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NHS ENGLAND – PRIVATE BOARD PAPER

Title: NHS England's responsibilities for quality
Rationale for paper being discussed in the Private meeting: To consider NHS England's functions around quality
Lead Directors: Jane Cummings, Chief Nursing Officer Steve Powis, NHS England Medical Director
Purpose of Paper: **For Information (following a request from NEDs)** This paper sets out NHS England's functions relating to service quality. It outlines an initial map of the functions and processes in place, and how this translates into actions to improve service quality. The paper also suggests areas where we could ensure consistency of practice across these functions and the wider organisation, whilst recognising that our impending running cost cuts means overall we are going to have to do less, not more, as an organisation.
The Board is invited to: • Note the functions, processes and governance in place across the organisation, and how we work across NHS England in order to take action; and • Note our work with NHSI and other ALBs to strengthen improvement capabilities across the NHS

NHS England's responsibilities for quality

Purpose

1. This paper maps out NHS England's formal functions relating to service quality. It gives an outline of the processes in place and how this translates into actions to improve service quality. The paper also suggests areas where we could ensure consistency of practice across these functions and the wider organisation.

Background

2. The Health and Social Care Act 2012 states that NHS England has a duty to continually drive improvements in the quality of care across a comprehensive health service. Quality is defined in statute as having three dimensions: safety, clinical effectiveness and patient experience. Our quality duty applies across all of NHS England's functions.

3. Since the failings at Mid-Staffordshire Foundation Trust, much of quality policy has been focussed on safety and the assurance of providers. Therefore, much of the formal quality architecture and the initiatives listed reflect assurance, with national organisations (especially regulators such as CQC and NHSI) being predominantly focussed on assurance rather than wider improvement. Wide ranging legal processes including safeguarding, professional regulation, coroners and the Parliamentary and Health Service Ombudsman (PHSO) functions have seen increased activity. This is in contrast with other less politicised health systems that balance assurance and improvement and in fact see improvement and culture as key to safe care. Furthermore, NHS England does not undertake investigations into historic complaints or concerns predating its existence, as we lack the powers, functional capability and resourcing to do so. We have not been asked to cover all quality improvement initiatives in this paper, for example the Five Year Forward View programmes are not within the scope of this paper

Discussion

4. We have attempted to map out some of our main formal quality functions around 4 areas:
    - Monitoring the quality of services
    - Complaints and concerns
    - Professional regulation
    - Untoward Incidents

5. For each of these areas, Appendix A sets out how the different functions operate, including:

    - What is our unique responsibility and how does this interact with the responsibility of other bodies?
    - Which directorate is responsible within NHS England?
    - How do we track timely and effective discharge of the responsibility?
    - How do we monitor patterns and act when needed?

6. Appendix B then maps out how these functions relate to other national bodies and how we work together. The table overleaf gives a summary of Annex A:

	Key functions	Theme	Taking action and governance
Monitoring the quality of services	Quality Surveillance Groups, National Clinical Audits, Safeguarding, CQC reports	Themes include tracking of clinical service quality and coordinated management responses to quality issues.	These functions are not an end to themselves, they require local and national organisations to come together to take action. Governance for QSGs comes through the Quality Assurance Board. [See Annex A for governance and sharing frameworks.]
Complaints and concerns	Complaints, PHSO Reports, Whistleblowing, safeguarding	Where NHS England receives concerns and how this is handled.	The regional DCOs are ultimately responsible for complaints, and are held to account through the Customer Contact Executive Group (CCEG) chaired by Emily Lawson. The CCEG includes membership from Nursing and TCO Directorates, the national primary care and governance teams, and regional complaints leads. NHSE England has policies in place for internal and external whistleblowing. There is a National Safeguarding Steering Group which the regions feed into.
Professional regulation	Medical Revalidation and appraisal	NHS England upholds professional standards, which ensure patient safety and support doctors' development, as part of our legal duty as a designated body across a wide range of providers. We work with the GMC as a national lead for this area of regulation.	The Professional Standards Oversight Group (PSOG) provides the governance reporting mechanism to provide assurance that the responsible officer statutory functions are being met in accordance with the NHS Medical Profession (Responsible Officer) Regulations and are being discharged effectively.
Untoward Incidents	Coroners reports, Serious incidents, mental health homicides investigations	These are functions where NHS England helps to drive learning where there has been a failure in care.	Cross directorate governance is in place for these functions through the Quality Assurance Group and its associated work streams and sub-committees.

7. Due to the wide range of legislation, policy and processes in place, there is no single governance process to cover all these areas and ensure we take appropriate action. However, we have identified a number of areas where we could ensure broader consistency as an organisation:

a) Clinical leadership on quality

8. Considerable work has gone into ensuring strong clinical input goes into quality assurance processes and determining appropriate action. Nursing and medical professionals decide on the correct escalation, based on potential harm and to ensure appropriate interventions will improve the quality of services and ensure better outcomes for patients. This is an area where we have reasonable strength as an organisation and fits with NHS England's values. There is further scope for nursing and medical colleagues across NHS England and NHS Improvement to improve the

impact of their leadership by sharing learning, reducing parallel processes across organisations and re-focusing energies on improvement. Beyond national organisations, there is scope for improving clinical leadership of quality improvement in NHS providers and embedding quality improvement into our broader workforce strategy.

b) Alignment of quality processes and governance

9. Since the establishment of NHS England, much work has been done to improve our handling of statutory functions around quality, to improve our governance and ensure consistency. For example, we recently reviewed and improved our internal processes around Serious Incidents and our processes for tracking and responding to Coroners' inquests and reports to prevent future deaths (s28 Coroners and Justice Act 2009). We propose that how this work develops is considered alongside the NHS England transformation programme being undertaken by TCO, and the work to better align our work with NHS Improvement.

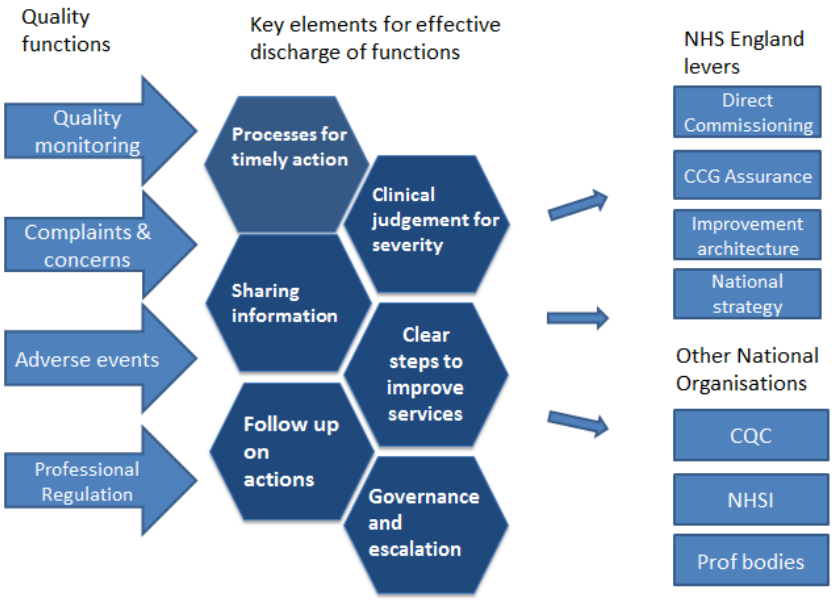
c) Improvement capacity and capability

10. NHS Improvement has lead responsibility for most "improvement" work, and we will be working with them on how this capability can be strengthened as part of our NHSE/I joint OD programme.

d) Local systems, integrated care and their emerging approach to quality and improvement

11. The functions in Appendix A are largely led by regional teams, with elements of coordination and support coming from national directorates (with clarity of role being essential). Legislation and policy remains largely focused on provider level accountability and improvement. Integrated Care Systems (ICSs) and the transformation agenda present an opportunity to create a system-wide approach to quality improvement in ICSs and reduce unnecessary reporting burden. This could be an opportunity to rebalance the system in terms of assurance versus improvement, build structured improvement capacity into ICSs, and equip areas to drive their own priorities and unlock local solutions. For example, to capitalise on strong systems of medical revalidation and appraisal in place, which are future proofed for changing models of care; or ensure our quality surveillance systems are fit for purpose for systems where providers and commissioners work collaboratively.

12. The diagram overleaf sets out how the quality functions, the key building block for efficient discharge and how they link back to NHS England's and other national organisation's functions:



Risks

13. There is a risk to service quality and NHS England's reputation if any of its functions are mishandled. NHS England's Corporate Risk Register includes quality and its ongoing mitigating actions cover the high level risks. However, due to the complexity and volume of quality concerns, challenges around individual cases cannot be completely mitigated and capacity is needed to respond to these appropriately.

14. The Board is invited to:

- Note the functions, processes and governance in place across the organisation, and how we work across NHS England in order to take action; and
- Note our work with NHSI and other ALBs to strengthen improvement capabilities across the NHS

APPENDIX A

Map of NHS England's service quality functions

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
Assuring the quality of services				
National Quality Board	The National Quality Board (NQB) provides coordinated leadership for quality on behalf of the national bodies: Department of Health & Social Care, Public Health England, NHS England, Care Quality Commission, NHS Improvement, Health Education England and the National Institute of Care Excellence. It promotes quality in all we do nationally; supports local quality improvement with providers, commissioners and those who use services; and identifies new challenges and opportunities to improve quality.	Medical Nursing CQC NHSI NICE PHE HEE DH NHS Digital	Under new joint chairmanship of Steve Powis and Ted Baker, we are currently reviewing the role and purpose.	The NQB has considered wide ranging data on service quality and evidence on international comparisons. It publishes guidance for quality system architecture such as Quality Surveillance Groups. It has also published cross-system guidance to Trusts as part of the Learning from Deaths programme and improvement tools as part of the Safe Staffing Programme. As part of the review of NQB's purpose, the membership will consider focused areas of clinical quality to act upon.
Quality surveillance/ risk summits	Quality Surveillance Groups (QSGs) bring together different parts of the health and care system, to share intelligence about risks to quality. QSGs operate at two levels: local and regional. There are currently 25 local QSGs, and four regional QSGs, all chaired and run by NHS England. Risk Summits provide a mechanism for key stakeholders to come together quickly to share and review information when a serious	Operations and Info	Local QSGs report up to Regional QSGs, who in turn report up to the Quality Assurance Group (QAG), chaired by Jane Cummings. The QAG pulls together the regional directors, regional medical directors, chief nurses and policy leads to consider escalated concerns and respond appropriately.	The QAG considers high level data on a range of areas such as coroners reports, investigations and information from QSGs. QAG has escalated and taken action on key quality issues such as concerns around the use of nasogastric tubes. It has also taken action to strengthen governance, consistency of approach and learning for key quality functions such as serious incidents and coroners reports.

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
	concern about the quality of care has been raised. The concern could be raised through a QSG or through another avenue. We have developed, piloted and rolled out a risk assessment tool that regions can use to identify potential problems outside of the CQC assessment. NHS England's role to monitor quality covers all providers of NHS funded care, including primary care, charities, care homes and private providers.			
Safeguarding	Safeguarding is a statutory requirement within the NHS. Boards are accountable for governance, to ensure that individuals are safeguarded throughout the system. NHS services have clear lines of accountability and responsible officers who work specifically within their organisations to safeguard both staff and patients.	Nursing	Regional Safeguarding Leads monitor governance across their region; Local Commissioning Offices monitor actions, risks and integrated working across the local health and social care economy.	Local and regional mechanisms are reviewed via national NHSE governance meetings: Regional Safeguarding Leads forum and National Safeguarding Steering Group, chaired by the Director of Nursing and deputy CNO
National Clinical Audits	NHS England is responsible for the strategic and operational contract management of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) delivered through Healthcare Quality Improvement Partnership (HQIP). The programme currently consists of over 30 national clinical audits (NCAs), six clinical outcome review programmes (CORPs) and the National Joint Registry (http://www.hqip.org.uk/ncapop-information-contact-and-publications-details-for-each-project/) spanning acute, primary and	Medical Directorate	Key deliverables are attached to each contract. There are also KPIs associated with the management contract between NHS England and HQIP. NHS England policy and clinical leads are responsible for input on content requirements of specific audits, alongside clinical and patient representatives, healthcare provider and third sector reps. An audit report publication control system has been implemented which ensures appropriate internal approval	There are different bespoke governance arrangements for reach audit e.g. the National Diabetes Audit has its own governance structure, the congenital heart disease (CHD) reports into NHS England's specialised commissioning directorate. All audits have a National Clinical Director, policy lead or subject matter expert leading them. Going forward, NHS England is to adopt a systematic approach to advising on audit publications. The aim

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
	community care. HQIP is responsible for operationally commissioning, developing and managing the NCAPOP portfolio.		and managed timings of publications.	is to develop an NCAPOP Partners Group (comprising NICE, CQC, NHS Improvement, NHS England) who will consider audit recommendations on a regular basis in order to maximise opportunities to improve the quality of patient care.
CQC reports	NHS England may receive CQC thematic reports and inspection reports on services it commissions. There may be actions for NHS England and these will be picked up by the relevant directorate.	Dependent on report. Operations or Spec Comm will usually coordinate.	It is currently the responsibility of CQC and relevant team to track progress on actions. These are not tracked centrally	Relevant team within NHS England where appropriate
Complaints and concerns				
MP letters	NHS England is responsible for replying to all letters received	TCO	Simon Enright is the responsible Director. 18 working days is the agreed target, known to all parties involved in handling letters; every case is measured against that target. Monthly reports on performance are prepared for senior management, and quarterly reports for DHSC	Two-weekly reports are prepared while Parliament is sitting: the SMT report, which gives the top three topics raised in letters and PQs each week, and the Issues Report, which gives NHSE directors a more detailed summary of Parliamentary activity and business. There is regular reporting of emerging issues to our stakeholder team, who use that information to proactively brief Parliamentarians. The CE office also receives a monthly report of all our MP letters.
Complaints/ contact centre	NHS England's specific responsibility in relation to complaints is set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. In summary, an individual has the right to choose who to complain to, either the provider or the commissioner of care. Neither CQC nor NHSI are required to comply with the complaints regulations.	TCO Nursing	DCOs are ultimately responsible for local performance delivery, measured against existing KPIs, and are held to account through the Customer Contact Executive Group (CCEG), chaired by Emily Lawson. The CCEG includes membership from Nursing and TCO Directorates, the national primary care and governance teams, and regional	Issues relating to primary care are managed locally and include interaction with local Performance Advisory Groups. Regions also share complaints intelligence with CCGs, either through bespoke reports or by sharing correspondence. Our customer relationship

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
			complaints leads. A six-weekly Quality Group comprising national teams (from Nursing and TCO) and regional complaints leads meets to review learning from complaints and deal with all other business relating to complaints. There is a monthly review on KPIs. An annual internal audit programme looks at the management of complaints and concerns regionally and nationally. Actions are owned and implemented via the Quality Group and the CCEG.	management system will identify individual cases with potential interest at a regional or national level. For dental complaints, the GDC also holds a complaints forum, which NHS England is part of, and complaints data is now shared with this group. NHS England completes a mandatory annual return of complaints data to NHS Digital which publishes this data annually.
Ombudsman investigations & reports	Under complaints regulations, if a complainant is unhappy with the outcome of their complaint they can refer the case to the PHSO. We have centralised contact with the PHSO to improve the consistency of our communication with them, and also to ensure we have oversight of all PHSO cases and any recommendations that they make.	Nursing Operations and Information	In the case of a national system review, the senior complaints manager in the customer contact centre will work with the relevant national directors/teams to respond to the PHSO.	Data on the number of open/closed PHSO cases is included in the complaints performance report which goes to the CCEG every six weeks. Unusually high activity in a sub region is acted upon as it may indicate an issue with the quality of local complaint handling.
Whistle blowing - external	Since April 2016, NHS England has been the 'prescribed person' for primary care whistleblowing. Essentially this means that staff in primary care organisations can make qualifying disclosures to us. Neil Churchill is working with primary care organisations in respect of the requirement for them to identify a local Freedom to Speak Up (FTSU) guardian.	Nursing	We maintain a central repository of all whistleblowing issues raised with us, but they are operationally dealt with at local level through DCO teams. The prescribed person regulations require us to make an annual report.	Quarterly reports are made to the Corporate Executive group
Whistle blowing – internal	NHS England now has an internal network of approximately 40 FTSU Guardians. It provides all staff groups with localised access	TCO	The supporting procedure sets out the four steps that can be used to raise a concern. Reporting channels have	To ensure the effective reporting and monitoring of internal cases, the local People and OD Advisory teams are

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
	to the FTSU process; the FTSU Guardians will support and help empower staff to feel confident to raise serious concern(s) regarding the practice of the organisation. The Voicing Your Concerns for Staff (Whistleblowing Policy) was authored by the NHS England Partnership Forum Policy Sub Group and was approved for internal publication in January 2016.		been opened to actively encourage the raising of concerns, any such matters can be raised with any NHS England Senior Manager or Director. If the concern is deemed so serious that it cannot be discussed at Director level, matters can also be raised directly with Emily Lawson, as NHS England's appointed FTSU Guardian, via a dedicated email address. The same route can also be used to raise concerns with the Chief Executive or alternative National Directors.	required to submit a monthly return to the People Strategy team. This ensures that all new cases and case closures are recorded within the central repository, enabling case progress to be tracked. The central repository provides an overview of cases to enable effective monitoring, and the identification of key themes which along with recommendations arising from the investigatory process are used to address practice at a local level and influence policy changes as required. Quantitative and qualitative data about formally reported concerns are reported within the annual report and accounts.
Historic complaints (i.e. relating to matters pre 2013)	NHS England generally does not undertaken investigations into legacy matters that pre-date our existence, as we lack the powers, functional capability and resourcing to do so. These matters are typically commissioned separately by DHSC as and when felt appropriate. The regional teams are not aware of any active legacy complaints which NHS England would have inherited from PCTs on 1 April 2013. There are two active PHSO complaints involving national policy teams & regional offices, both of which have attracted a high media profile (including a sepsis case in the South and an eating disorder case in M & E).			

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
Professional regulation				
Revalidation	NHS England has statutory duties under the Medical Profession (Responsible Officers) (Amendment) Regulations 2013. We are a designated body for approximately 45,500 GPs on the medical performers list, and for 500 responsible officers from all (821) designated bodies across a wide variety of sector organisations. We also have a role for ensuring revalidation is in place and successfully implemented for nurses.	Medical Operations and Information	NHS England has a number of processes in place to assure medical revalidation, including: The Framework of Quality Assurance (FQA) which assists responsible officers in providing assurance to their organisations' boards. The FQA Annual Organisational Audit (a standardised template for all responsible officers to complete, to assure Higher Level Responsible Officers) Higher Level Responsible Officer Quality Review (which ensures that there are robust systems in place to underpin the statutory responsibilities of the responsible officer).	The Professional Standards Oversight Group (PSOG) is the governance mechanism to ensure the Responsible Officer statutory functions are being met in accordance with the Regulations and are being discharged effectively. The GMC have recently launched data products to monitor data coming from revalidation.
Adverse events				
Serious Untoward Incidents	NHS England has a role in serious incidents (SI), both as a commissioner of services and as a leader of the commissioning system, as defined in the Serious Incident Framework. Specifically our teams: • Ensure that CCGs have appropriate oversight of SI management. • Assure the robustness of NHS England-commissioned providers' serious incident investigations, including patient/family involvement and action plan implementation • Oversee individual investigations where escalated • Monitor and update StEIS locally.	Operations and Info Nursing	All NHS England-commissioned Serious Incidents are logged and reported to the Quality Assurance Group. The *Serious Incident Escalation Policy* ensures all SIs are appropriately shared and escalated through DCOs, regions and national teams. The Patient Safety Group that reports to QAG shares and develops best practice for regional safety functions. It developed internal guidance for our role around SIs, which was endorsed by the QAG.	Significant SIs are escalated through NHS England's escalation policy and can be reported by Regions to the Quality Assurance Group. All serious Incidents are uploaded on to the National Reporting and Learning System and the Strategic Executive Information System held by NHSI. NHSI's Patient Safety Team monitor for patterns and take action where necessary, normally issuing a Patient Safety Alert.

Function	***Responsibility***	***Lead Directorates***	***How we track discharge of the function***	***How do we monitor patterns and act when needed?***
	• Work with partners to support the sharing of learning			
Coroners reports	A Regulation 28: Report to Prevent Future Deaths is a report made by a Coroner where they believe action should be taken to prevent future deaths. The Coroners and Justice Act 2009 gives Coroners a statutory right to make these reports to a person, organisation, local authority or government department or agency. NHS England usually receives approximately 40 reports a year. These tend to be addressed to NHS England, Simon Stevens as CEO, Steve Powis as the National Medical Director and occasionally other senior members of NHS England. NHS England may also be asked by DHSC or other ALBs to contribute to a response where it is deemed that NHS England is the lead organisation on the issue.	Medical Directorate	Regulation 28 reports usually come into the National Medical Director's office. Private office commissions a response from the relevant policy team and national clinical director. Reports are legally checked, logged on the national record by the customer contact centre and signed off by the National Medical Director before they are sent back to the Coroner.	When reports are received and responded to, these are sent to regional and local NHS England teams via the regional medical directors. In 2017 a national Coroners' working group was established. The group consists of regional medical colleagues who meet every 6-8 weeks to review all reports received over the previous two months. The group focuses on what lessons could be learnt, who else would benefit from sharing this information and emerging themes. Following discussions with NHSI, there is now NHSI representation at these meetings and we are beginning to develop a shared process of learning.
Mental health homicides	NHS England is responsible for commissioning independent investigations into mental health homicides.	Nursing	Tracking of this function is done by the Independent Investigations Governance Committee (IIGC). A review was commissioned in September 2017 to examine regional and national governance and assurance processes in relation to Mental Health Homicides. Further information will be provided prior to the March Board meeting.	The IIGC monitors trends and determines which issues it needs to act on. The Quality Assurance Group also receives a tracker of these investigations.

Appendix B

NHS England's role around quality and interactions with organisations

	Monitoring the quality of services	Complaints and concerns	Professional Regulation	Untoward Incidents
NHS Improvement	NHS Improvement has policy responsibility for patient safety and the operational systems to support this. NHSI monitors quality through its Single Oversight Framework. We are considering how this framework could align with the CCG IAF for ICSs. NHSI are represented at local and regional QSGs and also at the QAG. We are considering how we formally combine QAG with NHSI governance. Joint quality committee are also being held in London and the South.		NHSI do not have regulatory power over the primary care clinicians we oversee.	NHS Improvement lead national policy on Serious Incidents through the Serious Incident Framework. We follow the guidance as a commissioner and assurer of commissioners. We will be working closely with NHSI to the revise the Serious Incidents Framework.
Care Quality Commission	CQC regulate the quality of service provision. CQC sit on regional and local QSGs where commissioners and NHSE can share concerns. It is important to consider the nature of a commissioner's role (day to day monitoring and supporting improvement) as opposed to a regulator (inspection programme and action only when deemed necessary)	CQC can use complaints and concerns as evidence to take action.	CQC would register providers where we have a role on professional regulation. However, CQC only regulates the provider, not the individual professional.	Safety is one of the five topics when CQC inspects a provider – this would include SI handling. CQC are currently undertaking a thematic review of never event.
General Medical Council	The GMC regulate the quality of medical professionals and education. GMC have		We work closely with the GMC through our	

	recently launched a number of data monitoring tools. We are in discussions about how best to use these.		professional regulation functions.	
Parliamentary Health Services Ombudsman		According to the complaints regulations, if a complainant is unhappy with the outcome of their complaint they can refer the case to the PHSO for an independent review. We have centralised the contact with the PHSO to help improve the consistency of the communication with them, and also to ensure we have oversight of all PHSO cases and any recommendations that they make. We also support the PHSO if they are having difficulty with engagement/ compliance from a primary care provider.		