NATIONAL QUALITY BOARD

20 February 2020
14:00 to 16.30

Skipton House (Room:5C1), 80 London Road, London, SE1 6LH

MINUTES

PRESENT		
Steve Powis (Chair)	Ted Baker (Chair)	
William Vineall	Wendy Reid	Imelda Redmond
Gill Leng	Hugh McCaughey	Viv Bennett
Aidan Fowler	Yvonne Doyle	Jonathan Benger
IN ATTENDANCE		
Natalie Warman (NHSE/I South East Region)	Dominique Black (Secretariat)	Kate Lupton (Secretariat)
Lucy Firth (Secretariat)	Clare Stone (Surrey Heartlands ICS)	Richard Owen (Secretariat)
Heather MacFarlane (NHSE/I)	Deborah Turner (NHSE/I)	Sue Tranka (NHSE/I)
Dr Alan Fletcher (NHSE/I)	Keith Conradi (HSIB)	
APOLOGIES		
Rosie Benneyworth	Kate Terroni	Lee McDonough
Mark Radford	Ruth May	

AGENDA

1. Welcome & Minutes of Previous Meeting
2. <u>THEME: PATIENT SAFETY</u>
   a) Update on the Introduction of Medical Examiners
   b) Update on National Learning from Deaths Programme
   c) Update from National Patient Safety Team on:
      - HSIB recommendations;
      - Patient Safety Strategy
3. <u>THEME: SYSTEM TRANSFORMATION</u>

a) Update on the review of the Shared Commitment to Quality and National guidance on quality surveillance groups

4. NQB Forward Look

1. Welcome & Minutes from Previous Meeting

1.1 STEVE POWIS (Chair) welcomed all to the first meeting of the National Quality Board (NQB) in 2020. Attendees and apologies were noted as above.

1.2 The minutes of the previous meeting on 9 December 2019 were approved and agreed as a true and accurate record and would be published in due course, alongside the associated agenda and papers.

1.3 The NQB agreed to bring back the following items to a future NQB meeting:

a) An update on the Williams Review into Gross Negligence Manslaughter in Healthcare;

b) An item on the Healthcare Quality Improvement Partnership (HQIP)

2. THEME: PATIENT SAFETY

a) Update on the Introduction of Medical Examiners

2.1 ALAN FLETCHER was invited to introduce this item as a verbal update.

2.2. Over the last year, good progress has been made in implementing the Medical Examiners system. All acute providers have been providing Medical Examiners statements since April 2019, and non-acute sites will commence at the start of April 2020. The target is to have as many Medical Examiners Statements in place by March 2021;

2. Recruitment has generally been progressing well. The National team is established, and Regional Medical Examiner Officers are in post. There are now over 570 Medical Examiners in place, with another 150 to be trained in the next few months. Medical Examiner offices will be established in 134 trusts.

2.4 Implementation of the National Data Set digital system has been challenging and will remain so as the system gets introduced in non-acute providers. The national team and engaging actively with stakeholders such as the Royal College of General Practitioners (RCGP), Coroner Registration Services etc to ensure there is support and understanding of the system.

2.5 Other current priorities were also highlighted, including:

a) Information governance – particular challenge around storing of local data and the need for GPs to have patient consent when sharing their record across different providers;

b) Varying levels of engagement across non-acute providers;

c) Need to agree appropriate salary for GPs taking on the additional role of Medical Examiner (in agreement with the BMA), and to minimise the additional work required of GPs.

The NQB was asked to:

a) **Note** the update;
b) **Promote** and **support** the implementation of medical examiners through work networks;
c) **Advise** of any opportunities the NQB are aware of to accelerate implementation and awareness of medical examiners, for example upcoming events.

2.6 The NQB noted the update and agreed to support the roll out of Medical Examiners to the community. The CQC offered to support with uptake amongst trusts who are failing to collaborate as they should;

2.7 The NQB made the additional following points:

a) Consideration of the programme for ICSs – the need to be clear with ICSs on what the requirements were and ensure that all system partners are working collaboratively to deliver them;

b) Need to clarify the timetable for roll out of the system within mental health trusts, and requirements and timetable for independent sector

c) The good progress made in Scotland with digitalisation – and support for a similar scheme in England;

2. b) Update on the National Learning from Deaths Programme

2.9 WILLIAM VINEALL introduced this item with associated paper (paper 3). The update covered progress made on the Learning from Deaths (LfD) programme and informed consideration of a new governance arrangement to create alignment of the LfD and Medical Examiner programmes;

2.10 The LfD programme has provided strong foundations for the work being undertaken within the Medical Examiners programme. There is a need for a single governance structure, which enables work on any follow-up policy issues from the LfD programme, and align with the Medical Examiners programme;

2.11 The proposed board will provide a single forum in which mortality issues are discussed. This will be important as safety and mortality issues continue to be prioritised. The Paterson Review, Cumberlege Review on maternity services

2.12 The NQB was asked to:

a) **Note** the overall progress made under the LfD programme;

b) **Note** achievements and outstanding actions from the LfD programme;

c) **Note** further considerations by family representatives of the former LfD Programme Board; including the merits of a system architecture review and

greater focus on the needs of the BME and other protected characteristic groups;

d) **Consider** the DHSC's recommendations for, and provide a view of, aligning future work on learning from deaths with the medical examiners system under a single governance arrangement.

2.13 The NQB noted the progress made and raised the following points:

a) Whether there is an ambition to include Learning Disabilities Mortality Review (LeDeR) in the LfD programme – confirmed that LeDer would be considered;

b) The importance of the proposed Board in enabling recommendations and findings from reviews such as the Paterson Review and Cumberlege Review to be discussed;

2. c) Update from the National Patient Safety Team on HSIB recommendations

2.14 AIDAN FOWLER was invited to introduce this item with associated paper (paper 1). The update outlined the establishment of a new Patient Safety Committee running in partnership with NAPSAC to oversee implementation of all HSIB recommendations across system partners and Royal colleges;

2.15 The update included the following points:

a) The NHSE-I Patient Safety Committee will have oversight of the recommendations but HSIB will retain responsibility for agreeing on responses to the recommendations;

b) A total of 50 recommendations have been made so far;

c) HSIB are proposing to test a joint committee across the ALBs.

2.16 **The NQB was asked to:**

a) **Note** the recommendations coming from the first meeting and give their approval;

b) **Note** the suggested reporting line of the committee and confirm this is appropriate;

c) **Discuss** any thoughts around the remit of this committee;

d) **Agree** to receive an update in Spring/Summer 2020.

2.17 The NQB raised the following points:

a) There is a strong link between HSIB recommendations and QSGs – need to ensure that QSGs are used to share recommendations where appropriate.

b) There is a need to trial the NHSE-I Patient Safety Committee reporting to the NQB (given its cross-ALB membership);

2.18 The NQB agreed on the approach and offered to support the Patient Safety Committee to engage bodies to act on the more challenging recommendations.

2) d) Update on the Patient Safety Strategy:

2.19 AIDAN FOWLER presented this item with associated paper (paper 2). The update provided a headline overview of the work ongoing to implement the NHS Patient Safety Strategy including work planned for the next quarter and the status of each strategic objective.

2.20 The current work of the Patient Safety team includes:

a) Release of a new style of NAPSAC alert. The aim is for all alerts to have a single, clearer template;

b) Consulting on the Patient Safety Specialists role specification and Patient Safety Partners Framework;

c) Supporting a range of programmes including the next phase of the Maternity programme, Medical Safety programme, Mental Health programme and early warning scoring;

d) Understanding what good patient safety culture looks like – meeting with organisations that are considered to be 'outstanding' and circulating a staff survey.

2.21 The NQB was asked to:

a) **Note** the implementation progress and plans;

b) **Advise** on the potential of further alignment to NQB initiatives.

2.22 The NQB noted the progress to date and highlighted the importance and complexity of measuring patient safety within an organisation;

2.23 The NQB offered to support by keeping the Patient Safety Strategy as a key priority and inviting the Patient Safety team to provide updates at future meetings.

3. a) Update on the review of the Shared Commitment to Quality and national guidance on quality surveillance groups

3.1 KATE LUPTON presented this item with associated paper (paper 4). The item provided an update on the work including a draft of the Shared Commitment and an outline of the new quality governance model.

a.2 The presentation included the following points:

a) The updated Shared Commitment and new quality surveillance model are pitched at systems, articulating what quality means to those working in ICSs and other systems, and what governance is required to manage quality;

b) Both outputs have been updated based on wide feedback from NQB members, ALBs, regional teams, systems and those accessing / using services;

c) The overall definition of Quality in the Shared Commitment now incorporates the word ‘equity’ at the core. The Seven Steps to Quality have remained the same;

d) The new quality surveillance model will be tested out with regional teams until early 2021. The model will need to be flexed within the regions to reflect local variation;

e) The revised Shared Commitment and Paper on Quality Surveillance will be finalised and distributed by mid-late April 2021.

3.3 The NQB was asked to:

a) **Review** the draft of the revised Shared Commitment and overview of the national quality governance model;

b) **Provide feedback** on the outputs, in terms of content and model proposed;

c) **Agree** to the timetable proposed for the quality governance work – with a period of testing until April 2021;

d) **Agree** next steps in terms of signing off the outputs in early April 2020.

3.4 The NQB broadly supported the updates to the Shared Commitment and noted:

f) Need to be clarify wording regarding ‘equity’ in the Shared Commitment;

g) Strong alignment of Patient Safety and Quality needs to be reflected in the Shared Commitment;

h) d) The role of Academic Health Science Networks (AHSNs) is key to quality surveillance and should be considered in the new model;

i) Role of Local Authorities in new QSGs also needs to be clear and effectively implemented.

3.5 The NQB noted the alignment to the Improvement Framework and the benefit to systems in terms of being able to show what good looks likes and how to build improvement capability.

3.6 System representatives noted the benefits for systems in terms of championing the importance of quality and having a national framework to guide prioritising and decision-making around quality locally and regionally.

4. NQB Forward Look

4.1 Richard Owen presented the item with associated paper (paper 5). The update presented a structure for the NQB meetings in 2020 and a list of agenda items the Secretariat feel is appropriate and relevant to discuss.

4.2 The NQB was asked to:

a) **Approve** the forward plan;

b) **Make suggestions** on any agenda items

4.3 The NQB approved the Forward Plan and agreed that the items closely align with the NQB's priority areas.

4.4 The following suggestions were made:

a) Items on Sustainability, EU Exit, Maternity and the new PHE report could be added;

b) Charles Vincent could be an interesting guest speaker to invite to the Professional Regulators meeting.

5. AOB

5.1 Gill Leng will take on the role of Interim CEO at NICE from the beginning of April 2020. Therefore, Kevin Harris will be attending the future NQB meetings in her place.

5.2 Nicola Bent will be starting a new role and will not be attending future NQB meetings.

a) The next NQB meeting will be held on 16 April 2020.