National Quality Board

Position Statement: Managing Risks and Improving Quality through Integrated Care Systems

The landscape of health and care is changing. The recently published White Paper - Integration and Innovation: working together to improve health and social care for all[1] – sets out the government's proposals for legislation, including the establishment of statutory Integrated Care Systems (ICSs). As ICSs develop and we recover from the pandemic, it is crucial that ICSs recognise their Triple Aim[2] duty to deliver high-quality care and put quality, including safety, at the forefront of planning and decision-making.

A shared commitment to delivering quality in ICSs

The strengthening of collaboration and partnership working across health and care provides significant opportunity to improve quality. However, we also know from past experience that structural change can put quality, including safety, at risk. Much of the National Quality Board (NQB)'s work since 2009 has focused on providing leadership for quality and supporting quality oversight during periods of transition[3]. For this reason, we understand the importance of "getting quality right" at this crucial time.

The NQB has refreshed its **Shared Commitment to Quality** to provide a common definition and vision of quality for those working in health and care systems. The refreshed version has been co-produced with systems and people with lived experience. It uses the existing Darzi-based definition of high-quality care as being safe, effective and providing a positive experience[4], with a greater emphasis on population health and health inequalities. The document and example system case studies can be accessed here: www.england.nhs.uk/ourwork/part-rel/nqb/

Key requirements for quality oversight in ICSs

Systems and their constituent partnerships and organisations will have two overarching quality responsibilities:

1. **To ensure the fundamental standards of quality are delivered** – including managing quality risks, including safety risks, and addressing inequalities and variation;
2. **To continually improve the quality of services**, in a way that makes a real difference to the people using them.

[1] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

[2] The Triple aim: better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources is proposed

[3] Previous NQB work and publications are available on the NQB website: https://www.england.nhs.uk/ourwork/part-rel/nqb/

[4] Department of Health (DH). High quality care for all: NHS Next Stage Review final report. London: Department of Health; 2008

Achievement of these responsibilities in the new operational landscape will require an important culture shift – from instructive to permissive and developmental ways of working, and from individual to collective ownership and management of quality concerns. As the development of ICSs progresses, clear accountabilities for the delivery of quality, including safety, will be needed for all parts of the system. In the interim, system partners must understand that they are all accountable for quality and that they therefore all have a responsibility to escalate concerns.

Quality oversight and improvement will largely be delivered locally through place-based partnerships, but ICSs will have an important role to play – ensuring that inequalities and variation in the quality of care and outcomes are addressed, that serious quality concerns are managed effectively, and that learning, intelligence and improvement are shared across the system and beyond to inform ongoing improvement.

The refreshed Shared Commitment sets out some **key principles** for systems to adopt in delivering their overarching quality, including safety responsibilities, which have been informed by previous NQB work and recent learning from systems. Alongside these, systems are expected to adopt some **consistent operational requirements** for quality oversight during the transition period and beyond.

	Principles	Consistent operational requirements
	**1. Quality is a shared commitment**	**1.** A designated executive clinical lead for quality, including safety, in the ICS, and clinical and care professional leadership embedded at all levels of the system.
	**2. Population focused vision**	**2.** A clear vision and credible strategy to deliver quality improvement across the ICS, which draws together quality planning, quality control, quality improvement and assurance functions to deliver care that is high-quality, personalised and equitable.
	**3. Coproduction with people using services, the public and staff**	**3.** A defined governance and escalation process in place for quality oversight – covering all NHS commissioned services and those commissioned jointly by the NHS and local authorities (included devolved direct commissioning functions)[5] and formally linked to regional quality oversight arrangements (Quality Committees / Joint Strategic Oversight Groups).
	**4. Clear and transparent decision-making**	**4.** An agreed way to measure quality, including safety, using key quality indicators triangulated with intelligence and professional insight, which is reported publicly and transparently at Board-level to inform decision-making and effective management of quality risks. Evidence must show that this is also mirrored by tracking of local metrics within services to inform progress and improvement.
	**5. Timely and transparent information-sharing**	**5.** A defined way to engage and share intelligence on quality, including safety – at least quarterly and delivered through a System Quality Group (refreshed Quality Surveillance Group), at least initially. This will not replace existing statutory responsibilities.
	**6. Subsidiarity**	**6.** A defined approach for the transfer and retention of legacy organisation information on quality in accordance with the Caldicott Principles.

[5] This includes: public, private, not for profit and third sector providers; primary care including general practice, dental, optometry and pharmacy; community services; secondary and tertiary services; mental health; military health and veterans services; directly commissioned services, including specialised commissioning and health and justice; services impacting on locally commissioned services.

System Quality Groups (formally Quality Surveillance Groups)

During 2021-22, systems are expected to set up a System Quality Group[6], a refreshed version of a Quality Surveillance Group (QSG)[7]. The NQB will work with systems and regions in 2021-22 to update the National Guidance on Quality Surveillance Groups and Risk Summits (held in response to serious quality failures). The effectiveness of these arrangements will signal system readiness and maturity. Key updates to the Terms of Reference of System Quality Groups are summarised below:

Terms of Reference of System Quality Groups	
Purpose	A proactive and collaborative forum, providing systems with: • A mechanism to identify system risks to quality and opportunities for improvement, including variation • A mechanism to escalate quality risks from place to system, and system to region (in collaboration with regulators and wider stakeholders/forums, e.g. safeguarding boards) • Opportunities to coordinate actions to drive improvement, respecting statutory responsibilities • Opportunities to identify, share and celebrate learning and best practice across the system.
Scope	A focus on population health and system quality priorities, e.g. across pathways/settings with particular emphasis on reducing inequities in access, experience and outcomes.
Membership	System-led. Membership expanded, with at a minimum Regional NHSEI teams, local authorities, CQC, HEE, public health, primary care, maternity, patient safety collaboratives, patient safety specialists, provider collaboratives and at least two lay members (inc Healthwatch).
Assurance	Accountable to the ICS Board (subject to legislation) and to Regional NHSEI teams for the quality of care of services. Responsible for ensuring good quality oversight, management of risks, sharing intelligence and working with regulators.

Systems will be expected to work closely with regional NHSEI teams and wider partners to effectively put in place these requirements during the transition period. Practical changes to deliver quality functions sensibly through ICSs, including patient safety functions and devolved functions (e.g. directly commissioned services), will be worked through in 2021/22 and managed appropriately. Regional NHSEI teams are working to update regional quality oversight meetings and support ICS quality leads over 2021-22, in collaboration with national NHSEI teams and wider partners. Engagement will be tailored to ICS needs and may include reviewing wider quality risks, sharing learning and benchmarking data, and supporting effective leadership for quality. In the event of serious or persistent quality failures, NHSEI and regulators will work collaboratively with systems to address issues, in alignment with the System Oversight Framework.

NQB work to support quality oversight in ICSs

The NQB will support the following work in 2021-22:

- **A quality toolkit**, drawing together a library of consistent indicators to help provide a single view of quality. Launched and further developed by NHSEI and available through NHS Viewpoint in Q1 2021/22
- Policy work to clarify **quality oversight arrangements at place and system level**, including risk management approaches. To inform updated guidance on QSGs and Risk Summits – Q 2-3 2021/22
- Policy work to further define **roles and responsibilities for quality** at place, system and regional level – Q2-3 2021/22
- Ongoing work to **review progress and impact**, and share and celebrate **learning, improvement and best practice** from systems on quality, including engagement across health and social care. Shared through networks, events and case studies.

[6] ICSs may choose to tailor this name. e.g. "Quality Board" and "Joint Intelligence Group" are examples of groups already established.

[7] https://www.england.nhs.uk/publication/quality-surveillance-groups-national-guidance/