**NQB (13) 3rd Meeting**

# NATIONAL QUALITY BOARD

**MINUTES** of a meeting held at MWB, 10 Greycoat Place, Victoria, London, SW1P 1SB

**Tuesday 16 July 2013, 13:00 – 16:00**

| PRESENT | | | |
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| David Nicholson (Chair) | | | |
| Jane Cummings | David Haslam | David Behan | Sally Brearley |
| Ian Cumming | Anna Bradley | Don Brereton | Emma Westcott |
| Tony Lambert | Hilary Chapman | Una O'Brien | Julie Mellor |
| Andrea Sutcliffe | John Oldham | Margaret Goose | Stephen Thornton |
| Philip King | Niall Dickson | | |
| IN ATTENDANCE | | | |
| Dame Carol Black | Richard Arnold | Jennifer Benjamin | |
| APOLOGIES | | | |
| Bruce Keogh | David Bennett | Jackie Smith | Duncan Selbie |
| Sally Davies | Ian Gilmore | David Flory | |
| SECRETARIAT | | | |
| John Stewart (NHS England) | Lauren Hughes (NHS England) | Sally Chapman (NHS England) | Amanda Hutchinson (CQC) |
| James Ewing (GMC) | Gina Naguib-Roberts (NHS TDA) | | |

Agenda

1. Welcome, context and purpose
2. Role and work programme of the NQB 2013-14 and 2014-15 (Paper Ref: NQB(13)(03)(01)
3. System-wide recommendations from the Mortality Review
4. Health and wellbeing of NHS staff (Paper Ref: NQB(13)(03)(02)
5. General update (Paper Ref: NQB(13)(03)(03)
6. Any other business

**ITEM 1: WELCOME AND INTRODUCTION**

DAVID NICHOLSON (Chair) welcomed members to the twenty fifth meeting of the National Quality Board (NQB). He also welcomed Emma Westcott attending for Jackie Smith at the Nursing and Midwifery Council, Toby Lambert attending for David Bennett at Monitor, and Philip King from the Care Quality Commission.

DAVID NICHOLSON (Chair) informed members that Professor Sir Bruce Keogh (Medical Director, NHS England) was unable to attend the meeting as he was that day publishing his *Review into the quality of care and treatment provided by 14 hospital trusts in England*. The publication of this report was significant both for the NHS and for all those interested in improving quality in the system and was a necessary, if difficult, step towards ensuring transparency and quality in the system.

In Bruce Keogh's absence, John Stewart (NHS England) would update members on the review and the key ambitions set out in the report later on in the agenda.

**ITEM 2: ROLE AND WORK PROGRAMME OF THE NQB 2013-14 AND 2014-15**

DAVID NICHOLSON (Chair) set out that now the Francis Inquiry had reported and the implications for the quality architecture were known, it was time for NQB members, many of whom were senior representatives of the statutory organisations with a responsibility for improving quality in the NHS, to discuss and agree the future work programme.

DAVID NICHOLSON (Chair) acknowledged that the paper, NQB(13)(03)(01), produced by the Secretariat to support the NQB in clarifying its role, scope and work programme for the next two years (2013/14 and 2014/15) focused predominantly on the NQB's alignment role. It was recognised that alignment should remain a continual focus for the Board as continual change within the health and care system was inevitable.

DAVID NICHOLSON (Chair) invited the Board to comment. The following points were made in discussion:

a) the paper was very helpful in consolidating the Board's earlier work and future opportunities for alignment;
b) in the absence of a system leader and a rapidly changing political atmosphere, there was a real requirement for a forum such as the NQB to facilitate alignment between organisations. It provided an environment of transparency and openness where

organisations could work together for improvement and accountability. The Board could provide a safe space in which tensions could be ironed out;

c) the NQB could examine how well the system was working and reflect on how well quality is being achieved in the round. It should provide leadership to the system and oversight of progress against the areas it originally initiated;
d) the NQB also had a role in establishing enthusiasm, optimization and ambition for the quality agenda, rather than just focusing on the bottom end of the quality curve, by establishing best and innovative practice and promoting this to the system. The 'flow work' in Sheffield was cited as an example;
e) the Board should consider what it can uniquely deliver in the next 6-12 months, for example, what was learnt about what good looks like in relation to the Keogh Mortality Review ambitions. There should be a single way of showcasing these examples to bring quality to life and allow recognition of the good work delivered by the NHS;
f) a national overview of Quality Surveillance Groups (QSGs) was required, bringing together themes, trends and guidance on how QSGs are fulfilling their roles;
g) the requirement for lay and expert members on the sub-groups was highlighted in providing a challenge function to the statutory organisation, in addition to the benefits of including patient organisations to provide both a patient perspective and to utilize their experience and relationship with clinicians to facilitate communication with this group;
h) Health Education England should be represented on the 'aligning quality architecture' work stream;
i) the work on patient experience needs to link in with the work being undertaken by Neil Churchill (Director of Patient Experience, NHS England); and
j) the social care lead in the Ombudsman should be involved in the work programme as appropriate.

DAVID NICHOLSON (Chair) thanked members for their contributions and summing up the discussion concluded that:

- the themes proposed as part of the NQB's ongoing work programme had been accepted. These should be taken forward by the Secretariat, bringing together organsiations and NQB members as appropriate;
- work was already underway to review Quality Surveillance Groups, however consideration was required as to whether and how national oversight might be provided, for example, with updates being brought to the NQB two or three times per year, or through a National QSG;

- patient safety would be considered in more detail once Professor Don Berwick had published the recommendations of his review. The links between patient safety and the health and wellbeing of NHS staff would be resonant in this work; and
- there could be real value in the NQB seeking to extol examples of excellence across the NHS in respect of quality, perhaps taking the eight Keogh ambitions and promoting examples of good practice against each.

**ITEM 3: SYSTEM-WIDE RECOMMENDATIONS FROM THE MORTALITY REVIEW**

DAVID NICHOLSON (Chair) invited JOHN STEWART (NHS England) to update members on the Bruce Keogh's *Review into the quality of care and treatment provided by 14 hospital trusts in England,* published that day.

JOHN STEWART (NHS England) informed members that in February 2013, the Prime Minister and Secretary of State for Health had asked Bruce Keogh to review the quality of care and treatment provided by hospital trusts with persistently high mortality rates, following the high mortality rates at Mid Staffordshire and associated links with failures in clinical effectiveness, patient experience, and safety, and professionalism, leadership and governance.

Fourteen trusts had been selected for review on the basis that they had been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Ten outliers were identified through SHMI and five through HSMR, with only Blackpool hospital trust appearing on both lists. It was acknowledged that this was a relatively unsophisticated way of selecting the hospital trusts to be reviewed and that the Care Quality Commission was developing a more comprehensive approach to risk assessing providers for inspection.

There were three stages to the review process:

- Stage 1: gathering and conducting analysis of a broad range of hard data and soft intelligence held by different parts of the system. The data packs produced helped to identify key lines of enquiry and allowed the teams to ask penetrating questions and focus on key areas of concern during the site visits.
- Stage 2: multidisciplinary review teams conduced both planned and unannounced site visits. The review teams comprised 15-20 members, including patient and lay representatives, senior clinicians, junior doctors, student nurses and senior

managers. The diverse composition of the teams was key in identifying the real range of issues. The rapid response review teams were in situ for two or three days depending on the multi-sites of the trust. Significant importance was placed upon the insight gained from staff, patients and those representing the local population, for example, clinical commissioning groups and Members of Parliament, with the use of patient and staff focus groups being most powerful allowing cultural assessment to be made.

- Stage 3: on completion of the reviews a meeting of all involved statutory parties was convened, based on the Risk Summit model, for the system to agree a coordinated plan of action and support with each trust to accelerate improvement.

JOHN STEWART (NHS England) informed members that the overall picture obtained was a spectrum of mediocrity, a lack of ambition and a failure to understand the need to involve staff and patients. Board capability was also an issue, in particular, , understanding data on quality and using it to drive improvement. There was also a lack of support, engagement and empowerment of frontline junior doctors and nurses in many organisations.

Rather than making a set of recommendations, Professor Sir Bruce Keogh had felt it important to describe achievable ambitions under which were a set of actions which sought to tackle the underlying causes of poor care.

DAVID NICHOLSON (Chair) asked NQB members to reflect on the findings of the review consider how the statutory organisations represented on the NQB could support action to bring about this necessary change.

The following points were raised in discussion:

k) the report was recognised as an astonishingly good piece of work undertaken in a considerably short time frame and should be seen in the context of the forthcoming Berwick report on patient safety;

l) a considerable amount could be learnt from the process followed by the Review Team and there were key lessons for CQC in taking forward its role in regulating health and care providers;

m) there was a strong sense that undertaking such a review incurred risks, and there was a profound interest in ensuring that the demand for public clarity and honesty was met, whilst building confidence and trust in the NHS;

n) there were concerns that there was a real risk of dislocation if there continued to be comparisons made between those trusts examined by the Keogh review and Mid Staffordshire NHS Foundation Trust;
o) a powerful message contained within the report was to listen to, and ask, the view of patients, carers and members of the public when assessing the quality of care being provided. This lesson must be learned as the new CQC inspection regime is developed;
p) the Keogh report had included an action around producing guidance to support nursing staffing. It was thought that the publication of a 'How to' guide on getting staffing right for nursing would be more powerful and meaningful if endorsed by the NQB and would be a strong example of alignment. NHS England had been working with NICE on the development of this guide, which was one of the actions included in Compassion in Practice;
q) there was currently a real issue with low staff morale in the NHS, and the need to recognise and promote the important work being carried out by NHS staff was highlighted. Improved morale was in the interests of patient care, given the identified links between staff morale and the quality of care received;
r) the need to reflect on how to balance the need to call Risk Summits whenever a health economy felt necessary, with the need to avoid diluting their impact by having too many, as well as the fact that they are operating within a sensitive environment should be considered; and
s) balance was also important in the review of the hospital complaints system (in line with ambition 3), the language used needed to be considered carefully to allow feedback that supported improvement.

Summing up the discussion, DAVID NICHOLSON (Chair) concluded that the Keogh Review process had added incredible value both in terms of improving the quality of care provided by the 14 organisations, but also in terms of the learning that had been gathered for how the system as a whole inspects and assures quality. These lessons must be embedded within the new systems and processes that were being developed following Francis. For the NQB it would be important that it played its full part in bringing the system together and supporting alignment. It would do so in the short term through the System Alignment for quality workstream it was overseeing, and through the development of the guidance it would look to develop on nurse staffing. However it was likely that the implications of the Keogh Reviews would continue to influence the NQB's work for some time, and in many areas.

**ITEM 4: HEALTH AND WELLBEING OF NHS STAFF**

DAVID NICHOLSON (Chair) invited DAME CAROL BLACK (Expert Adviser on Health and Work, Department of Health) to present on the work she was undertaking on the links between the health and wellbeing of NHS staff and the quality of care patients received.

DAME CAROL BLACK informed members that evidence showed that healthy, engaged workforces in well-managed, safe organisations led to high-performing, resilient workforces and enhanced productivity, contributing to a well-functioning society and better economic performance. Workplaces provided a natural environment in which health behaviours could be influenced. The workplace would be a specific priority for Public Health England in its aim to help employers to facilitate and encourage their staff to make healthier choices.

The topic of staff health and wellbeing had featured on the Government's agenda for some time. In particular, the review undertaken by Dr Steve Boorman (2009) demonstrated that reducing absence by a third would gain 3.4 million days, 14,900 additional full time equivalents for care, and annual savings of £555million.
There had been considerable activity and progress on NHS staff health and wellbeing since 2009: it was reflected in the NHS Operating Framework; was strongly supported by Public Health England, Trade Unions, other key bodies and the NHS Future Forum; good work had been undertaken by NHS Employers and the Royal College of Practitioners Audit Unit; fifty-two NHS organisations had signed up to the Public Health responsibility deal; and the NHS Staff Health Pledge had been signed by a number of key statutory organisations (including many represented on the NQB).

The Health and Wellbeing Improvement Framework (Department of Health) highlighted five high-impact changes that NHS organisations could follow to improve staff health and wellbeing and reduce sickness absence: developing local evidence-based improvement plans; strong visible leadership; supported by improved management capability; better, local high-quality accredited Occupational Health services; and with all staff encouraged and enabled to take more personal responsibility.

York Teaching Hospitals NHS Foundation Trust was highlighted as an example of the potential impact of leadership on sickness absence. Trust Board engagement was used to drive progress, with the Trust Board visibly involved in events to promote better staff health and wellbeing, which was communicated to staff. This engagement delivered sickness absence savings of £2.7million a year, and a seventy-two per cent reduction in long-term absence.

DAME CAROL BLACK highlighted that Public Health in the workplace requires an attitudinal change with corresponding changes in behavior. The NHS should be the exemplar in the delivery of this.

DAVID NICHOLSON (Chair) thanked Dame Carol Black for her presentation and invited members to discuss the issue of staff health and wellbeing. The following points were raised in discussion:

t) there was considerable support for the ambition to improve the health and wellbeing of NHS staff. Those delivering healthcare and advising the public on health improvement should embody the message;

u) it was noted that the take up for Employers for Carers had not been strong in the public sector. The stress arising from caring for patients should be covered in the notion of wellbeing. Although it was acknowledged that stress is not related to specialty, but to leadership, support from colleagues and team working;

v) the Civil Service had allocated a considerable budget to support Departments' health and wellbeing agendas. This included the introduction of a 'carer's passport' which had proved very effective in conveying caring responsibilities to a new manager / employer, enabling conversations to take place. Work had also been undertaken on the issue of domestic violence, which had highlighted there was a much bigger hidden problem than initially perceived. Steps had also been taken to address the connection between absence and disconnection and serious debt, with active steps taken to direct towards debt advice services; and

w) Health and Wellbeing Boards were suggested as an alternative way to access primary care as contact thus far had been via clinical commissioning groups.

DAVID NICHOLSON (Chair) thanked members for their contributions to the discussion. In summing up, a first step was for each organisation to look at how it was approaching staff health and wellbeing.

**ITEM 5: GENERAL UPDATE**

DAVID NICHOLSON (Chair) introduced the General Update paper, NQB(13)(03)(03) which provided NQB members with progress on the following work areas:

Mid Staffordshire NHS Foundation Trust Public Inquiry – Update

Members were asked to note the update provided in the paper.

Human Factors

DAVID HASLAM (NICE) reminded members that at its last meeting the NQB had been keen for the Human Factors work to complement and align to the Berwick Review.
Following feedback from the Berwick Group - that it was impressed by the commitment and enthusiasm for the Human Factors agenda and the importance of embedding Human Factors as part of the patient safety agenda, but that there was a risk that the statement could be perceived as a heavy top-down approach - the statement was now to be recast as providing leadership to the Human Factors agenda, supporting organisations to embrace Human Factors locally (in line with the work the Berwick Group). The NQB supported this approach and acknowledged that, as the Berwick was not to report until the end of July, the final statement would now not be brought to the NQB for sign-off until its October meeting.

Quality Surveillance Groups

LAUREN HUGHES (NQB secretariat) explained that the review was to examine: how effectively QSGs were operating; identify good and bad practice, including any barriers to their success; and, identify any support required to allow QSGs to maximise their potential. The review was to support the development of revised guidance, FAQs and support materials by the end of October 2013.

Members particularly requested that the review explore how quality was monitored in providers and how the relationships between QSGs and clinical commissioning groups were developing. It was part of NHS England's responsibilities to help commissioners understand how to assure quality of providers and to use the levers at their disposal, which would need to include how they can best work as part of QSGs. Further updates on the progress and findings from the QSG Review would be brought to the NQB.

Quality Accounts 2013-14

RICHARD ARNOLD (NHS England) set out the approach and timescales for the review for 2013/14 as recommended by the Quality Account Stakeholder Group, and also the proposed independent review of Quality Accounts to examine their effectiveness in driving quality locally for 2014/15.

The NQB approved the review timetable for the 2013/14 Quality Accounts and that the Friends and Family test be included. The discussion then focused on the independent review of Quality Accounts.

The following points were raised in discussion:

x) the evaluation was welcomed, however clarity was required in relation to the purpose of Quality Accounts before any evaluation could be made;

y) the Quality Accounts for the trusts identified through the Keogh Review should be examined to see whether these had identified the quality concerns that later transpired through the reviews;

z) in undertaking any analysis it was important to ask for from patients and the public, staff and commissioners and regulators;

aa) the production of Quality Accounts had become an industry in itself. Consideration should be given to what data was important given the purpose of Quality Accounts with a view to minimizing the burden and costs of production on providers;

bb) the effectiveness of Quality Accounts in demonstrating accountability and driving quality needed to be examined; and

cc) it was important that all organisations produced Quality Accounts if they were to be fully effective.

The NQB requested sight of the terms of reference for the review prior to making a decision on whether the review could be supported. A paper was to be brought to the next meeting for further discussion.

<u>NICE Quality Standards</u>

LAUREN HUGHES (NQB secretariat) set out that work was being undertaken by NICE and NHS England to examine how to give Quality Standards more traction in the system, including how they could be used by commissioners in their contracts with providers.

The following points were raised in discussion:

dd) concerns were raised about the use of Quality Standards within provider contracts and potential unintended consequences.

ee) Quality Standards were seen as a good tool in raising standards;

ff) Quality Standards were currently quite specialty specific, however, NICE and NHS England were having discussions on cross-cutting issues so as to ensure there were standards for non-disease specific areas.

Work of the former National Quality Team

LAUREN HUGHES (NQB secretariat) set out that:

- The document *'Quality in the new health system – maintaining and improving quality from April 2013'* (published January 2013) may need to be updated to reflect recent announcements and should include the development of a public facing version and support for commissioners in how they can fulfill their responsibilities in respect of quality;
- Following the publication by the NQB of 'Maintaining and improving quality during the transition' (March 2011) and 'How to prepare for handover' (May 2012), the quality handover processes had been followed between PCTs and CCGs / NHS England and between SHAs and NHS England. In each region, Quality Handover Assemblies with commissioners, NHS England and regulators took place to ensure risk to quality was minimized and to mainstream this handover activity.
- The common measures identified as sensitive to quality issues had been captured as part of the National Quality Dashboard and were being used by QSGs. The Dashboard was to be incorporated into the NHS England Integrated Intelligence Tool.
- Four of the five 'How to' guides published by the NQB ('How to Handover for Quality was excluded) needed to be updated to reflect recent announcements concerning the quality architecture, the findings of the Keogh Mortality Review and further response to the Mid Staffordshire Inquiry to be published in autumn 2013. In response to the Keogh Mortality Review findings and as part of the implementation of Compassion in Practice, a further guide was to be developed on getting staffing levels right in respect of those caring for patients, as had been discussed earlier on in the meeting.

The following points were raised in discussion:

- the work on nurse staffing guidance was important and there was a need to ensure cross-system buy-in. It was requested that development of the guide be brought to the NQB's October meeting for discussion; and
- it would be important that NQB member organisations collectively updated the existing 'How to' guides, and these should be circulated to members via correspondence for comment and sign off as they were available.

**ITEM 6: ANY OTHER BUSINESS**

The next meeting was on 1 October 2013, in London.

**NQB SECRETARIAT**