NQB (18)(02)

NATIONAL QUALITY BOARD

05 April 2018
14:00 to 17:00

Public Health England Offices (Board Room, 4th Floor), Wellington House, 133-155 Waterloo Road, London, SE1 8UG

MINUTES

PRESENT		
Steve Powis (Chair)	Ted Baker (Chair)	
Jane Cummings	Steve Field	Sean O'Kelly (on behalf of Kathy McLean)
Ruth May	Wendy Reid	Paul Cosford
Gillian Leng	Jennifer Benjamin (on behalf of Lee McDonough)	
IN ATTENDANCE		
Celia Ingham Clark (NHSE/I)	Donna Forsyth (NHSI)	Lauren Mosely (NHSI)
Richard Owen (Secretariat)	Anne Booth (Secretariat)	Dominique Black(Secretariat)
APOLOGIES		
Andrea Sutcliffe	Kathy McLean	Lisa Bayliss-Pratt
Viv Bennett	Martin Severs	Lee McDonough

AGENDA

1. Welcome & Minutes of Previous Meeting
2. Early Warning Scores
   2.a) National Early Warning Score 2: Update on Roll-Out Since NQB Endorsement
   2.b) Paediatric Early Warning Score: Establishment of National PEWS Programme

   Board
3. The Future of NHS Patient Safety Investigations
4. Any Other Business

DISCUSSION SESSION: National Quality Board Refresh 2018

1. Welcome & Minutes from Previous Meeting

1.1 STEVE POWIS (Chair) welcomed attendees to the second meeting of the National Quality Board (NQB) of 2018. Attendees and apologies were noted as above.

1.2 The minutes of the meeting on 14 February were approved pending a revision and would be published in due course, alongside the associated agenda and papers.

2. Early Warning Scores

2.1 CELIA INGHAM CLARK (Guest) introduced this item and associated paper (Paper 1). The paper provided an update on the roll-out of the updated National Early Warning Score (NEWS2) (previously presented at the NQB) and on development of a national Paediatric Early Warning Score (PEWS) for England.

2.2 With regards to NEWS2, Celia noted that a sub-group of the Sepsis Board (NEWS2 Working Group) had been established to support its roll-out in acute and ambulance trusts by 2019. An NHSI survey had found that NEWS (either version) was being used by approximately 75% of acute trusts. A National Patient Safety Alert (NPSA) on NEWS2 was planned, and an amended sepsis/AMR CQUIN incorporating an expectation around NEWS2 was due for publication imminently. The NEWS2 Working Group was also looking to build an evidence base for the roll-out of NEWS2 in primary care and community settings.

2.3 With regards to PEWS, Celia noted that the early identification of child deterioration was difficult as children respond to illness in a different way, are harder to assess and can deteriorate more rapidly than adults. The detection of child deterioration needed to be improved across the NHS as

current methods were wide-ranging and used in paediatric units predominantly. A joint NHSE/RCPCH PEWS Programme Board had been established to oversee the development of a national PEWS for England.

2.4 The NQB was asked to:

- **Acknowledge** the work on NEWS2, **continue** to support and endorse its roll-out across acute hospital settings, and **endorse** its roll-out in other settings;
- **Endorse** the use of the RCP's NEWS2 training module to provide sepsis accreditation to a greater number of NHS staff;
- **Discuss** how to enhance existing alignment arrangements across ALBs to ensure the successful roll-out of NEWS2; and
- **Acknowledge** and **support** the early work to develop a national PEWS for England.

2. a) National Early Warning Score 2: Update on Roll-Out Since NQB Endorsement

2.5 The NQB acknowledged the work on NEWS2, and reiterated its continued support and endorsement of its roll-out across acute hospital settings.

2.6 The NQB supported the use of NEWS2 in primary care, community settings and ambulance services to reduce the risks associated with interface issues and build on the evidence base for the use of NEWS2 in these settings.

2.7 The NQB endorsed the use of the RCP's NEWS training module to provide sepsis accreditation to a greater number of NHS staff.

2.8 During discussion on how to enhance existing alignment arrangements across ALBs to ensure the successful roll-out of NEWS2, the following points were made:

a) The CQC was now looking for the use of NEWS2 during inspections. An increase in usage had been observed;

b) Discussions were ongoing to try to achieve formal endorsement of NEWS2 by NICE; and

c) The NHSI-funded and coordinated Patient Safety Collaboratives (delivered locally by the Academic Health Science Networks) were establishing initiatives to encourage the use of NEWS2. If systems other than NEWS2 were in use, learning was being captured on the reasons for this.

2.9 In addition, the following offers of support were made:

a) STEVE FIELD offered to link with Celia on improving the uptake of NEWS2 within primary care;

b) WENDY REID offered to explore the possibility of HEE hosting the RCP's NEWS training module via its e-Learning for Healthcare platform so training on NEWS2 could become part of the generic training for all Doctors; and

c) RUTH MAY and GILLIAN LENG offered to work with Celia to explore the evidence base on observations policies such as requiring observations to be taken by Registered Nurses only.

2. b) Paediatric Early Warning Score: Establishment of National PEWS Programme Board

2.10 The NQB acknowledged and supported the early work to develop a national PEWS for England.

2.11 The following offer of support was made:

a) GILLIAN LENG offered to work with Celia to explore the evidence base on systems in use across other countries for detecting deterioration in children.

3. The Future of NHS Patient Safety Investigations

3.1 DONNA FORSYTH (Guest) introduced this item and associated paper (Paper 2). The paper provided an update on the NHSI 12-week engagement exercise to gather views on how and when the NHS should investigate Serious Incidents. Responses to the engagement would be used to shape a new Serious Incident Framework.

3.2 LAUREN MOSLEY (Guest) highlighted the system aspects of this work. She noted that whilst the Serious Incident Framework set clear expectations for providers, commissioners and regulators also had responsibilities. These accountability, oversight and assurance arrangements would also be reviewed as a number of issues had been identified. Providers experienced burdensome reporting arrangements due to the number of different organisations requesting information from them and there was evidence of providers being performance managed on the number or types of Serious Incidents reported which discouraged working across organisational boundaries.

3.3 The NQB was asked to:

- **Note** the engagement that would inform the review of the Serious Incident Framework;
- **Confirm** areas of the engagement that NQB wished to bring back for discussion as proposals for the new Serious Incident Framework were further developed; and
- **Provide views** in relation to the key issues upon which the engagement was centred and how NQB could take a global view on this alongside:

- o the work of CQC on the never events thematic; and
- o the cross-system work led by the MHRA on safety messaging.

3.4 The NQB noted the engagement that would inform the review of the Serious Incident Framework and supported this important piece of work.

3.5 The NQB provided views in relation to the key issues upon which the engagement was centred and noted four main areas that it wished to bring back for discussion as proposals for the new Serious Incident Framework were further developed:

a) Failure to ensure proper patient, family and carer support and engagement in investigation processes;

b) Lack of staff support and engagement during investigations;

c) Staff reporting having insufficient time, expertise and resources to conduct high quality investigations; and

d) The perceived punitive nature of the Serious Incident investigation process, language and terminology which inhibits improvement.

3.6 As Patient Safety was likely to become a priority area of future focus for the NQB, this would enable a global view to be taken in future meetings. Related work included but was not limited to the CQC thematic review of never events, and the MHRA-led cross-system work on improving the impact of non-mandatory safety-related messages issued by national bodies to the system.

3.7 The following offers of support were made:

a) WENDY REID offered to signpost Donna to the research available on the training of clinical teams in Serious Incident investigation; and

b) STEVE FIELD offered to link up Donna with Professor Nigel Sparrow, Senior National GP Advisor to the CQC, to explore how the review could better consider primary care and dental services.

3.8 The NQB thanked Donna and Lauren for presenting this work which would be brought back to a future meeting as the work progressed.

4. A. O. B.

4.1 STEVE FIELD drew the NQB's attention to the publication of the *Shared View of Quality in General Practice* on 28th March 2018. This document, which was aligned with the *NQB Shared Commitment to Quality*, aimed to reduce duplication and administrative workload as a result of quality assurance for professionals working in general practice. It was developed jointly by national organisations collectively responsible for the regulation and oversight of general practice. In response to queries from an NQB Member, Steve highlighted that the accessibility of services was covered in the document, and interface issues were being looked at in the Local System Reviews which would be brought to a future meeting.

Next NQB meeting: 06 June 2018 [ADDENDUM: This meeting was cancelled]