NQB (13) 2nd Meeting

NATIONAL QUALITY BOARD

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MINUTES of a meeting held at Richmond House, 79 Whitehall, London, SW1A 2NS

Tuesday 21 May 2013, 13:00 – 16:00

PRESENT			
Bruce Keogh (Chair)			
Richard Gleave	David Haslam	Philip King	Sally Brearley
Ian Cumming	Helen Buckingham	Don Brereton	Katerina Kolyra
Juliette Beale	Hilary Chapman	Paul Philip	Julie Mellor
Anna Bradley	Andrea Sutcliffe	Margaret Goose	Peter Blythin
Peter Blythin	Stephen Thornton		
IN ATTENDANCE			
Don Berwick	Mike Durkin		
APOLOGIES			
David Nicholson	Una O'Brien	Jackie Smith	David Behan
David Flory	Duncan Selbie	David Bennett	Jane Cummings
Niall Dickson	Sally Davies	Ian Gilmore	John Oldham
SECRETARIAT			
John Stewart (NHS England)	Lauren Hughes (NHS England)	Sally Chapman (NHS England)	Amanda Hutchinson (CQC)
Paul Macnaught (DH)	William Vineall (DH)		

Agenda

1. Welcome, context and purpose (Paper Ref: NQB(13)(02)(01)
2. Review into the safety of patients in England (Paper Ref: NQB(13)(02)(02)
3. Human Factors in healthcare (Paper Ref: NQB(13)(02)(03)
4. Quality architecture post-Francis (Paper Ref: NQB(13)(02)(04)
5. Patient experience (Paper Ref: NQB(13)(02)(05)
6. Future work programme (Paper Ref: NQB(13)(02)(01)
7. Any other business

ITEM 1: WELCOME AND INTRODUCTION

BRUCE KEOGH (Chair) welcomed members to the twenty fourth meeting of the National Quality Board (NQB). He also welcomed Paul Philip attending for Niall Dickson at the General Medical Council, Peter Blythin attending for David Flory at the National Trust Development Authority, Katerina Kolyva attending for Jackie Smith at the National Medical Council, Richard Gleave attending for Duncan Selbie at Public Health England, and Juliet Beal attending for Jane Cummings at NHS England.

BRUCE KEOGH (Chair) reminded members that it was the first NQB meeting since the establishment of the new system on 1 April 2013, which allowed the Board the opportunity to reflect on what it had collectively achieved to date, and where it could focus going forward in 2013/14 and beyond following the outcome of the Francis Inquiry.

It was proposed that the NQB used the following high level themes to frame its future work agenda:

- driving and enabling improvement in patient safety;
- driving and enabling improvement in patient experience;
- driving and enabling improvement in clinical effectiveness; and
- overseeing the quality architecture.

The agenda had been structured to cover these themes.

ITEM 2: PATIENT SAFETY

BRUCE KEOGH (Chair) welcomed Professor Don Berwick (Chair, National Advisory Group on the Safety of Patients in England) who was attending the meeting via teleconference and

invited him to introduce the work he was leading on patient safety. The terms of reference for the Group had previously been circulated to the Board for information.

DON BERWICK set out that, prior to the publication of the report of the Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust (January 2005 – March 2009), he had been asked by the Department of Health to advise on steps to accelerate progress on patient safety and formulate recommendations on the basis of the Mid Staffordshire NHS Foundation Trust Public Inquiry as to how to quickly and efficiently move to a whole-system approach to make "zero-harm" a reality in England.

An Advisory Group had been established comprising experts in human factors, patient safety, cultural change, practice and complex systems. The Group had held virtual bi-monthly meetings since February 2013. Seven sub-groups had been established to cover the following priority areas:

- *Aims for Improvement* - set up to consider the scope of the Advisory Group's work and what it was seeking to achieve in its recommendations.

- *Building Capacity through training, education, and technical* capability – set up to examine the role of education, training and technology in supporting patient safety improvement and building the capacity of the entire system to deliver safer care.

- *Structural recommendations: Oversight, accountability and* influence – set up to consider how regulators and regulations, standards, accountability and governance processes, performance management and other processes could support, embed and drive improvement in patient safety.

- *Patient and Public Involvement* - set up to embed patient voice and ensure patients and the public are central to the delivery of patient safety at every level, from the one to one interaction between patients and clinicians, through local and national organisation leadership, to education and training.

- *Measurement, tracking, transparency and learning* - set up to work on the principles of and mechanisms for measuring safety and safety related outcomes and processes and advising on how those measures should be tracked, shared openly and transparently and used for learning and improvement

- *Consideration of legal penalties/criminal liability and its impact on safety* – set up to examine the role for the use of sanctions, penalties, criminal liability (either individually or on an organisational basis) in underpinning the safety of healthcare and ensuring patients were protected from harm.

- *Implications for Leadership* - set up to consider the role of and advice for leaders in all parts of the system, from frontline leaders to national politicians, on how they could contribute to improving patient safety.

In addition to the original seven subgroups, the Advisory Group identified the need to ensure that staff, staffing and the working environment were covered in their recommendations. This workstream examines the link between empowered and motivated staff and safety and also picks up culture change along with several of the subgroups listed above.

Recommendations from each sub-group would be considered by the full Advisory Group at the end of May. Once agreed, the sub-groups would produce narratives to accompany their recommendations during June. The whole report would then be considered, edited and finalised during July, before submission to the Government and NHS England by the end of July.

Once the Advisory Group had made its recommendations in July, NHS England would have responsibility for driving forward the recommendations, working with the Government to manage and drive solutions.

BRUCE KEOGH (Chair) thanked Don Berwick for setting out the work of the Advisory Group and invited the Board to comment. The following points were made in discussion:

a. although the validity of the sentiment could not be questioned, it was considered that the term ‘zero harm’ failed to acknowledge that healthcare is inherently risky, with as many consequences to taking action as to not taking action;

b. further consideration of the social care perspective was required, particularly given the shared commitment to integrated care. There was a need to make links across sector boundaries, including safeguarding of children and adults, as patient needs could not be met in a fragmented system;

c. the workstream on structures and relationships would require input and engagement from the organisations represented on the NQB as they would have a role in taking forward any recommendations;

d. the NQB could add value in supporting better alignment between statutory organisations, in terms of systems, processes and structure and in relation to behaviours and values;

e. consideration should be given to the link the work of the Advisory Group and the findings from the reports into events at Mid Staffordshire and Winterbourne View in relation to patient safety;

f. education and training would be vitial components to systematically improving patient safety. It must be seen as the responsibility of the entire NHS workforce; and

g. bi-lateral conversations should be initiated via the Advisory Group, prior to recommendations being set, to discuss areas where individual organisations had a specific interest, and / or would be required to take forward the recommendations.

DON BERWICK thanked members for their input and invited further comments from the Board following the meeting particularly in relation to structures and relationships, social care and education.

BRUCE KEOGH (Medical Director, NHS England) thanked members for their contributions to the discussion. He said that the NQB's role was to promote better alignment between organisations, and it could play an important part in supporting implementation of the recommendations from the Advisory Group. He asked that statutory organisations engage with the Advisory Group, which the Patient Safety Team in NHS England would facilitate.

ITEM 3: HUMAN FACTORS IN HEALTHCARE

BRUCE KEOGH (Chair) invited DAVID HASLAM (Chair, NQB Human Factors Sub-group) to introduce the paper, NQB(13)(02)(03), on Human Factors in healthcare.

DAVID HASLAM set out that there were two main areas upon which the Sub-group was to update the Board:

- progress on the joint statement on Human Factors in healthcare; and
- initial thoughts on provision of i) oversight, leadership and co-ordination of the Human Factors agenda, and ii) Human Factors expertise to the NHS to support the delivery of the actions in the joint statement.

DAVID HASLAM informed the Board that much consideration had been given to the use of the term 'Human Factors' following previous concerns that it might not be recognised or

understood on the ground in the NHS. He explained that the Sub-group had given this considerable thought and was now convinced that the term should be retained as it was internationally recognised, supported by a body of research, used by other safety critical industries, and was starting to gain traction in the NHS. By way of a comparison, he reminded members that that it had taken some time for the term 'clinical governance' to embed into NHS language but that it was now a commonly used term.

There was further work to do on the joint statement. The Sub-group was keen to ensure appropriate links were made to work to implement the recommendations from the Mid Staffordshire NHS Foundation Trust Public Inquiry, in particular the work of Don Berwick. The process to refine and sign organisations up to the joint statement of actions at Annex A of the paper, NQB(13)(02)(03) had begun and would need to be completed before publication.

BRUCE KEOGH thanked DAVID HASLAM for the work of the Sub-group and the progress made, and asked DON BERWICK for his views on the work of the Human Factors Sub-group.

DON BERWICK concurred the science of Human Factors was at the forefront of the patient safety strategy, and agreed that embedding a recognition of Human Factors across the NHS could achieve significant gains in the quality of healthcare. It was important that Human Factors knowledge was harnessed and applied in the NHS.

The following points were raised in discussion:

a. a clearer definition about the science of Human Factors was required up front in the paper, reflecting the definition of the term developed by the Department of Health's Human Factors Reference Group;

b. consideration should be given to how a knowledge of Human Factors could be used to inform the transition through healthcare from childhood to adolescence, and also to improve care later in life;

c. there was potential learning from Human Factors science for how the NHS deals with and responds to failure, both due to actions of individuals or as a result of organizational failure. For example, Human Factors frequently featured in route cause analysis of complaints. Such understanding needed to be embedded more widely in how failure was dealt with;

d. education and training in Human Factors was vital for all professionals. It should be built into a broad range of curricula and should feature in Continuing Professional Development; and

e. the current draft of the statement was predominantly focused on the acute health sector. It needed to be broadened to have application in other care setting, including social care.

DAVID HASLAM then presented the second part of the paper, NQB(13)(2)(3). He set out that the Human Factors Sub-group was of the view that, if the Human Factors agenda was to be successful, oversight, leadership and co-ordination would be required. The Sub-group's preferred option would be that this would sit initially with the NQB as most of the essential organisations were represented and they were already heavily engaged in the agenda. Consideration had also been given to whether and how Human Factors expertise should be available to the NHS.

The following points were raised in discussion:

f. the NHS Trust Development Authority were featuring human factors in their work with NHS Trusts, particularly in relation to those nearing the end of the foundation trust pipeline or where there were quality problems;

g. the National Quality Board would be an ideal forum to provide oversight, leadership and co-ordination of the agenda, however it did not include human factors experts and so expertise to advise the Board would need to be accessible;

h. organisations nationally in the NHS may also need to access human factors expertise, where they did not already have it internally. Bureaucracy in relation to the delivery of the expert advice to the NHS should be kept to a minimum;

i. it was still the case that the concept of human factors could create anti-bodies in the NHS system, when comparisons are drawn with other industries such as the aviation, or oil industries; and

j. the key to embedding a recognition of human factors would be to make it relevant and applicable to all NHS professionals, and have it as a golden thread running throughout the values and behaviours of the system. Commissioners were a particularly important audience for raising awareness of Human Factors.

Summing up the discussion, BRUCE KEOGH concluded that work was progressing well. The joint statement was to be finalised to ensure it was fit for purpose and brought back to

the next NQB meeting on 16 July. The NQB would continue to provide oversight leadership and coordination for the agenda. Further options on the provision of expertise were to be developed for consideration at the next meeting.

ITEM 4: QUALITY ARCHITECTURE POST-FRANCIS

BRUCE KEOGH (Chair) presented the paper, NQB(13)(02)(04), on the quality architecture following the publication of Sir Robert Francis' report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

The NQB was reminded of the mechanisms it had introduced over the past twelve months, underpinned by a range of tools and guidance, to strengthen the overall system's focus on quality:

- Quality Surveillance Groups (QSGs) had been introduced to bring together regulators and other parts of the system that had information and intelligence on the care being provided to the local community, which provided a proactive mechanism for the sharing of information, concerns and determining further action;
- Risk Summits had been introduced to address specific concerns over the quality of care provided;
- a series of 'How to Guides' provided the tools and guidance to strengthen the focus on quality through the transition; and
- the National Quality Dashboard had been instituted, bringing together a set of indicators to provide a single view of quality in acute providers, and was being integrated into NHS England's Integrated Intelligence Tool.

BRUCE KEOGH highlighted that changes were starting to take place following the Francis Inquiry recommendations on fundamental standards:

- the Chief Inspector of Hospitals was appointed on 21 May 2013. The Chief Inspector would have a significant role in inspecting hospitals, determining their rating, sharing knowledge, and would also have authority to initiate a single failure regime;
- there was to be a new hospital ratings system which would provide a 'single version of the truth' on quality of care; and
- hospitals with the highest mortality ratings were under review as part of the Keogh Mortality Review, which was due to report in July.

The NQB was asked to reflect on the existing architecture, and the new elements which had been announced, and consider where there was a need for greater alignment.

In discussion, the following points were made:

k. the Board had contributed significantly to strengthening the quality architecture. Sponsorship and leadership by the Board had given an authority to specific work areas and contributed to their success. The Board should now consider its role in tackling the complex and tricky alignment issues within the new system;

l. there were conversations taking place about various alignment issues in relation to the quality architecture bilaterally and multilaterally between statutory bodies. These should be brought together and overseen by the NQB;

m. alignment issues which merited consideration, in addition to those in the paper included making the connection between quality of care and the need for care to be person-centred and coordinated; ensuring the Quality Dashboard in NHS England was linked to the work CQC has commissioned from McKinsey on surveillance; aligning the role of the new Chief Inspector of Hospitals with Monitor's role; providing clarity as to who sets the standards for the care pathway; tackling the potential overuse of the Risk Summit mechanism which could dilute its effectiveness; understanding what should happen within contract reviews in relation to quality;

n. the opportunity now presented itself to take advantage of learning in relation to quality improvement, concentrating on the front end of the quality curve rather than continually focusing on preventing and identifying quality failure;

o. any action taken by the Board should be complementary and should not duplicate efforts elsewhere, for example in integrated care. It should take time to review the architecture it had already put in place. This would be taken forward in respect of Quality Surveillance Groups in coming months, and on Risk Summits and rapid responsive reviews following on from the Keogh Mortality Reviews; and

p. the NQB needed to focus on alignment between and across sectors, in particular in relation to secondary care with primary care and social care, to reflect the importance for patients in having a single pathway of care.

BRUCE KEOGH (Chair) thanked members for their contributions to the discussion. It was agreed that the discussions already underway would be brought together under the oversight of the NQB. The following meeting would more generally take stock of the role

and focus of the NQB going forward to ensure it was best placed to challenge the system and secure alignment.

ITEM 5: PATIENT EXPERIENCE

BRUCE KEOGH (Chair) invited NEIL CHURCHILL (Domain Director, Patient Experience, NHS England) to present to the Board on the work he was leading to develop a work programme to improve patient experience and influence.

NEIL CHURCHILL introduced the item and explained that although good work had previously been undertaken on patient experience, it was not cohesive and there were significant gaps. There was a significant risk of fragmentation and duplication. The quality of patient experience needed to be improved to ensure it was an equal part of the quality metric. It was hoped the NQB could play a key role in embedding the common purpose of improving patient experience across its member organisations and exploiting the tools and levers across the system to drive improvement.

NEIL CHURCHILL set out the evidence on patient experience:

- there was a recognised link between patient experience and health outcomes;
- patient experience was improved where people had more control over their care and had the ability to make more informed choices over their treatment;
- there was a strong correlation between staff well-being and patient experience, and staff experience with patient experience;
- there was a link between patient experience and the cost of care; and
- patient experience could impact on organisational reputation.

NEIL CHURCHILL explained that there was a requirement for quantitative and qualitative data if patient experience was to be understood. There were considerable gaps in the data available; hospital and cancer data were good, whereas data in other areas could be weak or partial. It was recognised that satisfaction was not a reliable measure, and a more granular measurement was required in addition to data that could be acted upon to drive improvement. The Friends and Family Test would add to available data but it was only one part of the solution.

There was also a need to draw insight from multiple sources to focus on improvements. In particular, insight into specific groups was required, for example the old and frail and Black and Minority Ethnic groups.

It was highlighted that patient experience was the least established part of the quality agenda, and that the Patient Experience team in NHS England had recently been established and were developing their work programme. It was therefore important that consideration was given to how to collaborate and make best use of thinking in this area. A sub-group of the NQB was proposed, which could focus on understanding and addressing issues related to improving the patient experience.

The NQB was asked to reflect on Neil Churchill's outline of the patient experience agenda and to consider how their organisations and the NQB as a body could contribute. The following points where raised in discussion:

q. there was consensus that patient experience was vitally important to quality of care and that the Board should be involved in this agenda given the value it could bring to the work programme. How this should be taken forward should be developed for consideration at the next meeting;

r. further understanding was required of the detail and ambition of the patient experience agenda. For example, how could patient experience metrics be used to compare organisations and hold them to account;

s. the Trust Development Authority, Care Quality Commission and the Health Service Ombudsman were keen to be actively involved with this agenda;

t. framing patient experience in a consumer context was welcomed as a means of helping people to understand what is available to them, how best to utilise the system, and also to provide an appreciation of its limitations and individual's responsibilities in return. However, it was recognised that there needed to be a common understanding as to what this meant in practice, specifically the argument that for there to be a consumer there needed to be competition and a market;

u. consideration should be given to the narrative on integrated care developed by National Voices, and how the 'I' statements from 'Making it Real' developed by the Think Local Professional Partnership could be better aligned;

v. carers needed to feature in the development of this agenda. This was particularly important in relation to dementia;

w. there had previously been a patient experience sub-group of the NQB, but it was no longer in operation and had not been able to secure as widespread engagement in the agenda as it would have liked. NHS England asking the NQB for its help and support in the agenda was an ideal opportunity to re-ignite the NQB's interest and work in this area, and to move it forward with momentum and purpose; and

x. it would be important to ensure that any work in relation to patient experience did not become too hospital focused. It should seek to address the importance of the transitions between care settings and sectors on patient's experience of services.

The CHAIR thanked members for their contributions to the discussions. In summing up, he concluded that there was widespread support for the NQB supporting and reinforcing the work on patient experience. At its next meeting, a proposal for how this might be taken forward should be considered. In the meantime, organisations should work in an individual way to support this agenda.

ITEM 6: FUTURE WORK PROGRAMME

The CHAIR invited John Stewart (NQB Secretariat, NHS England) to present paper NQB(13)(02)(01).

JOHN STEWART introduced the paper and explained that this was the first meeting of the NQB under the new system and since the Francis Inquiry has reported, providing the opportunity for the NQB to return to its original focus of leadership and future alignment of quality and consider the areas upon which it wanted to focus. This had been difficult previously due to the uncertainty as to the implications for the quality architecture from the Francis Inquiry recommendations.

The Secretariat had proposed that the NQB should focus on the three dimensions of quality – clinical effectiveness, patient safety and patient experience - in addition to the broader oversight of the overall quality architecture.

DAVID HASLAM (Chair, Quality Information Committee) raised a specific issue in relation to the future role of the Quality Information Committee (QIC). The National Data Quality Review had been published on the NQB page of the NHS England website, which raised the question as to whether there was a continuing need for the committee, and what its remit would be should it continue, for example in relation to data standards. There was an option that QIC reported into the Information Standards Commissioning

Group (ISCG), although members were concerned that it did not necessarily have a broad enough remit to cover all the recommendations set out in the report.

The following points were raised in discussion:

y. there was clearly more of a need for NQB to bring organisations together across the system than ever before, given the implications of the Health and Social Care Act 2012. The NQB's unique contribution was that it could align the roles and responsibilities, and how they are discharged, of the statutory organisations across the system;

z. the remit of the NQB needed to be firmly grounded in identifying areas where greater alignment and collaborative action would lead to greater quality improvement. It need to be clearly defined in this way;

aa. in order to determine the areas on which the NQB should focus, it would be helpful to reflect on what it has achieved to date, where it has added most value and where there are demands from the system for support in alignment; and

bb. the role of the QIC was to consider the alignment of the quality information agenda. Greater clarity was needed on the role and focus of the ISCG before the NQB could determine whether or not QIC should report into that group.

The CHAIR summed up the discussion by setting out that the clear purpose of the NQB was to bring together issues of mutual challenge or interest to ensure all organisations working in an increasingly fragmented system were aligned to have the maximum impact on improving quality. A detailed item setting out the proposed focus of the NQB going forward should be a substantive item on the agenda for the next meeting on 16 July.

ITEM 7: ANY OTHER BUSINESS

The CHAIR invited members to introduce any items of other business. The minutes of the meeting were to be circulated following the meeting.

The next meeting was on 16 July 2013, in London.

NQB SECRETARIAT

MAY 2012