NATIONAL QUALITY BOARD

06 September 2017
14:00 to 17:00

Care Quality Commission (Room: T.310, 3rd Floor), 151 Buckingham Palace Road, London, SW1W 9SZ

MINUTES

PRESENT		
Bruce Keogh (Chair)	Ted Baker (Chair)	
Andrea Sutcliffe	Steve Field	Kathy McLean
Ruth May	Viv Bennett	Judith Richardson (on behalf of Gillian Leng)
Matt Neligan (on behalf of Martin Severs)	William Vineall (on behalf of Lee McDonough)	
IN ATTENDANCE		
Mark Radford (NHSI)	Michael Macdonnel (NHSE)	Will Smart (NHSE)
Meera Sookee (NHSE)	Nicola Bent (NICE)	Lauren Hughes (NHSE)
Luke O'Shea (NHSE)	Lucy Ellis (NHSE)	Anne Booth (Secretariat)
Ali Gray (Secretariat)	Dominique Black(Secretariat)	
APOLOGIES		
Jane Cummings	Wendy Reid	Lisa Bayliss-Pratt
Paul Cosford	Gillian Leng	Martin Severs
Lee McDonough		

AGENDA

1. Welcome & Minutes of Previous Meeting
2. Learning from Deaths Programme: Update
3. Safe, Sustainable & Productive Staffing Improvement Resources
4. Sustainability & Transformation Partnerships & Quality
5. Digital Technology 'Wannacry' Cyber Incident: Update
6. Any Other Business

WORKSHOP SESSION: International Comparisons & High Impact Solutions

1. Welcome & Minutes of Previous Meeting

1.1 BRUCE KEOGH (Chair) welcomed attendees to the fourth meeting of the National Quality Board (NQB) of 2017. A special welcome was given to Professor Ted Baker, new CQC Chief Inspector of Hospitals and co-Chair of the NQB. Deputies, apologies and guests were noted as above.

1.2 The minutes of the previous meeting on 07 June 2017 were approved as a true and accurate record of that meeting pending a correction requested by NICE. The minutes of that meeting would be published in due course, alongside the associated agenda and papers.

2. Learning from Deaths Programme: Update

2.1 WILLIAM VINEALL (on behalf of Lee McDonough) introduced this item and associated paper (Paper 1). The paper provided a progress update on the Learning from Deaths (LfD) Programme led by the Department of Health, and the Child Death Review Programme led by NHS England, including the alignment of these.

2.2 The NQB was asked to:

- Note progress made against the LfD Programme;
- Agree for the second edition of *National Guidance on Learning from Deaths* to be published in summer 2018; and
- Note the work on child death review, and how this links with the LfD Programme.

2.3 The NQB noted that good progress had been made overall on LfD Programme, as outlined in Paper 1 (within the context of addressing the

recommendations of the CQC's report *Learning, candour and accountability* of December 2016).

2.4 The NQB advised that the second edition of *National Guidance on Learning from Deaths* should be published in spring 2018, rather than summer 2018, if possible.

2.5 The NQB noted the progress update on the Child Death Review Programme, including the complex interactions between this work and the LfD Programme, as outlined in Paper 1. The draft *Child death review comprehensive national guidance* would be circulated to the NQB for comment by the end of the week.

2.6 With regards to the progress update on the LfD Programme, each trust had published or was in the process of publishing its updated policy on learning from deaths. The Quality Accounts Regulations had been amended to specify the new reporting requirements for trusts which would come into force 1 November.

2.7 Communications and media handling were discussed. It was agreed that proactive communications would be required to ensure data published by trusts in their annual Quality Accounts would not be misinterpreted by the media as this could undermine the aims of the programme. This would include explaining why the data could not be used for comparisons between trusts. WILLIAM VINEALL offered to raise this with the LfD Programme Board.

2.8 The work underway to address Recommendations 5 and 6 of the CQC's report *Learning, candour and accountability* of December 2016 was discussed:

- It was noted that NHS Digital was working with the Department of Health on the development of provider systems and processes to help alert providers to all their deaths, and the provision of guidance on a standard

set of information to be collected by providers on all patients who have died. This work encompassed data sharing, use of existing data and potential new data collections.

- It was agreed that the Healthcare Safety Investigation Branch should be invited to the next NQB meeting to understand more about their approach to investigations.

2.9 It was pointed out that new approaches around learning should not be restricted to investigations of deaths, but to other incidents where something had gone wrong. WILLIAM VINEALL offered to look into the feasibility of this.

3. Safe, Sustainable & Productive Staffing Improvement Resources

3.1 MARK RADFORD (Guest) introduced this item and associated papers (Papers 2 & 3). Paper 2 set out the background to the Safe, Sustainable and Productive Staffing Improvement Resources, and outlined the NQB Safe Staffing Steering Group-approved processes for stakeholder engagement and publication. Paper 3 set out the key feedback received on improvement resources 1 to 4 and response to the feedback. The working draft improvement resources 1 to 4 were provided in a separate pack.

3.2 The NQB was asked to:

- **Note** the NQB Safe Staffing Steering Group-approved processes for stakeholder engagement and publication, and publication timetable;
- **Note** the key feedback from the engagement processes and how this was taken into consideration in development of improvement resources 1 to 4;
- **Comment** on the working draft improvement resources 1 to 4; and

- **Agree** to approve via correspondence the final draft improvement resources 1 to 4 for publication.

3.3 The NQB was assured by the Safe Staffing Steering Group-approved processes for stakeholder engagement and publication, and noted the publication timetable, as summarised in Paper 2. It was highlighted that the publication process included a step seeking advice and support from Sir Robert Francis.

3.4 The NQB noted the key feedback from the engagement processes and how this was taken into consideration in development of improvement resources 1 to 4, as summarised in Paper 3.

3.5 Following discussion, the NQB decided to delegate responsibility for comment and sign-off (for publication) of all improvement resources (1 to 8) to the NQB Safe Staffing Steering Group, given the highly specialised and nursing-specific nature of the topic. However, the NQB requested sight of the remaining improvement resources 5 to 8 prior to engagement and prior to publication, particularly the resource for Urgent and Emergency Care which could potentially be a cause of contention.

3.6 The NQB advised that the NHS England CEO and Finance Team should be given sight of all the improvement resources prior to publication.

4. Sustainability & Transformation Partnerships & Quality

4.1 MICHAEL MACDONNELL (Guest) was invited to provide a verbal update on Sustainability and Transformation Partnerships (STPs) and quality. 44 STPs had been established with the aim of building meaningful integrated health and social care systems. Michael noted that a national event for clinical STP leads was planned for 26 September 2018, and a network of STP clinicians across the country had been established.

4.2 The NQB was asked to:

- Advise on how to build clinical engagement on, and ensure meaningful clinical involvement in, the development of STPs.

4.3 The NQB stated the importance of this work and the key role clinicians would play in STPs. It was recognised that different STPs were at different stages of development with variation in the levels of clinical engagement and involvement between STPs. The NQB advised that clinicians needed to be inspired, encouraged and enabled to become more involved in STPs.

4.4 The NQB emphasised the importance of local-level clinical STP leadership and warned against a top down approach from the national level. However it was felt that it would be beneficial to establish a link between the NQB and local-level clinical STP leadership. The network of STP clinicians across the country could be utilised for this.

4.5 The NQB advised that general engagement with all health and social care professionals was also important. For true integration, local-level contributions from professionals working in local authorities and social care providers were required.

4.6 In conclusion, the NQB agreed that this topic should be brought back to a future meeting for a fuller discussion or workshop.

5. Digital Technology 'Wannacry' Cyber Incident: Update

5.1 WILL SMART introduced this item and associated paper (Paper 4). The paper provided an update on activity in the aftermath of the 'Wannacry' ransomware cyber incident on 12 May 2017. It was tabled to give the NQB an opportunity to discuss and consider the clinical impact of and learning from such incidents.

5.2 Will noted that whilst the NHS was not specifically targeted by the attack, it was particularly vulnerable due to poor IT management and a lack of preparedness. A national incident response report focussing on technological aspects would be published in the autumn of 2017, and activities were underway to improve cyber resilience across the NHS.

5.3 Robust business continuity planning from both a technological and clinical perspective was key to dealing effectively with incidents of this nature in future. A major positive step was the emergence and increasing importance of the role of Chief Clinical Information Officers (CCIO) within NHS organisations.

5.4 The NQB was asked to:

- Note the headline figures regarding impact of the 'Wannacry' ransomware cyber incident;
- Note the ongoing activity and challenges around cyber and the planned investment in cyber resilience;
- Discuss the key learning that needs to be taken on board by clinicians now, e.g. to prevent a future cyber incident and limit the clinical impact following a potential successful cyber incident; and
- Consider the potential role of the clinician and the clinical informatician in the future.

5.5 The NQB noted the headline figures regarding the impact of the 'Wannacry' ransomware cyber incident, provided in Paper 4. It was highlighted that many of the cancellations were down to medical imaging devices not functioning. The reliability of the figures was questioned due to a lower than expected number of patients affected. Will responded that the data had been collected in real-time and the lower than expected number may be because many pathways were not yet digitised. The NQB commented that

the lower than expected number may also reflect good management of the incident on the frontline. The NQB asked whether any examples of patient harm had been identified. Will responded that this was being checked and confirmed.

5.6 The NQB noted the ongoing activity and challenges and the planned investment in cyber resilience, as outlined in Paper 4. Work was underway to set standards for cyber resilience and define "what good looks like".

5.7 In terms of learning and the future, the NQB advised that clinical staff within NHS organisations should run cyber incident simulation exercises to test out and refine their business continuity plans in this area.

5.8 The NQB commented that the wider ramifications within the system from the cyber incident should not be omitted from the report, for example the impact on the ability of hospitals to discharge patients to care homes due to an inability to communicate with adult social care services.

5.9 In conclusion, WILLIAM SMART offered to bring the final national incident response report to the NQB once this had been published.

6. Any Other Business

6.1 **Measuring Quality Working Group** – Info. Paper 1 was referred to. NQB members with a particular interest in measurement who would like to be involved in the work of the NQB Measuring Quality Working Group were asked to contact the NQB Secretariat.

6.2 **Youth National Quality Board at Expo 2017** – Info. Paper 2 was referred to. NQB members were asked to promote the session which would take place on 11 September 2017.

Next NQB meeting: Wednesday 22 November 2017.