NQB (12) 5th Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held at Care Quality Commission, Finsbury Towers, Bunhill Row, London

Tuesday 4 September 2012, 13:00 – 16:00

PRESENT			
Bruce Keogh (Chair)			
Jane Cummings	David Haslam	Margaret Goose	John Oldham
Jo Williams	Stephen Thornton	Sally Brearley	Una O'Brien
Mike Rawlins	Hilary Chapman	Don Brereton	Niall Dickson
Ian Gilmore	Kathy McLean (NHS TDA)	Toby Lambert (Monitor)	Lisa Bayliss-Pratt (HEE)
APOLOGIES			
David Nicholson	Victor Adebowale	Jackie Smith	Tim Kelsey
Duncan Selbie	David Bennett	David Flory	Ian Cumming
SECRETARIAT			
Lauren Hughes (DH)	John Stewart (DH)	Brendan Gage (GMC)	

Agenda

1. Welcome	
2. Pathway Peer Review	(Paper ref NQB(12)(05)(01))
3. National Data Quality Report	(Paper ref NQB(12)(05)(02))
4. Patient Led Assessments of the Care Environment	
5. NQB's forward work programme for 2013	(Paper ref NQB(12)(05)(03))
6. General Update	(Paper ref NQB(12)(05)(04))

ITEM 1: WELCOME AND INTRODUCTION

BRUCE KEOGH (Medical Director, NHS Commissioning Board and Department of Health) welcomed members to the twenty second meeting of the National Quality Board (NQB). He welcomed Una O'Brien, Permanent Secretary at the Department of Health, and Anna Bradley, Chair, Healthwatch England, to their first NQB meeting. He also welcomed Kathy McLean, deputising for David Flory at the NHS Trust Development Authority, Toby Lambert, deputising for David Bennett at Monitor and Lisa Bayliss-Pratt**,** deputising for Ian Cumming at Health Education England.

BRUCE KEOGH (Chair) reminded members that following the discussion on the future role of the NQB at the previous meeting in September, David Nicholson had written to all NQB members providing clarity on the on-going role of the NQB. This meeting would therefore be important as the Board would be asked, in the context of that letter, to begin thinking collectively about what its forward work programme might look like. It would also be discussing some more specific elements of its existing work programme which had come to fruition, including a report on data quality from the Quality Information Committee, the conclusion of work to develop a model of Patient-led Assessments of the Care Environment, and a more general update. Firstly, the NQB would be asked to consider a proposed model for peer review, which could be a useful and effective component of the overall architecture for quality improvement, particularly in the context of the Mid Staffordshire NHS Foundation Trust Public Inquiry

ITEM 2: PATHWAY PEER REVIEW

BRUCE KEOGH (Medical Director, NHS) welcomed Professor Barry McCormick to the meeting and invited him to introduce the work he had been undertaking on pathway peer review.

BARRY MCCORMICK introduced a paper he had developed in conjunction with the Health Foundation on a model of pathway peer review. In developing the paper he had sought to: define the problem; provide a diagnosis; determine what the treatment must do; suggest what the right treatment might be; and analyse how it would offer value for money.

The problem seemed to be characterised by the serious failings that had occurred at Mid Staffordshire NHS Foundation Trust – where there had been systemic organisational failure, rather than a single team that had failed. In terms of a diagnosis, it seemed that at that trust, there had been a focus on narrow measures of performance rather than quality of care as a whole. The culture had been hierarchical and territorial and there was a lack of transparency of information, which had contributed to a failure to act.

The necessary treatment for this diagnosis would need to involve consideration of all aspects of quality, drive organisational improvement, overcome internal inertia within organisations and bring different organisations together in the common pursuit of better care.

BARRY MCCORMICK proposed that the roll out of a model of pathway peer review could treat this diagnosis. It involved the production of condensed, highly informed reports by peers following the review of pathways or services, identifying where there could be quality improvements. The model aligned an established model of self-regulation with pathways that were recognised by patients. It was a useful addition to the overall system of risk-based regulation.

Three options for how the model might operate in practice were proposed in the paper. NQB members were asked for their views on whether the system should seek to adopt such an approach, and which option was most attractive

The following points were raised in discussion:

a. clarity was needed on what was meant by a ‘pathway’. The term was commonly used although could mean different things to different people. Ideally it would refer to a set of linked processes / components that deliver care to address the health needs of a patient, which in turn were supported by clinical guidelines setting out how services should be delivered in that pathway;
b. in principle the concept of patient pathways was positive. However in practice, the pathways that commissioners and providers tended to define did not encompass all of the health needs of a particular patient. Patients would require services across different pathways;
c. there were questions as to the strength of the evidence as to whether peer review changed clinical behaviour
d. the proposed model of pathway peer review was very focussed on hospital settings. This did not reflect the importance of primary and community care which would be providing increasing elements of pathways of care;
e. the concept of review by peers was attractive in principle, but would need to be considered carefully. The CQC’s experience in their programme of Dignity and Nutrition Inspections, where nurses were included on review teams, demonstrated that the nursing profession on the whole could be more lenient towards peers.

However there was a sense that peer to peer challenge could be powerful particularly within the medical profession, and could be a mechanism of empowering clinicians to improve.

f. the price tag of £40m p.a. was felt to be prohibitive, given that the CQC regulated 40,000 organisations across the health and care system on a budget of £160m p.a.
g. if the approach were to be considered further, there would need to be thought as to the coverage of the programme – would it be comprehensive across all services? Would it be voluntary? If it were to be mandatory, how would clinicians' time be covered, and where would the costs fall?
h. there was clearly some benefit in peer to peer review and challenge, however it may not be expedient in the current circumstances to embark on establishing a new structure / bureaucracy. There could be value in somehow harnessing the value of peer to peer challenge and building it into existing mechanisms. For example, there could be an option to incorporate peer to peer challenge within Monitor's approach to assessing quality governance within foundation trusts. The new architecture of clinical senates and networks would see peer to peer challenge further built into the new system. CQC already had 200 professionals signed up as associates who were involved in compliance activity. There would also be value in aligning those peer review schemes that already existed, so as to maximise their impact and cement their place in the system;
i. there was a difference between peer review and the accreditation of services, which was another area of NQB interest. This would need to be recognised and made explicit;
j. whilst peer to peer interaction could be useful in driving improvement, it needed to be grounded by retaining the primacy of the patient perspective. The output of existing peer review programmes was often inaccessible to service users, being very technical in nature. Any pathway peer review model should be designed and enacted so as to make the outputs relevant and useful to patients;

BRUCE KEOGH (Chair) thanked Barry McCormick for presenting his paper and NQB members for expressing their views. He concluded that the model proposed was one possible approach, and as the discussion had clearly demonstrated, there were a number of approaches already being used in the NHS. There was clearly a place for peer review in the system, however at the present time it was not felt that establishing a significant new programme of activity was helpful or practical. He asked Barry to continue to keep the NQB informed of his work in this area. Statutory NQB members were asked to consider how they might incorporate peer to peer elements into the regulatory and oversight functions for which they are responsible.

ITEM 3: NATIONAL DATA QUALITY REPORT

DAVID HASLAM (Chair, Quality Information Committee) introduced paper NQB(12)(05)(02) which attached a final draft of the First National Data Quality Report. He thanked the Quality Information Committee (QIC) for their hard work in developing the report. He introduced Samantha Riley (Quality Information Committee member) who had been working to develop the report on behalf of QIC.

SAMANTHA RILEY explained that the report brought together work from across the system on data quality. The evidence gathering activity to inform the report had involved two elements: a literature search, and engagement with organisations who were active in the area of data quality. Issues identified had been categorised according to whether they related to data involved directly in care, or data involved indirectly in care. Six themes had been identified under which recommendations had been grouped.

Issues relating to data quality were not new; they had been around for years. To date there had been a lack of joining up between organisations, and of leadership for and ownership of solving the problems. The NQB offered an ideal forum in which to grasp some of these issues and to take forward activity to overcome them. The NQB were asked to endorse the QIC's report and its recommendations, and agree to its publication.

The following points were made in discussion:

a. the QIC report was commended as a good piece of work, particularly given that it had been developed by organisations from across the system;
b. the system should be aiming to get to a place whereby information is only collected where it is collected through the process of patient care. There was some way to go to get to this point;
c. the themes and recommendations in the report were sensible, and had been identified as issues for some time. The report needed to take the system to the next step in terms of overcoming the issues that had been identified. It was felt that more work was needed to translate the recommendations into actions with assigned owners and timescales;
d. a significant limiting factor in maximising the potential of information to drive improved patient care was the inability to share information between organisations. Information governance rules were often acting as barriers to improvement. Some

organisations had been able to overcome these barriers and enable information sharing. Such examples should be shared and used as templates. This could be an additional recommendation from the report;

e. data in primary care was particularly poor, and interoperability was urgently needed. In some areas there was electronic transfer of information between general practices but this needed to become far more widespread;
f. connections between the report, the Information Strategy and the IT Strategy needed to be made. They too were concerned with interoperability and data standards. It should also reference areas of priority for the Government, such as access to GP records, and movement of records between acute and primary care; and
g. the bulk of the report and recommendations focussed on technical issues. There were significant issues concerning the culture in the NHS, and how it valued data quality. More was needed in terms of leadership and training.

Summing up the discussion BRUCE KEOGH thanked QIC for their work to develop the report, which the NQB had welcomed. He asked that QIC do some further work to the report, as follows, before bringing it back to the next NQB meeting:

h. strengthen the recommendations in respect of how information governance can become an enabler rather than an inhibitor;
i. make better links between the report and other strategies and priorities; and
j. attach responsibility and deliverables to each recommendation, agreed by those organisation who will be taking forward the actions.

ITEM 4: PATIENT LED ASSESSMENTS OF THE CARE ENVIRONMENT

JANE CUMMINGS introduced paper NQB(12)(05)(03) which brought together the conclusions of the work to develop a model of patient-led assessments of care settings. She thanked the NQB members who had worked with the Steering Group on this project. There had been several areas on which the NQB had provided steers – the paper provided an update on each:

- extending the model beyond hospital settings – the Steering Group had extended the application of the model to all settings in which people were cared for, including hospices and independent sector treatment centres, with the exceptions of people's own homes as it was felt that this would be disproportionately intrusive;
- assessment teams should be patient-led – the draft guidance said that assessment teams should be constituted of 50% patient-members;

- patient feedback into the process would be essential – a lot of work had gone into receiving patient feedback and incorporating it into the process. The OGC Gateway review of the project had been very positive on this point;
- the model should be piloted – the assessments had been piloted in 64 hospitals, and feedback had been very constructive; and
- concerns on cost – the Steering Group had been careful to ensure that the cost of such assessments was comparable to their predecessors, Patient Environment Action Teams.

JANE CUMMINGS invited NQB members to comment on the final model and provide their support to the role out of the model.

The following points were raised in discussion:

k. there was overwhelming support and endorsement for the work that had taken place since the NQB last discussed PLACE. The NQB's steers had been taken on board and real improvements had been made;
l. the argument that the model would be inappropriate for use in people's homes was accepted. However, this did not negate the need for some form of assurance that people were receiving the care they needed where they were resident in their own home. It would be expedient to roll out the model, understand how it was operating, and then consider whether with some adjustments it could be appropriate for use in people's homes;
m. if done properly, involving patients in the operation and oversight of health services takes time and attention. Issues such as time commitments and mobility needed to be considered. The model had been adjust to reflect these considerations – patient assessors were now asked to spend part or half days, rather than full days;
n. an outstanding issue had been whether patient assessors should undergo criminal records bureau checks prior to being included in an assessment team. There had been significant debate by the Steering Group on this issue, who were keen to balance the need to protect patients and support volunteers, with the desire to avoid additional burdens on individuals or organisations. There were also legal issues surrounding whether trusts could request enhanced checks from volunteers. A resolution had been reached and a form of words developed. The NQB felt that these words could be strengthened, making more explicit reference to the need for providers to take volunteer management seriously, and to take account of the wellbeing of patients, staff and volunteers in respect of such assessments;

o. other outstanding issues concerned remuneration and training of volunteers. In relation to the former, Jane Cummings would be issuing further guidance once consensus on a common policy had been reached amongst national NHS organisations. On the latter, the Department of Health would be leading on training for volunteers until 1 April 2013, after which it would be the responsibility of the NHS Commissioning Board;
p. there was the potential to align recruitment of volunteers with Healthwatch England's activity to develop patient networks; and
q. it would be important to evaluate the model and its impact on improving care at an appropriate point. 12-15 months following roll out was suggested.

BRUCE KEOGH thanked the PLACE Steering Group for its work, and for taking on board the NQB's steers so comprehensively. The NQB were supportive of the model and approach. The programme should come back to the NQB so that its evaluation could be considered in due course.

ITEM 5: NQB'S FORWARD WORK PROGRAMME FOR 2013

BRUCE KEOGH reminded members that David Nicholson had written outlining the on-going role and operation of the NQB, following the discussion at the last NQB meeting in September. The NQB now needed to think about where it might focus its work programme going forward. He asked Margaret Goose, Stephen Thornton and Hilary Chapman to outline some suggestions they had prepared to initiate the discussion.

The following points were made in discussion:

a. the Mid Staffordshire NHS Foundation Trust Public Inquiry was likely to be defining for the system, as a whole and the NQB would need to reflect on its findings and recommendations fully before determining its forward work programme;
b. the NQB needed to be disciplined in what it decided to focus on. It should identify a small number of focussed issues on which it could add value within its available resource and the powers at its disposal, which were limited. The NQB's value came from its ability to recommend actions to statutory organisation;
c. the new system was predicated on organisations working together in partnership, joining up to deliver a common purpose of improving quality and outcomes. The NQB should focus on those issues where it was uniquely placed to address;
d. the NQB's cross sector perspective, focussing on the NHS's boundaries with public health and social care made it an ideal forum to oversee action on those indicators which overlapped the NHS, Adult Social Care and Public Health Outcomes

Framework. Such indicators might include unplanned hospitalisations (NHS and adult social care interface) and preventing avoidable mortality (NHS and public health interface);

e. there were fundamental issues concerning older and vulnerable people which it may be useful for the NQB to focus on;
f. there was a potential role for the NQB around supporting services to deliver integrated care, focussed on patients' needs; and
g. there was merit in keeping the place and role of the NQB under discussion over coming months, as the Mid Staffordshire NHS Foundation Trust Public Inquiry played out.

BRUCE KEOGH thanked members for their contributions to discussions on the future work programme. Several useful and viable suggestions as to areas of focus had been made. He asked the Secretariat to consider these and come back with proposals to the next meeting of the NQB, in light of the soon to be published findings and recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

ITEM 6: GENERAL UPDATE

BRUCE KEOGH drew members attention to the general update on the NQB's existing work programme set out in NQB(12)(05)(03). This provided updates on final mandated indicators for 2012/13 Quality Accounts; the work of the NQB's Clinical Human Factors Sub-group; finalising the NQB's report, 'Quality in the new health system'; and establishing Quality Surveillance Groups.

The following points were raised in discussion:

h. on clinical human factors, the sub-group were seized of the need to ensure that their input led to tangible actions to embed a recognition of human factors in how the NHS operates;
i. on the NQB's report , 'Quality in the new health system', NQB members welcomed the intention to develop a plain English version for use by patients, lay participants and others; and
j. consideration was need as to the training that local Healthwatch representatives on Quality Surveillance Groups required to be most effective in their contributions.

Summing up the meeting, BRUCE KEOGH thanked members for their work and dedication throughout 2012. He thanked in particular Tim Kelsey and Lord Adebowale who had made a significant contribution to the discussion, debate and work of the NQB over the last three years. Given their appointments to the Board of the NHS Commissioning Board, they would be stepping down from the NQB as of January 2013.

The next meeting of the NQB was scheduled for 22 January 2013 in London.

NQB SECRETARIAT
17 DECEMBER 2012