NATIONAL QUALITY BOARD

29 November 2021

13:00-15:00

Virtual meeting

MINUTES

PRESENT		
Ted Baker (Chair)	Rosie Benneyworth	Wendy Reid
Kate Terroni	Viv Bennett	Clenton Farquharson
William Vineall	Jonathan Benger	Yvonne Doyle
Ruth May	Mark Radford	Kevin Harris
IN ATTENDANCE		
Matt Fogarty	Jacob Lant	Cathy Hassell
Rob Stones	Sam Illingworth	Kate Pye
Kate Lupton	Meera Sookee	Pete Scott
Alison Tariq	Dominique Black	Matt Neligan
APOLOGIES		
Stephen Powis (Chair)	Anna Severwright	Hugh McCaughey
Chris McCann	Aidan Fowler	

AGENDA
1. Welcome & Minutes of Previous Meeting
2. Elective Recovery Strategy
3. Development of Quality in ICSs
4. The Emerging Role for the CQC in Assessing ICSs
5. HEE Quality Strategy & Framework
6. Any Other Business

1. Welcome & Minutes from Previous Meeting

1.1 TED BAKER (chair) welcomed all to the fifth National Quality Board (NQB) of 2021. Attendees and apologies were noted as above.

1.2 The minutes of the previous meeting on 14 September 2021 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 TED BAKER informed NQB members that the publication of the NQB's Shared Ambition for Compassionate, Inclusive Leadership took place the previous Friday, 26 November 2021, and that this would be covered further under Any Other Business.

1.3 There were no additional Matters Arising to table before progressing to the meeting agenda.

2. Elective Recovery Strategy

2.1 ROB STONES, Director of Elective Recovery and Performance at NHSE&I, provided a verbal update on the development of the imminent Elective Recover Strategy.

2.2 The publication of the strategy is imminent. It will lay out where the significant additional investment, as a result of the Health and Social Care Levy, will be targeted to help reduce the elective backlog. It provides a plan that sets out the priorities for delivery which has been co-designed with clinical leads, Royal Colleges and wider partners. The strategy is based on four pillars: 1) increasing capacity to deliver, 2) maintaining clinical priority and safety, 3) transformation, 4) better information and support to patients.

2.3 There remains a lot of uncertainty about the volume of unmet demand. There is a focus on returning to the nationally constituted standards for delivering effective elective care with no patient waiting more than 104 weeks.

2.4 TED BAKER raised that transformation is key, but it should not be at the expense of those waiting for procedures. There should not be conflict between Urgent & Emergency Care and wider services but there are difficulties finding sufficient capacity for emergency patients coming through the door every day.

2.5 ROSIE BENNEYWORTH raised that transformation needs to be carried out in conjunction with primary care as it can have a negative impact on primary care if done unilaterally. Have those behind the strategy considered ramping up shared decision making as a way of increasing good outcomes? Are we reviewing waiting lists to make sure all those on the lists want to be there? And how are we prioritising in terms of inequalities?

2.6 ROB STONES responded that the work is mindful of the pressures on primary care, and the team has been working with the primary care teams at NHSE&I

and the Royal College of General Practitioners. On shared decision making, the plan will be clear on the need for regular clinical review and the need to ensure that health inequalities are a key consideration. The inequalities dashboard rollout will support this and has had positive feedback.

2.7 VIV BENNETT flagged that community services restoration is not always visible, and that the wait for non-consultant appointments can be a non-visible concern. How can we ensure that this receives some focus?

2.8 JACOB LANT cited that moving patients to surgical hubs could exacerbate health inequalities. How will the strategy ensure this option is available to all patients?

2.9 ROB STONES addressed the point on operational delivery, stating that the concern about community services was being considered, including variation across providers and specialties. Work is ongoing by the Royal Colleges to address the fact that standard Referral to Treatment times do not cover non-consultant led and non-admitted patients.

2.10 TED BAKER requested that the item return to NQB in 2022.

3. Development of Quality in ICSs

3.1 KATE LUPTON updated NQB on the development of the NQB Guidance on System Quality Groups. The guidance provides a framework for quality management within ICSs and model Terms of Reference for System Quality Groups. It has been co-developed with ICS, regional and national partners and builds on the NQB Position Statement for ICSs (April 2021) and wider ICS guidance.

3.2 KATE talked NQB members through the slides and the main feedback received so far on the draft document. A launch event will be undertaken on 8 December 2021 to share the guidance.

3.3 TED BAKER highlighted the importance of the guidance for ICSs. He requested that the document be a little clearer on transparency and how light should be shone on the quality problems. SQGs will provide good assurance if they seek out problems rather than reassurance.

3.4 KATE TERRONI asked why, if an SQG covers the quality of all health and social care services in a place, the lead needs to be a medical professional. KATE also asked about success factors and what any ‘improvement’ offer may be. How can we support an SQG to be as interested in a small care home provider as a larger NHS provider?

3.5 VIV BENNETT supported the strong focus on population health and health inequalities in the document. This links to OHID work on various elements of quality, and VIV requested that a discussion on the quality framework for public health be brought toa future NQB meeting.

3.6 VIV also highlighted the need to consider children's services in this work, alongside adult services.

3.7 CLENTON FARQUHARSON asked how people who draw on care should be involved, noting the need to ensure coproduction is a core element of decision-making in ICSs.

3.8 RUTH MAY praised the work and questioned whether there is enough focus on experience of care and also children's services.

3.9 In response to Ruth's point, CATHY HASSELL suggested that NHSE&I is taking a two-pronged approach to quality and children's services. The first is to support ICSs to develop quality capabilities in general, and the second is the work of the NHSE&I Children and Young Peoples' Programme. There are now funded Children's Leads in all ICBs and research is being undertaken with ICSs to test their readiness for supporting C&YP across health and social care. It may be appropriate to bring this 'readiness research' to a future meeting.

3.10 ROSIE BENNEYWORTH asked how we can ensure that quality is 'everyone's business' within ICSs, as their development presents a significant opportunity to get this right.

3.11 JACOB LANT asked what current infrastructure Medical and Nursing Directors have to call on to investigate and answer questions on what quality looks like.

3.12 KATE LUPTON highlighted that the draft guidance has a strong focus on local authority engagement, including recommending that there is a Local Authority lead as SQG Deputy or Co-Chair. In terms of lived experience, the QSG guidance recommended there be one lay member but the draft SQG guidance has increased this to 'at least two lay members with lived experience'. KATE also confirmed that the Guidance will be updated further as SQGs and ICSs evolve.

3.13 TED BAKER invited MATT NELIGAN, Director of System Transformation at NHSE&I, to to provide a broader update on the development of Integrated Care Systems, including current priorities and milestones.

3.14 MATT reported 38 of the 42 ICS chairs had now been appointed. NHSE&I is currently appointing delegation commissioning permissions for primary care services, to come into effect from next April. It is expected these will apply to 13 or 14 ICBs mainly in the areas of pharmacy, optometry and dentistry. ICBs are producing Readiness to Transition statements to assure their progress to April 2022. There are currently no 'red flags' in relation to quality. The Bill has been Moved in the Lords, with Second Reading taking place on 7 December. However this still leaves a tight timetable leading up to April 2022.

3.15 TED BAKER thanked MATT for attending and providing a short update.

4.The emerging role for the CQC in assessing ICSs

4.1 TED BAKER invited ROSIE BENNEYWORTH, Chief Inspector of Primary Medical Services and Integrated Care to introduce the item. ROSIE presented the slides for Paper 2.

4.2 The CQC is developing its approach to assessing ICSs. It will also gain new duties to assess local authorities and for the national standards of food in hospitals. The CQC would like to align with the NHSE&I oversight of ICSs to avoid a duplication. This work is likely to become operationalised from 2023, following coproduction and end-to-end testing in early 2022.

4.3 ROSIE stated that the CQC may assess ICSs in 3 areas: leadership, integration, and quality and safety. It is undecided whether the CQC will be rating ICSs and there are some elements that the CQC wants to test with ICSs in the next few months. It is hoping to produce a statement on the 'direction of travel' and will ensure that provider regulation, system regulation and local authority assurance connect together into a single assessment framework that tracks experience across pathways/ journeys of care and is underpinned by evidence. CQC has used a similar approach and methodology in the review of provider collaboratives.

4.4 A number of questions are currently being considered, including: how to assess ICSs of different sizes and responsibilities; how to assess provider collaboratives; and how to assess and regulate prevention and early intervention activities.

4.5 WILLIAM VINEALL commended the presentation and remarked that the draft legislation is still changing. It's important that the role of the CQC adds value, above and beyond what else is happening, and how any new duties are discharged in practice is the most important part of this.

4.6 TED BAKER remarked that if the NHS needs to transform, it needs good ICS leadership in order to do so and providing an assessment and support regime is one of the most important things that the wider system can do to support this.

4.7 MATT NELIGAN suggested that one of the things repeatedly raised by ICS leaders is "how we can learn from local government on peer-led approaches to improvement?" How we can ensure strong systems emerge, that systems take responsibility for systems and seek out peers and best practice, and how we can avoid 'the centre' telling ICSs what to do.

4.8 YVONNE DOYLE raised that Directors of Public Health have good experience of sector-led improvement, and auditing that is both supportive and enquiring. ROSIE BENNEYWORTH highlighted the different interpretations of 'peer review' and that mechanisms that enable learning, improvement and best practice – without adding activity/ bureaucracy – must be enabled.

4.9 It was agreed that the discussion would be brought back to the NQB as it develops.

5.HEE Quality Strategy & Framework

5.1 SAM ILLINGWORTH, Director of Education Quality and Reform at Health Education England, was invited to present HEE's Quality Strategy Framework (Paper 3). Sam detailed how HEE's Quality Strategy sets-out the priorities, principles and overarching processes for continuous quality improvement and innovation in the education and training of the healthcare workforce. The Quality Strategy is underpinned by the HEE Quality Framework, which makes clear the quality standards we expect of clinical learning environments, safeguarded through the NHS Education Contract. First published in 2016, HEE has been reviewing and refreshing these two documents and the refreshed framework and strategy was published on the HEE website on the 16 November, with a full launch taking place from December 2021.

5.2 CLENTON FARQUHARSON noted a strong focus on diversity, quality and inclusion through standards and data. CLENTON flagged the importance of intersectionality - moving away from characteristics and silos - to see the whole person. He asked how is HEE going to look at data when it collects it in single characteristics? In response, SAM ILLINGWORTH agreed the important of viewing data through a contextual, organisational lens, using cross-cutting quality metrics.

5.3 TED BAKER thanked HEE for the work it does and the support of CQC/JSOG.

6. Any Other Business

6.1 PETE SCOTT confirmed that 2022 NQB meeting dates has been set. The Secretariat is also developing a Forward View with agenda items for 2022. NQB members were invited to review and propose any additional or replacement items for the Forward View.

6.2 The NQB's Shared Ambition for Compassionate, Inclusive Leadership was published on the NQB webpage on Friday 26 November. KATE LUPTON requested NQB members share the statement with their organisations and networks, and that an email from NQB Secretariat with draft copy for us will be circulated shortly.

6.3 TED BAKER closed the meeting. The next meeting of National Quality Board will take place on Monday 7 February 2022, 1pm-3pm.