Good Governance Institute

NHS

South London Commissioning Support Unit

Board Assurance Prompt – quality schemes in healthcare providers for better commissioning

What is this guide? Who is it for?

Working with South London Commissioning Support Unit (SLCSU) and their client Clinical Commissioning Groups (CCG), GGI has developed the 'Commissioning for Quality' programme to help clinical commissioners address their post-Francis quality responsibilities. A core tenant of this work has been raising awareness and confidence amongst those on governing bodies in CCGs around the quality assurance processes active within NHS providers. This resource for governing bodies and boards (Board Assurance Prompt – 'BAP') focuses on the ways in which quality review schemes can contribute to a framework of greater quality assurance in healthcare commissioning.

This briefing is targeted primarily at CCGs, and aims to provide insight into the quality of care services being commissioned. As such, this BAP will also be relevant to Health and Wellbeing Boards, HealthWatch, the Boards of NHS providers, and patient advocate organisations. A key element in securing quality in health care provision is ensuring partnership working and information sharing across organisational boundaries. As well as acting as a quality assurance resource, this BAP aims to foster constructive dialogue in local health and social care economies.

Quality schemes

While the Care Quality Commission (CQC) and Monitor are positioned as overarching regulators of health and social care services in England, a range of other quality review bodies operate throughout the healthcare sector. Some have done so for decades. Many of these quality schemes relate to practice-specific quality assessment, and as such can offer detailed and timely insight. Indeed, in constructing their quality and risk profiles, CQC incorporate the data provided by some of these quality review schemes. However, many such schemes have become siloed within a single profession or group and are poorly used by provider management and even less so by CCGs.

The structure of assessment methods we found have been implemented range from voluntary self-assessment processes, to on-site inspections by bodies with the power to suspend licensing and accreditation. Fundamental to the value of such schemes is the fact that they can provide aggregated information on the state of practice within an organisation or field. The outputs of these schemes can act as an easily accessible and clearly communicated touchstone for both the legacy and current environment of quality across the healthcare landscape.

Through the 'Commissioning for Quality' programme, GGI, SLCSU, and their client CCGs have analysed how the quality assurance schemes that exist within healthcare providers can add value to the assurance around care quality for commissioners. In the course of this research, we have identified a number of such quality review schemes that may be useful in providing greater line of sight within quality assurance for commissioners.

As a means of organisation, and following initial feedback from a variety of stakeholders, we have focused primarily on schemes that exhibit the following traits:

- Use of standards
- Incorporate an element of external review
- Lead to a published report
- Have their own quality assurance process

The development of robust quality assurance frameworks in commissioning health and social care is inherently challenging. The prevalence of quality concerns in areas of handover and patient pathway bear testament to this. Assurance entails the synchronisation of operational processes that need to work efficiently and seamlessly across various care and support services. While review schemes can certainly offer timely and insightful information on quality, such resources will be truly effective when allowed to operate flexibly within a structure of support for commissioners. Genuine quality assurance requires an environment of consolidated partnerships and information sharing.

With SLCSU and their client CCGs, GGI have created a 'map' of relevant quality schemes being used in local providers in parts of London and South East and recommend this approach to others. Examples of quality schemes we have incorporated in this work include:

- Clinical Pathology Accreditation (CPA)
- Joint Advisory Group on Gastrointestinal Endoscopy (JAG)
- National Peer Review Programme
- Medical Deanery Research and Junior Doctor Exit Interviews

The rest of this guide

We have used the BAP format for this briefing on quality assurance programmes. BAPs are a series published by the Good Governance Institute and in common with other resources in this series, we set out a series of assurance questions that might be asked to ensure that an organisation is robustly engaged with quality assurance schemes, and that local health and social care organisations are constructively working together. These assurance questions are examples only, and are intended to provoke thought among commissioners and providers about current frameworks of quality assurance. We also include a maturity matrix to test and guide the local development of quality assurance, and to facilitate the sharing of better practice and innovation. A mapping of quality assurance schemes active in a number of London providers is incorporated for reference, and to foster further development of quality assurance frameworks in the commissioning landscape.

Why is this important?

Selected quotes from the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' (The Francis Report):

"For the future, it is clearly important that commissioners are able to understand and explore the significance of safety and quality indicators in relation to the providers from whom they commission services."
(Vol 1, Recommendation 5.261, p.480, 2013)

"The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation."
(Vol 1, P.687, Recommendation 132, 2013)

"Commissioners need to have a view of the standard of service being provided for their patients. They are sufficiently proximate to their commissioned providers to be able to engage with a local level of detail."
(Vol 1, P.283, Conclusion 3.149, 2013)

Accreditation, certification the work of UKAS, and beyond

The United Kingdom Accreditation Service (UKAS) is the sole national accreditation body recognised by the government to assess organisations that provide certification, testing, inspection, and calibration services. UKAS describes accreditation as:

> "a formal, third party recognition of competence to perform specific tasks. It provides a means to identify a proven, competent evaluator so that the selection of a laboratory, inspection or certification body is an informed choice. UKAS accreditation means the evaluator can demonstrate to its customer that it has been successful at meeting the requirements of international accreditation standards."
> **UKAS, 2014**

Accreditation is about encouraging continuous quality improvement and implementing best practice. However, not all quality schemes act as accreditation bodies. The range of quality review initiatives active throughout the healthcare sector means that many operate as assessment programmes, implementing regular service reviews as a means of providing quality assurance insight.

For instance, the **Human Tissue Authority (HTA)**, which regulates the use of human tissue for research, patient treatment, education and training, and public display, operates a continuous licensing system. This licensing is supported by a sector-specific compliance monitoring framework that involves the collection of regular compliance updates from licensed establishments. HTA also conducts inspections in order to check that licensed establishments maintain good standards and follow appropriate procedures. As an output of these initiatives, HTA issues reports to the licensed organisations outlining required improvement measures, and identifying best practice. Such reports could serve as a useful source of assurance on the quality of care being commissioned.

Furthermore, the research of **Medical Deaneries** has been identified as a potentially useful resource for supporting commissioning quality assurance. A particularly valuable aspect is the programme of junior doctor exit interviews undertaken as part of General Medical Council quality assurance initiatives. These trainee surveys can offer a wealth of information on institutional culture across the NHS. Currently, such quality assurance outputs are not shared with commissioners as part of standard practice.

Such quality schemes can facilitate and supplement efforts by healthcare organisations in their aspirations for service development, and in providing transparency to key stakeholders. A fundamental strength of these various quality programmes is that, when seen collectively, they can offer a rich source of continuous insight into the quality of care at a particular organisation.

Moreover, increased commissioner knowledge of quality schemes operating within a particular discipline or geographical area allows for informal benchmarking, whereby a locally focused dialogue can develop around quality assurance.

The role of 'soft intelligence' throughout the healthcare economy has been acknowledged in the Francis report. Recognising the importance of relationship-building is particularly pertinent in the continually progressing commissioning landscape, as organisations develop and partnerships mature. We view the GGI Commissioning for Quality programme as a contributory factor to this framework, around which robust quality assurance can be developed and secured.

The outputs of these quality schemes will by no means serve as a comprehensive source of quality assurance in commissioning. They provide an additional extra resource to work commissioners should be doing anyway to monitor quality issues in providers they contract with. Nevertheless, such programmes can certainly offer valuable and timely information on the quality of healthcare provision, and have an important role to play in contributing to a nuanced and holistic quality environment.

	Example assurance question	Insufficient answer	Credible answer
1	**Are we aware of the quality schemes active in the providers we commission services from?**	Various quality schemes operate at providers. We are not aware of their assurance outputs or review criteria.	We are aware of key assurance resources, and are actively seeking to contribute to their development and to facilitate improved information sharing.
2	**Are quality scheme outputs considered/ included in the construction of quality accounts?**	Draft Quality Accounts are shared by providers in accordance with NHS England requirements.	Yes, there are consultative processes in place with providers around commissioner input into the construction of Quality Accounts, including specific assurance resources from review schemes.
3	**How are we embedding shared decision making principles in relation to quality assurance?**	Quality assurance schemes are the remit of providers. We are not involved in decision making in relation to these initiatives.	Partners are committed to co-creation of assurance frameworks. We have developed shared decision-making standards, and collaborate areas in need of quality assurance, and according to what criteria.
4	**How well is information pertinent to quality assurance and review schemes being shared?**	We are not aware of the structure or timings of quality review outputs.	We recognize that relationship building is key to robust quality assurance. We are continually developing relationships with providers and quality assurance bodies around the legitimacy of access to provider assurance systems.
5	**Are we identifying weaknesses and additional areas to direct the focus of quality scheme activity?**	The work of quality review schemes is separate to us.	We are always concerned about this. We have developed relationships with assurance bodies, and communicate or commissioning priorities and concerns in order to shape assurance activity.
6	**Have we identified key patient pathways in need of quality assurance?**	We are aware of certain pathway challenges, but have not aligned these with quality review scheme resources.	We have systems providing evidence of effectiveness of handover of patients within and between providers, facilitating confidence in the quality of patient handover. There is a process is place to escalate concerns of handover failure for immediate action.

Commissioning for Quality – 2: Quality Review Schemes and Assurance

A Good Governance Institute maturity matrix

May 2014

To use the matrix: identify with a circle the level you believe your health and social care economy has reached and then draw an arrow to the right to the level you intend to reach in the next 12 months. 0 ----> ?

Targeted to a whole health and social care economy

Progress Levels / Key elements	0 No	1 Basic Level – Principle Accepted	2 Basic level – agreement of commitment and direction	3 Early progress – in development	4 Results – being achieved	5 Maturity – comprehensive assurance
Knowledge of schemes and their use by providers	NO	Commissioners have mapped provider assurance systems and identified weakness/gaps in particular at handover to other providers.	Commissioners have agreed with providers the legitimacy of access to providers' assurance systems.	Commissioners have confidence in provider assurance systems being used by providers to gain assurance.	Providers routinely share outcomes of their assurance systems with commissioners in Quality Surveillance and quality assurance meetings.	Providers' assurance systems and are developed in partnership with commissioners with open access to outcomes and improvement plans.
Relationship building	NO	Commissioners have identified owners of assurance systems in key providers and shared rationale for interest with providers.	Providers have recognised and understood why commissioners want awareness of provider systems and how they are used.	Commissioners and providers have agreed protocol for access to both information and assurance of who provider Board uses and how this is acted upon.	Commissioners have built relationships with owners of assurance systems in key providers so that they can influence assurance system development.	Providers and commissioners have an annual process in place to agree programmes and priorities and a means of escalating concerns for immediate action.
Handover and patient pathways	NO	Commissioners have identified key patient pathways and mix of providers that need quality assurance.	Commissioners are seeking compliance with supply-chain style standards to patient handover and return to place of safety.	Commissioners have systems providing evidence of effectiveness of handover of patients within and between providers.	Commissioners have confidence in the handover of patients within and between providers.	Providers and commissioners have a process in place to escalate concerns of handover failure for immediate action.
Commissioner role in accreditation standards	NO	Commissioners mapping of provider assurance systems has identified weaknesses/gaps in standards and/or application.	Commissioners have sought and acquired access to providers of assurance systems.	Commissioners are routinely consulted by providers of assurance systems.	Commissioners have collectively sought and acquired influence over national/commercial assurance systems reflecting commissioning priorities and concerns.	Commissioners have been able to demonstrate local improvements through influence over national/commercial assurance systems.
Processes of assurance	NO	Commissioners have identified best practice in application of assurance within providers.	Commissioners have shared best practice in application of assurance with their providers.	Commissioners have encouraged their providers to undertake audit of practice in application of assurance within their own governance.	Commissioners have identified improvement in providers practice of application of assurance within their governance.	Commissioners have independent assurance of the robustness of providers application of assurance across the whole patient pathway for all services commissioned locally and out of area.

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