NQB (18)(05)

NATIONAL QUALITY BOARD

05 December 2018
14:00 to 17:00

Skipton House (Room: 125A, 1st Floor), 80 London Road, London, SE1 6LH

MINUTES

<table>
<tr><th colspan="3">PRESENT</th></tr>
<tr><td colspan="3">Steve Powis (Chair) | Ted Baker (Chair)</td></tr>
<tr><td>Ruth May</td><td>Wendy Reid</td><td>Paul Cosford</td></tr>
<tr><td>Viv Bennett</td><td>Gillian Leng</td><td>Martin Severs</td></tr>
<tr><td>William Vineall (on behalf of Lee McDonough)</td><td>Imelda Redmond</td><td>Aidan Fowler</td></tr>
<tr><th colspan="3">IN ATTENDANCE</th></tr>
<tr><td>Anna Edwards (CQC)</td><td>Frances Healey (NHSI)</td><td>Jennifer Benjamin (DHSC)</td></tr>
<tr><td>Cathy Hassell (NHSI)</td><td>Rashmi Shukla (PHE)</td><td>Pauline Philip (NHSI)</td></tr>
<tr><td>Lauren Hughes (NHSE)</td><td>James Maguire (Clinical Fellow)</td><td>Lisa Murphy (Clinical Fellow)</td></tr>
<tr><td>Richard Owen (Secretariat)</td><td>Anne Booth (Secretariat)</td><td>Dominique Black(Secretariat)</td></tr>
<tr><th colspan="3">APOLOGIES</th></tr>
<tr><td>Jane Cummings</td><td>Andrea Sutcliffe</td><td>Steve Field</td></tr>
<tr><td>Kathy McLean</td><td>Lisa Bayliss-Pratt</td><td>Lee McDonough</td></tr>
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AGENDA

1. Welcome & Feedback from Previous Meeting
2. *THEME: PATIENT SAFETY*
   a) Never Events Thematic Review
   b) National Patient Safety Alerting Committee
   c) Patient Safety Strategy
3. *THEME: REDUCING UNWARRANTED VARIATION*
   NQB National Clinical Audit and Patient Outcomes Programme Partners Sub-Group

4. Public Health System Quality Framework
5. Winter Pressures
6. Any Other Business

1. Welcome & Feedback from Previous Meeting

1.1 TED BAKER (Chair) welcomed attendees to the fifth meeting of the National Quality Board (NQB) of 2018. Imelda Redmond, National Director at Healthwatch, and Aidan Fowler, National Director of Patient Safety, were introduced and welcomed to their first meeting. Imelda would be the NQB Patient and Public Representative. Attendees and apologies were noted as above.

1.2 The previous meeting on 03 October had been devoted to the NHS Long-Term Plan (LTP). The NQB had been given an opportunity to contribute to the development of four LTP workstreams. Feedback from this session was approved for publication in due course.

2. *THEME: PATIENT SAFETY*

a) Never Events Thematic Review

2.1 ANNA EDWARDS (Guest) introduced this item and associated Paper (Paper 1). The previous Secretary of State for Health and Social Care had asked the Care Quality Commission, in collaboration with NHS Improvement, to examine the underlying issues contributing to the occurrence of Never Events and thereafter the learning that could be applied to wider safety issues. The paper summarised the key findings and recommendations of the review, the report of which was due for publication in December 2018.

2.2 Anna outlined the findings and noted recommendations under seven themes: 1) Patient Safety Strategy; 2) Leaders in patient safety in NHS trusts; 3) Standardisation of clinical processes and other elements; 4) National patient safety alert development for all bodies issuing alerts; 5) Never Events Framework; 6) Common curriculum for patient safety education, training and CPD; and 7) CQC assessment of safety across all sectors.

2.3 The NQB was asked to:

- **Endorse** (formally, collectively and publicly) the recommendations of the CQC/NHSI Never Events Thematic Review; and
- **Discuss** the role NQB may have in oversight and co-ordination of the work of the different ALBs in taking forward specific recommendations, given there was no current governance group to oversee delivery of the recommendations.

2.4 The NQB endorsed the recommendations of the CQC/NHSI Never Events thematic review and emphasised that tackling cultural issues would be key to reducing the occurrence of Never Events and improving patient safety in general.

2.5 The NQB was very supportive of the recommendation for leaders in patient safety in NHS trusts and the recommendation for a common curriculum for patient safety education, training and CPD. The need for further building of the evidence-base around the latter was highlighted.

2.6 During discussions on the review, the NQB advised that the final report should reflect the findings and recommendations in relation to Board members, non-professional staff and digital and technological solutions.

2.7 Thinking of implementation and the broader context, the NQB agreed that it would be helpful if work on patient safety could be linked with work underway on quality improvement.

2.8 In discussing the role it may have in oversight and co-ordination of the work of the different ALBs in taking forward specific recommendations, the NQB noted the small number of recommendations and need for prioritisation. It was agreed that that the report should be brought back to the NQB once published for further consideration about the governance needed to ensure successful implementation of the recommendations.

b) National Patient Safety Alerting Committee

2.9 AIDAN FOWLER introduced this item and associated paper (Paper 2). The paper described the establishment of the National Patient Safety Alerting Committee (NaPSAC) in response to a request from the previous Secretary of State for Health and Social Care to more clearly identify which nationally-issued safety advice and guidance was safety-critical and mandatory.

2.10 Aidan noted that in January 2018, the MHRA had held a UK-wide summit on working in partnership to improve the impact of safety messages (including National Patient Safety Alerts) issued to the health and social care system. The summit identified the importance of separating safety-critical alerts requiring mandatory organisational action from other safety messages.

2.11 The NaPSAC was established by NHS Improvement to take forward this cross-system work and would operate by 'credentialing' each alert issuing body/team to issue National Patient Safety Alerts. The NaPSAC would develop common thresholds, standards and a consistent format for National Patient Safety Alerts, oversee the development and management of the credentialing process for alert-issuing bodies/teams and monitor the National Patient Safety Alerts published by each credentialed alert issuer to ensure they adhere to the agreed thresholds, standards and format.

2.12 Progress to date had been good, facilitated by strong commitment from all partners. Recruitment of a Patient and Public Representative to the NaPSAC was nearing completion.

2.13 Due to the cross-system nature of the NaPSAC a reporting line to the NQB was proposed, with NaPSAC constituted as a sub-committee of NQB.

2.14 The NQB was asked to:

- **Note** progress on establishing National Patient Safety Alerts; and
- **Agree** for NaPSAC to be constituted as a sub-committee of the NQB.

2.15 The NQB noted the progress made on establishing National Patient Safety Alerts via the NaPSAC.

2.16 It was clarified that NaPSAC was concerned with identifying, and ensuring the appropriate content and format of, safety-critical alerts requiring mandatory organisational action. The MHRA was leading a piece of cross-system work aimed at improving the impact of non-mandatory safety messages. In addition, the MHRA was now responsible for the Central Alerting System (CAS), the web-based cascading system for issuing a wide variety of safety messages (including National Patient Safety Alerts and Emergency Preparedness, Resilience and Response Alerts) to the NHS and others. The MHRA was in the process of redeveloping CAS and NaPSAC was taking a keen interest in this.

2.17 GILLIAN LENG noted that there may be opportunities to better utilise NICE Interventional Procedures Guidance which examine whether procedures are safe and effective for routine use. GILLIAN LENG agreed to work with FRANCES HEALEY (Guest) to explore whether NICE Interventional Procedures Guidance could be better utilised to further the patient safety agenda.

2.18 The NQB agreed for NaPSAC to be constituted as a sub-committee of the NQB and asked for 6-monthly reporting as standard for NQB sub-groups.

c) Patient Safety Strategy

2.19 AIDAN FOWLER introduced this item and associated paper (Paper 3). The paper introduced the NQB to the vision for a Patient Safety Strategy for the NHS which would sit alongside the NHS Long-Term Plan.

2.20 Aidan noted that the overall ambition for the Patient Safety Strategy was for the NHS to be the safest healthcare system in the world. To realise this ambition activity was proposed under three key areas: 1) Insight; 2

Infrastructure; and 3) Initiatives. The proposals would be consulted on from December 2018 to February 2019, prior to finalising and publishing the strategy in April 2019.

2.21 The NQB was asked to:

- **Note** the vision for a Patient Safety Strategy for the NHS; and
- **Provide** initial comments on this in the context of the wider quality agenda.

2.22 The NQB noted the vision for a Patient Safety Strategy for the NHS and emphasised the importance of culture in achieving this vision.

2.23 The NQB provided initial comments on the vision (which would be developed further for wider engagement) including:

a) Clarity around system responsibility in achieving the vision would be helpful, as would emphasis on the whole-system approach needed – covering, for example, primary care, place-based learning and digital and technology;

b) Measurement should be built into the strategy, for example, the measures that would be used for determining success in relation to the ambition – for the NHS to be the safest healthcare system in the world. More detail around 'decreasing harm in key areas by 50%' would aid understanding;

c) The STP/ICS-level should be reflected; and

d) Synergies between the strategy and the maternity and neonatal safety element of the NHS Long-Term Plan should be explored. LAUREN HUGHES and AIDAN FOWLER agreed to link-up with regards to this.

2.24 Aidan thanked the NQB for their comments which would be considered in development of the Patient Safety Strategy.

2.25 It was agreed that NQB member organisations should respond to the consultation on the Patient Safety Strategy and the NQB as a collective should be given a final opportunity to feed into this at their next meeting in February 2019.

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

NQB National Clinical Audit and Patient Outcomes Programme Partners Sub-Group

3.1 CATHY HASSELL (Guest) introduced this item and associated paper (Paper 4). Previously, in August 2018, the NQB agreed to establish a NQB National Clinical Audit and Patient Outcomes Programme (NCAPOP) Partners Sub-Group to advise on the content of the NCAPOP and develop an approach for responding to NCAPOP recommendations to improve the quality of patient care. The NQB requested sight of the sub-group's Terms of Reference and Work Plan.

3.2 The paper provided the NQB with a progress update from the NCAPOP Partners Sub-Group, including its Terms of Reference and Work Plan (referred to as a Commissioning Plan). Cathy noted that the sub-group had undertaken a review of national-level NCAPOP recommendations to identify ways in which implementation could be improved.

3.3 The NQB was asked to:

- **Agree** the Terms of Reference for the NQB NCAPOP Partners Sub-Group; and
- **Note** the Commissioning Plan for the sub-group.

3.4 The NQB agreed the Terms of Reference for the NQB NCAPOP Partners Sub-Group including 6-monthly reporting as standard for NQB sub-groups. It was agreed that the next report to the NQB should include the findings of the review of national-level NCAPOP recommendations.

3.5 The NQB noted the Commissioning Plan for the sub-group.

3.6 During discussions the NQB gave the following steers:

a) National clinical audits should be encouraged to look beyond inpatient settings to the whole patient pathway, including primary care;

b) Consideration should be given to whether those working in clinical audit and utilising audit findings are adequately represented on the sub-group;

c) The sub-group should consider whether the programme is aiming for clinical audits that are patient focussed, speciality focussed or both (depending on clinical question) and should articulate its position in relation to this; and

d) The sub-group should consider the system for implementing national clinical audit recommendations and whether this is robust.

3.7 Cathy thanked the NQB for their steers which would be considered by the NQB NCAPOP Partners Sub-Group.

4. Public Health System Quality Framework

4.1 RASHMI SHUKLA (Guest) introduced this item and associated paper (Paper 5). The paper provided the NQB with an overview of the project to develop a Quality Framework for the Public Health System. The framework would exemplify a system-wide commitment to high quality in public health aligning, where appropriate, with the existing frameworks for adult social care (*Adult*

Social Care Quality Matters) and healthcare in the NHS (*NQB Shared Commitment to Quality*).

4.2 Rashmi noted that the framework was being developed in parallel with ten service specific *What Good Looks Like* publications (being led by PHE and ADPH). The framework was taking a broader scope to include the characteristics of high quality public health functions.

4.3 Due to the locally led and wide-ranging nature of public health an extensive engagement exercise had been undertaken across the country. Over 150 people had been engaged with including public health professionals from local government, the NHS, academic institutions, think tanks and the voluntary and community sector. Further engagement was planned with launch of the framework expected in Q1 2019.

4.4 The NQB was asked to:

- **Note** the progress that had been achieved to date on developing the Quality Framework for the Public Health System;
- **Comment** on the draft framework and share its experience of implementing the *NQB Shared Commitment to Quality* framework; and
- **Agree** to consider endorsement of the final framework once completed.

4.5 The NQB noted the progress that has been achieved to date on developing the Quality Framework for the Public Health System and was pleased with efforts to align this with existing quality frameworks. It was noted that some public health services are provided by the NHS (commissioned by local authorities).

4.6 The NQB provided a number of comments on the draft framework including:

a) Alignment should be sought with the 'Prevention, Personal Responsibility and Health Inequalities' workstream of the NHS LTP and *Prevention is better than cure* Green Paper expected in 2019;

b) Reducing health inequalities, particularly in relation to access, was as a key area this framework should focus on; and

c) Local translation of the framework would be key to its success so continued engagement with local public health stakeholders should be prioritised.

4.7 The NQB welcomed the opportunity to consider endorsement (via correspondence) of the final framework once completed.

5. Winter Pressures

5.1 PAULINE PHILIP (Guest) gave a verbal update on the NHS-wide preparations being undertaken for winter 2018/19.

5.2 Pauline noted the continued drive to transform emergency and elective care that will support delivery throughout the winter period. For winter 2018/19 important progress was expected in several areas including:

- more effective flu vaccines for older people, children and at-risk working age adults;
- new £240 million spending for social care to support winter pressures;
- primary care extended access across the country with an additional nine million appointments per year; and
- national roll-out of NHS111 online.

5.3 In addition to this, local, regional and national coordination of urgent and emergency care delivery over winter was now in place. Engagement was also

underway with local system leaders responsible for maintaining delivery and escalating concerns.

5.4 The NQB was asked to:

- **Note** the update provided.

5.5 The NQB noted the update and commended the level of commitment shown by staff across local systems in preparing for winter.

5.6 The NQB noted the progress made on transforming the model for urgent and emergency care to improve out-of-hospital services (e.g. NHS 111) so more care is delivered closer to home and hospital attendances and admissions are reduced.

5.7 The NQB discussed seasonal flu vaccination amongst healthcare workers as a key measure to reduce the burden of flu over the winter period. The need to shift culture around seasonal flu vaccination was highlighted.

6. Any Other Business

6.1 It was noted that quality improvement themed items had been planned for the February 2019 NQB meeting, including an item (deferred from this meeting) outlining the action areas for a more systematic approach to quality improvement building on the NICE-led Quality Improvement Roundtable Event held in June 2018.

6.2 The NQB priorities agreed earlier in the year were reiterated:

1) Workforce;

2) System Transformation to Improve Care & Meet Population Needs;

3) Digital & Technology;

4) Patient Safety; and

5) Reducing Unwarranted Variation.

6.3 The NQB agreed that the priority areas around Workforce and Digital should be prioritised on upcoming NQB agendas.

6.4 WENDY REID offered to bring an item on the 'Workforce' workstream of the NHS LTP to an upcoming NQB meeting.

6.5 MARTIN SEVERS offered to bring an item on the 'Digital & Technology' workstream of the NHS LTP to an upcoming meeting.

Next NQB meeting: 07 February 2019