To: The Board

For meeting on: 28 September 2018

Agenda item: 5

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Report on: Quality Report

Introduction

1. Quality is one of the five themes of NHS Improvement's 2020 objectives and our aim for the trust provider sector is for it to continuously improve care quality, helping to create the safest, highest quality health and care service.

2. The purpose of this paper is to update the Board on NHS Improvement's approach to quality and safety issues, specifically in relation to the provider trust sector but also in respect of our wider system responsibilities for patient safety. The paper also provides an update on the new Quality Committee which is being established to enhance NHS Improvement's quality oversight and governance arrangements.

Background

3. Over recent years the NHS and social care systems have come under increasing pressure, meeting rising demand for services within a very challenging financial environment. Demand for NHS and social care services has consistently risen over the last five years. This has resulted in significantly increased activity across the NHS, for example planned inpatient activity has risen about 4% per year.

4. It is less well understood how the longer term increase in pressures have impacted on the quality of care received in terms of experience, effectiveness and safety. It appears that in many areas, staff have maintained or even improved these areas of quality, despite the significant growth in demand for services. NHS and social care service users have broadly speaking reported similar experience scores overall in areas such as acute care, general practice, community mental health and local authority provided social care.

5. The effectiveness of acute care shows some improvements, such as in stroke care, cancer and hip replacements. Preventable admissions continue to rise, but

on a trajectory broadly in line with the previous decade, not suggesting a simple relationship with pressures or performance. On safety, improvements have been seen in some areas nationally such as medication incidents causing severe harm, hospital infections, incidents of pressure ulcers and venous thromboembolism.

6. Improving quality - alongside health and wellbeing, finance and efficiency - is a key ambition of the *Five Year Forward View*, and underpins the development of Sustainability and Transformation Plans at a local level.

7. NHS Improvement is a member of the **National Quality Board (NQB)**. The purpose of the NQB is to provide coordinated leadership for quality on behalf of the national bodies: Department of Health, Public Health England, NHS England, Care Quality Commission, NHS Improvement and the National Institute of Care Excellence. NHS Improvement is represented on NQB by the Executive Medical Director and the Executive Director of Nursing.

8. In December 2016 the NQB published ***Shared Commitment to Quality*** to provide a nationally agreed definition of quality and a guide for clinical and managerial leaders wanting to improve quality. The shared definition of quality is at **Appendix A**.

Provider Oversight

9. NHS Improvement's **Single Oversight Framework (SOF)** sets out how we oversee NHS trusts and NHS foundation trusts. The framework helps us to determine where providers may benefit from, or require, improvement support if they are to meet the standards required of them in a safe and sustainable way. Under the SOF, NHS Improvement monitors and gathers insights about providers' performance across the five themes of **quality of care**, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

10. Under each theme, a defined set of indicators act as 'triggers'. That is, where a provider has failed to meet the required standard for a 'trigger' indicator for two months or more, NHS Improvement will initiate discussions with the provider to identify the reasons for this, and what support may be required to ensure performance improves. Based on their identified needs, NHS Improvement teams will work with providers to determine and co-ordinate an appropriate, tailored support package for each support need identified. The support offered may include directly provided support from NHS Improvement, resources available through other organisations and/or support facilitated by other parts of the sector.

11. In respect of the **quality of care theme**, NHS Improvement uses the Care Quality Commission's (CQC) most recent assessment of whether a provider's care is **safe**, **effective**, **caring** and **responsive**[1], in combination with a range of

[1] CQC currently ask the same five questions of all services they inspect: Are they safe? Are they Effective? Are they caring? Are they responsive to people's needs? Are they well led? In addition, a 'use of resources' assessment will be introduced from autumn 2017.

other quality indicators. Where CQC's assessment identifies a provider as 'inadequate' or 'requires improvement' against any of the **safe**, **effective**, **caring** or **responsive** key questions, this will represent a potential support need. A list of the SOF quality indicators (which are currently being reviewed) is at **Appendix B**.

Special Measures (Quality) and Challenged Providers

12. The Special Measures (Quality) regime was introduced in July 2013 following a review of NHS trusts with high rates of mortality by Professor Sir Bruce Keogh. Since inception, 35 trusts have entered the regime, and 20 have exited (although two of these trusts have subsequently re-entered). Of the current 15 trusts in Special Measures (Quality), 5 are also in Special Measures (Finance).

13. NHS Improvement prioritises rapid quality improvement by providers in Special Measures (Quality), with dedicated support to address their specific challenges, including embedded improvement directors, funding for improvement programmes, monitoring of robust improvement plans, building leadership capacity, facilitating change and providing, where indicated, intensive bespoke support on patient experience and staff engagement. Each Special Measures (Quality) provider is allocated a programme budget (currently £500k) to fund improvement activities.

14. NHS Improvement also works intensively with providers at risk of Special Measures (Quality), so called Challenged Providers, to help them improve quality. Our quality improvement package uses a collaborative approach and we tailor our offer to address the needs of different providers at risk. Each Challenged Provider is allocated a programme budget (currently £200k) to fund improvement activities.

15. The Special Measures (Quality) regime is overseen by a board co-chaired by the Executive Medical Director and the CQC's Chief Inspector of Hospitals, and including representatives from NHS England, Health Education England and the General Medical Council.

16. NHS Improvement has an objective to reduce to zero the number of NHS providers in Special Measures (Quality) by 2020.

Requires Improvement to Good Programme

17. NHS Improvement has a number of specific programmes of work intended to support providers to improve the quality of the care they provide, particularly in relation to the CQC's 'safe' and 'well-led' domains. These include maternity improvement, end of life care improvement, falls reduction, pressure ulcer reduction, infection prevention and control, reviews of leadership and developing leadership capacity and capability.

18. A broader programme to support providers rated by the CQC as 'requires improvement' to improve their performance across all CQC domains is currently being implemented. An initial group of 30 providers, identified by NHS Improvement's regional teams as being most likely to be able to improve

sufficiently to reach CQC's 'good' rating, will be supported through peer to peer learning and targeted workshops.

19. NHS Improvement has an objective to ensure two-thirds of inspected NHS providers are rated as 'good' or 'outstanding' by the CQC by 2020.

Patient Safety

20. NHS Improvement's responsibilities for patient safety extends all areas of NHS-funded healthcare in England, including primary care, community services, mental health trusts, ambulance services and acute trusts. **The Board received a paper on the organisation's approach to patient safety at its July meeting**.

21. NHS Improvement's National Patient Safety Team is legally responsible for delivering two statutory patient safety duties across the NHS:

    - collecting information about what goes wrong in health care, in part by using the National Reporting and Learning System (NRLS), which the Team is responsible for managing; and

    - using that information to provide advice and guidance "for the purposes of maintaining and improving the safety of the services provided by the health service".

22. The insight and knowledge gained through routinely analysing this information is used to support safety improvement work across the system. Over two million records of patient safety incidents are reported to the NRLS each year (97% are no or low harm). NHS Improvement reports the number and type of incidents quarterly (shortly to be monthly).

23. In addition to its statutory duties, and it's work with the Patient Safety Collaboratives, the National Patient Safety Team is also taking forward work in 2017/18 (alongside the Nursing Directorate) to support the NHS to achieve the specific safety aims of the Secretary of State in relation to:

    - maternal and neonatal safety;
    - antimicrobial resistance and infection prevention and control
    - learning from deaths and improving investigations; and
    - medication safety.

Quality Committee

24. At its July meeting the Board approved a proposal to enhance NHS Improvement's quality oversight and governance arrangements by establishing a Quality Committee.

25. The purpose of the Quality Committee will be to support the Board and the Chief Executive by providing assurance that mechanisms are in place to identify, manage and escalate quality concerns/issues affecting the trust provider sector.

The Committee will support improvements in patient care in providers of NHS services through overseeing NHS Improvement's approach to improving clinical quality.

26. The Quality Committee will receive reports as required from relevant NHS Improvement directorates and working groups, along with a dashboard of key quality metrics and other information, to enable it to form an overall view on the state of quality in the trust provider sector and to constructively challenge where necessary. The Committee would meet at least four times a year.

27. Since the July meeting, the Board has confirmed that the Quality Committee will be chaired by Sarah Harkness. Lord Darzi will be the other Non-Executive Director member. The Committee will meet for the first time in October.

Conclusion

28. The Board is asked to note NHS Improvement's approach to quality and safety issues.

From the NQB's *Shared Commitment to Quality*

The areas which matter most for people who use services are:

Safety: People are protected from avoidable harm and abuse, and when mistakes occur lessons are learned.

Effectiveness: People's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Positive experience (caring, responsive and person-centred): Staff involve and treat people with compassion, dignity and respect. Services respond to people's needs and choices and enable them to be equal partners in their care.

To provide this high-quality care, providers and commissioners must work together and in partnership with local people and communities. They must be:

Well-led: they are open, collaborate internally and externally, and are committed to learning and improvement.

Sustainable: they use their resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture.

Equitable for all: they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

Single Oversight Framework - Quality Indicators **Appendix B**

NHS Improvement will use the indicators[2] below to supplement CQC information to identify where providers may need support under the theme of quality.

Measure	Type	Data frequency	Source
All providers			
Written complaints – rate	Caring	Quarterly	NHS Digital (publicly available)
Staff Friends and Family Test % recommended – care	Caring	Quarterly	NHS England (publicly available)
Occurrence of any Never Event	Safe	Monthly (6-month rolling)	Strategic Executive Information System (STEIS)/NHS Improvement (publicly available)
Patient Safety Alerts not completed by deadline	Safe	Monthly	Medicines and Healthcare products Regulation Agency (MHRA)/NHS Improvement (publicly available)
Acute providers			
Mixed sex accommodation breaches	Caring	Monthly	NHS England (publicly available)
Inpatient scores from Friends and Family Test − % positive	Caring	Monthly	NHS England (publicly available)
A&E scores from Friends and Family Test − % positive	Caring	Monthly	NHS England (publicly available)
Maternity scores from Friends and Family Test − % positive	Caring	Monthly	NHS England (publicly available)
Emergency c-section rate	Safe	Monthly	Hospital Episode Statistics (HES) Minimum Data Set
CQC inpatient survey	Organisation-al health	Annual	CQC (publicly available)

[2] These indicators are currently being reviewed and will be finalised in October 2017 following a feedback exercise.

Measure	Type	Data frequency	Source
VTE risk assessment	Safe	Quarterly	NHS England (publicly available)
Clostridium difficile – variance from plan	Safe	Monthly	Public Health England (PHE – publicly available)
Clostridium difficile – infection rate	Safe	Monthly (12-month rolling)	PHE (publicly available)
MRSA bacteraemias	Safe	Monthly (12-month rolling)	PHE (publicly available)
Proposed new metric *Escherichia coli* (E. coli) bacteraemia bloodstream infection (BSI)	Safe	Monthly	PHE (publicly available)
Hospital Standardised Mortality Ratio	Effective	Quarterly	Dr Foster Intelligence (licensed data)
Summary Hospital Mortality Indicator	Effective	Quarterly	NHS Digital (publicly available)
Potential under-reporting of patient safety incidents[3]	Safe	Monthly	National Reporting and Learning System (NRLS)/NHS Improvement – publicly available
Emergency readmissions within 30 days following an elective or emergency spell at the provider/emergency readmission within 30 days following discharge from hospital	Effective	Monthly	HES
Community providers			
Community scores from Friends and Family Test – % positive	Caring	Monthly	NHS England (publicly available)
Mental health providers			
CQC community mental health survey	Organisation-al health	Annual	CQC (publicly available)

[3] This indicator is valid only at the level of extreme outliers for under-reporting as per CQC Intelligent Monitoring methodology and only in non-specialist acute trusts.

Measure	Type	Data frequency	Source
Mental health scores from Friends and Family Test – % positive	Caring	Monthly	NHS England (publicly available)
Admissions to adult facilities of patients who are under 16 years old	Safe	Monthly	NHS Digital (publicly available)
Care programme approach (CPA) follow-up – proportion of discharges from hospital followed up within 7 days[4] – Mental Health Services Data Set	Effective	Monthly	NHS Digital (publicly available)
% clients in settled accommodation	Effective	Monthly	NHS Digital (publicly available)
% clients in employment	Effective	Monthly	NHS Digital (publicly available)
Potential under-reporting of patient safety incidents[5]	Safe	Monthly (6-month rolling)	NRLS/NHS Improvement (publicly available)
Ambulance providers			
Ambulance see-and-treat from Friends and Family Test – % positive	Caring	Monthly	NHS England (publicly available)
Return of spontaneous circulation (ROSC) in Utstein group	Effective	Monthly	NHS England (publicly available)
Stroke 60 minutes	Effective	Monthly	NHS England (publicly available)
Stroke care	Effective	Monthly	NHS England (publicly available)
ST Segment elevation myocardial infarction (STeMI) 150 minutes	Effective	Monthly	NHS England (publicly available)

[4] NHS Improvement is following the development of indicators to measure 48-hour follow-up, in line with evidence, and will consider amending this in a future version of the SOF.
[5] This indicator is valid only at the level of extreme outliers for under-reporting as per CQC Intelligent Monitoring methodology.