NATIONAL QUALITY BOARD MINUTES 10 APRIL 2025

Via Microsoft Teams

NQB MEMBERS PRESENT

- Stephen Powis - National Medical Director, NHSE, CO-CHAIR
- Aidan Fowler – Interim Chief Inspector of Healthcare, CQC, CO_CHAIR
- [redacted]
- Sarah Price – Director of Public Health, NHSE
- Rosie Benneyworth – Interim CEO, HSSIB
- Sue Ibbotson – Head of Clinical Excellence and Quality, UKHSA
- Stella Vig - Medical Director for Secondary Care and Quality, NHSE
- Jamie Waterall - Deputy Chief Public Health Nurse, OHID
- Jonathan Benger - Chief Medical Officer, NICE
- Mark Radford – Deputy CNO, NHSE
- Sarah McClinton - Chief Social Worker for Adults, DHSC
- William Vineall - Director of NHS Quality, Safety and Investigations, DHSC

IN ATTENDANCE

- Julian Hartley, CEO, CQC
- Andrea Lewis - Regional Chief Nurse – South East and Interim DCNO England for Quality, Sustainability and Innovation, NHSE
- Matt Mansbridge – senior safety investigator, HSSIB
- Ramani Moonesinghe – interim National Director of Patient Safety, NHSE
- Nichola Crust – Senior Safety Investigator, HSSIB
- [redacted]
- Steve Tolan – Deputy Chief AHP Office, NHSE
- Samantha Lungu - Senior Policy Advisor -Education and Training Policy & Professional Regulation Team

SECRETARIAT:

- [redacted]

APOLOGIES:

- Deborah Sturdy – Chief Nurse for Adult Social Care
- James Bullion – Interim Chief Inspector of Adult Social Care and Integrated Care
- Duncan Burton - Chief Nursing Officer for England.
- Prem Premachandran - Interim Medical Director, CQC,
- Jayne Chidgey-Clark – National Guardian for the NHS
- Charlie Cassells - Director of Operations and Strategy, National Guardian's Office
- [redacted]

AGENDA
1. **Welcome, introductions and apologies**
2. **Learning from Deaths in Mental Health Inpatient Services**
3. **Recommendations to Impact.**
4. **NQB Safer Staffing and AHP Guidance**
5. **Quality Strategy for the NHS**
6. **Update on the CQC Way**
7. **Any other business**

1. Welcome, introductions and apologies

1.1 Members were welcomed to the second NQB meeting of 2025.

1.2 Members were informed that Aidan Fowler will co-chair NQB (on behalf of CQC) and the chairs took the opportunity to pass on thanks to Prem Premachandran for his contribution as co-chair.

1.3 Sarah McClinton, new Chief Social Worker for Adults, Ramani Moonesinghe, interim National Director of Patient Safety and Julian Hartley, Chief Executive of CQC were welcomed to today's NQB.

1.4 Members confirmed they were content to approve the minutes of the previous meeting on 24 February 2025 for publication alongside the agenda.

2. Learning from Deaths in Mental Health Inpatient Services

2.1 Rosie Benneyworth and Nikki Crust shared a presentation on the report which identified significant challenges in maintaining safety, conducting effective investigations, managing data on deaths and ensuring system-wide learning. The investigation also found gaps in discharge planning, crisis service accessibility, and access to community therapy that were potentially contributing to poor patient outcomes, including deaths.

2.2 The report emphasised the need for a systemic approach to safety investigations and learning with a focus on collaboration, transparency, and oversight, with a shift from procedural practices to a culture rooted in empathy, person-centred care and active involvement of families.

2.3 The NQB were asked to note the report and where appropriate discuss the content. It is expected that the findings of this report will contribute to the government's long-term plan in relation to mental health settings.

2.4 NQB members referenced the Lampard Inquiry, which is investigating

approximately 2,000 mental health inpatient deaths in Essex.

2.5 Aidan Fowler highlighted that the definition of deaths, in terms of what should and shouldn't be looked at, is important. The use of numbers that include deaths from natural causes and where the cause of death is unknown presents a contextual issue.

2.6 Jamie Waterall highlighted that where there are unmet physical health needs in inpatient services, there is a risk that people die prematurely. As a healthcare system there is a risk that we often undertreating the risk factors, albeit it's important to differentiate and understand the context.

3. Recommendations to impact

3.1 Rosie Benneyworth and Matthew Mansbridge introduced this item. It covered two updates from the Recommendations to Impact working group, including:

1. Development of **safety recommendation principles** which represent discussions within the recommendations to impact working group, and
2. Proposal for **a recommendation's hub**, as part of a wider structure to track recommendations, responses and actions.

3.2 The NQB were asked to:

1) Note, and if appropriate, discuss the content of the principles.
2) Discuss the content of the paper for the recommendations hub and decide whether to support the proposals to date.
3) Agree next steps.

3.3 NQB members highlighted it's important to drive change across the system. There is a need to equip leaders with information in an easy and coordinated way and recognition that the system is overwhelmed with information from lots of different sources.

3.4 It was emphasised that the introduction of a '*Recommendations Hub*' could bring this together and present an opportunity to demonstrate how things are being implemented, however there remained questions about the scope of the work. Given existing work, it was felt important to keep recommendations related to covid separate at this point.

3.5 Rosie Benneyworth highlighted there is a plan to have a set of criteria for recommendations that come into the hub and work is underway to define this. The Royal Colleges are engaged and are keen to look at this in the work they do too.

3.6 NQB members recognised that the proposal will only work if we get the national system to take a role in this. We all need to collaborate and ensure the approach is not overly bureaucratic but that is workable and adds value.

3.7 It was agreed that the NQB can currently endorse a set of safety recommendations principles, but the Board will await the outcome of the Review of patient safety across the health and care landscape where the future role of the NQB will be considered.

3.8 It was agreed that the proposal for a recommendations hub could be reflected on further when the review is published.

4. NQB Safer Staffing and AHP Guidance

4.1 Mark Radford introduced this item. The first part was a progress update on the NQB Safe and Effective staffing programme, including the development of four new safer staffing improvement resources and updates on the eight existing improvement resources. It was proposed that a new safe staffing resource is added to the programme: Children and Young People's Community Services.

4.2 The second part was an update to the NQB on work that has commenced to develop a first resource focused on the fifteen Allied Health Professions.

4.3 The NQB were asked to:

1) Note the programme updates.
2) Approve adding one new safe staffing resource to the programme: Children and Young People's Community Services.
3) Approve adding Allied Health Professions to the improvement guidance.

4.4 NQB members noted the items and approved 2 and 3.

5. Quality Strategy for the NHS

5.1 Andrea Lewis, Aidan Fowler and [redacted] shared a verbal update on the focus, scope and timeframes for the development of a Quality Strategy for the NHS, feedback on the definition of quality and priorities for the strategy.

5.2 The Quality Strategy Advisory Group have heard that this work should be owned and led by the NQB.

5.3 The NQB were asked to:

1. Note the update.
2. Provide feedback on the work to date, including key priorities.

5.4 NQB members highlighted in terms of data, there needs to be more outcome measures and multi-source measures need to come together.

5.5 Rosie Benneyworth referenced a recent global ministerial summit on safety. Sustainability was a big focus point, particularly on how climate emergency impacts people's health. She also highlighted that the Organisation for Economic Co-operation and Development (OECD) have identified 13% of health care spend is on safety failure. If you link these findings with productivity, it's often about financial levels and not the outcomes for patients. For example, clinicians could see a patient several times but misdiagnose them.

5.6 Jamie Waterall emphasised there is a growing recognition that the £4 billion we spend on local authority commissioned public health services has an increased focus on quality improvement. Jamie offered to have a follow-up discussion on how we ensure that there is join-up between public health and healthcare and also recommended that there needed to be a stronger emphasis on equity within the strategy document.

5.7 Ramani Moonesinghe highlighted that timeliness is an important factor we need to pull out clearly, it may be part of efficient but feels like this is an omission.

5.8 Julian Hartley felt that efficient was important to include as it speaks to the financial challenges and use of resources remains very important. He also emphasised the importance of aligning with CQC's assessment framework.

5.9 In summary, NQB members supported the development of the strategy but felt that dropping 'sustainable' in the quality definition was an omission and this should be kept in due to these contextual factors.

6. Update on the CQC Way

6.1 Julian Hartley introduced this item.

6.2 This was a verbal update from Julian Hartley on The CQC Way which set out the current work to reset and refocus on CQC's purpose, values and ways of working. Julian referenced how this work had taken into account a number of external reviews including sector feedback, the Review into the operational effectiveness of the CQC, Review of CQC's single assessment framework and its implementation, Review of CQC's single assessment framework by the Care Provider Alliance and colleague feedback.

6.3 The NQB were asked to note and discuss the update.

6.4 Members fed back that they were pleased about the steady progress, supported by the appointment of CQC's new Chief Executive and Chair.

7. Any Other Business

7.1 [redacted] updated members on the draft NQB position statement and request for feedback. Importantly, it reminds systems that quality is most at risk in times of change- a key finding from the Francis review and emphasises the importance of ensuring the fundamental standards of Quality are met to maintain and improve the quality of care. It also serves as an acknowledgement to the change of government, publication of key documents related to quality and signposts to existing NQB documents including the forthcoming Quality Impact Assessment (QIA) guide.

7.2 Previously we discussed the need for the NQB to put out a position statement on quality. A similar communication was sent out in 2021 when CCGs moved into ICBs and this was welcomed.

7.3 A draft was shared with members earlier this week for comment and approval via email correspondence by 18 April 2025.

7.4 The next meeting will be held on Monday 23 June 2025, 14:00-16:00.