NATIONAL QUALITY BOARD

10 August 2018
10:00 to 13:00

Skipton House (Room: 137B, 1st Floor), 80 London Road, London, SE1 6LH

MINUTES

PRESENT		
Steve Powis (Chair)	Ted Baker (Chair)	
Jane Cummings	Andrea Sutcliffe	Steve Field
Kathy McLean	Lisa Bayliss-Pratt	Paul Cosford
Gillian Leng	Manpreet Pujara (on behalf of Martin Severs)	Jennifer Benjamin (on behalf of Lee McDonough)
IN ATTENDANCE		
Matt Tagney	Richard Arnold	Mark Bennett
Jason Yiannikkou	Frances Healey	Maria van Hove
Cheuk Wong	Richard Owen (Secretariat)	Anne Booth (Secretariat)
APOLOGIES		
Ruth May	Wendy Reid	Viv Bennett
Martin Severs	Lee McDonough	

AGENDA

1. Welcome & Minutes from Previous Meeting
2. *THEME: SYSTEM TRANSFORMATION*
   - 2. a) Long-Term Plan
   - 2. b) Local System Reviews: National Report
3. *THEME: REDUCING UNWARRANTED VARIATION*
   National Clinical Audit Programme Partners Group
4. *THEME: PATIENT SAFETY*
   - 4. a) Learning from Deaths Programme: Update
   - 4. b) Williams Review into Gross Negligence Manslaughter in Healthcare
   - 4. c) Gosport War Memorial Hospital: Panel Report and Next Steps
5. Healthcare Workers Seasonal Flu Vaccination

6. Any Other Business

WORKSHOP: National Quality Board Refresh 2018

1. Welcome & Minutes from Previous Meeting

1.1 TED BAKER (Chair) welcomed attendees to the third meeting of the National Quality Board (NQB) of 2018. Attendees and apologies were noted as above.

1.2 The minutes of the meeting on 05 April were approved as a true and accurate record and would be published in due course, alongside the associated agenda and papers.

2. ***THEME: SYSTEM TRANSFORMATION***

2. a) NHS Long-Term Plan

2.1 MATT TAGNEY (Guest) provided a verbal update on the NHS Long-Term Plan (LTP), including the process and timeline for its development over the summer months.

2.2 Matt noted that work on the LTP had commenced with an expected completion date of autumn 2018. The LTP would cover 10 years, the first two of which would be focussed on delivery of the N*HS Five Year Forward View*. A number of workstreams had been identified within the categories 'life course programmes', 'clinical priorities' and 'enablers'. 1-3 leads had been assigned to each workstream and they had been tasked with bringing together appropriate expertise, including clinical expertise, to develop the proposals. Extensive engagement was taking place including engagement led by programme teams to co-develop, refine and test emerging policy proposals.

2.3 The NQB was asked to:

- **Consider** how best it could best contribute to development of the LTP over the coming months.

2.4 The NQB welcomed the opportunity to contribute to development of the LTP, with a number of Members noting that involvement had already been sought from their organisations.

2.5 The NQB advised that in developing the LTP:

a) A whole system approach should be taken involving engagement with social care, primary care and community care;

b) Alignment should be sought with the forthcoming *Green Paper on Social Care for Older People* and *Health and Care Workforce Strategy for England to 2027*;

c) Efforts should be taken to ensure momentum on delivery of the shorter-term elements; and

d) An arrangement should be agreed for how the LTP would be adapted over time to ensure responsiveness in the evolving context.

2.6 ANDREA SUTCLIFFE offered to link-up Matt with frontline social care providers (via trade associations) so engagement with this group could be sought.

2.7 Matt offered to circulate (via the NQB Secretariat) an up-to-date summary of LTP workstreams with named leads.

2.8 It was agreed that the LTP should be brought back to the NQB in October for a further opportunity for NQB contributions.

2. b) Local System Reviews: National Report

2.9 STEVE FIELD introduced this item and associated paper (Paper 1). The paper presented the key findings, identified common barriers and recommendations of the Local System Reviews National Report published in July 2018 – *Breaking Barriers: How older people move between health and social care in England*.

2.10 In July 2017, the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government asked the CQC to undertake a programme of targeted reviews of 20 local authority areas. 19 of the 20 sites selected were sub-optimal performers. The reviews aimed to answer the question 'How well do people move through the health and social care system, with a particular focus on the interface?'

2.11 The reviews found good intent among organisations to work together to a common plan, but a reality where most were focused on their own organisational goals. Four overarching recommendations were made: 1) Encouraging and enabling commissioners to bring about effective joined-up planning and commissioning; 2) A new approach to performance management; 3) A move to joint workforce planning; and 4) Better regulation and oversight of local systems.

2.12 The NQB was asked to:

- **Note** the national report – its key findings and recommendations; and
- **Consider** how the NQB may be able to support implementation of the recommendations.

2.13 The NQB noted the findings and recommendations of the CQC's report *Beyond Barriers: How older people move between health and social care in England*.

2.14 The NQB highlighted that the majority of local systems selected by the DHSC for CQC review had been sub-optimal. The NQB recommended that the CQC should be commissioned to undertake reviews of high performing

systems, as well as systems that had demonstrated recent improvement, in order to gather and share insights, learning and examples of best practice from these.

2.15 The NQB made a number of other observations including that:

a) Effective and robust systems leadership underpinned all elements of effective systems working, including a shared vision and purpose, clear governance and accountability arrangements, strong relationships, and joint commissioning; and

b) Whilst innovation was an important part of improving systems working, many of the solutions were linked to tackling 'the basics' such as poor relationships and a lack of trust.

2.16 In considering how it could support implementation of the recommendations the NQB committed to focussing its efforts on supporting improvement in systems leadership amongst clinical leaders.

3. ***THEME: REDUCING UNWARRANTED VARIATION***

National Clinical Audit Programme Partners Group

3.1 RICHARD ARNOLD (Guest) introduced this item and associated paper (Paper 2). The paper outlined a proposal for the establishment of an NQB sub-group which would bring together NQB member organisations to advise on the content of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and consider ways of implementing national clinical audit recommendations to improve the quality of patient care.

3.2 This proposal had been brought to the NQB previously in November 2017. At this time the NQB recognised the rationale and purpose for establishing the NQB sub-group. However it was felt that it would be the wrong time to

take this forward as the contract was out to tender. It was agreed to bring the proposal back to the NQB for a decision following award of the new contract. The contract was subsequently awarded to the Healthcare Quality Improvement Partnership (HQIP).

3.3 The NQB was asked to:

- **Consider** the opportunities to stimulate quality improvement in heatlhcare services in England presented by national clinical audit;
- **Endorse** the establishment of a NCAPOP Partners' Group which would both ensure the NCAPOP portfolio best supports the collective aims of NQB members; and consider national clinical audit recommendations on a regular basis, to maximise opportunities to improve the quality of patient care. As a sub-group of the NQB, the group's Terms of Reference and Work Plan would be shared with the NQB for approval and regular progress updates would be provided; and
- **Nominate** representatives from NQB member organisations to join the NCAPOP Partners' Group.

3.4 The NQB considered the opportunities to stimulate quality improvement in healthcare services in England presented by national clinical audit, including monitoring and stimulating improvement in care associated with the clinical priority programmes.

3.5 The NQB endorsed the establishment of a National Clinical Audit and Patient Outcomes Programme (NCAPOP) Partners' Group as a sub-group of the NQB.

3.6 The NQB noted that the new sub-group would add value by helping to increase the impact of national clinical audit and the following initial steers were offered:

a) Clear criteria should be defined, not only for the initiation of a national clinical audit, but also for ending an audit;

b) National clinical audits should be undertaken for patients with multiple long-term conditions to stimulate improvement in care for this increasingly common patient group;

c) Consideration should be given to including a patient and public representative on the sub-group, as well as appropriate local systems representation;

d) The number of national clinical audit recommendations should be streamlined and better targeted to aid implementation;

e) The timeliness of national clinical audit publications should be improved; and

f) The complexity of national clinical audit publications should be reduced to enable them to be understood by non-specialists, including trust board members and patients.

3.7 NQB Members agreed to nominate (via the NQB Secretariat) representatives from their organisations to join the NCAPOP Partners' Group.

3.8 It was agreed that the draft Terms of Reference and Work Plan for the NCAPOP Partners' Group should be brought back to a future NQB for ratification.

4. ***THEME: PATIENT SAFETY***

4. a) Learning from Deaths Programme: Update

4.1 JENNIFER BENJAMIN (on behalf of LEE MCDONOUGH) introduced this item and associated paper (Paper 3). The paper updated the NQB on progress and next steps on the national Learning from Deaths (LfD) Programme.

4.2 In terms of progress, all 221 acute, mental health and community trusts had published a policy on how they respond to and learn from deaths. Two major reports had been published: 1) NQB's *Guidance for NHS trusts on working with bereaved families and carers* (in July 2018); and 2) *Learning Disabilities Mortality Review (LeDeR) Programme Annual Report 2017* (in May 2018) and the Government's planned response (in September 2018). Other areas of progress were outlined in the paper.

4.3 In terms of next steps, the intention to extend the LfD policy to primary care and ambulance trusts was highlighted. This would be supported by a second edition of the NQB's *National Guidance on Learning from Deaths*. Alignment of the LfD Programme with the planned introduction of Medical Examiners was also mentioned.

4.4 The NQB was asked to **provide a view** in relation to:

- Plans for the NQB's second edition of *National Guidance on Learning from Deaths* (with publication assumed for early 2019) to include the application of LfD policy to primary care and ambulance trusts; and
- The process for developing LfD policy to apply to primary care, including leadership on policy development from NHSE.

4.5 The NQB was asked to **note**:

- Governance of actions arising from a families session at the LfD Programme Board on 10 May, including that the CQC's review of its assessment of trusts' implementation of the Duty of Candour and NHSI's

review of the Serious Incident Framework will report regularly to the Programme Board but not form part of the LfD Programme.

4.6 The NQB supported in principle plans to extend the LfD policy to primary care and ambulance trusts via publication of a second edition of the NQB's *National Guidance on Learning from Deaths*. However, it was agreed that resource requirements resulting from the extension should be considered to ensure roll-out in these settings would be achievable.

4.7 The NQB noted the process outlined in the paper for developing the LfD policy to apply to primary care, including leadership on policy development from NHSE.

4.8 The NQB discussed implementation of the LfD policy in secondary care and agreed that a second edition of the national guidance providing clarification on the expectations placed on trusts would be helpful. Although it was too early to evaluate the impact of trust implementation, early anecdotal evidence was positive.

4.9 The NQB noted related work including the CQC's review of its assessment of trusts' implementation of the Duty of Candour and NHSI's review of the Serious Incident Framework which sit outside the LfD Programme but report to it on a regular basis.

4.10 It was agreed that consideration should be given to inviting a trust medical director to a future NQB meeting to provide feedback on implementation and impact as part of a LfD Programme update.

4.11 It was agreed that the LfD Programme should continue to be brought back to future NQB meetings at appropriate points in time as the programme progresses.

4. b) Williams Review into Gross Negligence Manslaughter in Healthcare

4.12 MARK BENNET (Guest) introduced this item and associated paper (Paper 4). The paper summarised the findings and recommendations of the *Williams Review Report on Gross negligence manslaughter in healthcare*, published in June 2018.

4.13 The review considered the wider patient safety impact resulting from serious and widespread concerns among healthcare professionals that any errors could result in prosecution for gross negligence manslaughter, even in the context of mitigating broader organisational pressures and failings.

4.14 The review found that a fear of prosecution and regulatory action for human errors inhibited openness which is essential to improving patient safety. A number of recommendations were made which aimed to: 1) Improve the investigation of allegations of gross negligence manslaughter involving healthcare professionals; 2) Consider the impact of criminal and regulatory investigations on the willingness of healthcare professionals to reflect on their practice; and 3) Address inconsistencies in the way that different healthcare professional regulators carry out their fitness to practise functions.

4.15 The NQB was asked to:

- **Note** the review's publication and recommendations; and
- **Consider** what role the NQB could play in bringing the recommendations together to achieve the maximum impact.

4.16 The NQB noted the *Williams Review Report on Gross negligence manslaughter in healthcare* and supported its recommendations.

4.17 In particular, the NQB voiced support for the recommendations around improving the quality of local investigations and improving assurance and consistency in the use of experts in gross negligence manslaughter cases.

4.18 Alignment across the NQB ALBs to support implementation of the recommendations was noted including:

a) The NQB Learning from Deaths Programme;

b) NHSI's review of the Serious Incident Framework; and

c) NHSI's work to support a "just culture" in healthcare, including publication in March 2018 of *A just culture guide*.

4.19 The lack of *Williams Review* engagement with senior nurses from the NQB ALBs was noted.

4.20 The NQB agreed to continue to align and support implementation of the *Williams Review* workstreams.

4.21 Potential work to revisit the Maintaining High Professional Standards (MHPS) framework was noted. STEVE POWIS offered support for any work resulting from the *Williams Review* on professional standards via NHSE's Clinical Policy and Professional Standards Group.

4. c) Gosport War Memorial Hospital: Panel Report and Next Steps

4.22 JASON YIANNIKKOU (Guest) provided a verbal update on the findings and conclusions of *The Report of the Gosport Independent Panel*, published in June 2018, which examined historical concerns about the care of patients at Gosport War Memorial Hospital between 1987 and 2001.

4.23 The panel found that, over the period, the lives of more than 450 patients had been shortened by the clinically inappropriate use of opioid analgesics, with an additional 200 lives also likely to have been shortened taking missing medical records into account. The report also found a catalogue of failings by the local NHS, the police and oversight and regulatory bodies.

4.24 The DHSC was leading the Government's response, expected to be published in the autumn. Whilst the findings of the investigation with respect to policy had, to some extent, been superseded by policy developments in the ensuing years, this would provide an opportunity to review existing policies to determine what improvements could be made.

4.25 A policy review would be undertaken focussing on: 1) System oversight; 2) Medicines management; 3) Raising concerns/speaking up; and 4) Patient voice.

4.26 The NQB was asked to:

- **Consider** the policy issues identified as being key areas for action in response to the report;
- **Suggest** additional areas for consideration where an update would provide assurance that events at Gosport would not be repeated; and
- **Commit** to working with DHSC in developing the Government's response.

4.27 The NQB recognised that the historical nature of the events presented challenges in identifying key action areas. It was noted that a great deal of work had taken place since 2001 to improve the death review process, including the introduction of the Learning from Deaths policy and the planned introduction of Medical Examiners.

4.28 The NQB considered and agreed with the policy issues identified as being key areas for action and suggested the following additional action areas for consideration in the response:

a) Guidance on the prescription of opiates should be considered; and

b) Work should be considered on issues around consent to treatment and the information provided to patients in relation to their treatment.

4.29 The NQB offered its continued support to the DHSC to identify and take forward the key action areas in response to *The Report of the Gosport Independent Panel*, if required.

4.30 In particular, STEVE POWIS offered support around the management of controlled drugs as an area of NHSE statutory responsibility.

5. Healthcare Workers Seasonal Flu Vaccination

5.1 STEVE POWIS provided a verbal update on plans to issue a letter in September 2018 from senior national clinical and professional leaders to chief executives of NHS trusts highlighting the importance of seasonal flu vaccination for healthcare workers. The letter would advise how trusts should plan to ensure every staff member is offered the vaccine to enable them to achieve the highest possible level of vaccine coverage this winter.

5.2 The letter was one of a suite of planned interventions to reduce the impact of flu on the NHS. Other interventions included a NICE Guideline on increasing the uptake of the free flu vaccination among people eligible, expected to be published in August 2018.

5.3 The NQB was asked to:

- **Support** the suite of interventions to reduce the impact of flu on the NHS.

5.4 The NQB strongly supported the suite of interventions to reduce the impact of flu on the NHS, including the planned letter from senior national clinical and professional leaders to chief executives of NHS trusts highlighting the importance of seasonal flu vaccination for healthcare workers.

5.5 The NQB recommended that the letter highlights the importance of protecting those patients with specific immunosuppressed conditions, where the outcome of contracting flu may be most harmful.

5.6 Alternative ways of improving the uptake of seasonal flu vaccination by healthcare workers were discussed including operating a mandatory system of vaccination or building a requirement into employee contracts.

6. Any Other Business

Quality Improvement Roundtable Event

6.1 GILLIAN LENG updated the NQB on the Quality Improvement Roundtable Event held in June 2018. This event was jointly hosted by NICE, NHSE and NHSI and considered future requirements for quality improvement across the health system. The primary aim was to identify any gaps or duplication in the current support for quality improvement, and to set out needs for the future. Themes from the event would be worked up into action areas for organisations to commit to.

6.2 The NQB noted the update on the event and voiced enthusiastic support for a more systematic approach to quality improvement across health and social care.

6.3 GILLIAN LENG offered to circulate (via the NQB Secretariat) the posters summarising the approach to quality improvement taken by the organisations involved in the event.

6.4 GILLIAN LENG offered to bring a paper to the NQB in December outlining the action areas for a more systematic approach to quality improvement for NQB discussion and commitment.