NQB (12) 1st Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held at Department of Health, Skipton House, Room 137B, 80 London Road, Elephant and Castle, London

Monday 27 February 2012

PRESENT		
David Nicholson (Chair)		
Jo Williams	Bruce Keogh	Sally Brearley
Victor Adebowale	David Haslam	Don Brereton
Mike Rawlins	John Oldham	Hilary Chapman
Stephen Thornton	Sarndrah Horsfall	Margaret Goose
Ian Cumming	Allan Bowman	Christine Beasley
David Behan		Tim Kelsey
APOLOGIES		
David Bennett	Sally Davies	Liam Donaldson
	Ian Gilmore	
SECRETARIAT		
Beth Hicks (DH)	Claire Barcham (DH)	Rebecca Clutterbuck(DH)
Rachel Markey (DH)	John Stewart (DH)	Toby Lambert (Monitor)

Agenda

1. Quality during and post transition (Paper Ref: NQB (12)(01)(01))
2. Public health Quality Standards (Paper Ref: NQB 12)(01)(02))
3. Patient-led inspections (Paper Ref: NQB (12)(01)(03))
4. Update on Nursing Quality & Care Forum *presentation on the day*

WELCOME AND INTRODUCTION

The CHAIR, David Nicholson (NHS Chief Executive, Department of Health), welcomed members to the eighteenth meeting of the NQB, and the first of 2012. Apologies were noted.

Updating the Board on several developments since the previous meeting, the CHAIR said that:

- SALLY BREARLEY had been appointed as Chair of the Nursing and Care Quality Forum that had been announced by the Prime Minister at the start of the year;

- following recent comments on the Health and Social Care Bill, including from some Royal Colleges, the Board should keep in mind its unique role in bringing members together to ensure that the right people and processes were in place to maintain and improve quality during the transition; and

- assuming the Health and Social Care Bill was enacted, the Board would need to discuss and decide on its own shape and role in the new healthcare landscape. In the meantime, the Board should extend the terms of members whose appointments were due to expire in March 2012 for a further six months to ensure continuity during the transition to the new system architecture.

Responding to the CHAIR'S opening remarks, the Board congratulated SALLY BREARLEY on her appointment as Chair of the Nursing and Care Quality Forum.

ITEM 1: QUALITY DURING AND POST TRANSITION

Part 1: Update on the work of the National Quality Team, including the NQB's phase two report on quality in the new system architecture

Introducing paper NQB (11)(06)(01), IAN CUMMING (Managing Director for Quality During Transition) reminded the Board that the National Quality Team had been established to support the Board in implementing its February 2011 phase one report, *'Maintaining and Improving Quality during Transition'*, and to enhance the operational focus on quality during the transition more generally. The team was also supporting the Board in developing its phase two report on how quality would operate in the new system architecture.

Continuing, he updated the Board on five specific strands of work he had been asked to lead:

Maintaining quality during the transition: this strand of work was focused on ensuring that NHS organisations implement a robust handover process, as recommended by the Board in its report, *'Maintaining and Improving Quality: Effectiveness, Experience, Safety'.* There was a body of evidence, including a valuable CHI report, *'Lessons from CHI Investigations 2000-2003'*, that showed the importance of a robust handover to mitigate any adverse impact of organisational change.

PCTs, SHAs, PCT clusters and SHA clusters had all produced handover documents. This was, in effect, a 'pilot process' to test handover arrangements before organisations formally passed responsibilities to successor organisations at the final point of handover at the end of March 2013. At this point the handover would be particularly complex, with responsibilities being passed on to multiple organisations. For example, PCT and SHA clusters would be handing over responsibilities to multiple organisations, including clinical commissioning groups, the NHS Commissioning Board, the NHS Trust Development Authority, Health Education England, local authorities and Public Health England.

Together with SIR BRUCE KEOGH and CHRISTINE BEASLEY, the National Quality Team had carried out assurance visits to check on the pilot process in each SHA cluster. There was consensus that the exercise was useful and highlighted the importance of holding detailed, face to face handover conversations. Issues arising during the assurance visits included:

- a lack of awareness of the Board's phase one report and the requirement to produce high quality handover documents, in spite of several communications. The Board would need to give thought to future communications on this issue to ensure maximum impact;

- variation in the quality and length of handover documentation. A 'How To' guide was therefore being developed which would include advice on how best to capture the most salient points. There was also a particular need for guidance to resolve some practical and technical issues, for example around storing data during the transition;

- differences in the focus and emphasis of the handover documents. For example, NHS London chose to include in their handover their ambition for improvement, so that their legacy document included not only risks, but also recommended solutions;

- how to ensure the need for public transparency around the handover process did not preclude the essential need to pass on more sensitive information and 'soft intelligence' on risks within the system;

- the importance of holding detailed, face to face handover conversations, as well as written documentation, as a way of sharing soft intelligence. Some handovers were missing important input from staff that had already left the organisation, reinforcing the need for the handover process to be ongoing rather than an activity that took place at a fixed point in time;

- a tendency for the handover documents to be more focused on the acute sector. More attention needed to be given to capturing handover issues in primary and community care, social care, mental health and the independent sector; and

- the importance of triangulating the intelligence with the regulators, LINks, OSCs and other relevant organisations, to ensure the legacy documents could be relied on for a consistent and accurate picture of an organisation prior to handover.

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

a. the fact that some handover documents focused on quality improvement was welcome. The handover should capture risks, but also carry forward innovation, best practice and ambition;

b. the handover process should be used to invoke a culture of learning and improvement, facilitating a climate where people felt able to raise concerns. This would help legacy documents to capture all relevant information, and not read like marketing tools;

c. there could be more opportunities to build in the patient voice, such as through greater involvement of the voluntary and community sector, and also staff experience. Whether patients and staff would recommend a provider to friends or family members needing care provided important insight into the quality of an organisation; and

d. Monitor and CQC should have an opportunity to comment on all legacy documents.

Concluding discussions on this strand of work, the CHAIR noted that the handover process conducted during 2011/12 had proved helpful and rightly

promoted transparency. It would be important for the National Quality Team to continue to support this work throughout 2012/13 as organisations moved towards the final point of handover / legacy. This should include the provision of practical tools and guidance on how to conduct a robust, proportionate and transparent handover, with particular emphasis on the importance of face to face conversations, supported by written documentation.

***Developing a single operating model for quality*:** this strand of work focused on developing a single operating model for quality, rather than the previous 10 differing models that had been adopted by the 10 former Strategic Health Authorities. A series of 'How To' guides were being developed to support this work.

The Board – took note

***Developing a dashboard of quality indicators*:** this strand of work, which formed part of the broader work to develop a single operating model for quality, aimed to identify a small number of quality indicators that the NHS Operations Executive could use to monitor quality from a national perspective, in the same way as for finance and performance. The Board had before them a draft version of the dashboard, which was based on the NHS Outcomes Framework. Further work was needed over the next month to finalise the indicator set.

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

e. for performance monitoring purposes, quality information needed to be current. The intention should be to select indicators that could be monitored on a monthly basis or even more frequently if possible;

f. any dashboard should be made publicly available- the complexity involved in interpreting some of the data was not a reason not to do this;

g. explaining the relationship between the dashboard and CQC's Quality and Risk Profiles would be essential. It would be important to make sure that the indicators on the dashboard represented a sub-set of the broader set of data CQC used to develop their risk profiles;

h. the dashboard was too focused on the acute setting. It would benefit from indicators of quality in primary care, mental health and community services; and

i. thought should be given to how best to harness social media and new communications technologies.

Summing up the discussion, the CHAIR said that the dashboard would be important in helping the NHS Operations Executive to monitor quality performance during the transition more broadly than the current set of performance data allowed and in a timely manner. However, it would be important to ensure there was clarity about how the selected indicators aligned with both the new NHS Outcomes Framework as well as the data CQC used to derive their provider level Quality and Risk Profiles.

***Maintaining and improving quality in the new system architecture*:** this strand of work focussed on supporting the Board to produce its phase two report on how quality would operate across the new system from April 2013. On 1 March, the Board would host an event designed to test a proposed model for assuring quality and responding to quality failures against a number of scenarios across different health and care settings. The Board would receive a report about the event at its April meeting.

The Board – took note, with approval

***NHS response to the Mid Staffordshire Public Inquiry*:** this strand of work was intended to help the NHS prepare to receive and implement findings from the Francis Inquiry. The Board would be kept informed of its progress.

The Board – took note

Summing up the overall discussion, the CHAIR thanked IAN CUMMING for his update. He said that the Board's *Review of Early Warning Systems* in 2010 had been an important document, but the low levels of awareness of the report across the service meant that the Board would need to think more creatively about communicating its phase 2 report on how quality would operate in the new system architecture. It was not enough to just publish a report and hope that the system would implement it. Concluding, he said that the Board would also provide a very important forum for thinking through how the overall system responded coherently and in an aligned way to findings and recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Part 2: Quality Improvement- NHS Commissioning Board perspective

Introducing the second part of the first item, SIR BRUCE KEOGH (NHS Medical Director) said that the NHS Next Stage Review put quality at the heart of the health system's priorities. He highlighted Lord Darzi's seven step quality framework to bring about high quality care for all, and noted the Board's significant impact on each step.

Continuing, he said that innovation was particularly important to delivering improved quality of care for patients. Although the quality framework helped build the infrastructure for quality in a systematic way, on its own it was not enough. The new healthcare landscape presented a tremendous opportunity to reduce the time it took for innovations to be picked up, spread and embedded in healthcare. A strategy and 'model for change' was needed to help the NHS take advantage of this opportunity.

JIM EASTON (National Director for Improvement and Efficiency) said that, on behalf of the NHS Commissioning Board, he was developing a strategy and model for change, which was designed to unite the different organisations

involved in the commissioning process around a common purpose: spreading innovation and driving continuous improvement in healthcare.

Continuing, he said that there were a range of difficulties to overcome in spreading innovation in healthcare. The NHS was generally very good at invention, but all too often failed to follow this up with active steps to identify the innovations that should be spread across the system and implemented at scale and pace. Not all new ideas could be mandated, but there were a range of levers that could encourage the NHS to adopt new behaviours, such as the tariff. The strategy and model for change therefore aimed to create a more organised and systematic approach to bringing about change and driving quality improvement. He said that there were eight pillars to the change model:

- Connect the change process to a higher purpose- does the improvement meet our shared NHS purpose?

- Leadership for change- do all our leaders have the skills to create transformational change?

- Engaging and mobilising for change- are we engaging and mobilising all the right people?

- Spread of innovation- are we designing for the active spread of innovation from the start?

- System drivers- are our processes, incentives and systems aligned to enable change?

- Transparent measurement- are we measuring the outcome of the change continuously and transparently?

- Improvement methodology- are we using an evidence-based improvement methodology?

- Rigorous delivery- do we have an effective approach for delivery of change and monitoring of progress towards our planned objectives?

The CHAIR invited the Board to comment on the NHS Commissioning Board's emerging change model for the commissioning system. In discussion, the following points were raised:

j. the model was extremely helpful. However, its success would depend on wider engagement to gain collective buy-in from the key players across the system. Many of the key players were represented on the Board, but other organisations would also need to be involved in taking the model forward, including health and wellbeing boards;

k. targeting the model at the commissioning system risked alienating other parts of the system. Instead, the overarching model should be adopted by the overall healthcare system and adapted as appropriate for different sectors;

l. the model needed to take into account that the NHS was not one organisation, but several. The Board had made steps towards greater alignment, but the model would still need to overcome the boundaries between sectors and organisations;

m. the model should not focus too heavily on payment levers. Whilst they may drive behaviour, it would also be important to address underlying cultures so that people valued change independently of any accompanying payment. Cultural barriers to change might include unwillingness to accept others' ideas or over-testing new ideas;

n. education and training would be important if the model was to bring about the cultural change desired. The role of Health Education England should be considered here. However, it would also be important that the model did not undermine individuals' confidence in exercising their professional judgment, in their patients' best interests;

o. the model would help respond to the need for greater prioritisation, and would be key to supporting the NHS to convert into action the priorities set in the Secretary of State's Mandate to the NHS Commissioning Board. The value of prioritisation could be seen from large organisations in the private sector, which tended to drive change around a small number of key improvements each year;

p. the NHS Constitution could provide an important tool for capturing and reinvigorating purpose and values, although it was unclear how far the NHS Constitution currently motivated people and how it could best be used to support the model; and

q. good lines of communication were essential to spreading new ideas. Healthcare leaders needed to know what the formal and informal networks were saying.

Summing up the discussion, the CHAIR thanked JIM EASTON for addressing the Board. He said that although the change model had been developed with the commissioning system in mind, given the high levels of support from members of the Board, there was a really powerful opportunity for the overall healthcare system to adopt it as a single model of change for the NHS. Getting the NQB and all its members to sign up to the model would be a very important first step, and the Board's phase two report on how quality would operate in the new system architecture provided a potential vehicle for setting out the Board's collective sign up to it.

ITEM 2: PUBLIC HEALTH QUALITY STANDARDS FOR THE NHS

Introducing paper NQB (12)(01)(02), SIR MICHAEL RAWLINS (Chair of the National Institute for Health and Clinical Excellence) said that the Board had requested a paper about proposals for a suite of NICE NHS Quality Standards on cross-cutting public health topics. He said that the NHS Future Forum, in its report on the NHS's role in the public's health, had also recommended that Quality Standards about public health topics should be developed for the NHS.

He noted the large amount of public health guidance produced by NICE over recent years, which had been targeted at both NHS and non-NHS audiences either separately or together. The paper before the Board, however, was specifically about developing NHS facing Quality Standards on public health topics.

Continuing, he referred the Board to the meaning of 'cross-cutting' considered in the paper: public health interventions delivered by the NHS. There were three proposed topics for NHS Quality Standards on public health, which would be based on existing NICE public health guidance addressed to the NHS:

- Smoking cessation: supporting patients to stop smoking in a range of health settings;

- Physical activity: encouraging activity in patients and staff across the health service; and

- Alcohol: preventing and managing alcohol misuse in a range of health settings.

The CHAIR invited the Board to comment on the proposals in the paper. In discussion, the following points were made:

r. the wording of the smoking cessation topic could be read to mean that the NHS should prevent people from smoking while they were present in health premises;

s. the word “patients” could be read as excluding people who do not consider themselves as patients, such as mental health service users. Quality Standards should be ambitious and apply to anyone present in an NHS setting, including those who are not there to receive services. “People” would therefore be more appropriate than “patients”; and

t. it was not clear why obesity was missing from the proposed Quality Standard topics.

Responding, MIKE RAWLINS said that the points raised could be taken on board. In terms of obesity, he said that whilst this was indeed an important cross government health issue, action to address it was mainly directed by non-NHS professionals. The NHS could, of course, play an important role in encouraging and supporting people to take more exercise and that was why a Quality Standard on physical activity had been proposed.

Summing up the discussion, the CHAIR said that the Board had agreed the proposed Quality Standard cross-cutting topics, subject to amendments to remove the phrase “in a range of health settings” and to replace references to “patients” with “people”.

ITEM 3: PATIENT-LED INSPECTIONS

Introducing paper NQB (12)(01)(03), CHRISTINE BEASLEY (Chief Nursing Officer, Department of Health) said that the Board was being asked to provide initial steers on the development of a new patient-led inspection regime to replace the current Patient Environment Action Team (PEAT) inspections. The Prime Minister had announced the new regime on 6 January 2012, as

part of a package of measures aimed at improving nursing care and hospital cleanliness.

Continuing, she said that the Department had already been considering how to improve the PEAT process as the rating system did not allow for sufficient distinctions to be made between providers. Concluding her opening remarks, she said that the Department was committed to the new regime being cost-neutral.

The CHAIR invited the Board to comments on the proposals in the paper. In discussion, the following points were made:

u. PEAT had embedded a culture of cleanliness and had led to significant improvements. The new process presented an opportunity to re-state its importance, avoid complacency and be more ambitious;

v. the existing PEAT process could produce results that seemed inconsistent with other quality assessments. In 2010, 96% of organisations achieved a ‘good’ or ‘excellent’ PEAT rating, which rose to 99% in 2011. There appeared to be little correlation between these results and recent CQC and Ombudsman reports on poor standards of care;

w. although the PEAT process was about cleanliness, food and other environmental factors, there were also some overlaps with clinical care;

x. the creation of a steering group as a sub-group of the Board to guide the development of the new patient-led inspections process was welcome, particularly in view of the need to align the new inspection regime with similar existing processes operated by other organisations. The steering group offered a good opportunity to set out how these processes all fitted together;

y. the proposed steering group membership was broadly right, but could benefit from greater representation from: professional bodies; Local Involvement Networks and local HealthWatch; the NHS Trust Development Authority; and hospital cleaning staff and members of the leisure and hospitality industries, who would bring different perspectives. However, it would be important that the group did not become too unwieldy;

z. the interpretation of 'patient-led' might be too limited by the wish to develop the new inspections process within existing resources. Although it would be important to involve patients in the design of the new process, most people would understand 'patient-led' to go beyond this, and mean that patients would also be carrying out the inspections. It might be possible to be more ambitious without significant extra expense: there were many examples of people volunteering to improve their local services. Foundation trust governors could provide a pool of potential volunteers;

aa. further consideration was needed about whether it was appropriate or helpful to carry out inspections without giving the hospital prior notice. A potential compromise might be self-assessment combined with patient-led spot checks;

bb. the scoring scale should include 'outstanding' at the top end, and use odd number ratings to ensure that hospitals fell on one side or the other, so they could not be ranked as middling;

cc. excluding hospitals with less than 10 beds from the new inspections process did not take into account the fact that smaller units could often have some of the highest risks. This threshold might in particular exclude mental health and learning disability units; and

dd. making the new inspections process mandatory would further distinguish it from PEAT. Exclusions could apply, for instance a

hospital rated ‘outstanding’ might undergo future mandatory inspections at longer intervals.

Summing up the discussion, the CHAIR said that the Board had:

- approved establishing a steering group as a Board sub-group and made recommendations for additional membership;

- advised that the steering group should further explore: the interpretation of ‘patient-led’; the use of self assessment and unannounced spot checks as an alternative to pre-announced inspections; the inclusion of clinical questions; and mandating inspections for all hospitals, including those with less than 10 beds; and

- agreed to provide any views on scoring systems directly to the secretariat.

ITEM 4: UPDATE ON NURSING QUALITY AND CARE FORUM

The CHAIR invited SALLY BREARLEY, newly appointed Chair of the Nursing Quality and Care Forum, to update the Board on the Forum’s progress and seek the Board’s views.

SALLY BREARLEY said that the creation of an independent forum on nursing quality was part of a package of initiatives announced by the Prime Minister on 6 January 2012. Current plans were that the Forum should be comprised of roughly 20 members, with broad expertise and experience. Initial thoughts were that the Forum might organise its work around four broad themes:

- Leadership;

- Values and cultures;

- Time to care; and

- Seeking and responding to feedback.

The Forum's scope would be nursing care in every setting where it is provided, which could, for example, include primary care, secondary care and care homes that employ registered nurses.

Continuing, she said there were a large number of reports that had recently considered nursing quality, and noted that the Forum would not simply produce one large report at the end of the process. It was likely to take a phased approach, carrying out a period of engagement and exploration followed up with recommendations or suggestions for others to carry out further pieces work, which the Forum would then return to later on.

The recommendations from the NHS Future Forum that linked to nursing might provide a useful starting point, such as the importance of values based recruitment. There were also some other key areas which the Forum would probably need to consider, including:

- Regulation of healthcare assistants; and

- Staffing and skills-mix issues, for instance staff to patient ratios.

During discussion, the following points were made:

ee. the Forum's genesis was, in large part, due to the Prime Ministers' concerns about the care of older people in hospitals;

ff. more helpful than another big report would be an understanding of why previous reports had not made a significant impact on nursing quality;

gg. education and training was fundamental to nursing quality. There was a large surplus of applications for places on nursing courses at some universities, but the value of practice-based learning – particularly to instil the values that nurses should share – should not be underestimated;

hh. the Forum should consider how its work might benefit from applying the 'change model' that JIM EASTON had presented to the Board earlier;

ii. hospices could provide good examples of high quality nursing, but there was a myth that community nursing was second class. How nurses were valued in different settings needed to be reshaped; and

jj. the Forum should consider how NICE might be able to help with the Forum's work.

The CHAIR thanked SALLY BREARLEY for updating the Board.

ANY OTHER BUSINESS

DON BRERETON informed the Board that on 21 February 2012 the Department of Health published the NHS Patient Experience Framework, which the Board's patient experience sub-group had agreed.