NQB (12) 2nd Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held at Department of Health, Skipton House, Room 125A, 80 London Road, Elephant and Castle, London

Tuesday 17 April 2012

PRESENT		
David Nicholson (Chair)		
Ian Cumming	Jo Williams	David Bennett
Christine Beasley	David Behan	Liam Donaldson
Andrew Dillon	Jackie Smith	Hilary Chapman
Ian Gilmore	Victor Adebowale	David Haslam
Margaret Goose		Don Brereton
APOLOGIES		
Bruce Keogh	Mike Rawlins	Sally Brearley
Niall Dickson	John Oldham	Allan Bowman
SECRETARIAT		
Beth Hicks (DH)	Claire Barcham (DH)	Amanda Hutchinson (CQC)
Lauren Hughes (DH)		Toby Lambert (Monitor)

Agenda

1. General update (Paper Ref: NQB (12)(02)(01))
2. Review of CQC registration regulations (Paper Ref: NQB (12)(02)(02))
3. Improving dignity in care (Paper Ref: NQB (12)(02)(03))
4. Quality in the new system architecture (Paper Ref: NQB (12)(02)(04))

WELCOME AND INTRODUCTION

IAN CUMMING (National Director, Quality During Transition) welcomed members to the nineteenth meeting of the National Quality Board. He said that David Nicholson would be joining the meeting in due course and take over the chair.

He reminded the Board that they had previously considered representation from professional regulation to be an important gap in their membership that needed addressing. He was therefore delighted to welcome Jackie Smith (Acting Chief Executive, Nursing and Midwifery Council) to her first meeting. Niall Dickson (Chief Executive, General Medical Council), had also accepted an invitation to join the Board.

Continuing, he noted that this would be Dame Christine Beasley's (Chief Nursing Officer, Department of Health) last meeting. On behalf of the Board, he thanked her for the contribution she had made to the Board's work programme over the last three years.

ITEM 1: GENERAL UPDATE

Introducing paper NQB (12)(02)(01), IAN CUMMING (National Director, Quality During Transition) invited members leading specific work programmes to update the Board on any developments.

Quality Standards: ANDREW DILLON (Chief Executive, NICE) said that the full library of NICE Quality Standard topics had now been referred by Ministers following the Board's advice. The development of the standards were being sequenced, starting with those topics where NICE Clinical Guidelines already existed. Responding to a point raised, he confirmed that the new Quality Standard Advisory Committees would each include two lay members.

Quality Information Committee (QIC): DAVID HASLAM (Chair, QIC) said that the aim of the committee was to improve the quality of information relating to quality. It aimed to do this by focussing on relevant strategic questions, for instance around alignment, rather than on more technical issues.

Now moving into its second year, QIC was reviewing its work programme and would report to the Board on this later in the year. It had also recently extended its membership to include representatives from professional regulatory bodies.

Responding to a point raised, he confirmed that NICE would be welcome to join the QIC.

Quality Accounts: The Board noted that trusts were testing the new reporting requirements it had recommended in its December 2011 meeting in their 2011/12 Quality Accounts before being mandated for the 2012/13 round of Quality Accounts.

Patient-led inspections: CHRISTINE BEASLEY (Chief Nursing Officer, DH) reported good attendance at the inaugural Steering Group meeting in March, including strong representation from the Care Quality Commission (CQC). The Steering Group had discussed the issues raised by the Board at its meeting on 16 February 2012, including: how to make the new process cost neutral yet ambitious; the meaning of “patient-led”; and how to select patients for involvement, working with Local Involvement Networks (in the future local HealthWatch). She informed the Board that funding for the development of the new process had also been agreed.

ITEM 2: REVIEW OF CQC REGISTRATION REGULATIONS

DAVID BEHAN (Director General, Social care and Local Government, DH) welcomed Richard Murray (Director of Finance, Strategy, Quality and DH) to the meeting and invited him to introduce paper NQB (12)(02)(02).

RICHARD MURRAY explained that primary legislation conferred on CQC its role and powers, whilst the framework of secondary legislation covered:

- which organisations must register with CQC;

- the essential safety and quality requirements that organisations must meet in order to register with CQC; and

- other requirements that registered organisations must meet – for instance around reporting information to CQC.

When CQC was established, the Department of Health committed to keeping the framework of secondary legislation under review. Now underway, the Department's review would consider whether recent developments meant the secondary legislation needed to change to keep CQC registration effective and proportionate – considering, for instance, relevant National Audit Office reports, the CQC capability review and the Health and Social Care Act 2012.

Continuing, he said that the review would also need to take into account events anticipated later in the year, including publication of the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, the NQB's own report on quality in the new system architecture, and the cross-Whitehall review of regulations known as the "Red Tape Challenge". He drew the Board's attention to paragraph 13 of the supporting paper which set out some specific questions that the review was planning to consider. Concluding, he said that although it was necessary to review the secondary legislation now, a broader and more strategic discussion was probably needed about how best to regulate for quality across health and social care in the future. The review would need to take account of any such discussion and how any conclusions might impact on the framework of secondary legislation.

DAVID BEHAN (Director General, Social Care and Local Government, DH) invited the Board to comment on the paper. The following points were made in discussion:

a. the paper provided a useful reminder of the importance of secondary legislation;

b. the Department's review had come at a helpful time, as CQC had started to review its strategic direction for the next five years;

c. it would have made more sense for the Board to consider the fundamental issues around CQC's role, powers and relationships with other regulators before looking at the detail of its regulatory framework. Some of these bigger questions went to the heart of whether the regulation of quality in health and social care was effective and proportionate, including:

    i. whether CQC's regulatory role was manageable in view of the system's size and complexity, or whether some quality assurance responsibilities should be given to other organisations such as the NHS Commissioning Board;

    ii. the extent to which CQC should only focus on the essential standards of quality and safety;

    iii. CQC's organisational design;

    iv. how to understand risk and ensure regulation was proportionate to it, including when 'light touch' regulation was appropriate;

    v. how to help CQC take faster enforcement action; and

    vi. whether providers had sufficient resources to deliver the essential standards of quality and safety;

d. the review should take into account developments in social care as well as healthcare, such as the final report of the Commission on Improving Dignity in Care. The Standing Committee on Carers should also have the opportunity to feed into the review;

e. the issues identified for the review should focus more on outcomes. Having a whistleblowing procedure in place, for instance, was meaningless if it didn't bring about a culture of openness;

f. the question of how to regulate single-handed professionals was important, but there was a risk of arbitrary distinctions between small teams with one or two clinicians;

g. the review should consider how to ensure that the 'essential levels of quality and safety' commanded the full confidence of frontline professionals. The Royal Colleges could help here; and

h. the review should consider how to address providers that continually breached registration requirements. A series of minor problems in a provider should raise concerns about the existence of more fundamental issues. New powers in the Health and Social Care Act 2012 to address those at risk of failure could help with this.

Summing up the discussion, DAVID BEHAN (Director General, Social Care and Local Government, DH) said that the Board had highlighted the need to reconcile the detailed questions raised by the review of regulations with bigger issues around CQC's role, functions, design and relationships. The system needed to take a position on these fundamental questions to inform the review.

He invited Dame Jo Williams, Chair of the Care Quality Commission, to present to the Board on CQC's review of its strategic direction at the next meeting.

ITEM 3: IMPROVING DIGNITY IN CARE

Part 1: Update on the work of the Commission on Improving Dignity in Care (the Commission), including its draft report and recommendations

DAVID BEHAN (Director General, Social Care and Local Government, DH) welcomed Keith Pearson (Chair, Commissioning on Improving Dignity in Care) and Louise Fish (Director of Communications, Commissioning on Improving Dignity in Care) to the meeting. He invited Keith Pearson to present their draft report and recommendations to the Board.

Introducing paper NQB(12)(02)(03), KEITH PEARSON said that the Commission had been established after the Local Government Association (LGA), Age UK and the NHS Confederation identified a need to explore issues around dignity and respect for older people in hospital and care settings.

The Commission had published a draft report for consultation, which included 48 recommendations for action across hospitals and care homes. It had received 230 consultation responses, which were broadly supportive of the issues identified in the draft report and its recommendations.

LOUISE FISH, said that the main messages from the consultation responses were:

- there should be a greater focus on the need for improved integration across health and adult social care services when planning and commissioning for older people's care;

- appropriate funding for adult social care was important to ensure dignity and respect in care, and better integration and strong leadership could help to release more resources. Equally, many staff and organisations provided excellent care to older people without relying on significant resources;

- appropriate staffing ratios were also important. The staff skill mix at ward level should match the needs of the patients being treated;

- much of the report's discussion around the roles and responsibilities of nurses could be applied equally to other clinical and support staff, to more accurately reflect interactions with patients and service users;

- spiritual support including chaplaincy could also be highlighted as an important part of ensuring dignity and respect;

- further work was needed on dignity and respect in the care given to older people in their own homes; and

- whilst the report focused on the care of older people, many of the recommendations were equally applicable to other vulnerable groups, such as people with learning disabilities.

Continuing, KEITH PEARSON explained that after publication of the final report, the Commission would implement an action plan aimed at ensuring the Commission's recommendations were acted on, which included:

- a 'hearts and minds' campaign;

- best practice materials, including some of the case studies the Commission had received through the consultation;

- help for individual staff members to recognise what dignity in care looks like and how to change their practice to achieve it;

- incorporating compassionate values in education and training and recruitment processes; and

- empowering patients, services users and their families to know what to expect from their care and give constructive feedback.

He highlighted how the Board's support could help the implementation of the Commission's action plan. Concluding, he said that he was particularly interested in hearing the Board's views on two specific recommendations:

- the creation of a care quality forum along side a nursing quality forum; and

- the regulation of healthcare assistants.

DAVID BEHAN (Director General, Social Care and Local Government, DH) thanked Keith Pearson and Louise Fish for the overview they had provided and invited the Board to comment on the Commission's draft report. In discussion, the following points were made:

i. the new Nursing and Care Quality Forum, which was announced by the Prime Minister in January 2012, would consider the quality of nursing and care in all care settings. A separate forum therefore felt unnecessary and risked duplication;

j. the Department of Health was considering the Commission's recommendation regarding the regulation of healthcare assistants and planned to issue a separate response;

k. the Commission had produced an excellent draft report which identified important issues and provided helpful recommendations. The LGA, Age UK and the NHS Confederation were to be commended for identifying a problem and taking the initiative to try to address it. The challenge now was how to use the report to drive forward change;

l. a relatively small proportion of care provider organisations had responded to the consultation, highlighting the need for further engagement with the

sector. Provider organisations would respond well to recommendations that set out measurable and auditable actions – for instance, patient surveys could be used to audit whether staff were having appropriate conversations with older patients;

m. the Commission should be mindful of the risk that frontline staff could find the report demoralising, particularly given the number of recent reports and recommendations issued to the health and care systems;

n. the large number of recommendations included in the draft report risked a 'tick-box' and superficial response, missing the transformative vision at the heart of the report. The recommendations could be condensed by grouping them around key themes – for instance continuity of care, integration of health and social care, and involving families in care;

o. it was difficult to translate some of the factors that affected dignity and respect into a set of actions – for instance, professionals' values and empathy or the example set by role models such as senior consultants. It might be more effective to combine a simple message that captured the report's vision and could be communicated widely with steps designed to create an environment that supported professionals to be compassionate and empathetic;

p. recommendations around education and training were vital in order to embed the right values in care professionals. They needed to understand from the beginning that compassion, dignity and respect were fundamental to care. These values should be built into recruitment, under- and post-graduate education, continuing professional development (including for senior staff) and performance management processes;

q. the recommendation that older people receive a comprehensive assessment of their health and care needs might be helpfully applied to all older people receiving health or care services – not just those about to be discharged from hospital;

r. bullying and harassment of patients and service users was an important issue, aggravated by their fear of speaking out in case of further persecution. Volunteers acting as intermediaries in hospitals to empower older patients to raise concerns was a welcome suggestion. The Commission could consider whether there was a role for HealthWatch here;

s. the report could build on the concept of 'never events', and set out a small number of things that should never happen in the care of older people, for instance the use of a urinary catheter based on staff convenience rather than patient need; and

t. the language in the report could be refined in some areas: the term "discharge" could imply that a pathway of care ended when a person left hospital – "transfer of care" might be more appropriate; the term "geriatric" could be interpreted with negative connotations; and the language around the comprehensive geriatric assessment suggested that this should always take place in a hospital, whereas there should be a more flexible approach to who carries this out and where.

Responding to the points raised in discussion, KEITH PEARSON thanked the Board. He would, in particular, consider further the Board's advice about the language used in the report, how the report addressed care professionals' working environment and recognised professionals' achievements and values, and how best to secure implementation of the recommendations.

Continuing, he said that the Commission planned to launch the action plan in the autumn, alongside a higher level narrative around the importance of dignity and respect in caring for people, supported by practical guides for providers on how the steps they could take to improve dignity and respect. This should reflect the Board's views on the importance of communicating the Commission's transformative vision.

Summing up the discussion, DAVID BEHAN (Director General, Social Care and Local Government, DH) said that the Board was supportive of the issues raised in the report and for the need for action. The challenge would be where to go next and how the problems could best be addressed through the new and emerging system architecture. Members of the Board from the Department of Health would take away the recommendations specifically for the Department and ensure the Commission received a full response.

Part 2: Consideration of the system's response to the Commission's final report and recommendations

The CHAIR (David Nicholson, NHS Chief Executive) invited David Behan to lead the Board in a discussion about how the system might respond to the Commission's final report and recommendations, once published. The following points were made in discussion:

u. many of the recommendations in the report could be carried forward by existing vehicles; for instance, the report could help NICE to identify topics for Quality Standards in social care, which could communicate best practice on providing dignity and care;

v. the response to the Commission should be driven from the bottom up. Values like dignity and respect were more likely to take root where individual professionals felt ownership of them, not where they were dictated by top management. However, the system needed to support individuals to maintain these values. National organisations should take dignity and respect into account when carrying out their functions, to ensure that all parts of the system were aligned towards dignity and respect;

w. the response should focus strongly on the vision at the heart of the Commission's report and highlight a compelling story that resonated with professionals;

x. the response should look to frontline leaders, for example ward sisters, to drive change;

y. the response should ensure that individuals and organisations share innovation and best practice in treating older people with dignity and respect; and

z. the response should line up with any actions arising out of the investigations into Mid Staffordshire NHS Foundation Trust and Winterbourne View care home, where a lack of dignity and respect was a fundamental issue.

Summing up the discussion, DAVID BEHAN (Director General, Social Care and Local Government, DH) said that members should consider how the Commission's draft recommendations might map across to existing and planned work programmes for their organisations. The Board would then use this as a basis for a further discussion about next steps.

ITEM 4: QUALITY IN THE NEW SYSTEM ARCHITECTURE

Introducing paper NQB (12)(02)(04), IAN CUMMING (National Director, Quality During Transition) updated the Board on the areas of work that he had been asked to lead:

Maintaining quality during the transition: it was proposed that, by June 2012, PCT and SHA clusters would have produced a plan for how they intended to hand over functions and responsibilities to successor organisations. An important point the Board raised in its last meeting was how to ensure soft intelligence was handed over, which the clusters' plans should address.

The CHAIR invited comments from the Board on the handover process. The following points were made in discussion:

aa. whilst handing over soft intelligence was important, organisations that possessed information sometimes did not act on it. The culture of 'guilty knowledge' needed to be addressed, by giving someone specific responsibility for following up on intelligence. At the same time, it would be important not to over-burden the system. It might not be possible to investigate every potential issue on the basis of ambiguous information. It was easier to distinguish warning signs in retrospect;

bb. if all handover information was put in the public domain, organisations could be reluctant to include soft intelligence not backed by a high degree of proof; and

cc. the transition must ensure that the culture of quality improvement is continued. Handover arrangements should include organisations' approach to quality improvement, and any unrealised future plans.

Responding to the points raised, IAN CUMMING (National Director, Quality During Transition) said that soft intelligence would not be expected to be made public. He also explained that a key section of the legacy documents would cover any programmes of work to improve quality that were planned or under way, which the new organisations might want to continue.

***Developing a single operating model for quality*:** the National Quality Team was preparing a series of "How To" guides, aiming to promote best practice on issues such as how to run a risk summit and how to prepare a legacy document. The draft documents had been sent to Monitor and CQC for comments. Once updated, they would be shared with Board members. The aim was to publish them shortly.

Responding to a question from the CHAIR, IAN CUMMING (National Director, Quality During Transition) agreed that a communications strategy would be needed to raise awareness of the guides. This could include promoting the guides amongst non-executive directors and through partner organisations.

***Developing a dashboard of quality indicators*:** the National Quality Team had been preparing a dashboard of quality metrics. Whilst not a performance management tool, the dashboard contained useful indicators, such as nurse/bed ratios. The aim was to make the dashboard user friendly, with a facility to drill down into data. Analysing these indicators could prompt further questions and conversations to help uncover any problems. The dashboard was fully aligned with CQC's quality and risk profiles. The National Quality Team was also working on a dashboard for quality in primary care.

Responding to a question from the CHAIR, IAN CUMMING explained that the dashboard had not originally been designed for the Board to use, but it could prove helpful. It was agreed that the Board should further consider the dashboard and how it might be used at its September meeting.

***Maintaining and improving quality in the new system architecture*:** Following publication of the Healthcare Commission's report into events at Mid Staffordshire NHS Foundation Trust in 2009, the Board had been asked to review the systems and processes in place in the NHS for detecting quality failures. The Board's subsequent '*Review of Early Warning Systems in the NHS'* report, published in February 2010, reinforced the concept of a risk summit and clarified roles and responsibilities for preventing and responding to failure throughout the system. This included the SHA being responsible for 'holding the ring' in the event of quality failure in a provider to ensure that any regulatory, commissioning and performance management action remained aligned and coordinated.

The Board was now reviewing this report in light of the new system architecture. The review was aiming to:

- clearly articulate the distinct roles and responsibilities of different organisations throughout the system with respect to quality. Statements on roles and responsibilities were being developed from existing work and aligned with the legislative framework;

- set out a new model for assuring quality and responding to failure that facilitated the different parts of the system in sharing information and intelligence on quality and taking aligned and coordinated action in the event of a quality failure; and

- signal some broader policy issues that would need addressing over the medium term– for example, bringing about greater alignment between professional and system regulation for quality.

On the second of these areas, he reminded the Board that it had considered at its December 2011 meeting a proposed model for assuring quality and responding to failure in the new system. He updated the Board on recent work on developing this model.

This model comprised two parts. The first, proactive part consisted of Quality Surveillance and Assurance Groups being established which would bring together different representatives from across a local area to regularly review and triangulate data and soft intelligence relating to quality The second, reactive part promoted the existing risk summit model as a means of ensuring co-ordination of the management, regulatory and commissioner response to a quality failure in a provider organisation. The risk summit would take responsibility for ensuring action happened, and also help minimise the burden of regulation on providers.

It was proposed that the proactive part of the model should operate at two levels - on the footprint covered by the NHS Commissioning Board's local offices and regional offices. The model proposed that the NHS Commissioning Board should chair the Quality Surveillance and Assurance Groups as the organisation responsible for commissioning for the population, on behalf of the taxpayer.

The proposed model had been tested at a recent Accelerated Solutions Event, with over 60 senior-level stakeholders. There had been widespread support for

the concept of Quality Surveillance and Assurance Groups, and universal support for promoting risk summits.

Testing the model raised a number of questions and issues, including:

- holding a risk summit should not necessarily be seen as a ‘punitive’ measure. A provider could trigger a risk summit as a means of gaining constructive support from commissioners and regulators;

- there would need to be a means of feeding staff and patient voice into the quality surveillance and assurance process;

- Quality Surveillance and Assurance Groups would need clear mandates and appropriate seniority of attendees; and

- there was a debate about whether meetings should be held in public or private. Whilst Quality Surveillance and Assurance Groups might have an element that was open to the public, it would be difficult to hold a risk summit as a public meeting given the sensitive information that may be discussed.

The CHAIR invited comments from the Board. The following points were made in discussion:

dd. the potential value of a risk summit in helping providers was well understood. However, there was a risk that providers might feel the proposed Quality Surveillance and Assurance Groups as an extra burden, particularly if they already had mature relationships with local commissioners and local representatives of regulators. Consideration should therefore be given to whether an ‘earned autonomy’ element could be built into the model;

ee. clear descriptions were needed of the roles and responsibilities for quality, and it was helpful that the report would be addressing this;

ff. it might be appropriate for representatives from the CQC to chair the proposed Quality Surveillance and Assurance Groups and risk summits. This could provide a clear signal that the quality regulator was in the lead, and respond to any concerns about confusion in roles for assuring quality and responding to failure;

gg. a merit of the proposal that the NHS Commissioning Board should chair the Quality Assurance and Surveillance Groups and risk summits was that the risk summit could be used to evaluate the impact of any proposed regulatory action. It may be more difficult to do this if the regulator was also chairing the risk summit; and

hh. an alternative model could see an independent chair of Quality Assurance and Surveillance Groups and risk summits.

Summing up the discussion, the CHAIR noted that there were different views on chairing arrangements of the proposed Quality Assurance and Surveillance Groups and risk summits. He asked for an options appraisal to be developed to support further conversations between Ian Cumming and individual Board members. A first full draft of the report should be considered by the Board at its next meeting.

ANY OTHER BUSINESS

The CHAIR said that he thought it would be useful for the Board to have a discussion about the NQB's future role and purpose in the new system, including membership, at the next meeting.