RESTRICTED

NQB(13) 1st Meeting

NATIONAL QUALITY BOARD

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MINUTES of a meeting held at Wellington House (room LG 26 & 27), 133-155 Waterloo Road, London, SE1 8UG

Tuesday 12 March 2013, 12.30 – 15.00

PRESENT		
David Nicholson (Chair)		
Julie Mellor	Bruce Keogh	Una O'Brien
Niall Dickson	Jane Cummings	David Haslam
Jackie Smith	Ian Cumming	David Bennett
Philip King	Andrea Sutcliffe	Ian Gilmore
Stephen Thornton	John Oldham	Sally Brearley
Margaret Goose	Don Brereton	
APOLOGIES		
Duncan Selbie	David Flory	Hilary Chapman
Anna Bradley	David Bennett	David Behan
SECRETARIAT		
Lauren Hughes (NHS CB)	John Stewart (NHS CB)	Amanda Hutchinson (CQC)
Kate Dixon (DH)		James Ewing (GMC)

Agenda

1. Welcome and introductions
2. Responding to the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry
3. Clinical Human Factors (Paper ref NQB(13)(01)(01))
4. National Data Quality Report (Paper ref NQB(13)(01)(02))
5. Any other business

ITEM 1: WELCOME AND INTRODUCTIONS

The CHAIR welcomed members to the twenty third meeting of the National Quality Board (NQB). He particularly welcomed Julie Mellor, Health Service Ombudsman who was joining the meeting for the first time, and had newly joined the NQB. It would be of great value to the NQB and to the wider system that this perspective could be represented in discussions.

The CHAIR explained that lay and expert members' terms of appointment had either formally expired or would expire shortly. These appointments would be extended from 1 April 2013 until 31 March 2014 as had been set out in his letter to members from December 2012.

DAVID NICHOLSON (the CHAIR) welcomed members to the 23rd meeting of the National Quality Board. This meeting was being held at a very timely point given that the Mid Staffordshire NHS Foundation Trust Public Inquiry had reported on 6 February 2013, and the Government was in the final stages of developing its initial response to the report, which would be published in coming weeks. The agenda had been arranged to provide system leaders in the NHS an opportunity to discuss the emerging themes from the response, and collectively consider taking these forward.

The National Quality Board was a vital component of the system, particularly in light of Francis, as the system could come together with critical friends to debate the issues, and also challenge organisations to resist the temptation to become predominantly focussed on preventing failure, but also to seek to drive excellent practice and high quality care at the other end of the quality curve.

ITEM 2: RESPONDING TO THE FINDINGS OF THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

UNA O'BRIEN (Permanent Secretary, Department of Health) outlined the latest thinking and key themes for the Government's response to the final report from the Mid Staffordshire NHS Foundation Trust Public Inquiry, which many of the statutory organisations around the NQB table had been actively involved in shaping and informing. This discussion was an opportunity to stress test the emerging response, and for members to provide their thoughts and reflections.

The leadership of the system were determined to follow through and implement the spirit and intent of Robert Francis QC's findings and recommendations. That the report was published at a time when the health system was in transition, with new organisations and working relationships was a challenge, but also an opportunity to ensure that the reformed system would operate in the interests of patients and their families.

The Government's challenge was to respond to and take forward the recommendations in a way that made practical sense given the current and future system. The initial response would seek to do this generally and in relation to some of the flagship recommendations from the report. It would set out a single view from the system, signal where the system was signing up to implementing recommendations immediately, where it would seek to achieve the intent of the recommendations in a different way, and outline a timeline for responding in full, and a process for people to engage in developing that full response.

The next phase would then need to focus on driving implementation, and on generating a movement for cultural change across the NHS. This was vital, as in taking forward the findings of the Public Inquiry, it should not become a 'tick box' exercise. The board of each statutory organisation nationally would be considering the implications of the Public Inquiry for their operations, and provider boards would be encouraged to do the same.

There would be several main elements to the initial response: being clear about required standards of care; emphasising the importance of kindness and compassion in delivering care and the need to support staff to be able to act in this way; spotting problems in quality early and acting on warning signs; and clear accountability across the system.

The following points were raised in discussions:

a. the response must provide clarity and simplicity in terms of the expectations on the NHS for action going forward. The emerging themes for the response felt right and provided that clarity and simplicity. They could be used to chorale a movement for change;
b. the overriding message coming out of Robert Francis QC's report was one of the need for cultural change. Changing culture was difficult, and people tended

to abreact to change being framed in such a way. It would be more effective to frame change in terms of 'doing things differently' and suggesting how they might be done differently;

c. the NHS had over the years demonstrated that it could change behaviours and cultures. An example was the systematic reduction in waiting times which had vastly improved services for patients. This had been achieved by the service uniting around a common value and measuring improvement. Could this approach be replicated in respect of culture? Change could be brought about by aligning the values of staff with those of the organisation and the NHS as a whole. Nationally, less would be more, as real change would come about by locally led improvement and ownership;
d. a theme that seemed to be missing from those outlined was one of 'listening to patients and their carers'. This needed to be paramount within the response and action to implement it;
e. the NHS needed to get the basics of decision-making right. Decisions should always be made based on what was best for patients and their families. However, this would need to be balanced by active management of public expectations in terms of what they could expect from their NHS given that it was a service with a finite budget. There needed to be a mature dialogue with the public on issues such as rationing of services;
f. in strengthening accountability there was a risk that this could have a detrimental impact on compassion, if it led to increased blame and fear within an organisation. The key question was how to encourage staff to come to work to care and be compassionate;
g. the theme on supporting staff to provide compassionate care and kindness was welcomed, however the response needed to be clear that this was not an issue unique to nursing. All healthcare professions needed to provide such care;
h. clarifying standards was welcomed as a theme. Key to this having maximum affect on improving care would be clearly communicating to patients about the standards they should expect. They could then become activate advocates for those standards being met. One area in which standards should be considered was safe staffing – was there a case for patients and carers being made aware if there were insufficient staff on a ward at any one time?
i. the issue of whether to regulate healthcare assistants would need to be addressed in some way as part of responding to the Public Inquiry;

j. transparency in terms of variation in quality was essential if the system was truly to improve the quality of care provided to patients. This would enable the public to agitate for change and improvement throughout the system;

k. the focus on preventing failures and early warning was welcomed, and the NQB had taken an active interest in this area since publishing its reporting 'Review of Early Warning Systems in the NHS' in 2010. The NHS needed to lower its bar for investigating issues. By exploring routinely minor incidents and why they occurred, it could prevent major incidents;

l. however, in focussing on preventing failure, the system should not fall into the trap of ignoring the leading edge of the quality curve. There were systemic issues which if addressed, could further drive improvement such as the role of pricing, harnessing competition, the power of commissioning, and taking a strategic approach to acute services in England as a whole;

m. the Government should avoid using financial incentives to encourage compassion and kindness in staff, as this had been proven to have the opposite effect. The private sector was a good source of evidence in this area. Caring, kindness and compassion must be encouraged through professional pride and the cultural environment;

n. there was little reference to the importance of joining up health and social care services in the Public Inquiry's report. Individuals would be seen in social care services as well as health services. Similar principles applied and problems were inherent in the social care sector as had been found by the Public Inquiry. The response should focus on providing person-centred care across services;

o. improving how complaints were received, listened to and acted upon would be a vital part of responding to the public inquiry. New arrangements should facilitate complaints information being used to improve services generally, as well as for the individual complainant. The Health Ombudsman would be contributing in this area in respect of analysis of what works and does not work with the current complaints system, research with staff and patients as to what good complaints handling looks like, and research on governance of complaints handling. They would also be vastly increasing the number of investigations they took forward which would enable them to collate more information about complaints and identify themes; and

p. education and training had a vital role to play in the NHS being able to employ people with the right values and behaviours. Health Education England was focussing on various elements of strengthening education and training

including: variation in the quality of medical and nursing training; what is expected from trainees in return for NHS investment in their education; how encourage more junior professionals (i.e. those in bands 1-4) to be as engaged as possible and providing compassionate care; and how HEE could engage with and get feedback on quality of care from those whom training it funds.

Concluding the discussion, the CHAIR said that across the system, the NHS needed to talk to people more and be open and honest about what had happened at Mid Staffordshire. This was a genuinely transformational moment but success was not guaranteed. Nationally less would indeed be more. A common purpose was needed for the system to unite around, which the NQB could help provide. National organisations should then focus on enabling those at the front line to make the changes they need to in the interests of patients. The scale of the report from the Public Inquiry and the number of recommendations can risk the central messages of serving patients in a compassionate and caring way and listening to them, and supporting and motivating staff to provide high quality care could get lost. NQB member organisations must ensure that this does not happen.

The CHAIR highlighted several areas in which the NQB might need to focus: identifying and promoting a common purpose; assessing how effective early warning system were in the NHS and considering how they should be strengthened; considering how the system should support staff to provide high quality compassionate care; and exploring how the system should listen and respond to patients.

ITEM 3: CLINICAL HUMAN FACTORS

DAVID HASLAM (Chair, NQB Clinical Human Factors Sub-group) introduced paper NQB(13)(01)(01) which provided an update on the work of the Clinical Human Factors Sub-group in corralling organisations across the health system to agree to take action to embed a recognition of human factors in their business.

At the NQB's September meeting, the Board heard from Sir Stephen Moss, Prof. Jane Reid and Prof. Bryn Baxendale about clinical human factors and their potential impact on quality and efficiency in the NHS. The Board was keen to pursue this important agenda, and agreed to establish a subgroup to focus on the issues. The Subgroup was tasked with considering how the functions of statutory organisations represented on the NQB could be better utilised to reflect the impact of human factors on quality.

The subgroup agreed that this coordinated action should take the form of a System-wide statement of actions, and hosted a workshop with members, other key organisations across the health system, and experts on human factors in the health sector and in other industries to identify potential actions. The potential actions were set out as an annex to the paper, and the NQB was asked to consider these, as well as the further issues that would need to be worked through in developing the joint statement set out in the paper.

The following points were raised in discussion:

q. the lay and expert members on the sub-group had been impressed by the enthusiasm and engagement from statutory organisations involved. There was a feeling that the NQB could add real value in this area by bring focus to Human Factors and identifying the tangible actions that could be taken forward to embed the agenda across the NHS;
r. the Department of Health had been facilitating work on Human Factors for some time. Efforts had focussed on gaining consensus amongst experts on the concept of Human Factors in a healthcare context. Now was that time that it could be taken to the next stage in terms of implementation;
s. the sub-group should look to identify the five or components or characteristics which an organisation that was safe and recognised Human Factors would have, which were measureable. Then national organisations should look to support providers to replicate these; and
t. a key challenge was translating the concept of Human Factors into plain English and relating it to common practice in the NHS so that people could understand its application in their own context. The joint statement should draw on real life examples of where a Human Factors approach has led to developments which have improved quality, such as the Surgical Checklist;
u. if the agenda is to become part of the business as usual of the NHS, it needs to find a home and leadership within one or two of the national statutory organisations represented on the NQB, who would take it forward once the Sub-group's work had concluded. The NHS Commissioning Board and Health Education England should be considered. There was an argument for relating it strongly to patient safety and programmes to it forward;
v. the issue of how and where Human Factors expertise would be available to the system would need to be worked through by the Sub-group.

Summing up the discussion, the CHAIR thanked the Sub-group for its work to date and encouraged it to continue with its work in light of the steers from the NQB and further consultation with experts and the service. It should ensure that it is aligned with other developments in the NHS, including the responses to the Mid Staffordshire NHS Foundation Trust Public Inquiry. The NQB would need to consider further how and where organisations could access Human Factors advice in the future.

ITEM 4: NATIONAL DATA QUALITY REPORT

DAVID HASLAM (the Chair of the Quality Information Committee) introduced paper NQB(13)(01)(02) which proposed the first National Data Quality Review Report to the NQB for sign off ahead of publication. The report had been presented to the National Quality Board on 3rd December 2012. The NQB asked that further work be taken forward on the report ahead of publication in various areas set out in the paper. This work had been done and the final version of the report was attached to the paper as Annex A.

There was widespread support from NQB members for the revised report, which members felt had taken on board members' previous comments. The key would be to identify how the recommendations would be implemented and where responsibility for overseeing implementation should sit. The CHAIR explained that the NHS Commissioning Board was setting up the Information Standards Commissioning Group, with representatives from many NQB member organisations. There was an argument that this should take on responsibility for implementing the report. He asked that the secretariat explore this option and report back to the NQB at a subsequent meeting.

ITEM 5: ANY OTHER BUSINESS

The CHAIR thanked members for a considered and productive discussion, particularly on the response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. At the next meeting the NQB would be able to reflect on how the response, which would then have been published, should be taken forward collectively.

The next meeting of the NQB would be on 21 May 2013, in London.