

NQB (12) 3rd Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held at Department of Health, Skipton House,
Room 125A, 80 London Road, Elephant and Castle, London

Monday 11 June 2012

PRESENT		
David Nicholson (Chair)		
Bruce Keogh (Chair)		
Ian Cumming	Jo Williams	David Bennett
Christine Beasley	David Behan	Liam Donaldson
Andrew Dillon	Jackie Smith	Hilary Chapman
Ian Gilmore	Victor Adebawale	David Haslam
Margaret Goose		Don Breerton
APOLOGIES		
	Mike Rawlins	Sally Brearley
Niall Dickson	John Oldham	Allan Bowman
SECRETARIAT		
Peter Blythin (NQT)	John Stewart (DH)	Amanda Hutchinson (CQC)
Lauren Hughes (DH)	Jo Lenaghan (NQT)	James Ewing (GMC)
Agenda		
1. NHS Quest		
2. Seven day services in the NHS (Paper Ref: NQB (12)(03)(01))		
3. CQC strategic review (Paper Ref: NQB (12)(03)(02))		
4. Quality in the new health system (Paper Ref: NQB (12)(03)(03))		
5. The future role of the National Quality Board		

WELCOME AND INTRODUCTION

BRUCE KEOGH (Chair) welcomed members to the twentieth meeting of the National Quality Board (NQB) and the third meeting of 2012. He welcomed two new members to the Board: Jane Cumming, Chief Nursing Officer at the NHS Commissioning Board Authority; and Niall Dickson, Chief Executive of the General Medical Council. He explained that the NQB had been established in 2009 following *High Quality Care for All*, the final report of the NHS Next Stage Review, and included four constituencies: the Department of Health, statutory organisations who held levers for quality improvement, expert and lay members.

JANE CUMMING (Chief Nursing Officer, NHS Commissioning Board Authority) thanked Bruce Keogh for the introduction. She was pleased to join the NQB and to have been appointed to the position of Chief Nursing Officer. There was a lot of work to do in establishing the NHS Commissioning Board, preparing to drive improvement across the five domains of the NHS Outcomes Framework, and in leading the nursing profession, which had had a difficult time recently. She would be working closely with the Nursing and Care Quality Forum, and would soon be launching her vision for nursing, which would focus heavily on putting respect back into nursing.

NIALL DICKSON (Chief Executive, General Medical Council (GMC)) thanked the Board for a warm welcome. He was pleased that the GMC were now members of the NQB. The nature of regulation was changing. There needed to be closer working between organisational and professional regulators. The professional regulators needed to see themselves as part of the quality improvement architecture, rather than their role solely being to react when there were quality problems. He looked forward to working as part of the Board to capitalise on the opportunity to align professional regulation with the wider system.

ITEM 1: NHS QUEST

DAVID DALTON (Chief Executive, Salford Royal NHS Foundation Trust and Chair, NHS Quest) presented on the work of NHS Quest, a network of NHS foundation trusts who shared an interest in quality improvement. The network

was established in 2011 with the aim of improving the quality of care their organisations were providing and reducing the incidence of avoidable harm. Their mission was to promote excellence, and improve poor performance. They had found particular benefit in the spread of innovation between their organisations. The NHS was often slow and ineffective in taking up new innovations. Together, NHS Quest organisations were able to learn from each other, acting as an incubator and laboratory for ideas.

The network operated at all levels within the member organisations: the board and management came together, as did health and care professionals and managers at clinical service and ward level to share information and learning on quality and safety. They had several work streams through which the network was focussing on driving improvement: leadership networks, measurement, improvement programme and capability building.

BRUCE KEOGH invited board members to comment on the work of NHS Quest, particularly where the NQB could work with the network to pursue their shared objectives of improving quality across the system.

The following points were raised in discussion:

- a. it was encouraging to learn of such a network voluntarily establishing itself to focus primarily on quality. Networks such as NHS Quest played a vital role in the spread of good practice and innovation, and making quality improvement happen across the service. Such a model was likely to be more common in the future, as this would be how organisations would support improvement;
- b. organisations which received the most benefit from their NHS Quest membership were those who were able to distribute involvement throughout their teams. They needed to get buy-in from staff from the boardroom to the ward, and be prepared to demonstrate improvements. Chief Executives were benchmarking their organisations against each other, as were clinical teams at ward level;
- c. NHS Quest members had to qualify for membership by being high performing organisations on quality. There were questions as to whether

this was the right approach. It could be counterproductive to only include those organisations that were already high performing, rather than those that had demonstrated potential and willingness to improve;

- d. Board members were interested in the quality metrics that NHS Quest were using to monitor quality across the member organisations. These had evolved over time through a process of trial and elimination. NHS Quest had learnt a lot about the hierarchy of measures over the previous 12 months and the set of indicators had improved significantly. They sought to triangulate information from their own systems, as well as that which fed or was produced by CQC and Monitor. NHS Quest had found that indicators were most powerful and useful where they were clinically relevant at ward level;
- e. there was no explicit involvement of patients and service users in the work of the network, but to be high performing organisations, the members individually would need to be actively involving and engaging their patients in delivery of care. There was a sense amongst some NQB members that NHS Quest as a brand may be something that patients would benefit from being aware of, although this risked it becoming some form of accreditation or kite mark. There was work underway with NHS Choices to identify NHS Quest members on their pages on that website; and
- f. NHS Quest had decided not to impose its 'brand' on network members. Rather it provided support which wrapped around improvement activities already going on in member organisations.

DAVID DALTON thanked NQB members for the opportunity to discuss the work of NHS Quest. There were real opportunities for the board and the network to work together as they were pursuing the same agenda, at different ends of the geographic spectrum. There was, for example, a role for NHS Quest to test guidance, documents or approaches which the NQB were developing, sense checking them against the realities of the front line. The network was still relatively new and it would continue to evolve over time, with new members joining and increasing its areas of focus. They particularly wanted to strengthen the network's effectiveness at spreading and sustaining knowledge, innovation

and best practice. NHS Quest would continue to keep the NQB up to date on their activities.

ITEM 2: SEVEN DAY SERVICES

BRUCE KEOGH (NHS Medical Director, Department of Health and NHS Commissioning Board Authority) introduced the paper NQB(12)(03)(01) explaining that the NHS had fallen behind wider society and industry in terms of the level of service provision at weekends. In practice this meant that equipment and facilities went unused for 2.5 days per week, as full service levels tended to wind down from lunchtime on Fridays. BRUCE KEOGH had been working with the Royal Colleges and professional leaders across the system to develop a narrative making the case for seven day working in the NHS. Key to this was the relative mortality for different days of the week – mortality rates were 10% higher on Saturdays and 11% higher on Sundays, compared to weekdays. Similarly there was evidence that five day working was detrimental to training, as junior doctors were not being trained at weekends.

MIKE RAWLINS (Chair, NICE) said that he had chaired a meeting of clinicians and Royal Colleges were there had been widespread support for the focus on seven day working. However, there was also recognition that making it happen would be difficult, with various barriers standing in the way, relating to contracts, workforce relations, financial considerations and support for training. NHS London were leading the way in systematically looking at overcoming these issues. The resounding conclusions were that there was no single national action that could be taken to make seven day services a reality. It would need system-wide efforts by various different organisations around the NQB table and beyond.

BRUCE KEOGH asked that the NQB endorsed the proposal that the NHS should focus on moving to delivering the same level of services to patients seven days a week.

The following points were made in discussion:

- g. a seven day service model in the NHS was fundamental to the true realisation of high quality care for all patients and service users. Until it became a reality, care would not be of the highest clinical effectiveness, as safe as possible and offer as positive an experience for patients as possible, regardless of when an individual presented at hospital. Whilst there were also valid efficiency arguments, quality had to be the primary reason for a push towards seven day services;
- h. if other industries were able to deliver seven day services, then it ought to be achievable in healthcare. The primary barrier would be the mindset of the system, its organisations and individual professionals. To overcome a reluctant or pessimistic mindset, it would be necessary to create a sense of discomfort with the status quo. This could be driven by Health and Wellbeing Boards and local Healthwatch demanding such provision for their communities;
- i. medical trainees and nurses held things together overnight in acute settings. To progress seven day working, there would need to be examination of the concept of 'on-call' and what it entailed. High quality, reliable and accessible community and primary care services would need to be available out of hours for the model to be effective;
- j. the European Working Time Directive (EWTD) was a significant constraint on being able to resource seven day services, particularly concerning junior doctor time. There was evidence that it was having an adverse impact on patient safety and on the quality of training for junior doctors. More senior, long-serving doctors had become accustomed to working five days per week, usually Monday to Friday. There was an opportunity to re-programme the profession with seven day working becoming the norm, if EWTD barriers could be overcome;
- k. staffing issues arose as a result of the increasing trend towards specialism amongst the medical profession. Clinicians had tended to become very specialised which was not conducive to a seven day model. More generalists would be essential to make the system work and post-graduate medical education needed to support this. Professor David Greenaway's review of post graduate medical education in the UK would look to address this issue;

- l. whilst there were effectiveness arguments, the affordability and cost implications would need to be carefully considered; and
- m. communication with patients and service users would be essential if this agenda was to be progressed publicly. There needed to be careful consideration as to how expectations would be raised, and whether these could actually be met. Part of the solution to poorer quality care at weekends may be education of service users so that they understood what they could expect, for example, if they presented on a Friday afternoon.

DAVID DALTON (Chief Executive, Salford Royal) was asked to set out his experiences of tackling these issues in his organisation. He reported that at his trust, they had calculated that they could save 50 lives per annum if their mortality rates were the same at weekends as during the week, and that they would need 30 fewer beds if their length of stay were the same. NHS Quest would relish the opportunity to work with the NQB on this agenda. They would consider what levers might be effective at driving a shift in approach, such as tariff, or CQUIN. It would be essential to include primary care as part of any strategy if seven day services were to become a reality.

BRUCE KEOGH thanked members for their contributions and David Dalton for adding his personal experience of the issues. Summing up the discussion he was clear that there was resounding support amongst NQB members for the drive to make the NHS a seven day service.

ITEM 3: THE CQC'S STRATEGIC REVIEW

The NQB were joined by several Care Quality Commission (CQC) board members for this item: John Hayward, Kay Sheldon, Martin Marshall and Jill Finney. JO WILLIAMS (Chair, CQC) introduced the paper (NQB(12)(03)(02)). The CQC had been established for three years and had been the subject of significant media and political attention ever since. The Department of Health had published a capability review of the organisation recently and the CQC were now undertaking a strategic review to ensure that it was able to meet the challenges it would face in coming years. The strategic review process included

widespread engagement with stakeholders and JO WILLIAMS was clear that the NQB were a critical part of that, given the breadth of views from across the system that were represented on the Board. She set out a number of questions which were being used as part of the review, and sought NQB members' views.

The following points were raised in discussion:

- n. there was a public perception that the CQC was a safety net and so it was inevitable that there was criticism when poor quality provision slipped through that net. The CQC therefore had a mammoth task. It was only feasible and practical that they took a risk-based approach, and so it had to communicate this with the public;
- o. the CQC needed to rebuild its reputation amongst the public. To do this, it would be vital for the CQC to be seen as completely independent from politicians, Government and the system. It would need to be clear as to what it was there to do and what it was not, and do more to explain the concept of risk in the system;
- p. it was possible that the CQC received such attention from the public and media as a result of service users finding it difficult to seek and receive redress. The complaints system was complex and difficult to navigate and so people expected that they could approach the CQC. However, the CQC did not have a role in dealing with complaints and providing redress, rather they used this information to steer their inspections. It would be key for the CQC to be clear as to their role in complaints, and for other parts of the system such as Healthwatch and patients' associations to become more visible as patient advocates and champions;
- q. whilst the CQC needed to be separate from the system, it could not fulfil its responsibilities without working with the rest of the system. Other organisations had different information and intelligence which would be vital in allowing the CQC to take a risk-based approach;
- r. there was a need to better align the systems of professional regulation and organisational regulation. The relationships between regulators were crucial in having an effective overall system of regulation with risk appropriately distributed. It should be recognised that on the whole,

where there was quality failure, there also tended to be professional failure;

- s. there was a question as to whether CQC should only focus on maintaining the essential standards of quality and safety, rather than also seeking to have a role in quality improvement over and above those essential standards. Where the CQC could be adding further value was to seek to raise the quality bar, making the aspirational standards of today the essential standards tomorrow;
- t. CQC could legitimately and usefully add value in respect of driving improvement by highlighting where they saw good practice. However it would be essential to be absolutely clear as to where overall responsibility for quality improvement would lie in the new system;
- u. it was suggested that the essential levels of quality and safety could include a requirement that providers actively sought to drive continuous quality improvement, and had processes in place to demonstrate this;
- v. information on the CQC's website was not felt to be consumer friendly. It was not easy to navigate and did not offer an easily understandable account of the quality of care in a particular provider, both in the health and care sectors; and
- w. the CQC were conscious that they were not methodical enough in evaluating the impact of their regulatory activities. They would be focussing on such evaluation over the following 18 months.

JO WILLIAMS thanked NQB members for the opportunity to consult with them as part of their strategic review process. They would be publishing their review document for public consultation in coming months.

ITEM 4: QUALITY IN THE NEW HEALTH SYSTEM

IAN CUMMING introduced paper NQB(12)(03)(03) which updated Board members on progress in taking forward its review of how quality would operate in the new health system. He explained that a draft report was attached to the paper, which following NQB member comments, would be published in draft over the summer. It was intended that it would be published in draft so that a final

version could be developed to take account of any relevant findings from the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Ian Cumming explained that two further documents would be developed and published alongside the NQB's final report: a version which would be relevant to patients and the public, and a version condensed for staff at the front line. He also highlighted that Health Education England and the National Institute for Health and Clinical Excellence would need to be included in the version of the report that would be published.

The following points were raised in discussion:

- x. the document was felt to provide a clear account of the distinct roles and responsibilities of the organisations it covered in relation to quality, although at present it was felt to be too acute focussed. There was a need to sense check it to ensure that the model it described was relevant in a primary care context;
- y. there needed to be clarity as to the scope of the model that the report was describing, particularly in terms of how far it would apply in the social care sector;
- z. the tone of the document in parts implied that patients were a passive actor in the system. The narrative needed to bring alive the active role patients would have in the new system, and how this could contribute to improving quality;
- aa. the current narrative focussed on transparency and the benefit it could bring to the system in maintaining and improving quality. This should be explained further as requiring candour – it was essential that different parts of the system were frank and honest with each other in discussing information and concerns on quality;
- bb. there were various important bilateral relationships in the system which could be specifically highlighted and explained, such as those between CQC and Monitor on regulating for quality, the NHS Trust Development Authority and Monitor on regulating NHS trusts, and the NHS Commissioning Board and Monitor on tariff;

- cc. the role of governors was crucial, and needed to be better explained, particularly in relation to its role in respect of the leadership of provider organisations;
- dd. there was a gap in the report concerning how performance management of primary care would operate in the new system. This may not have been determined yet, but that needed to be made clear;
- ee. the role of the professional regulators was well defined but it did not clearly link back to the rest of the system. It needed to be absolutely clear how the regulation of professionals related to the regulation of organisations;
- ff. it would be useful for patients and their representatives to have access to the information that commissioners and regulators should look at to make judgements on risk in the system. The final document would include a table setting out what information and actions each part of the system had at its disposal, by way of a 'toolbox' for quality in the NHS;
- gg. consideration needed to be given to how the patient voice was heard by the Quality Surveillance Groups. Health and Wellbeing Boards would have links to these groups, and Healthwatch would be members of both. Further options included feeding web 'chatter' about providers into discussions;
- hh. there were questions that needed to be worked through concerning how and to what extent the discussions and conclusions of Quality Surveillance Groups were captured, and whether they would be made public. There was a balance to strike between transparency and facilitating a full and frank discussion; and
- ii. focussed and effective work was needed to promote awareness and drive implementation of the model that the NQB would describe in its published report.

Summing up the discussion, DAVID NICHOLSON (Chair) concluded that:

- jj. the operation of primary care needed to be better reflected in the NQB's report, including the interactions between CCGs, the NHS Commissioning Board and primary care providers;

- kk. an implementation plan needed to be developed including actions by all relevant statutory members of the Board who had been involved in developing the report; and
- ll. the report should be updated in line with comments from members and recirculated for final sign off.

ITEM 4: THE FUTURE ROLE OF THE NATIONAL QUALITY BOARD

JOHN STEWART (NQB Secretariat) presented to the Board on the future role of the National Quality Board. He explained that the Board had been in operation since 2009 and had achieved a significant amount in that time. It had been effective where it had sought to align actions of different parts of the system so as to best drive and enable improvements in quality. It had perhaps been less effective at providing external-facing leadership for quality, which had been one of its original objectives. However there were questions as to whether this was an area in which the Board could add value.

There were several questions which the Board would need to think about in working through where it should fit, and on what it should focus, in the new health and care system, including:

- What should the Board's scope be going forward - NHS, social care and public health?
- What about its purpose, should it be less advisory and more 'getting on with the task of system alignment for quality' through identifying shared goals and following through on agreed actions?
- Is the concept of 'pooled sovereignty' helpful and worth holding on to?
- How might the Board's membership need to change? Should it include new national bodies, CCGs and Local Government?
- What role should the Department of Health play on the Board?

The discussion that would be had at the NQB meeting would be the beginning of a wider discussion on mechanisms for bringing the system together. Once initial ideas had been raised, the Secretariat would consult with NQB members individually with a view to bringing proposals back to the NQB's September meeting.

The following points were made in discussion:

- mm. the Board would need to be clear in future about what it wanted to achieve, and then challenge itself to achieve those objectives and add value to the system in doing so. It could not be allowed to be a 'talking shop';
- nn. the key question which should be answered was where the NQB could uniquely add value to the system, given that it operated above organisational interests;
- oo. the NQB was not best placed to ensure operational effectiveness of the system. This was the place of the statutory members of the Board, who had statutory responsibility for such actions. Rather the Board could advise on operational effectiveness, based on members' experience and evidence;
- pp. there was a question as to whether the Board in the new system would advise Ministers or the NHS Commissioning Board. The NHS Commissioning Board was itself only one member of the NQB. The NQB could have a role in advising any or all of its member organisations;
- qq. seeking views from stakeholders external to the NQB and its member organisations may provide insight into where the Board could best add value; and
- rr. it would be important that the Board in the new system fully undertook its responsibilities in relation to the boundary between health and social care. It was uniquely placed to support the joining up of the sectors.

Summing up the discussion, DAVID NICHOLSON (Chair) reflected that when the NQB was originally created it was designed to provide a forum in which organisations could come together to consider issues of quality, with other perspectives being included in the discussion. This model seemed to be more relevant in the new system than ever before. The challenge going forward would be in enabling the Board to have more impact in the system and allowing it to adapt its focus away from acute care, and towards the major challenges facing the system, such as managing long term conditions and joining up health and social care. These challenges would have an impact on the membership of the

NQB, which needed consideration. The Secretariat would meet with members individually and come back to the September meeting with proposals.

ANY OTHER BUSINESS

DAVID NICHOLSON (Chair) invited members to raise any other business.

MARGARET GOOSE highlighted that there was concern that various agendas were being pursued by the DH and other parts of the system that might not be aligned: the information strategy, patient choice, personal budgets and policy on making 'no decision about me without me' a reality.

DAVID NICHOLSON tasked the NHS Commissioning Board Authority with considering the issues, and coming back to the NQB in due course with recommendations.

The next meeting of the Board would be on 4 September 2012, in the CQC's offices in London.