NATIONAL QUALITY BOARD

7 October 2024 10:30-12:30

Virtual Meeting

MINUTES

PRESENT:

- Prem Premachandran – Medical Director, CQC (CO-CHAIR)
- Stephen Powis – National Medical Director, NHSE (CO-CHAIR)
- Aidan Fowler – National Director of Patient Safety, NHSE
- Chris Dzikiti – Interim Chief Inspector of Healthcare, CQC
- Deborah Sturdy – Chief Nurse, Adult Social Care, DHSC
- Duncan Burton – Chief Nurse for England, NHSE
- James Bullion – Interim Chief Inspector of Adult Social Care and Integrated Care, CQC
- Judith Richardson – Programme Director – Clinical Directorate, NICE
- Louise Ansari – National Director, Healthwatch England
- Matthew Style – Director General, Secondary Care and Integration, DHSC
- Mark Radford – Chief Nurse of HEE and Deputy Chief Nursing Officer, NHSE
- Rosie Benneyworth – Interim Chief Executive, HSSIB
- Sarah Price – Director of Public Health, NHSE
- Shona Arora – Director of Health Equity, UKHSA
- William Vineall – Director, Acute Care and Quality, DHSC

ATTENDEES:

- [redacted]
- Kiren Collison – Deputy Medical Director for Primary Care, NHSE
- [redacted]

APOLOGIES:

- Sarah Price – Director of Public Health, NHSE
- [redacted]
- Jonathan Benger – Deputy Chief Executive, Chief Medical Officer, NICE
- Jamie Waterall – Deputy /chief Public Health Nurse, OHID
- Jayne Chidgey-Clark – National Guardian, NGO
- Erika Denton – National Clinical Director for Transformation, NHSE

AGENDA
1. Welcome and introductions, minutes of the previous meeting.
2. RASCI tool and principles for assessing and managing risk in integrated care systems.
3. Findings and reflections from the rapid review in Nottingham mental health services.
4. Primary care patient safety strategy.
5. HSSIB report: Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare.
6. Any other business.

1. Welcome and Introductions, minutes of the previous meeting

1.1 STEVE POWIS (co-chair) welcomed all to the fourth National Quality Board (NQB) of 2024. Attendees and apologies were noted as above.

1.2 The minutes of the previous meeting on 8 July 2024 were agreed as an accurate record and will be published in due course.

2. RASCI tool and principles for assessing and managing risk in integrated care systems.

2.1 [redacted] presented this item. The item covers two pieces of quality strategy work developed by NHS England in collaboration with wider partners:

1) RASCI tool (Responsible, Accountable, Support, Consulted, Informed).

2) NQB Principles for Assessing and Managing Risks across Integrated Care Systems (previously entitled Dynamic Risk Assessment Framework).

2.2 Both pieces of work are for use across health and care systems, including local authorities, as aligned with the NQB's other guidance.

2.3. Firstly, the RASCI tool is a well-established tool used to clarify responsibilities and accountabilities to ensure the delivery of high-quality care. This can apply to different levels, including wards, teams, services and pathways, as well as individuals. NHSE have updated the tool at the request of providers, integrated care systems and wider teams, including the NHS England national specialised commissioning team. RASCI is a particularly helpful tool to use in scenarios where multiple agencies are involved and responsibilities might not be immediately clear (e.g. concerns about a large independent sector provider commissioned by multiple ICBs).

2.4 NHSE plan to share the tool through national, regional and system quality networks, and to upload to NHSFutures. The tool has been developed to be used interactively in meetings and workshops, alongside the NQB's wider guidance. NHSE have included two case studies and will develop further case studies as the updated tool is used.

2.5 Secondly, the Principles for Assessing and Managing Risks across Integrated Care Systems have been developed to align with the NQBs other guidance for ICSs, and particularly the National Risk Response and Escalation Guidance which sets out how quality risks should be managed. The document sets out key principles to use when assessing risks in multi-factorial and fast-changing environments where system solutions are required, such as rapid closures of units, medicines shortages or pandemics. Case studies have been developed through testing with integrated care systems and wider partners. NHSE propose to share the principles via regional and system quality networks and via the NHS Futures site, and to work with selected systems in the new year to gather further understanding and learning on implementation.

2.6 The NQB were asked to:

1) Provide feedback on the resources and dissemination strategies proposed.
2) Provide feedback on the proposal to test the Principles for Assessing and Managing Risks across ICSs with systems in the new year.

2.7 DUNCAN BURTON asked whether we need to broaden our thinking with other players across the health and care system.

2.8. ROSIE BENNEYWORTH thanked the team developing the work for taking initial feedback on board and offered to get involved to support next steps. Rosie highlighted that Easy Jet and British Airway's safety management systems (SMS) use risk to drive decisions and change. She emphasised more support around risk management. Given the link with SMS she asked whether this is linked to the SMS group chaired by NHSE.

2.9 [redacted] noted that it is linked to SMS. The team have also worked closely with Patient Safety at NHSE and continuing this alignment will be important.

2.10 AIDAN FOWLER highlighted risk management in terms of acute services. Broadly there is a lot of risk at the front door. Airlines tend to use better data, quantify and decide about what they tolerate at the front door. We don't currently use data sufficiently.

2.11 SARAH PRICE noted there are different thresholds across different hospitals. Systems might appreciate guidance about how to use and interpret this accordingly.

2.11 DEBORAH STURDY queried the involvement of the LGA.

2.12 [redacted] stated LGA were involved via the Regional Quality Groups.

2.13 [redacted] emphasised the most powerful point is to get the system together to challenge risk. Local authority risk and primary care don't have the same influence. The idea is to get mitigation across the pathway by getting key stakeholders in a room to talk about risk across the pathway. Things aren't currently mapped to make informed decisions.

2.14 ROSIE BENNEYWORTH asked how we are linking this up to ICBs about decisions around funding. Risks are not used to drive decisions and prioritisation.

2.15 NQB agreed that this work would be reviewed further at the November 2024 NQB.

3. Findings and reflections from the rapid review in Nottingham mental health services.

3.1 CHRIS DZIKITI presented this item. The Secretary of State for Health and Social Care commissioned CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008, to look at 3 specific areas:

- Rapid review of the available evidence related to the care of Valdo Calocane (VC).
- Assessment of patient safety and quality of care provided by NHFT
- Assessment of progress made at Rampton Hospital since the most recent CQC inspection activity.

3.2 This review was delivered in three parts. The first two parts, an assessment of patient safety and quality of care provided by the trust and assessment of progress made at Rampton Hospital since the most recent CQC inspection, were published in March 2024. The third part, a rapid review of the available evidence related to the care of VC during the period he was under the care of NHFT, alongside a small number of other cases for benchmarking purposes, to determine whether this evidence indicates wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire was published in August 2024.

3.3. The paper shares a high-level update on the areas reviewed, recurring themes and recommendations.

3.4 NQB were asked to note the update and discuss.

3.5 ROSIE BENNEYWORTH highlighted the importance of this work and noted that it aligns to work from HSSIB. There is a theme of people not being listened to. In terms of risk assessment tool, people are worried about being blamed and in terms of inpatient investigations community services are a regular theme.

3.6 CHRIS DZIKITI talked about the importance of discharging people effectively. CQC are meeting DHSC to review all recommendations every 3 months. There is an important role for DHSC, CQC and NHSE to bring changes. Speaking to families has been critically important. We must consider what we can do that is good in response to this tragic event. Improvements must be made, especially in the community.

3.7 MATTHEW STYLE welcomed the report from CQC. The effectiveness of engagement between CQC and families is especially worth noting. All oversight levers need to be aligned in response to these findings and this is a test of us all collectively.

4. Primary care patient safety strategy.

4.1 KIREN COLLISON and AIDAN FOWLER presented this item. The NHS Patient Safety Strategy (2019) is the first national strategy for improving patient safety and applies to all

sectors. It was recognised that this needed more specific interpretation for primary care and the NHS England Primary Care Patient Safety Strategy was published on 26 September 2024.

4.2 The strategy describes local and national commitments to improve patient safety in primary care, supporting all areas in this sector to fully implement the NHS Patient Safety Strategy and focuses on:

- developing a supportive, learning environment and just culture in primary care, with sharing across the system so that services can continually improve.
- ensuring that the safety and wellbeing of patients and staff is central, and that our approach to managing safety is systematic and based on safety science and systems thinking.
- involving patients in the identification and co-design of primary care patient safety ambitions, opportunities and improvements.

4.3 This strategy is about setting the ambition and vision for patient safety in primary care to encourage discussion and exploration across all primary care platforms. It is not about implementing everything on day one in all sectors, it is about providing ideas and opportunities that can be shared iteratively.

4.4 The NQB were asked to:

1) Note the content of the Primary Care Patient Safety Strategy.

2) Consider how NQB member organisations can support and promote the ambitions within the strategy.

4.5 KIREN COLLISON highlighted that this work pulled people together across all four pillars of primary care, including pharmacy, dentistry, optometry and general practice.

4.6 97% of general practice encounters are safe, but there is room for improvement and there could be under reporting. This document sets the ambition for where we want to get to, looking at both patient and staff safety.

4.7 AIDAN FOWLER emphasised that we must take the next steps, as we have traditionally focused on secondary care. Much of safety in this context is around logistics.

4.8 LOUISE ANSARI queried how Patient Participation Groups will be considered.

4.9. KIREN COLLISON highlighted that integrated care boards (ICBs) look at the strategy locally. Each ICB has a patient safety specialist. There are implementation groups including commissioners and providers to test and work out where the gaps are.

4.10 ROSIE BENNEYWORTH congratulated everyone involved and asked how NQB members can support roll out.

4.11 KIREN COLLISON highlighted the importance of members using their networks.

4.12 AIDAN FOWLER said there is a nervousness in primary care about how to approach investigation. Getting it right is important, but there is concern about secondary care

judging activity. Errors occur which impact productivity, but don't necessarily result in harm. This goes back to using data well. Without the information, how do we know what they are? This highlights the importance of speaking to patient safety specialists who know the issues. Tracking patient pathways is especially important and can be improved. AIDAN referenced the Jessica Brady cancer diagnosis case study as a key example of how improvements can be made.

4.13 PREM PREMACHANDRAN (chair) highlighted the importance of taking this work forward.

5. HSSIB report: Recommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare.

5.1. ROSIE BENNEYWORTH shared an update. Recent inquires highlighted the issue of improving the effectiveness of quality and safety recommendations in healthcare.

5.2. HSSIB have written to all inquiry chairs to update on progress and work out next steps. There is an offer of a PhD student to map who makes recommendations into the system.

5.3 There have been a number of workshops and the plan is to offer a repository this financial year. HSSIB having discussions with Penny Dash regarding understanding the patient safety landscape.

5.4 STEVE POWIS thanked Rosie for the report and queried scope of the recommendations repository, noting that public inquiries aren't always confined to health. It could be unwieldy across multiple government departments e.g. education and housing.

5.5 ROSIE BENNEYWORTH highlighted the next piece of work will consider scope and who has access to it – e.g. providers, patients etc. At present there are no plans to look at other sectors.

5.6 STEVE POWIS queried whether the Department for Education have a similar issue and their approach.

5.7 WILLIAM VINEALL emphasised the importance of honing the scope. The Cabinet Office hope to come back with a high-level response in the autumn, so it needs to be a feasible scope. There are issues around the cost of recommendations too.

5.8 LOUISE ANSARI highlighted that recommendations often appear to be duplicative. Listening to patients and the public is often a recommendation across a number of reviews. Will bringing the duplicative recommendations together make them happen.

5.9 ROSIE BENNEYWORTH noted that we continually see problems and we make more recommendations. Diagnostic is important, but how do we make sure things happen. Need to shift culture to implementation rather than diagnosis.

5.10 JAMES BULLION referenced work in Nottinghamshire, particularly around local government inter-connectivity. Strong networks around community safety and community protection. Work with groups at national as well as local level. Community safety and

public protection networks in the local government community would be interested and could use their aggregations particularly when it comes to mental health.

5.11 It was agreed that this item would return to NQB after the workshops.

6. Any other business

6.1 PREM PREMACHANDRAN asked members if they had any other business to raise.

6.2 [redacted] noted the role of the NQB policy leads group. It was highlighted that this forum is used to help inform the NQB agenda and members can feed in using this route.

6.3 The next NQB meeting is 18th November 2024.