NATIONAL QUALITY BOARD

25 February 2014

13.00-16.00

Room 124A

NHS England, Skipton House, 80 London Road, London, SE1 6LH

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STATUS OF ACTIONS FROM 25 FEBRUARY MEETING

Work stream	Action	Status
Patient Safety	• Mike Durkin (Director: Patient Safety, NHS England) to consider the comments received by NQB members in developing the patient safety collaboratives. • Mike Durkin to provide update on patient safety at a future meeting, this may include consideration of potential indicators for the patient safety website.	Actioned For future meeting
Human Factors	• Mike Durkin (NHS England) to lead the Human Factors agenda with partners across the system. • Mike Durkin (NHS England) to work with NICE to commission guidelines on Human Factors. • Mike Durkin to ensure the role of Human Factors in procurement is recognised and to link in with the MHRA on this area. • HEE to consider Human Factors as a mandatory part of the curricula.	Ongoing Ongoing Ongoing Ongoing
Patient Experience	• Patient Experience Sub-group to progress work to develop a patient experience narrative and explore the development of a series of 'always events' and update at the next meeting. • Anna Dixon (DH) to bring a statement to a future meeting on the plans for the review of the NHS Outcomes Framework and its coverage. • John Stewart (NHS England) to bring a paper to a future meeting on the relevance of the NHS Outcomes Framework to organisations.	Ongoing For future meeting For future meeting
Complaints	• Anna Dixon (DH) and Neil Churchill (NHS England) to examine the complaints pathway and identify steps to address the fragmentation across the system. Update at next meeting.	For next meeting
System Alignment	• Secretariat to ensure that a community care and primary care lens is applied to future updates. • Secretariat to consider how to revise the *'Quality in the new health system document'* in line with comments received. Draft to the next meeting.	For next meeting For next meeting
AOB	• Anna Dixon (DH) to use comments from expert and lay members to inform the discussion at the Health and Care System Leaders Forum on the future role of the NQB.	Actioned

NQB (14) 1ST Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held at Room 124A

NHS England, Skipton House, 80 London Road, London, SE1 6LH

Tuesday 25 February 2014, 13:00 – 16:00

PRESENT			
Bruce Keogh (Chair)			
Stephen Thornton	David Haslam	Neil Churchill	Sally Brearley
Helen Hughes	Anna Dixon	Don Brereton	Emma Westcott
Stan Silverman	Hilary Chapman	Amanda Hutchinson	Margaret Goose
John Oldham	Ian Gilmore		
IN ATTENDANCE			
Mike Durkin			
APOLOGIES			
David Nicholson	David Bennett	Jackie Smith	Duncan Selbie
Sally Davies	David Behan	David Flory	Niall Dickson
Anna Bradley	Una O'Brien	Julie Mellor	Amanda Edwards
Jane Cummings	Ian Cumming		
SECRETARIAT			
John Stewart (NHS England)	Lauren Hughes (NHS England)	Sally Chapman (NHS England)	James Ewing (GMC)

Agenda

1. Welcome, context and purpose
2. Patient Safety (Paper Ref: NQB(14)(01)(02)
3. Human Factors in Healthcare (Paper Ref: NQB(14)(01)(01)
4. Patient Experience (Paper Ref: NQB(14)(01)(03)
5. Complaints (Paper Ref: NQB(14)(01)(04)
6. System alignment for quality (Paper Ref: NQB(14)(01)(05)
7. Any other business

ITEM 1: WELCOME AND INTRODUCTION

BRUCE KEOGH (Chair) welcomed members to the twenty eighth meeting of the National Quality Board (NQB). He welcomed Emma Westcott (NMC) attending on behalf of Jackie Smith, Neil Churchill (NHS England) attending for Jane Cummings, Helen Hughes (PHSO) attending for Julie Mellor, Anna Dixon (DH) attending for Una O'Brien, Stan Silverman (NHS TDA) attending for David Flory, and Amanda Hutchinson (CQC) attending for David Behan.

BRUCE KEOGH (Chair) informed members that the Health and Care System Leaders Forum recognised the value of the NQB and had given strong support for its continuation. Further discussions were to be held on the future role of the NQB and members would be informed of the outcome in due course.

ITEM 2: PATIENT SAFETY

BRUCE KEOGH (Chair) reminded members that Mike Durkin (Director: Patient Safety, NHS England) had presented to the December meeting and was now returning to update them on his work on patient safety. He asked that specific consideration be given to where the NQB organisations could most usefully align in support of this important agenda.

MIKE DURKIN informed members that the NHS England Board had given support for the establishment of fifteen Patient Safety Collaboratives across England and that the NQB's earlier comments had been used to inform their overall design.

The programme continued to be in the design phase. A 'Design Day' in January had been held to identify design principles, which included:

- Patients, their carers and families must be at the core of the planning of this initiative and not an add-on;
- Enabling priorities to be set locally in each Collaborative - national support and focus should only be used to add extra value, to make improvement easier to do;
- Emphasising a strong focus on measuring what we are trying to improve, and measuring it correctly – at the frontline, for improvement;
- Learning from what is already being done, not just in this country but across the world, and ensure best practice can be shared across all healthcare settings;
- Being inclusive, listening to and involving all levels of staff within healthcare organisations;

- Putting a simple vision at the heart of the Collaboratives rather than a complex system of structures and directions, and communicating it well, to establish an identity;
- Having a central focus on learning, sharing and innovating – bringing clarity to the breadth of available information;
- Using patient safety data transparently and where appropriate to recognise where problems exist, not for blame, punishment or performance management;
- Setting up Collaboratives at the right scale to ensure local buy in, so that all local people feel they can access and contribute towards their work; and
- Ensuring formative, real-time evaluation to keep the programme on track.

Members were informed that there would be further clarity on timelines once funding had been confirmed at the end of the financial year.

BRUCE KEOGH thanked Mike Durkin (NHS England) for updating the Board and asked NQB members to consider how they could support the successful delivery of this programme.

The following points were raised in discussion:

a) work was underway between NICE and NHS England, with NICE looking to develop a suite of safety interventions as the evidence base was now available;
b) the involvement of patients, advocates and patient representatives was fully endorsed. To support their involvement it was suggested a narrative be developed setting out the role of the Patient Safety Collaboratives and how they fit with other parts of the architecture, e.g. Strategic Clinical Networks, Academic Health Science Networks (AHSNs), Healthwatch and Collaborations for Leadership in Applied Health Research and Care (CLAHRCs);
c) how improvements resulting from the Collaboratives would be mainstreamed, and those organisations that would need to take action, should be included in considerations from the start, and factored into planning. Spread of knowledge would be a vital component of the network, which would require clear evidence and data to encourage the adoption of change at a local level;
d) the Collaboratives programme was seen as a key mechanism to drive forward the commitments made in the NQB's Human Factors in Healthcare Concordat, to ensure best practice became common practice;

e) strong links were identified with the work being undertaken by Norman Williams and David Dalton on candour and this should be taken into consideration;
f) the focus on primary care was welcomed, which was seen as potentially providing more 'bang for buck' than a purely acute focus. There was felt to be little sharing between primary and secondary care currently, therefore a systematic approach would be required to maximise the impact of Collaboratives. Taking a pathway approach could be beneficial, with the approach to improvements in stroke care in London was identified as an example which was yet to be replicated across the system;
g) a naturally defined health geography was not necessarily compatible with the AHSN geography, so different solutions may be required for each part of the country;
h) technical assistance to the Collaboratives might be required, made available from central funding or through NHS Improving Quality;
i) success criteria for the Collaboratives should be identified from the outset and factored into their development. Test criteria should also form part of the evaluation process. Mary Dixon-Wood and Martin Marshall were providing advice to the programme on evaluation;
j) practical concerns in relation to organisational and change fatigue were identified. Initial focus should be on those that want to be part of the programme as others would follow once there were clear examples of the difference the collaboratives could make; and
k) it was seen as important to move away from measurement of harm towards management of risk, with an emphasis on the patient.

MIKE DURKIN thanked members for their contributions. In relation to the wider safety agenda, members were assured that connections across organisations were being made through the Safer Care Working Group - established to consider the commitments made in *Hard Truths* and chaired by NHS England. This Group, which included most of the statutory organisations, professional and organisational regulators, reported to the DH's Francis Assurance Board.

It was also highlighted that there would be a publically accessible website on safety in organisations, which would be live on NHS Choices by June. It was suggested that the NQB may be able to support this work in future through discussion of potential indicators.

BRUCE KEOGH thanked members for their contribution and invited Mike Durkin to update members on progress at a future meeting.

ITEM 3: HUMAN FACTORS

BRUCE KEOGH invited David Haslam (Chair, Human Factors Sub-group) to update members on progress against the commitments set out in the NQB's *Human Factors in Healthcare Concordat* which had been published and referenced in the Government's response to the Francis Inquiry, *Hard Truths,* in November.

DAVID HASLAM reported that the Concordat had been well received, with other organisations considering retrospective endorsement. However, the required impact would not be achieved if there was no emphasis on delivery of the commitments set out in the Concordat, hence progress reports from signatory organisations had been commissioned and were set out in the paper (NQB(14)(01)(01).

NQB members were asked to provide a steer on:

- where delivery of this programme should sit;
- whether they wished to continue to receive updates on progress; and
- whether NICE should be commissioned to produce guidelines on Human Factors topics.

The following points were raised in discussion:

l) it was considered that the role of the NQB was not to programme manage the Human Factors agenda as a specific work stream. Rather it would be important that Human Factors was not seen as separate to the business as usual of the statutory organisations but embedded within their work and the activities of the NHS;

m) the Human Factors agenda should be led by those with responsibility for safety, with Mike Durkin (Director: Patient Safety, NHS England) playing an important role, particularly through the establishment of the Patient Safety Collaboratives;

n) HEE and the Leadership Academy should lead on ensuring Human Factors became a mandatory part of the curricula. It was suggested that there should be an aim for a critical mass of NHS employees to have an understanding of how to apply Human Factors approaches at a practical day-to-day level;

o) a piece of work should be undertaken with the leaders of National organisations (Chief Executives, Non Executives and Chairs) to raise their awareness of Human Factors as being key to them in running a safety critical industry. The DH was to

consider including Human Factors on the agenda for the workshops / seminars it was running for Chairs and Non Executives of its arm-length bodies;

p) awareness should also extend beyond Chairs and Non Executives, empowering all staff to employ Human Factors techniques;
q) procurement needed to recognise Human Factors. Mike Durkin (Director: Patient Safety, NHS England) was to link in with the MHRA on this issue;
r) it was suggested that the Safer Care Working Group, Sub-group of the DH Francis Assurance Board, could own the commitments set out in the Concordat in the same way it owned the response to Berwick and Francis. This should be discussed with the Group; and
s) NQB members agreed NICE should develop guidelines on Human Factors that complement existing guidelines.

BRUCE KEOGH thanked members for their contributions and confirmed that Mike Durkin (Director: Patient Safety, NHS England) should lead the Human Factors agenda working with partners across the system. This would include working with NICE to develop Human Factors guidelines and should extend to the role of procurement with links made to the work of the MHRA. An annual update against the commitments set out in the Concordat would be brought to the NQB to ensure that momentum was not lost.

ITEM 4: PATIENT EXPERIENCE

BRUCE KEOGH (Chair) invited Don Brereton (Chair, Patient Experience Sub-group) to update members on the work of the Patient Experience Sub-group.

DON BRERETON noted that the mapping exercise, in which all NQB organisations had participated, was now complete. This work had been used to inform an NQB Patient Experience workshop in February.

The workshop - which aimed to identify areas for the Sub-group to pursue on behalf of the NQB - had been well attended by representatives from the NQB organisations and their enthusiasm for this agenda was clear. The key message from the workshop was that there should be a shared narrative for patient experience to support collaboration between organisations, reflecting current frameworks and best evidence. It should describe what a good patient experience looks like and what should be aspired to in future.

There had also been an appetite to supplement this work through the identification of key interventions to improve patient experience, for example ‘always events’ - events that should always take place between the patient and service provider. This proposal would need to be explored with the Picker Institute which had adopted a similar model in the US. In addition, it was thought that it may be useful to examine patient experience in relation to different patient / service user pathways.

A key question raised at the workshop was whether the narrative should cover both health and social care. It was recognised that from the patient and family perspective, there was no distinction, and there was a need for health and social care to be joined-up.

BRUCE KEOGH thanked Don Brereton for updating members and asked members to provide their views on the proposed work programme for the Sub-group.

The following points were raised in discussion:

t) in the short-term it was recognised that the development of a patient experience narrative would be a helpful enabler to alignment in this area, and would be of particular use to those organisations that were just starting to identify and shape their role in this area;

u) support was also given for the development of a number of ‘always events’. It was thought that this could be particularly important in areas such as specialised services, helping those that surveys do not reach to think about what they need;

v) a longer-term piece of work for the Sub-group could be the review of the user and patient experience elements of the NHS Outcomes Framework, in particular influencing its coverage, scope and measurement, to be completed by 2016; and

w) given the objectives of the Sub-group, surveys were also seen as an important area given current misalignment, and there was an opportunity to influence expenditure on surveys and their future focus.

BRUCE KEOGH acknowledged the work of the Sub-group and the need to garner the momentum for, and commitment to, this agenda. As an initial piece of work, the Sub-group was to develop a narrative and examine the potential to develop a series of ‘always events’. The ability to influence the NHS Outcomes Framework could add value and this was to be given further consideration. The points in relation to social care were recognised and should be given further consideration, although it would be important to recognise the limitations of the narrative in relation to social care input and the evidence base in this area.

ITEM 5: COMPLAINTS

BRUCE KEOGH (Chair) invited Anna Dixon (DH) to set out the work being taken forward by the DH Complaints Programme Board.

ANNA DIXON explained that following the Clewyd / Hart Review into complaints handling in the NHS, the Complaints Programme Board had been established to bring together national bodies to implement the actions in relation to complaints handling set out in *Hard Truths*. It was also intended that the Programme Board would look more widely at complaints handling across health and social care.

In particular, the three most significant areas were highlighted as:

- CQCs work to strengthen the consideration of complaints within its inspection regime;
- work to improve transparency and alignment around data flows, which was being explored through a sub-group of the Programme Board; and
- adherence to the statutory obligations to: gather and share best practice happening in the system now; promote what should be happening locally (in line with statutory duties placed upon organisations); and encourage action at a local level as set out in *Hard Truths*.

Members were informed that the Programme Board was not, however, seen as the place to take forward the cross-system responsibility to articulate and promote best practice to encourage local behaviour change. NQB members' views were sought in particular on how this challenge may be approached, the levers and incentives that may be available, and where ownership for this work should sit.

The following points were raised in discussion:

x) consideration should be given to what good looks like for all actors in the system from the perspective of the individual patient through to the responsibilities of the Board;

y) a strong link with patient experience was acknowledged - if patient's had a good experience, there was likely to be no need for complaints;

z) focus should be given to those voices that were not heard, rather than those that were articulate and persistent, otherwise a rich seam of information would be lost;

aa) the devastating impact of complaints on staff was highlighted, and how staff respond to complaints was identified as a key issue. Support should be given to staff throughout the complaints process and behaviours confronted as required;

bb) consideration needed to be given to how the complaints system was accessed by individuals (previously it was the PCT and PALS), and how much public awareness there was of how to complain, including the second stage of the complaints procedure used when resolution had not been reached with the trust. Clear guidance should be made available to patients and the public;

cc) a mechanism was needed for those that wanted to raise observations and reflections for improvement rather than complain;

dd) it was suggested that often it was not the complaints process, but the response of the organisation that was at fault and it was therefore important to examine how organisations respond to intelligence and use it to improve. In particular, support was required for trusts to triangulate information and drive improvement;

ee) care needed to be given to language used to explain this work to the public;

ff) the Clewyd / Hart focus had been on hospitals, and it was thought that this approach should be broadened out to include, for example, primary care and dentists;

gg) consideration needed to be given as to how the system could respond in a consistent way once a complaint had been received;

hh) a complaints checklist was suggested; and

ii) capacity in the system to deal with complaints needed to be strengthened.

In summing up the discussion, BRUCE KEOGH recognised that the complaints pathway needed to be examined as a matter of urgency, with steps taken to address the fragmentation across the system and ensure organisations respond in a consistent way to the complaints they receive. There would be some action that needed to be taken in the short term to make the existing system work effectively, with longer term action to fundamentally examine how the system is arranged. DH and NHS England were to progress this work and update members at the next meeting.

ITEM 6: SYSTEM ALIGNMENT

BRUCE KEOGH (Chair) invited Amanda Hutchinson (CQC) and John Stewart (NQB secretariat and NHS England) to update members on the joint work being taken forward on system alignment by CQC, Monitor, the NHS TDA and NHS England.

AMANDA HUTCHINSON informed members that HEE was to be included in the work programme going forward. In relation to the three workstreams, a brief update was provided:

- On **governance, leadership and culture,** the aim was to develop the 'well-led' framework for all acute, mental health, community and ambulance providers by March.

- On **surveillance**, work to consider how to align data and data requests was now considering primary care data. The work on fundamental standards, requested by Robert Francis, was now out for formal consultation for response by 4 April. National Voices were considering whether the regulations needed to recognise person-centred care. The new CQC inspection regime was to be extended to cover mental health, community health services and GP out of hours care. Its acute provider handbook would be published for consultation in early April, covering acute, mental health and community providers. These would include key lines of enquiry and the judgement on ratings.

- On **accountability,** further work was required on the single failure regime.

In discussion, NQB members urged organisations to extend the work on system alignment which seemed to predominantly be related to hospitals, into community care and primary care.

BRUCE KEOGH then asked John Stewart to update members on the review of Quality Surveillance Groups (QSGs).

JOHN STEWART reminded members that QSGs had been in existence for a year. There continued to be variation in the effectiveness of QSGs, with some finding their scope challenging and further work required to support the sharing of learning and good practice. However, QSGs were considered to be a positive addition to the new system, helping to build relationships and identify problems locally and regionally. Following a period of engagement with QSG members, revised guidance to support QSGs in becoming more effective was to be published shortly. There was also to be continued work to support QSGs in reaching their full potential. Members were asked whether the revised guidance circulated with the papers for the meeting addressed the needs of QSGs.

The following points were raised in discussion:

jj) care should be taken to not over-formalise the operation of QSGs, as the initial intention was to allow local freedom to determine how best to identify issues and seek resolution;

kk) the guidance needed to provide advice on how QSGs should interact with providers;

ll) consideration should be given to a more formal evaluation of the system benefits of QSGs in relation to managing risk and quality;

mm) support was required for secretariats, in particular a standardisation of minutes may be helpful; and

nn) it was suggested a top-down view of quality be provided by NHS England and Monitor. This would include the identification of those health economies that had a propensity for failure, indicators for which could include: overspending; distance from tertiary provider; and split sites.

BRUCE KEOGH thanked members for their comments and asked John Stewart to lead the discussion on the review of the NQB's *'Quality in the new health system'* document.

JOHN STEWART reminded members that a number of guides had been produced by the NQB to provide greater clarity to the system: *'Review of early warning systems'*; later followed by *'Quality in the new health system'*. At the last NQB meeting it had been agreed that it would be helpful to revise *'Quality in the new health system'*, which had been published in January 2013, in advance of the new system going live and whilst the system was still in flux. It was highlighted that the process of producing this document had been as important as the document itself as it had forced organisations to work together. There was now an opportunity to produce a useful guide for those outside the statutory organisations.

Although much of the content was already available, NQB members were reminded that they had indicated the need for a future version to include an improvement focus, covering Strategic Clinical Networks, NHS Improving Quality, the Patient Safety Collaboratives and the Academic Health Science Networks. In addition, consideration of the look and feel of the final product was required to make it as relevant, accessible and useful as possible.

The following points were raised in discussion:

oo) absolute clarity was required on which organisation had ultimate responsibility in each area and how they worked in partnership;

pp) individuals, particularly patients and public, should be clear how each part of the system works for them and who they should approach if they have a concern;

qq) there should potentially be different documents for different audiences, or a more interactive approach which would have the advantage of being easily updatable. The approach should be tested with stakeholders, for example CCGs;

rr) consideration should be given as to whether there should be a stronger link up to the NQB from QSGs, with an aggregation of Regional QSG reports brought to the NQB to provide real intelligence on the system and the issues that need to be tackled. It was suggested that NQB meetings could be divided into two sections, the first part being a report from QSGs and the second retaining the current format. This needed further thought;

ss) the system target diagram developed by DH could be used as a format for making the document more interactive. It would be important to test any mapping of the system with patients and the public;

tt) discussions should be held with NHS Choices on how their website, which had a very high numbers of users, could support users to understand the health system; and

uu) the guide should include a section on accountability and transparency.

BRUCE KEOGH thanked members for their contributions. The secretariat was to consider how to progress this work and bring a draft for consideration to the next NQB meeting.

ITEM 7: ANY OTHER BUSINESS

BRUCE KEOGH (Chair) reminded members that this would be the last meeting for the existing expert and lay members whose appointments were to end in March. The expert and lay members were thanked for their valuable contribution to the work of the NQB, providing challenge to the statutory organisations and considerable input into the work of the Sub-groups.

The expert and lay members offered the following reflections on their time with the NQB:

vv) the mixture of opinions from expert, lay and statutory organisations was unique at this level and it was important to refresh this input rather than lose this mix ;

ww) the voice of the expert and lay members had added huge value to the discussions and had allowed a degree of grounding in the work of the NQB;

xx) the work of the NQB had advanced considerably over time and it was considered that the challenge would be to maintain momentum and drive improvement without adding to bureaucracy;

yy) the system alignment work programme was recognised as having been important and continued to be valuable as the system was still in flux;

zz) the work of the NQB had been particularly successful where there had been senior commitment from organisations at Board level;

aaa) a lot of work had been progressed on the assurance agenda, but the improvement agenda had not really been touched upon and should be given greater emphasis going forward;

bbb) the NQB required a strong chair and underpinning administrative support if it were to continue to be effective. Continuity of the chair and secretariat was seen as key in ensuring its success;

ccc) the time it had taken for organisations to reach a point where they could work together effectively, whilst ensuring people are not held back from their individual positions, should not be underestimated;

ddd) it was felt that the NQB did not work as effectively on political / media sensitive issues;

eee) there was a sense of achievement in that the patient experience work, first begun in 2011, was now clearly on the agenda and recognised as important;

fff) in health and social care there was always a dynamic set of issues, most of the work had been in relation to the acute sector and further consideration needed to be given to the interface with the non-acute sector; and

ggg) it was considered important that the NQB did not attempt to performance manage the system.

BRUCE KEOGH thanked the expert and lay members for their thoughts, which Anna Dixon (DH) was to feed back to DH to inform the discussion on the future role of the NQB at the Health and Care System Leaders Forum.

ANNA DIXON informed members that the Health and Care System Leaders Forum was clear that quality should remain at the top of the agenda and that it was the role of the NQB to take this forward. There was a need to keep the right level of commitment, and to refresh and repurpose the Board.

BRUCE KEOGH acknowledged the progress that had been made on alignment during the time of the NQB and thanked all members for their contributions.

The next meeting was to be on 17 June 2014.