NATIONAL QUALITY BOARD

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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	Victor Adebowale	Ian Cumming
Jo Williams	Stephen Thornton	Sally Brearley	Katerina Kolyra
Mike Rawlins	Hilary Chapman	Don Brereton	Niall Dickson
David Bennett	Allan Bowman	Tim Kelsey	David Flory
Ian Gilmore	John Oldham	Margaret Goose	
IN ATTENDANCE			
Stephen Moss	Jane Reid	Bryn Baxendale	Gavin Larner
APOLOGIES			
David Nicholson	Una O'Brien	Jackie Smith	
SECRETARIAT			
Lauren Hughes (DH)	Peter Blythin (NQT)	Toby Lambert (Monitor)	Amanda Hutchinson (CQC)
Sapphire Wright (NHSCBA)	Brendan Gage (GMC)		

Agenda

1. Welcome and Introduction
2. Clinical Human Factors
3. General Update (Paper Ref: NQB (12)(04)(01))
4. Looking ahead to the Francis Inquiry
5. Role of the NQB in the new system (Paper Ref: NQB (12)(04)(02))

ITEM 1: WELCOME AND INTRODUCTION

BRUCE KEOGH (Medical Director, NHS Commissioning Board Authority and Department of Health) welcomed members to the twenty first meeting of the National Quality Board. He welcomed David Flory (Chief Executive, NHS Trust Development Authority) to his first meeting, and Ian Cumming to his first meeting as Chief Executive of Health Education England.

ITEM 2: CLINICAL HUMAN FACTORS

BRUCE KEOGH (Medical Director, NHS) welcomed Stephen Moss (Chair of the DH Human Factors Reference Group) to the meeting and invited him and his colleagues, Professor Jane Reid and Professor Bryn Baxendale, to present to the Board on the subject of Clinical Human Factors and the work of the reference group. A report from the DH Human Factors Reference Group had been circulated to members for information.

STEPHEN MOSS explained that there were various definitions of Clinical Human Factors (CHFs) but on the whole they related to the recognition that there were certain problems, mistakes and difficulties in health care which arose as a result of human tendency and error. Most things that went wrong in the system were basic failures and often predictable (for example, failure to follow a standard process). These mistakes could be caused by factors such as the working environment, working conditions or extreme pressure and stress being felt by staff. This school of thinking advocated the development and implementation of high quality and reliable systems which took into account how humans related to their working environment and helped to improve this interaction with a view to improving quality and safety.

Several key factors had been missing, preventing CHFs from being successfully applied in the NHS. For example, a lack of professional leadership and engagement with CHFs; an absence of a common language and understanding of CHFs; no system-wide acknowledgement and drive for integrating CHFs; and minimal preparatory professional education and continuous professional development.

It was felt that the time was right to place more emphasis and focus on CHFs for several reasons. Firstly, there was a rich evidence and ‘best practice’ base on which to build, along with a better appreciation of standardisation in practice. Secondly, there was a commitment amongst professionals to taking this forward, along with a professional and political imperative to make it happen. Thirdly, there was stakeholder and expert interest. Finally,

there were significant opportunities to embed CHFs within the modernised NHS, alongside other changes that were taking place.

BRUCE KEOGH (Medical Director, NHS) thanked Stephen Moss and his team for the presentation and invited the Board to comment. The following points were made in discussion:

a. the work on CHFs was welcomed and commended. By connecting the evidence base with systems improvement methodology and an understanding and foundation in CHFs, there was an opportunity to improve outcomes for people using services;
b. the NHS was a complex system and there were some difficult issues at work, such as the changing structure and financial challenges, but there was a need to do something about CHFs. The organisations represented on the NQB were capable of taking this forward and pursuing coordinated and aligned action;
c. the NQB's final report on 'Quality in the new health system' could include reflections on the impact of human factors on the quality of care provided and what organisations on the NQB would be doing to minimise such impacts. Similarly, the agenda needed to be taken forward in the context of the forthcoming final report from the Mid Staffordshire NHS Foundation Trust Public Inquiry and in work across the professions to improve professionalism and the quality of care;
d. human error could often be a result of pressure and distraction, which the working environment needed to recognise, and staff needed to be supported to manage. There should be a challenge to NQB members as to what extent their actions were placing needless pressure on the system and on individuals and teams;
e. recognising the impact of CHFs should be part of the business as usual of self-improving clinical teams – they should be regularly asking questions of themselves about why things were working well or otherwise and how their actions and behaviour could have an impact;
f. there was a role for the CQC to look at the implication of CHFs in its regulatory activity, including its monitoring and compliance;
g. NICE had been aware of CHFs, but had not yet determined how its work could address the issues. Now was the time to look at where NICE could make a difference, for example, in developing its clinical guidelines;
h. the need for standardisation of equipment and procurement was essential – there were some basic steps which could be taken to design out CHFs, and which should be universal across the service; and
i. individual patients were the one consistent factor in their care pathway and they could be better empowered and involved in ensuring the care they received was

appropriate and correct. For this to happen it was important that patients were well informed about what they should expect from those providing care. Patients' organisations would be able to advise on how best to pursue such an approach.

BRUCE KEOGH (Medical Director, NHS) thanked members for their contributions to the discussion. In summing up, he concluded that:

j. there was widespread support from the NQB for pursuing work around clinical human factors. It was an important area, with a real potential impact on patients, which needed to be addressed;
k. there were several organisations who had indicated that their functions could be better utilised to reflect the impact of human factors on quality and they were keen to look into the area further; and
l. to support them in doing so, a sub group of the NQB would be set up to collectively determine and coordinate action. It would be chaired by Mike Rawlins (Chair of NICE) and would look to agree a set of actions that various organisations would take to pursue this agenda. This could form part of the system's response to the Mid Staffordshire Public Inquiry.

ITEM 3: GENERAL UPDATE

Introducing paper (12)(04)(01), BRUCE KEOGH explained that the paper had been circulated for information and invited questions and comments from the Board.

The following points were raised in discussion:

m. there was a need for better follow through on issues previously discussed and actions previously agreed by the NQB. For example, the Board had previously agreed that there should be a patient version of the NQB's 'Quality in the new health system' draft report, yet the Board had no way of knowing whether this action had been completed. This was being progressed and would be published once the Board's report was updated and finalised. However, more generally the NQB could benefit from more systematic updates on actions that it had previously agreed;
n. in the NQB's recently published report on 'Quality in the new health system', more needed to be done to communicate it with clinical commissioning groups. There were other channels which the NQB could pursue which would be more effective than the bulletins that had already been used;
o. on Quality Accounts, it would be helpful to have the 'mandatory indicators' broken down by type of Trust (e.g. Acute, Mental Health, Ambulance etc.). There was a

question as to whether publication of data against mortality indicators for Mental Health Trusts should be obligatory;

p. on quality standards, the NQB was pleased that NICE were actively seeking to join up efforts around health and social care wherever possible. In terms of the search facilities that would be on the NICE website, it would be important that one of the criteria was for patients and the public or their representatives. It would also be useful to see quality standards as they were completed and published. There had been previous discussions about quality standards on the topic of experience of care for children and young people. This was on the radar for NICE but had not yet been taken forward; and

q. in the 'Social Care Provider Quality Profiles' section of the paper there was reference to a tool which would 'help people access simple information online to help them compare care providers across England'. It was noted that there was an online system being launched in October 2012 called 'Find Me Good Care', which would fulfil a similar function. It would be important to ensure that there was no duplication of actions across the system.

Summing up the discussion, BRUCE KEOGH concluded that work was progressing well on various fronts. Once the NQB's role in the new system was determined, it may be sensible for the NQB to receive more detailed programme-style updates on progress against the actions it had agreed at previous meetings so that it could ensure that these were being followed through.

ITEM 4: LOOKING AHEAD TO FRANCIS

BRUCE KEOGH (Medical Director, NHS) invited Gavin Larner (Director, Professional Standards, Department of Health) to present to the Board on likely issues that would arise with the publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

GAVIN LARNER explained that the Francis report was expected to present a wide ranging critique of the health service, including issues around the patient voice, trust governance, clinical governance, roles of the Primary Care Trusts, Strategic Health Authorities, regulators and the Department of Health and on the culture within the management community, nursing, commissioning and of the NHS as a whole.

The system's response to the report would be an important test of how the statutory bodies would interact with each other and externally under likely intense scrutiny, pressure and media spotlight. The response would need to be coherent, aligned and demonstrate that the system recognised what had gone wrong and was working together to improve in the new architecture, with a shared set of values and a common purpose.

In discussion, the following points were made:

r. it was noted that establishment of the NQB post-dated the events at Mid Staffordshire, and there was an acknowledgement that whilst there had been significant improvements in the system since the serious failings took place, there was still a long way to go and much more work to do;

s. it was suggested that the system's response to the report should be measured, circumspect, compassionate and humble. It was important that the Board was able to demonstrate leadership in this. There needed to be explicit establishment of a common purpose and shared set of values and goals, focussing on patients and their carers. There was perhaps a need for a statement from the NQB, on behalf of the system, which captured these sentiments;

t. it was possible to learn from good practice as well as bad. Whilst cases such as Mid Staffs were shocking and unacceptable, they were in the minority. There was a vast amount of good work and best practice taking place in the NHS which needed to be highlighted and shared;

u. the lines of questioning that the Public Inquiry had taken during its oral evidence sessions had changed over time from 'who did what wrong' to 'what was the culture in the system that allowed this to happen.' It was therefore likely that culture would form a significant part of the report;

v. changing 'culture' was difficult and complex, as it was by definition a nebulous and intangible factor. The levers around cultural change were not obvious and at a national level there were no longer the top down levers to enact this sort of change. Consideration should be given to the ambition, capability and process of enacting cultural change and what organisations represented on the NQB could do in respect of each of these;

w. whilst it was difficult, it was possible to change practice, for example, the successful adoption of VTE assessment as standard practice on admission to hospital. However, there was evidence that just because an organisation did VTE well did not necessarily mean it had a good culture. It was therefore important to draw a distinction between good practice and good culture;

x. there was a need for high quality leadership in the new system that would drive the change in culture. There was a question as to whether the Medical Directors could take a more central role in driving improvement and a change in culture across the system; and
y. there was a need to empower and enable staff to stand by their personal and professional values. Staff in the health service should feel valued and included, not alienated by nor distant from their organisations. It was suggested that a narrative was developed for staff in order to help them understand how they would fit into the new system and what their role and contribution would be to delivering high quality and safe care for patients. It was suggested that the Board had a collective responsibility to make things simple and straightforward for those who provide care and could take the lead in developing such a narrative.

BRUCE KEOGH (Medical Director, NHS) thanked members for their contributions to the discussion. It was agreed that Gavin Larner would reflect on the discussion and would take forward the actions that the NQB had suggested, including a narrative for NHS staff to coincide with publication of the Public Inquiry's report and potentially a system-wide joint statement.

ITEM 5: ROLE OF THE NQB IN THE NEW SYSTEM

BRUCE KEOGH (Medical Director, NHS) invited Lauren Hughes (NQB Secretariat, Department of Health) to present paper NQB (12)(04)(02).

LAUREN HUGHES introduced the paper and explained that it had been informed by the views of Board members following individual meetings with them. The paper provided a summary of views that NQB members had expressed and set out a proposition as to where the Board should sit within the new health system from April 2013.

The following points where raised in discussion:

z. the NQB's unique benefit was that it brought together the leaders of the statutory organisations responsible for the quality of care in the NHS, alongside lay and expert members, to drive forward issues relating to quality and to ensure that their actions were aligned. It was vital that this role was maintained and strengthened in the new system;
aa. the Board had been valuable in focussing organisations on quality issues. Whilst the Board had made significant progress and was continuing to do so, there was more

work to do. The NQB were keen to reignite work on live issues of quality as soon as possible. Sub-groups should be established as task and finish groups wherever possible, whilst care should be taken to avoid establishing a multitude of standing committees;

bb. the Board should be more proactive and forward thinking, not just considering issues such as early warning signs of poor quality. Rather it should seek out opportunities to drive changes and improvements in quality;

cc. there was confusion as to how the Board could be advisory and operational, yet not executive, in nature. The Board was not intended to be an operational body, rather it was best placed to advise the different parts of the system represented on the Board, and Ministers and Government if necessary. More consideration as to the Board's core purpose was needed;

dd. the NQB was unusual in that it was not part of a hierarchy or bureaucracy but instead brought together different levels of experience and areas of expertise within the system. The Board therefore did not feel it was necessary for the NQB to be attributed to have accountability to any other group;

ee. on membership, the Board currently included a mixture of chairs and chief executives of statutory organisations. It was felt to work well in its current format and with current membership;

ff. there was consideration as to whether providers should be represented on the Board. There was concern that if the organisations that regulators were trying to regulate were included, it might create a different dynamic. However, it was essential that the provider point of view was represented and it had worked well with that mechanism being through expert membership. This approach should continue;

gg. there was a question as to whether Clinical Commissioning Groups should be represented on the Board. They would be collectively represented by the NHS Commissioning Board. It was suggested that a Clinical Commissioning Group representative could be an expert member and it was noted that Healthwatch should be represented individually and independently on the Board; and

hh. the issue of who should chair the Board was yet to be agreed.

BRUCE KEOGH (Medical Director, NHS) thanked members for their contributions to the discussions. In summing up, he concluded that:

ii. the Secretariat should bring back proposals on two areas: a) the Board's membership, reflecting the new system; and b) how it could be more consistent in its follow through on actions;

jj. there was a need to articulate a clear purpose for the Board, which focussed on where it could add value through its work programme; and

kk. there were several issues on which there was demand for the Board to take forward cross-system work. These should be socialised with the Board and, where there was interest from members, taken forward.

The next meeting was in the process of being rescheduled. Members were keen that meetings were held in London as far as possible. The next confirmed meeting was on 3 December 2012, in London.

NQB SECRETARIAT
SEPTEMBER 2012