a well-led organisation is reflected in CQC's assessments and ratings, as set out in its provider handbooks, while Monitor and TDA now use the updated well-led framework as the point of reference for NHS trusts and foundation trusts

How do we define “quality”?

Organisations have built on the Darzi definition of quality, adapting it to reflect how they view quality given their perspective, e.g. provider vs. population.

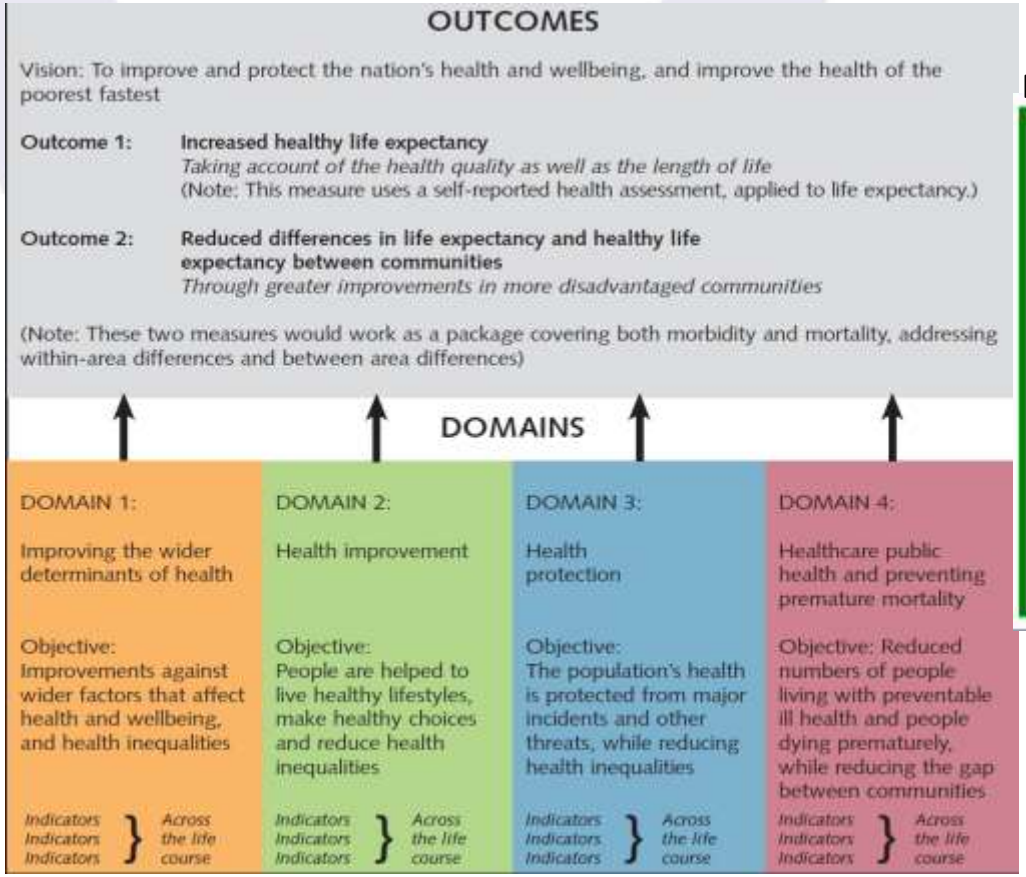
Many share a common structure:

HSC Act 2012 definition	Clinical effectiveness			Positive experience		Safety	Other
CQC 5 questions	effectiveness			Caring	Responsive	Safety	Well led *(From April 2016, this will also include “Use of Resources” in relation to NHS bodies)*
NHS Outcomes Framework	Preventing amenable mortality	Recovery from illness and injury	Quality of life for people with long term conditions	Positive experience		Keeping people safe from avoidable harm	
Adult Social Care Outcomes Framework	Delaying and reducing the need for care and support	Enhancing quality of life for people with care and support needs		Positive experience		Safeguarding and keeping people safe from avoidable harm	
Monitor							Well led
TDA							Well led

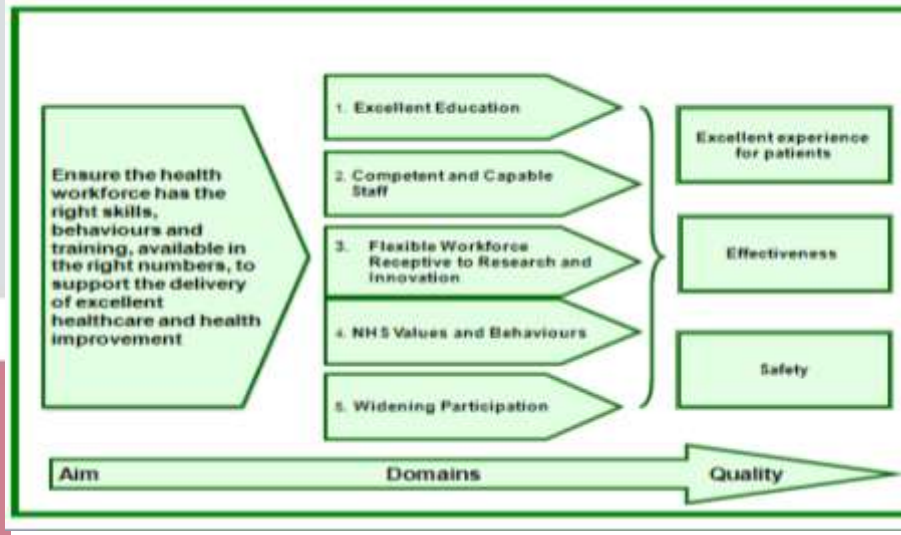
How do we define “quality”?

Others, understandably do not share a common structure:

Public Health Outcomes Framework



Education Outcomes Framework



The Institute of Medicine (IOM) defines quality as:

- **Safe:** avoiding injuries to patients from the care that is supposed to help them.
- **Effective:** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- **Patient-centered :** providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- **Equitable:** providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status

Discussion points

- What approach should the NQB take to “define” the quality gap ?
- How do we fully reflect the importance of “value” to our understanding of quality?

Measuring the ‘quality gap’

Purpose and Principles

The **purpose** of agreeing shared system-level quality measures is to:

- measure quality and track improvement nationally; and
- aid prioritisation.

In the short term we propose a pragmatic approach to selecting 'a basket of metrics' that we can use to measure the 'quality gap', using the following **principles:**

- Use existing measures wherever possible, to avoid additional burden to providers and commissioners;
- Focus on a small number of key sources;
- Identify a clear purpose to each measure which acknowledges any limitations and avoids unintended consequences;
- Ensure coverage of each of the Darzi domains, plus well-led, within the wider context of quality and value;
- Evaluate measures to ensure their validity over time

However, the system would benefit from a coherent **measurement strategy** to coordinate and target national and local effort on quality measure development and utilisation. This is a gap in the system with no identified lead. The NQB can play an important role in leading the system to use measurement to drive quality improvement, working with the improvement architecture. This would involve overseeing the development of comparable measures of quality across major pathways of care and other areas of priority.

Metrics

The basket of metrics will need to reflect quality at a number of levels:

- National and local
- Commissioner and provider (for all sectors including acute and community health services, mental health, adult social care)
- Population
- Pathway *(including 5YFV priorities – cancer, mental health, maternity, diabetes, LD)*
- All aspects of quality: safety, effectiveness, experience – as well as well led, and use of resources, within the wider context of value

Potential sources of metrics may include the following:

- CQC Intelligent Monitoring System and Ratings
- Morbidity and mortality data
- TDA's Oversight and Escalation Scorecard
- Outcomes indicators from NHS Outcomes Framework and CCG Outcomes Indicator Set
- CCG Scorecards
- NHS England Acute Quality Dashboard (used to support Quality Surveillance Groups)
- NICE quality standards and indicators

For each metric, the NQB will need to decide whether to attach a system level target and trajectory.

Possible metrics

	Level	Source	Measure	Target / Threshold
1.	Commissioner	CCG scorecard	Quality indicators	
2.	Provider	CQC ratings	Ratings for safe, effective, caring, responsive and well-led – by service for: • Hospitals • General Practice • Care Homes	X % improvement over time (requires improvement to good; inadequate to requires improvement)
3.	Provider	Staff survey	Selected indicators	
4.	Provider	NHS National Patient Survey Programme	Selected indicators	
5.	Population, CCG	NHS outcomes framework: Levels of Ambition Atlas	Overarching outcomes • Potential Years of Life Lost from causes amenable to healthcare • Health related quality of life for people with LTCs • Avoidable emergency admissions • Independence following discharge • In-patient experience • GP patient experience • Avoidable deaths in hospital	
6.		Adult social care outcomes framework	Overarching measure for each domain e.g. 1A Social care related quality of life Plus selected outcome measures.	
7.		Public health outcomes framework	Outcome measures and selected indicators.	
8.	Population, pathway		Cancer: 1 year survival rates; 30,000 lives saved; Access times	
9.	Population, pathway		Diabetes: Prevalence; Treatment; Prevention programme	
10.	Population, pathway	MHMDS	Mental Health: Recovery; Access; Employment	
11.	Population, pathway		Learning Disabilities	

Discussion points

- Does the NQB agree with the principles and approach for selecting measures ?
- Should the NQB take a lead on developing a measurement strategy for health and care ?

Next steps

- Map availability of quality measures (and development plans) across the system
- Select priority measures and identify measurement “gaps” with input from analyst colleagues
- Test proposals through wider stakeholder engagement

Prioritisation

What are the existing quality priorities?

Clinical priorities from 5YFV

- Improving the quality of care and access to cancer treatment
- Upgrading the quality of care and access to mental health and dementia services
- Transforming care for people with learning disabilities
- Tackling obesity and preventing diabetes

Cross cutting quality priorities from 5YFV

- measure and publish meaningful and comparable measurements for all major pathways of care for every provider
- continue to redesign the payment system so that there are rewards for improvements in quality
- reviewing and refocusing the work of the NHS Leadership Academy and NHS IQ.
- develop a framework for how seven day services can be implemented affordably and sustainably

Prioritisation

The NQB will need to develop a mechanism for identifying quality priorities, which together its member organisations will drive improvement across the system.

The NQB will need to consider priorities from a number of perspectives:

Commissioner	vs	provider
Individual patient	vs	population
Hospital	vs	community / primary care
Physical	vs	mental health

For 2015/16 the NQB has already determined a set of priorities, which it will work to deliver. During 2015/16 it will need to develop a methodology for identifying future priorities, from 2016/17 onwards.

This methodology will need to enable the NQB to determine priories where there is:

a) Evidence of variation; either between providers / geographies / population groups or according to international comparisons
b) Evidence of scope for significant improvement

Sources of evidence will include, but not be limited to:

- CQC analysis and intelligence following inspections, including the State of Care report
- Analysis of CCG and Health and Wellbeing Board prioritisation decisions
- National data on outcomes, including mortality, morbidity and the burden of disease
- Equalities and inequalities data
- NHS RightCare intelligence and Atlas of Variation analysis
- Intelligence from Clinical Senates on the drivers and barriers to major services changes

Discussion points

- How does the NQB want to position itself in relation to the setting priorities for the system ?

- What role should NQB play to support the delivery of these priorities ?

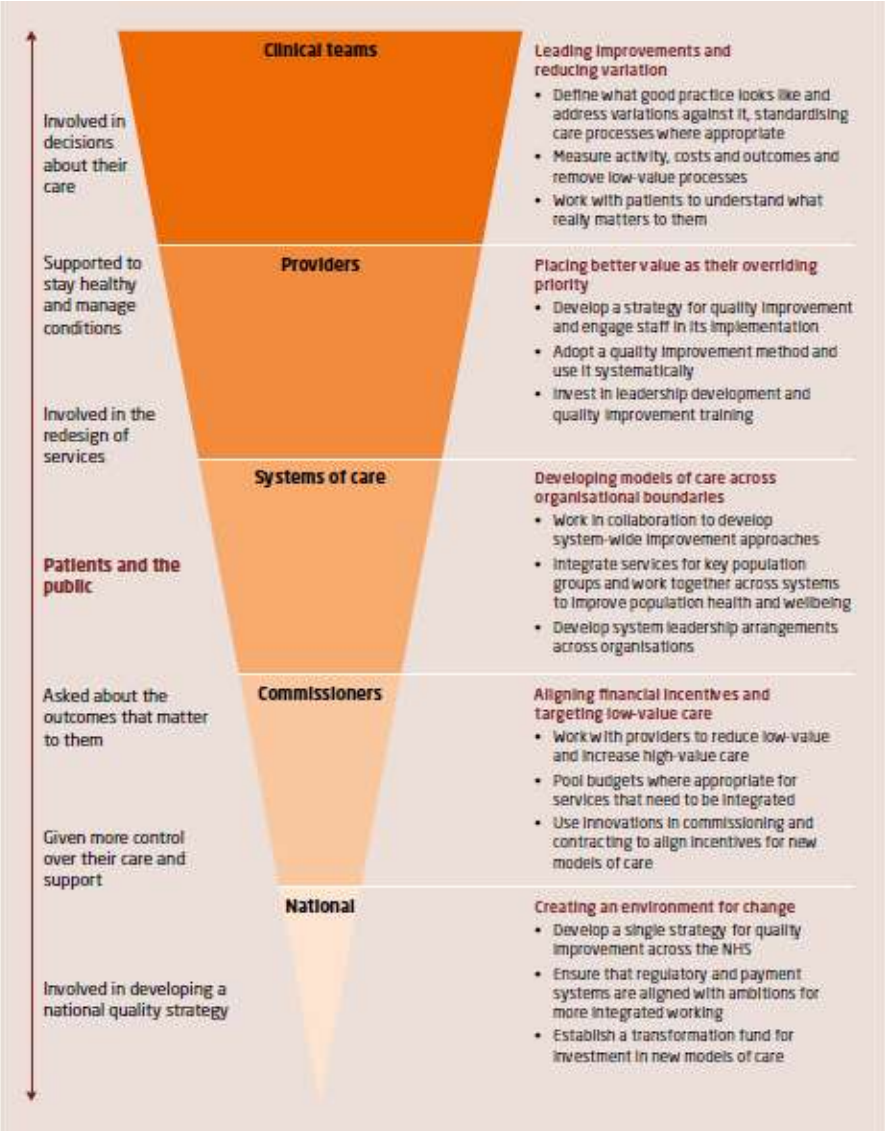
Roles and responsibilities

We need a coherent system for quality improvement

There are multiple influences on quality, with representation at both a national and local level:

- Providers
- Professionals and staff
- Commissioners
- Regulators
- Public voice
- Researchers and innovators
- Improvement bodies

In their report "***Better value in the NHS: The role of changes in clinical practice***" (July 2015), The Kings Fund provide a useful "agenda for action" for all parts of the system :



The NHS Quality Framework

Darzi outlined the seven steps to high quality care for all in his report, *High Quality Care for All.* These are outlined below:

Bring clarity to quality	Measure quality	Publish quality	Reward and recognise quality	Leadership for quality	Innovate for quality	Safeguard quality
Being clear about what high quality care looks like in all specialties and reflecting this in a coherent approach to the setting of standards.	In order to work out how to improve we need to measure and understand exactly what we do. The NHS needs a quality measurement framework at every level.	Making data on how well we are doing widely available to staff, patients and the public will help us understand variation and best practice and focus on improvement.	The system should recognise and reward improvement in the quality of care and service. This means ensuring that the right incentives are in place to support quality improvement.	Quality is improved by empowered patients and empowered professionals. There must be a stronger role for clinical leadership and management throughout the NHS.	New treatments are constantly redefining what high quality care looks like. We must support innovation to foster a pioneering NHS.	Patients and the public need to be reassured that the NHS everywhere is providing high quality care. Regulation – of professions and of services – has a key role to play in ensuring this is the case.

- The Quality Framework is a conceptual framework for helping to think about how to systematically drive quality improvement.
- It can seem quite system-focused, but it is also relevant at local and service level.
- It is now timely to review this framework and develop it light of the 5YFV, and other recent policy developments.
- In the meantime, we have mapped available “tools and levers” and NQB members’ roles to the seven steps for high quality care (following slides)

Tools and levers which NQB members have to deliver the Quality Framework

Bring clarity to quality	Measure quality and publish quality	Reward and recognise quality	Leadership for quality	Innovate for quality	Safeguard quality
NICE Quality Standards	Indicators in NHS Outcomes Framework and CCG OIS	Tariff	National Quality Board	Academic Health Science Centres	CQC registration, monitoring and enforcement
NICE Clinical Guidelines	Clinical Audit	CQUIN	Clinical Senates	Academic Health Science Networks	Quality Surveillance Groups
CQC handbooks	Indicators for Quality Improvement	QOF	CNO, NMD, NCDs and teams	NICE technology appraisals and compliance regime	Professional regulation
NHS England Commissioning Guides and other products	Quality Accounts	Better Care Fund	Health and Wellbeing Boards	Clinical Networks	Monitor licensing
	CQC quality monitoring, inspections, rating and reporting	Standard contract	Professional leadership from professional bodies		Standard Contract
	NHS Choices and other sources of info for patients	Quality premium	NHS Leadership Academy		
	Care.data	Clinical Excellence Awards	Health Education England		
	Patient safety website				

Based on organisations' own articulation of their roles and responsibilities for NQB.

NQB member roles aligned to seven steps to quality

Bring clarity to quality	Measure quality	Publish quality	Reward and recognise quality	Leadership for quality	Innovate for quality	Safeguard quality
CQC: Five key questions; provider handbooks DH: patient safety Monitor: defining clinical sustainability NHS England: NHS Outcomes Framework and Indicators; CCG assurance framework; quality improvement architecture; clinical priorities NTDA: planning guidance NICE: Development of quality standards, advice, information, recommendations, including VFM; accredits external guidance	CQC: Monitoring and inspecting NHS England: NHS Outcomes Framework; data and indicators for commissioning Monitor? NTDA: Oversight and escalation scorecard; mortality surveillance NICE: works with HQIP HSCIC to collate data on uptake of NICE guidance and standards	CQC: Reporting; ratings; independent voice; highlight system-wide concerns	CQC: Ratings; sharing good practice; partnership working Monitor: incentivises quality and efficiency NHS England: through direct commissioning; driving continuous improvement in quality and outcomes NTDA: shares good practice, events, tools NICE: works with others to incentivise evidence-based practice and improvement	CQC: Well-led question; encouraging improvement DH: System steward; system design; link with government HEE: vision for education and training; link with professional regulators Monitor: Well-led framework; focus on senior leadership NHS England: Driving continuous improvement in quality and outcomes; priorities for improvement; professional leadership; QSGs and risk summits NTDA: specialist leads in priority areas; supports aspirant FTs; professional leadership support	CQC: ensure regulation is not a barrier; regulation of integration, pathways and place DH: better joined up health and social care NICE: supports introduction of innovative medicines and technologies	CQC: Registration; enforcement of fundamental standards DH: sets legal framework Monitor: licenses providers; risk assessment framework; enforcement; special measures NHS England: statutory functions e.g. revalidation, controlled drugs; patient safety NTDA: special measures and other interventions

Based on organisations' own articulation of their roles and responsibilities for NQB.

Discussion points

Initial mapping of roles and responsibilities raises the following questions for discussion:

- Do the seven ‘roles’ still look right today? How should the framework incorporate the need for active improvement support and capability building?
- To what extent should the Quality Strategy define roles and responsibilities of all organisations which influence quality, or is the focus primarily on NQB members?
- How do we incorporate roles and responsibilities for quality in adult social care?
- Are our quality frameworks consistent and aligned effectively to ensure we ‘bring clarity to quality’?
- Is the importance of professional regulation in quality reflected adequately?

Quality Strategy: Next Steps

- Identify any NQB members who want to be involved in specific sub-streams:

  - Defining quality
  - Measuring the 'quality gap'
  - Prioritisation
  - Roles and responsibilities

- Continue to develop thinking and come back to NQB meeting on 28th October 2015

- Test with NQB Stakeholder Forum in November 2015