NQB (13) 5th Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held at Room 404 & 405
NHS England, Southside, 105 Victoria Street,
London, SW1E 6QT

Tuesday 3 December 2013, 13:00 – 16:00

PRESENT			
Bruce Keogh (Chair)			
Jane Cummings	David Haslam	Paul Bate	Sally Brearley
Ian Curran	Julie Mellor	Stephen Thornton	Emma Westcott
Tony Lambert	Hilary Chapman	Anna Dixon	Duncan Selbie
John Oldham	Ian Gilmore	Margaret Goose	Anna Bradley
Stephen Goulder	Una O'Brien	John Illingworth	
APOLOGIES			
David Nicholson	David Bennett	Jackie Smith	David Behan
Sally Davies	Don Brereton	David Flory	Niall Dickson
Ian Cumming	Amanda Edwards		
SECRETARIAT			
John Stewart (NHS England)	Lauren Hughes (NHS England)	Sally Chapman (NHS England)	James Ewing (GMC)

Agenda

- Welcome and introduction
- Health Foundation study tour to Hyderabad and Bangalore
- Patient Safety (Paper Ref: NQB(13)(05)(01)
- Patient Experience (Paper Ref: NQB(13)(05)(02)
- System Alignment for Quality (Paper Ref: NQB(13)(05)(03)
- General Update (Paper Ref: NQB(13)(05)(04)
- Any other business

ITEM 1: WELCOME AND INTRODUCTION

BRUCE KEOGH (Chair) welcomed members to the twenty seventh meeting of the National Quality Board (NQB). He also welcomed John Illingworth (Health Foundation) attending for the first item, Stephen Goulder (SCIE), attending on behalf of Amanda Edwards, Ian Curran (HEE) attending for Ian Cumming, Emma Westcott (NMC) attending for Jackie Smith, and Toby Lambert (Monitor) attending for David Bennett.

BRUCE KEOGH (Chair) informed members that Sir David Nicholson (NQB Chair) had asked him to chair all future NQB meetings until a new chair was selected by the Health and Care System Leaders Forum.

BRUCE KEOGH (Chair) outlined that the meeting would focus on the three following themes: patient safety; patient experience and system alignment. There would also be a presentation at the start of the meeting from Hilary Chapman (NQB Expert member) and John Illingworth (Health Foundation) on their recent study tour to India.

ITEM 1: HEALTH FOUNDATION STUDY TOUR TO HYDERABAD AND BANGALORE

JOHN ILLINGWORTH (Health Foundation) explained that the purpose of the trip had been to learn from innovative healthcare delivery models in India, in particular, how to deliver efficiencies whilst maintaining and improving the quality of care.

HILARY CHAPMAN (NQB Expert member) provided some context on the healthcare system in India and challenges faced, for example:

- life expectancy at birth in India is 64 years old, compared to 80 years in the UK;
- infant mortality (per 1,000 births) in India is six times higher than that in the UK;
- India accounts for 45% of world's incidence of CHD;
- it was one of the most privatised healthcare system in the world;
- there is chronic underfunding of public healthcare system, with out of pocket health spend forces 20m people below the poverty line each year; and
- 700 million rural Indians lack access to basic healthcare.

HILARY CHAPMAN (NQB Expert member) and JOHN ILLINGWORTH (Health Foundation) then set out background and learning from the four organisations visited:

Narayana Health, Bangalore

Founded in 2001, Narayana Health aimed to provide '*high quality affordable cardiac care to masses'*. No one is turned away for lack of funds, and the quality of care received is the same regardless of the ability to pay. Of the revenues received, 15% was reinvested back into society. In addition, the 80% national attrition rates for nurses had been reduced to 60%, and there was an aim for 30% of management roles to be filled by nurses.

The following elements were identified as potential lessons for the NHS:

- there was a very commercial mindset, with every asset sweated;
- although clinical freedom was not evident due to standardisation, this did not stifle innovation;
- relatives were an integral part of the recovery process;
- there was a high use of 'cloud' technology and there were 50.000 tele-med patients; and
- there was strong emphasis on data.

Vaatsalya

Vaatsalya provided services to rural and semi-rural areas, in locations where there had been no healthcare provision before, treating 400,000 outpatients and 40,000 inpatients per year. The main focus was on customer service rather than clinical effectiveness, and there was a concept of relative quality.

In terms of success factors that could be applied to the NHS, the following were identified:

- the use of lean processes;
- standardisation and 'product' specialization;
- the leasing of buildings and equipment; and
- a real focus on customer service (100% of patients were called about their experience).

Prasad Eye Institute

India accounts for over 20% of the 285 million visually impaired across the world. The Prasad Eye Institute was established in 1986 to address the 80% of impairments that are preventable.

Its delivery model was based on excellence and continuous quality improvement, with a high emphasis on research and innovation. The treatment provided was the same, regardless of ability to pay. There was a clear focus on sustainability without neglecting the vulnerable, however, it was noted the values and standards did limit opportunities to expand.

The following success factors were identified as important to the NHS:

- the focus on continuous quality improvement;
- the was a range of surgery packages but clinical standards were the same;
- there was a routine monitoring of quality (using 64 metrics); and
- research was translated into practice.

Life Spring

It was highlighted that in India more than 100,000 women died per year from pregnancy related causes. Life Spring was expanding chain of twelve 'no frills' maternity hospitals in semi-rural India providing affordable maternity and infant care. There was a high-volume of care delivered: 25,000 babies had been delivered since 2005; 40,000 were women examined annually; and, antenatal visits had increased from 2 to 6.5 per woman.

It was observed that assets were used to the best of their ability and there was strong leadership. A lot of the services were provided close to home through community care and delivery suites, which influenced realistic decision making about care, with complex cases being referred out early. In addition, due to the empowerment of local communities, it had been observed that they expected more of other services.

In terms of success factors to be applied to the NHS, it was suggested consideration be given to:

- hiring auxiliary nurse midwives rather than general nurse midwives;
- the achievement of 10% attrition rates;
- locating facilities strategically near the homes of the target population; and

- the use of real time data and patient feedback.

The following points were raised in discussion:

a) the main conclusions were that innovative practices were evident throughout the tour and efficiencies were being made to meet social need;
b) there was much to be learnt from approaches to healthcare provision outside the UK, for example Cuba had a particular focus on primary care and prevention, with medical education focused on the social determinants / underlying causes of ill health; and
c) other study tours to India had highlighted:
    - a focus on tracking of key data;
    - emphasis during induction processes to ensure healthcare employees understood the culture they were joining and to ensure they followed standardised procedures;
    - there was a balance to be struck between standardisation and innovation – when presenting an innovative idea, it had to be shown that not only current levels of quality would be improved, or at least maintained, but that costs would also be reduced;
    - full services were provided out in the community, for example a mobile clinic would provide an eye test and the lenses would be ground there and then to ensure the patient left with glasses on the same day; and
    - there was a sense that there was a compelling moral argument for efficiency savings (as this resulted in the treatment of more patients) rather than it being seen as a target imposed from the top down.

BRUCE KEOGH (Chair) thanked HILARY CHAPMAN (NQB Expert member) and JOHN ILLINGWORTH (Health Foundation) for their presentation and for bringing their learning to the Board and for highlighting specific areas for application to the NHS. It was important for the NQB to continue to receive learning from other countries, particularly in relation to driving quality within an efficiency driven system.

ITEM 2: PATIENT SAFETY

BRUCE KEOGH (Chair) invited Mike Durkin (Director for Patient Safety, NHS England) to update members on the work he was undertaking on the patient safety collaboratives.

MIKE DURKIN (Director of Patient Safety, NHS England) set out that his work had been informed by two of the reviews following the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry:

- Don Berwick's review '*A promise to learn, a commitment to act*'; and,
- Bruce Keogh's '*Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*'

A key element of the work would be a publicly available website on safety, providing relevant and reliable patient safety data at ward level. A second key element would be transparency, building on what was meant by candor and moving this debate further, particularly in relation to willful neglect and misleading information at organisation level.

The aim of the Patient Safety Collaborative Programme was then to bring about system change, develop continual learning and improvement in patient care, and make this endemic and systematic. Learning from the work would be used to develop a resilient and sustainable system.

The NQB recognised that it was critical that the system aligned around the patient safety agenda as it would have more impact if it were owned by all statutory organisations with responsibility for quality, and that all national organisations should be challenged on their contribution to improving patient safety.

The following points were raised in discussion:

d) there were risks to the success of the proposed approach as it could be perceived as top-down. A balance should be struck between what could only be delivered at a national level and what support and help was required on the ground. It was suggested there could be a common national goal as well as local goals based on local priorities to energise the work;
e) as presented, the collaboratives could appear to be recording, measuring and investigating harm rather than engaging in prevention, which was vital to keeping patients safe;

f) when developing and launching the collaboratives approach it would be important to be clear about the evidence base as to why this approach had been chosen and why it would be successful. This would help gain buy in from those on the ground;

g) families and patient groups needed to be involved in the collaboratives and the safety of vulnerable patients properly considered. NHS England would be holding a session in January involving these groups and the proposed website was to offer the opportunity for further involvement and discussion on what was meant by candour;

h) measurement was viewed as critical - not only in relation to harm, but also learning from those organisations that were getting it right;

i) it would be vital that success criteria for the collaboratives' activities were developed at the outset. It was suggested that cultural barometer instruments / indicators could be used to test the impact of the collaboratives on the safety culture within the organisation;

j) understanding the underlying causes of harm would be fundamental. Human Factors presented a key tool in understanding the causes of harm and should be a key part of the priorities for the collaboratives;

k) the aspiration / ambition for the collaboratives should be given due consideration - the Human Factors Concordat set out an aspiration to excellence, taking organisations beyond competency. It promoted capability in patient safety and quality improvement, through education and training. A similar aspiration was needed for improving patient safety;

l) there was concern around the impact of there being yet another group established and the time and effort that would be taken to ensure that Academic Health Science Networks (AHSNs), Local Education and Training Boards (LETBs), Collaboration for Leadership in Applied Health Research and Care (CLAHRCs) and patient safety collaboratives linked together, which could otherwise be used to address the quality agenda. It was therefore necessary to be clear on the distinctive roles of each group;

m) the key features of the collaboratives were discussed. It was important to set out from the start what was to be achieved (for example % increase / decrease) by when and clarity provided in terms of expectation, method and timeline;

n) the patient safety collaboratives were seen as having a hospital focus, however it was noted that patient safety incidents were also prevalent in the

community, for example, most pressure ulcers (a core collaborative improvement area) occurred in care homes;

o) mental health should be prioritised given the importance of this group.
p) Human Factors should be part of the core curricula;
q) care should be given to ensure simplicity when involving patients in relation to candour and the safety thermometer;
r) to support this agenda, the GMC and NMC could give consideration to aligning the bar for fitness to practice between doctors and nurses. In addition, it was suggested a more evidence-based approach to standards would be helpful as medical errors constitute a high part of the fitness to practice case load;
s) HEE could contribute by working with others to support the established workforce to be innovators and quality improvers, and to explore how the curricula could be changed in support of patient safety (which it was already looking at in respect of Human Factors); and
t) CQC proposed that it examines the ability of organisations to learn from safety incidents through its inspection processes. Its key lines of enquiry for its safety domain would be key.

In summary, BRUCE KEOGH (Chair) set out that the NQB had Board level representation from all the main players in the new system. The key question was what each organisation was going to bring to the table to improve patient safety, building on what had been outlined in discussion.

Mike Durkin (NHS England) should attend the next NQB meeting on 25 February to set out the latest thinking in establishing patient safety collaboratives, reflecting the NQB's comments, and setting out expectations of each NQB member organisation to support the successful delivery of this agenda.

ITEM 3: PATIENT EXPERIENCE

BRUCE KEOGH (Chair) asked Stephen Thornton (Patient Experience Sub-group member) to update members on the second meeting of the Patient Experience Sub-group held on 13 November, on behalf of Don Brereton (Chair, Patient Experience Sub-group).

STEPHEN THORNTON (Patient Experience Sub-group member) introduced the paper on patient experience, NQB(13)(05)(02). He drew the NQB's attention to the initial findings of the mapping exercise that was underway with the organisations represented on the Sub-group to identify how each organisation defined patient experience, work being undertaken in this area and any gaps.

The findings to date had shown a multiplicity of different definitions of patient experience and no real alignment between the definitions provided by the different organisations. It was highlighted that the national organisations could do much more to identify areas that would support improvement in the quality of the patient experience and that, with the response to the Francis inquiry fresh in mind, it was a timely moment to explore opportunities for better alignment.

It was proposed that the mapping exercise be extended to include the other organisations represented on the NQB, not just those on the Sub-group, to obtain a clear understanding of what patient experience meant to each organisation and what work was being undertaken to support this.

The following points were raised in discussion:

r) there was concern about the emphasis organisations across the system were giving to this area, and members reinforced their commitment to this work;
s) the importance of an academic evidence base for the work was highlighted and it was questioned to what extent the work NICE had undertaken on patient experience and the evidence behind this work had been used to inform the work of the current Sub-group;
t) CQC had identified that 'experience' per se was not meaningful, and its work to develop key lines of inquiry focused on levels of caring and responsiveness. The latest Key Lines of Enquiry were to be shared to inform the mapping exercise;
u) work being undertaken to collect and draw insight from users should also be considered, for example complaints policy, feedback from the Friends and Family test, and from the Citizen Insight Network;
v) DH was in discussion with CQC and NHS England to ensure surveys were aligned and covered all patient groups, including adult social care;
w) consideration should be given to national aspirations in relation to user and patient experience;

x) the Sub-group could make a bid to the potential OECD Quality Review to look at patient centred-ness as a dimension of patient experience; there was a need to take a different approach if progress was to be made in this area. It was suggested that the difficulty in defining patient experience was influential in the lack of progress made in this area, without definition it would be difficult to measure, track and ultimately monitor; and

y) the need to access external advice on how to assess patient experience was to be considered, for example could the sub-group draw on Which? or the King's Fund.

In summary, BRUCE KEOGH (Chair) set out concerns that national and local organisations claim patient experience to be central to their business, but that the initial findings showed this to be the poor relation to the other domains of quality in terms of a national focus. There was a need to progress this work quickly and identify tangible areas for improvement. DH was to be a key partner in this work, and an update on the work of the Sub-group was to be brought back to the February meeting.

It was also agreed that the NQB would benefit from a session on large scale system change at a future meeting.

ITEM 4: SYSTEM ALIGNMENT

BRUCE KEOGH (Chair) invited Paul Bate (CQC) to update members on the collaborative work being taken forward by NHS England, Monitor, the NHS TDA and the CQC,

PAUL BATE (CQC) reminded members that there were a significant number of areas in relation to quality around which it made sense for the four organisations to align. These had been grouped into three workstreams: culture, leadership and governance; surveillance; and accountability.

It was highlighted that as part of the culture, leadership and governance work programme, the organisations were working together to deliver the commitment to develop the same definition and framework for leadership, their respective approaches to assessing culture, leadership and governance would be developed into a single 'well-led' framework for all acute, mental health, community and

ambulance providers. This work to define what a ‘well-led’ organisation looked like was seen to be critical as, over and above alignment, it aimed to achieve a single framework and clarity to providers.

As part of this work, a project was being undertaken on governance, leadership and culture, led by Michael West at the King’s Fund. This included a review of evidence on leadership and culture to develop an assessment framework and tools for CQC.

Attention was drawn to the considerable amount of work being driven forward on surveillance. In particular, that as part of the work to develop data to support surveillance, NHS England and CQC had started to align how they use information and what indicators they use. This would help support Quality Surveillance Groups (QSGs) and the CQC’s surveillance activity. They had begun this work on patient safety data in particular but the joint working approach would be continued where possible.

In addition, work was being progressed on the Accountability workstream including the single failure regime and fit and proper persons test. The work on the Foundation Trust assessment and authorisation process was also seen as crucial as this aimed to ensure Foundation Trusts were not only adequate, but good.

There would be a number publications over the coming months, including the CQC’s acute provider handbook early 2014, and the commissioning system’s planning guidance by NHS England and planning guidance for providers from Monitor and the NHS TDA in December.

The following points were raised in discussion:

z) there was resounding support for the work that was being taken forward as part of the system alignment work programme;

aa) the need to ensure that the quality system is aligned with the education system was reiterated, and that it would be vital for HEE to be a member of the 'Quad';

bb) complaints handling, and learning was seen as a vital area for alignment that could be factored into the system alignment work going forward. This should be explored ahead of the next NQB meeting;

cc) the health and social care system was becoming increasingly integrated and so alignment would need to be considered across the sectors as well as across the health system;

dd) concerns were raised that CCGs did not have a voice and consideration should be given as to how, through this workstream, the NQB could ensure that the system was operating effectively and in an aligned way from the CCG perspective. NHS England was trying to represent this view but recognised that this was difficult given that there was not a formal 'representative body' for CCGs collectively. The NHS Commissioning Assembly was looking to become more active in this area and it was suggested that they could be more closely involved in influencing the system alignment work programme;

ee) this work should be taken forward in the context of two underlying factors: quality failures were not always the fault of the provider organisation, instead they could be as a result of systemic failures or an unsustainable configuration of service across a health economy; and, it was the commissioner's role to ensure that resources were put to best use across a health economy. The single failure regime in particular needed to reflect these components;

ff) there was a case for the work on system alignment to move from focusing on failure to focusing on driving improvement - how are organisations and their activities aligned in driving improvement in quality and outcomes along the quality curve;

gg) it would be useful to stress test the alignment that was being secured across the system, to ensure that in a case of actual failure, there was sufficient alignment and joint working; and

hh) there was a strong call for a clear narrative that would communicate the different roles and responsibilities of the different players in the system, how they worked together and how that related to providers and patients.

<u>Quality Surveillance Groups</u>

BRUCE KEOGH (Chair) then asked Lauren Hughes (NQB secretariat) to update members on the review of Quality Surveillance Groups (QSGs).

LAUREN HUGHES (NQB secretariat) reminded members that the NQB had identified the need for QSGs. Following a pilot phase, the network of 4 regional and 27 local QSGs had been up and running across the country from 1 April 2013, when Strategic Health Authorities had ceased to exist. QSGs provided a forum for different groups to share information on quality in a planned and organised way.

Recognising that there was still considerable change taking place across the system, the NQB had requested that the cross-system Steering Group, which had overseen establishment of the network, review the QSG model to understand how it was operating and how it could be supported to be most effective - removing barriers and putting enablers in place where necessary.

The review, which included observing meetings and surveys, would lead to revised guidance on how to make QSGs more effective, and further training and support being made available as needs were identified.

The following points were raised in discussion:

ii) QSGs were actively finding issues and were viewed as one of the most beneficial changes of the reforms. As a result of QSGs there had also been a real increase in health and social care alignment and good practice was being shared;

jj) effectiveness of QSGs was however still variable and revised guidance following the review should seek to address this and share good practice wherever possible;

kk) concerns were raised over the variability of the approach to minuting QSG meetings. This should be addressed in the revised guidance; and

ll) the involvement of CCGs was vital in QSGs as they had the most local view on the quality of services, and day-to-day contact with providers. Their full participation should be encouraged and NHS England should work with CCGs to ensure they understood the role of QSGs and their place as members.

BRUCE KEOGH (Chair) thanked Paul Bate (CQC) and Lauren Hughes (NQB secretariat) for their updates. The NQB had agreed that their January 2013 report, *Quality in the new health system*, should be revised to provide a clear narrative as to how the system operated to maintain and improve quality, in light of the changes to the system post Francis. This narrative should be communicated clearly and widely; and as part of this work, analysis should be undertaken to identify gaps in the current quality architecture and set the scene for the future direction of the NQB. On QSGs, the NQB would sign-off the final version of the QSG guidance via correspondence.

ITEM 5: GENERAL UPDATE

Staffing guidance

BRUCE KEOGH (Chair) invited Jane Cummings (NHS England) to update NQB members on the publication of the staffing guidance, *A guide to support staff and commissioners in making the right decisions about nursing, midwifery and care staffing capacity and capability*, published on the NQB website on 19 November in line with the response to Francis.

JANE CUMMINGS (NHS England) thanked the team that had developed the guidance. The guidance had received good coverage and a lot of publicity, most recently being discussed at the Chief Nursing Officer summit.

Human Factors Concordat

BRUCE KEOGH (Chair) then invited David Haslam (Chair, Human Factors Sub-group) to update members on the publication of the Human Factors in Healthcare Concordat, which had also been published in line with the response to Francis on the NQB webpage.

DAVID HASLAM (Chair, Human Factors Sub-group) reported that feedback to date had been extremely positive, however, to prevent the Concordat from being perceived as an edict from the Centre, it was critical that work was undertaken on the next steps.

The following points were raised in discussion:

r) the work on Human Factors should be integrated with wider work programmes, and where work was already underway in this area, this should be made more explicit. In particular, this work should be encapsulated by the NHS England's Patient Safety agenda.

s) Mike Durkin (Director: Patient Safety NHS England) should engage with the Design Council and MHRA on their contributions to patient safety in terms of the design of technology and medical devices.

t) Human Factors related to both patient safety and quality improvement, a key challenge was how to change the culture of existing staff towards optimising human performance; and

u) there was a need to demonstrate the practical nature of Human Factors in relation to patient safety, for example use of instruments for testing organisational culture to understand whether they were safe and reliable.

Quality Accounts Review

BRUCE KEOGH (Chair) asked John Stewart (NQB secretariat) to update members on the Quality Accounts Review.

JOHN STEWART (NQB secretariat) reminded members that at the October meeting they had given their support for the review, which was set out in detail in the paper, NQB(13)(05)(04). Lay members were asked to be involved in testing information from the review.

OECD Quality Review

BRUCE KEOGH (Chair) then asked Anna Dixon (Department of Health) to update members on the Organisation for Economic Co-operation and Development (OECD) Quality Review, which had been previously discussed at the October meeting.

ANNA DIXON (Department of Health) informed members that the Department was exploring with the OECD and devolved administrations the option of undertaking a UK quality review. Consideration would need to be given to scope and timing, particularly in relation to the topics. An update would be brought to the NQB in due course.

BRUCE KEOGH (Chair) thanked members for the updates provided.

ITEM 6: ANY OTHER BUSINESS

BRUCE KEOGH (Chair) thanked members for their contributions to the meeting and invited members to raise any other business for consideration by the group.

JOHN STEWART (NQB secretariat) introduced a paper on seven day services, tabled at the meeting. Members were informed that the paper was to be taken to the NHS England Board that week and was being brought to the NQB for comment in advance. NQB members were asked to comment on the draft paper in correspondence to the secretariat.

The next meeting would be held on 25 February in London.