NATIONAL QUALITY BOARD

12 June 2019
14:00 to 17:00

Skipton House (Room: 125A), 80 London Road, London, SE1 6LH

MINUTES

PRESENT		
Steve Powis (Chair)	Ted Baker (Chair)	
Ruth May	Hugh McCaughey	Aidan Fowler
Kate Terroni	Rosie Benneyworth	Sam Illingworth (for Wendy Reid)
Amir Mehrkar	Paul Cosford	Catherine Swann (for Viv Bennett
Imelda Redmond	William Vineall (for Lee McDonough)	
IN ATTENDANCE		
Sally Allum (Surrey Heartlands, ICS)	Clare Stone (Surrey Heartlands, ICS)	Richard Owen (Secretariat)
Anne Booth (Secretariat)	Richard Marchant (GMC)	Dominique Black (Secretariat)
Mark Davies (Department for Health and Social Care)	Judith Hendley (NHS E-I)	Matt Fogarty (NHS E-I)
Alan McGlennan (Royal Free London NHS FT)	Nima Roy (NHS Graduate Trainee)	Karen Fechter (NHS E-I)
Katie Barton (CQC)	Maria Van Hove (Clinical Fellow)	
APOLOGIES		
Wendy Reid	Lisa Bayliss-Pratt	Viv Bennett
Lee McDonough		

AGENDA

1. Welcome & Minutes of Previous Meeting
2. THEME: SYSTEM TRANSFORMATION
   a) Quality and Integrated Care Systems
   b) Vision for Future Improvement in the NHS
3. THEME: WORKFORCE
   a) Report of Independent Review of Gross Negligence Manslaughter and Culpable Homicide
4. THEME: PATIENT SAFTETY
   a) National Learning from Deaths Programme Update
   b) National Guidance on Learning from Deaths for Ambulance Trusts
   c) NHS Patient Safety Strategy
5. Any Other Business

1. Welcome & Minutes from Previous Meeting

1.1 STEVE POWIS (Chair) welcomed all to the third meeting of the National Quality Board (NQB) 2019. KATE TERRONI, Chief Inspector of Adult Social Care at the Care Quality Commission was introduced and welcomed as an NQB member. PAUL COSFORD, Director of Health and Medical Director at Public Health England was thanked for his contribution to the NQB. Paul has taken a new role as Emeritus Medical Director at Public Health England. YVONNE DOYLE will be taking over from Paul at the next NQB. Attendees and apologies were noted as above.

1.2 The minutes of the previous meeting on 04 April 2019 were approved. There was one amendment to the previous minutes, ROSIE BENNEYWORTHS's job title was inaccurate and should state, Chief Inspector of Primary Medical Services and Integrated Care. The rest of the minutes were agreed as a true and accurate record and would be published in due course, alongside the associated agenda and papers.

2. THEME: SYSTEM TRANSFORMATION

a) Quality and Integrated Care Systems

2.1 TED BAKER introduced this item. In December 2016, the NQB produced a Shared Commitment to Quality. At the previous NQB meeting on 04 April, the NQB agreed to initiate work to review the NQB Shared Commitment to Quality. The review will consider how the framework could be revised to enable its translation at local level and the NQB are keen for Surrey Heartlands ICS to be involved in this.

2.2 Surrey Heartlands have been invited to attend this NQB as they are particularly engaged and keen to work with us. The NQB recognised that different ICSs are at different levels of maturity and others will also need to be engaged with as part of the review.

2.3 SALLY ALLUM and CLARE STONE (Guests) introduced this item and associated paper (Paper 1). As part of this item the ICS reflected on how the document has helped them to date and what could be improved in a revised version.

2.4 Surrey Heartlands are trying to learn from the best and pave their own way. In the South east region there are four ICSs in varying stages of maturity. The focus of this presentation was Surrey Heartlands.

2.5 Surrey Heartlands described the challenges, learning and emerging themes. They described the support the local region can offer and how the NQB can support the development of this work in ensuring that quality maintains a high profile for local populations, citizens and patients.

2.6 Surrey Heartlands have used the NQB's seven steps outlined in the Shared Commitment to Quality and the CQC's Key Lines of Enquiry.

2.7 The presentation raised issues about how quality escalation might work in the future.

2.8 The NQB was asked to:

- **Consider** and **discuss** the recommendations to:

  a) Agree a definition of quality that includes our wider system partners of social care and public health and is relevant to local systems;

  b) Influence a mechanism for regulation and assurance across a system;

  c) Articulate what the NQB escalation of system quality risks might look like and the journey of how to get there – this includes defining the check points for quality to move from an STP to an ICS;

  d) Promote a narrative that leads and empowers systems to behave differently between regulators, providers, commissioners and Local

Authorities to deliver the best services for people in their local communities; and

e) Continue to work collaboratively with Surrey Heartlands and utilise the combined expertise and resource to shape and define quality for other emerging ICSs across the country.

2.8 The NQB noted the update and made the following suggestions:

a) We need alignment from the national, regional, system, provider, service and the individual. This is necessary as we risk doing things differently across the seven regions;

b) Need clarity about how to build a continuous improvement culture;

c) In the current financial climate, sometimes quality gets squeezed out. We need to be clear about how to prevent this from happening;

d) The importance of performance, finance and quality as integrated workstreams;

e) In relation to Primary Care Networks, to what extent will quality governance vary from one location to another? We will need some parameters of what good governance looks like, so the rest of the system understands it;

f) The importance of a single language conversation, so everyone understands. There are many local stakeholders to take on board. Need to stay aligned to the committee chaired by Ara Dazi intended to simplify key messages;

g) There is so much data that there is a risk that we can define quality in different ways; and

h) The importance of a positive culture across the system to work through the challenges identified above.

2.9 Members of the NQB were supportive of the work in Surrey Heartlands and will take their suggestions into consideration when refreshing the Shared Commitment to Quality.

2.10 The following NQB support offer was made:

a) ROSIE BENNEYWORTH (Member) offered to have a longer discussion on primary care with Surrey Heartlands ICS – particularly in terms of how to engage with Primary Care Networks.

b) Vision for Future of Improvement in the NHS

2.11 Hugh McCaughey (Member) introduced this item on the agenda. Hugh outlined a vision for the future of improvement within the NHS, including plans to develop a National Improvement Framework which will be based on the Juran trilogy: 1) Quality Planning; 2) Quality Assurance and Control; and 3) Quality Improvement. The NHS People Plan was referenced as being central to this work.

2.12 The presentation included the following key points:

a) How do we shift from inspection/control to improvement? The emphasis was made that both are needed, but how do they complement one another?

b) We want one definition and one framework but the interpretation at different levels will be different;

c) There is a risk that our focus and attention is drawn to bottom of the pack, e.g. trusts in special measures; and

d) How do we create a culture of continuous improvement across the whole distribution? So that even the good and outstanding are improving.

2.13 The NQB was asked to c**omment** on the vision described and provided the following feedback:

a) Good quality assurance comes from cultures that are problem seeking not comfort seeking. It was highlighted that quality assurance and quality improvement are a continuum;

b) There is a need to consider improvement in the system as a whole. Acute hospitals have had lots of training and attention, but primary care for example, needs focus too;

c) Whilst you want to narrow and move distribution, to do that you will have to focus more on some groups. Some will need more attention than others, namely those in special measures;

d) Can understand the proposal but at this stage it is difficult to see how this can be implemented? Can we make more explicit about what this means for a local service?

e) The importance of engaging the regions in development of this product. Should this be called a 'National' Improvement Framework, or should the word 'National' be taken out? The Board also considered that national programmes can set the tone for local delivery; and

f) The risk that the terms performance and improvement are being used interchangeably.

2.14 The following NQB support offer was made:

a) HUGH McCaughey (Member) offered to liaise with CLARE STONE (Guest).Clare was keen to define what goods like at system level and a gold standard which becomes a blueprint of what people work towards.

2.15 The NQB will be engaged as the proposal to develop an Improvement Framework progresses.

3. THEME: WORKFORCE

a) Report of Independent Review of Gross Negligence Manslaughter and Culpable Homicide

3.1 RICHARD MARCHANT (Guest) was invited to present this item on behalf of LESLEY HAMILTON and the associated paper (Paper 2).

3.2 In January 2018 the GMC commissioned an independent review of how the law on gross negligence manslaughter and culpable homicide is applied in medicine. The report of that review was published on 6 June 2019.

3.3 The report looked at unexpected death in a healthcare setting, the role of coroners, police, CPS, and the GMC. The report also considered the relationship between the GMC and the medical profession.

3.4 There are 29 recommendations in the report. Approximately a third of which are directed at the GMC. The report highlights the importance of getting things right at the very early stage in the process. The GMC tend to get involved when a lot has already happened.

3.5 The overarching theme is the need for a more just culture that is focussed on learning rather than blame.

3.6 Recommendation 19 refers to the importance of expert medical opinion at the earliest opportunity.

3.7 The Board discussed the impact of these investigations and particularly the impact it has on the mental health and wellbeing of those involved. Members also highlighted that the Patient Safety Strategy fed this into the review. It is also important to make the links with the NHS People Plan

3.8 The NQB noted that many of the recommendations are aimed beyond the GMC. The recommendations fall under several themes and the following are particularly relevant to the NQB:

a) Families and healthcare staff

b) System scrutiny and assurance

c) Expert reports and expert witnesses

d) Local investigations into patient safety incidents

e) Reflective practice

f) Support for doctors

3.9 The NQB agreed to bring this item back in a year as a package with the Williams Review

4. THEME: PATIENT SAFETY

a) National Learning from Deaths Programme Update

4.1 WILLIAM VINEALL (Guest) introduced this item and the associated paper (Paper 3). He introduced MARK DAVIES – Director of Population Health and Senior Responsible Officer for the Medical Examiner programme.

4.2 William updated the NQB on progress made under the national Learning from Deaths (LfD) Programme and the introduction of medical examiners. He provided an update on:

a) The progress made against each of the eight LfD workstreams (detailed at Annex A in Paper 3);

b) Extending the LfD programme to ambulance trusts and primary care;

c) The Learning Disabilities Mortality Review Programme (LeDeR); and

d) Medical examiners.

4.3 The Department for Health and Social Care have taken on child death reviews from the Department for Education and there is a role for the Care Quality Commission in terms of how serious incidents are taken into consideration as part of investigations.

4.4 **The NQB was asked to:**

a) Note progress made against the LfD programme and the introduction of medical examiners from April 2019;

b) Provide a view on applying LfD policy to primary care, in particular if LfD should be included in the 2020/21 GP contract negotiation process; and

c) Provide thoughts on the future alignment of work on medical examiners, as this is rolled out, with future work on learning from deaths.

4.5 The NQB highlighted the need for a single process to gather the learning for both medical examiners and LfD. The LfD Programme can now be used as a Quality Improvement tool, but emphasised the importance of continuing to engage with families in this work.

4.6 The NQB asked for this to be presented as one programme rather than two in the future (the programme to include LfD and medical examiners)

4.7 The NQB asked for a report in six months about how these items fit together.

4.8 The following NQB support offer was made:

a) WILLIAM VINEALL (Deputy) offered to liaise with SALLY ALLUM (guest). Sally can put William in contact with the lead in the South who has learning from mental health homicides

b) National Guidance on Learning from Deaths for Ambulance Trusts

4.9 Judith Henley (Guest) introduced this item and the associated paper (Paper 4).

4.10 In early Autumn 2018, the Department of Health and Social Care asked NHS Improvement to lead on the development of learning from deaths guidance for ambulance trusts. This paper (paper 4):

a) provides a high-level summary of the guidance, including reporting requirements;

b) describes the process of development and stakeholder engagement, including issues raised through this and mitigation; and

c) sets out plans for publication.

4.11 Work is underway to align the National LfD Guidance for Ambulance Trusts with the roll-out of the medical examiner system. Including:

a) Guidance to trust based medical examiners will include signposting cases to ambulance trusts where they had been involved in the care of the patient who has died; and

b) In parallel to publishing this guidance for ambulance trusts, brief guidance will be issued to other parts of the system, including acute and community and mental health trusts, about the need to alert ambulance trusts to the deaths of patients who had previously been in their care, particularly where there is a concern.

4.12 The NQB members highlighted:

a) The challenge of co-ordinating multiple agencies, in a world where responsibility has moved from CCGs to ICSs;

b) The importance of the language used in this document aligning to that used in the Patient Safety Strategy. For example: Root cause analysis is no longer used;

c) The importance of a joint conversation, for example, bringing in primary care professionals;

d) This guidance must be completely aligned with Patient Safety Incident Response Framework (PSIRF), e.g. stipulates timelines; and

e) Confirmed the guidance will use the NQB branding when published.

4.13 The NQB suggested Judith Hendley (Guest) liaise with Matt Fogarty (Guest) to ensure the language used in this guidance reflects that used in the Patient Safety Strategy and the PSIRF.

c) NHS Patient Safety Strategy

4.14 AIDAN FOWLER (Member) and MATT FOGARTY (Guest) introduced this item and the associated paper (Paper 5). This is the third time this item has been covered at the NQB. This paper presented the NHS National Patient Safety Strategy which is due for publication by early July. The paper outlined how the strategy has been updated following NQB comment in February 2019 and a consultation exercise.

4.15 Matt highlighted that this is what we intend to publish on the 2nd July as it is the Patient Safety Congress on the same day.

4.16 The Patient Safety Strategy has been part of an extensive consultation exercise and there is broad support for the proposal. Further to consultation there is now more detail on measurement, mental health, primary care and other areas.

4.17 Various sections of the strategy have been authored by different individuals across the system, including contributions from NHS Resolution, Health Education England and various others.

4.18 The strategy outlines three aims for the NHS:

a) Insight – how do we learn from things that go right and wrong?

b) Involvement – including a patient safety syllabus; and

c) Improvement – practical action.

4.19 The NQB raised the following feedback:

a) How do we future proof this strategy for emerging types of providers e.g. on-line services;

b) There is still more action needed to create a supportive culture which is not about blaming people;

c) Combined Boards of NHS England & Improvement will be on the 27th June – therefore the strategy will be in the public domain a few days early;

d) The NQB has had oversight and provides strong support;

e) Make sure this strategy is aligned to the People Plan and avoid working in silos; and

f) The Secretary of State has provided endorsement and the NQB members agreed to help cascade the key messages.

4.20 The NQB agreed the following actions:

a) MATT FOGARTY (Guest) and AMIR MEHRKAR (Member) to work together on NHS Digital wording in the strategy;

b) The social media infographic to be shared with NQB members for circulation. NQB members to promote via all routes; and

c) An offer from MATT FOGARTY (guest) for his team to present the Patient Safety Strategy to NQB organisations through the lens of the recipients.

5. AOB

5.1 The NQB thanked Anne Booth for her contribution to the National Quality Board. Anne has been a key member of the Secretariat for the last two years and is moving on to a new role at NHS England & NHS Improvement.

5.2 Next meeting is 7th August 2019.