NQB (17) 2nd Meeting

NATIONAL QUALITY BOARD

MINUTES of a meeting held in room 137B Skipton House, 80 London Road, London, SE1 6LH

Wednesday 1 March 2017, 14.00 – 17.00

PRESENT		
Bruce Keogh (Chair)	Mike Richards (Chair)	
Paul Cosford	Martin Severs	Ruth May
Lee McDonough	Gillian Leng	Kathy McLean
Neil Churchill (on behalf of Jane Cummings)	Sanjiv Ahluwalia (on behalf of Wendy Reid)	
IN ATTENDANCE		
Lauren Hughes (NHS England)	Richard Owen (NQB Secretariat)	Luke O'Shea (NQB Secretariat)
Kate Eisenstein (NQB Secretariat)	Victoria Howes (CQC)	William Vineall (DH)
Tim Jones (DH)	Matt Fogarty (NHSI)	
APOLOGIES		
Jane Cummings (NHSE)	Lisa Bayliss-Pratt (HEE)	Andrea Sutcliffe (CQC)
Viv Bennett (Public Health England)	Steve Field (CQC)	Wendy Reid (HEE)

AGENDA

1. Welcome and minutes of the last meeting
2. Learning from Deaths Programme
3. Coordinating Investigations
4. NHS Improvement's approach to Patient Safety
5. A.O.B

ITEM 1: WELCOME AND MINUTES OF THE LAST MEETING

BRUCE KEOGH (Chair) welcomed everyone to the second meeting of the National Quality Board (NQB) of 2017.

He also welcomed Martin Severs, NHS Digital Medical Director and Caldicott Guardian, to his first meeting as a member of the NQB.

He asked the NQB to agree / approve the minutes of the last meeting and to note that, once agreed, they would be published, alongside the agenda and papers from the last meeting.

The NQB agreed the minutes of the last meeting.

ITEM 2: LEARNING FROM DEATHS

WILLIAM VINEALL introduced *Paper 1: Learning from Deaths*. The paper:

- Asked for NQB's views on an advanced draft of a National Framework on Learning From Deaths on behalf of the NQB. A working draft was planned for publication on Tuesday 14 March and presentation at the national Learning from Deaths Conference on Tuesday 21 March to test views from provider and family/carer representatives
- Provided an update on how DH were engaging family/carer representatives in the development of the guidance
- Included the letter that was sent to Trusts on 22 February from CQC and NHS Improvement alerting them to preparations needed to meet their new responsibilities from April 2017

NQB members were specifically asked to:

- Provide comments on the draft guidance
- Agree that the Chairs would sign-off the draft guidance by Friday 10 March
- Agree that a "working draft" of the guidance would be published on the NQB's webpage by Tuesday 14 March

Board members discussed the draft guidance and reflected on the feedback from families and carers. Members of the NQB had a number of comments, these included:

- Clarity on the status of document and ensuring that the document would be presented as a “working draft” that would be updated and improved based on feedback
- That Trusts would be given time to implement the Guidance rather than being judged on what they were doing from the 1st of April
- That the guidance would give examples of the time needed to take forward learning. When done well this would need a number of staff to be taken out of their day jobs in order to focus on learning
- General concern that data on mortality reviews would be used for judgment rather than improvement and this could act against a culture of transparency and improvement
- That families must be involved in decision making for whole Learning from Deaths programme
- That the guidance would be clear on how it related to the Duty of Candour
- clarifying that guidance would support learning from all deaths rather than only considering what can be learnt from avoidable deaths
- Ensuring the criteria for case review aligned with other guidance, definitions and practice
- For the guidance to balance processes for Trusts with learning and improvement. It was suggested that the Guidance could set out the appropriate improvement architecture

NQB agreed to:

- Provide more detailed comments on next iteration by correspondence and a final version would be signed off by the Chairs and NHS Improvement by 10 March

MIKE RICHARDS (Chair) thanked WILLIAM VINEALL for the update and members for their input into the delivery of the document.

ITEM 3: COORDINATING INVESTIGATIONS

LAUREN HUGHES introduced *Paper 2: Coordination of serious incident investigations involving two or more providers*. The paper set out how investigations into serious incidents involving two or more providers should be coordinated according to current guidance (Serious Incident Framework 2015). It also considered how effective these coordination arrangements were in practice and outlined potential actions to improve coordination.

NQB members were asked to**:** Note/provide views on the content and conclusions of the paper, including the next steps.

General discussion points included:

- Agreement that the focus should be on improving coordination within the roles and responsibilities of the Serious Incident Framework
- That NHS Improvement would be looking to update the Serious Incident Framework later in 2017
- Recognition that identification of the best organisation to co-ordinate an investigations was a complex task. It would normally need an open and honest conversation between the relevant commissioners would normally be needed in order to take account of local issues
- CCGs would need to be engaged on the publication of the 'working draft' Learning from Deaths
- To keep under review how STPs would have a role in coordination of investigations

NQB agreed that:

- NHS England would strengthen assurance processes around how CCGs coordinate investigations in order to ensure more consistency and ensure links with CQC and NHSI

BRUCE KEOGH (CHAIR) thanked colleagues at NHS England for turning the paper around in a short space of time.

ITEM 4: NHS IMPROVEMENTS APPROACH TO PATIENT SAFETY

KATHY MCLEAN introduced *Paper 3: NHS Improvement's approach to Patient Safety*.NHS Improvement's 2016/17 business plan committed to publish by the end of the financial year, ''*the NHS Improvement offer on patient safety; describing priority areas up to 2020 and how the central team will work with national partners and regional and improvement teams across NHS Improvement*''.

NQB were asked to provide views on the draft. Feedback included:

- Broad support for the direction of travel of the document
- For the document to consider alignment of roles with the Healthcare Safety Investigation Branch
- To ensure that services who need support on aspects of patient safety would get the correct support from NHS Improvement
- For the future work to go beyond our current structure of hospitals and GPs and consider new models of care and patients accessing more services through technology
- To consider how as a system we horizon scan for risks, rather than focus on issues that concerned us 5-10 years ago. For example, would healthcare acquired infections still remain as high a risk as previously
- For the draft to further consider how NHSI would work with colleagues in providers, CCGs and NHS England Regions who have a role in patients safety

NQB Secretariat would invite HSIB to a future meeting.

MIKE RICHARDS (CHAIR) thanked KATHY MCLEAN for bringing the draft to NQB for discussion.

ITEM 5: ANY OTHER BUSINESS

BRUCE KEOGH (CHAIR) confirmed that there was no further business and concluded the meeting.

The next meeting of the NQB was set for 7st June 2017.