NATIONAL QUALITY BOARD

8 February 2023

Virtual Meeting

MINUTES

PRESENT		
Sean O'Kelly	Stephen Powis	Anna Severwright
Vin Diwakar	Kate Terroni	William Vineall
Jamie Waterall	Aidan Fowler	Clenton Farquaharson
Louise Ansari	Yvonne Doyle	Victoria O'Brien
IN ATTENDANCE		
Charlotte McArdle	Richard Owen	Ann Casey
Michael Marsh	Meera Sookee	Priscilla Jean-Noel
Natalie Vanderpant	Rebecca Wann	Simon Kelly
Rosie Benneyworth	Emily Audet	Imogen Stringer
Jane Docherty	Daniel McDonnell	Kate Lupton
Dominique Black	Fiona Butterfield	Latoyah Tawodzera
Frances Smithson		
APOLOGIES		
Ruth May	Susan Hopkins	Deborah Sturdy
Wendy Reid	Mark Radford	
AGENDA		
1. Welcome and minutes of previous meeting		
2. UEC Recovery Plan		
3. Effective staffing Update		
4. Update on Prevention of Future Deaths Processes		
5. Update on Children and Young People's Transformation		
6. Quality in ICSs		
7. Any other business		

1. Welcome and minutes of previous meeting

1.1. Sean O'Kelly (Co-chair) welcomed all to the first National Quality Board (NQB) of 2023. Attendees and apologies were noted as above.

1.2. The minutes of the previous meeting on 28 November 2022 were approved and agreed as a true and accurate record. They will be published in due course, alongside the associated agenda and papers.

2. UEC Recovery Plan

2.1. Sean O'Kelly welcomed Vin Diwakar to verbally update on the UEC Recovery Plan. NHSE and DHSC published the UEC Recovery Plan last week, heavily drawn from the UEC strategy work. The Recovery Plan focusses on actions to take over the next 2 years to ensure services we offer patients best meet their needs in shortest time to minimise waits, whilst recognising the huge pressures

services are under. There are five parts to the plan, which is integrated on the role of the system:

- Increasing UEC capacity – additional bed capacity including using virtual wards, increasing ambulance capacity and processes to optimise flow, bringing bed occupancy down.
- Increasing Workforce size and flexibility - including improving retention and wellbeing.
- Improving discharge – the roll out of transfer of care hubs, scale up intermediate care and social care and optimising safe discharge of patients.
- Expanding care outside hospital - including virtual wards and new types of care outside hospital
- Making it easier to access the right care - review of NHS 111 services to align with better with primary care (primary care recovery plan later this year) and different models of NHS 111.

2.2. CQC have seen good practice for intermediate care which could be a helpful vehicle in a number of those areas. YD will work with CQC to gather intelligence and examples of good practice.

2.3. NQB commented on the focus being on the whole system. Demand and capacity work has been undertaken across whole UEC pathway. Potential for big integrated data sets and population health provides data opportunities for the future. HSIB can assist with reviewing things that went well or not so well and would support being involved in any wash up, AF and RB will link in.

2.4. The Recovery Plan is about populations of all ages, not just adult services, but the same formula is not necessarily relevant for all children and young people in UEC services.

2.5. UKHSA colleagues share an interested in the virtual work. UKHSA can also provide good modelling data for respiratory infections by region as there are differences.

2.6. NQB discussed the need to define intermediate care and use of NICE guidelines including the four pillars to consider the outcome measures for the UEC plan. Healthwatch can assist with communicating to the public on virtual wards.

3. Effective Staffing Update

3.1. Sean O'Kelly invited Ann Casey to talk to this item. The NQB Effective Staffing work was approved for progression by NQB in March 2022. This paper provides an update on that work and shares a paper on professional judgement to ask for approval to publish with NQB branding.

3.2. Maternity safer staffing is progressing with a task and finish group carrying out an evidence review initially, with experts from several academic organisations. Mental Health safer staffing groups have appointed a chair and are now appointing a deputy. There has been some delay in this work due to the NHSE restructure. Revised milestones and lifecycle stages and are on target.

3.3. The Professional Judgement guidance is a framework developed following research funded by the National Institute for Health Research, alongside academic experts and NHS trust staff, aiming for a consistent approach to

applying Professional Judgement. The framework is a sense checking tool for professionals, if there is a high risk at any stage there are internal escalation and governance processes within organisations.

3.4. There is applied knowledge to the safer nursing care tool in this document to ground it in practice, but it is applicable throughout. Current vacancies are a significant constraint, the ongoing Risk Assessment to maintain patient safety in wards will be critical.

3.5. CQC have commissioned a literature review on what good Professional Judgement looks like.

3.6. NQB provided support for this work and the framework itself and agreed it would be helpful to provide a case study showing how to link the framework to the tool. The guidance should make explicit the link and process to take to a trust board meeting.

3.7. It was agreed that NQB secretariat would circulate the guidance to members and request written comments for consideration prior to publication.

4. Update on Prevention of Future Deaths Processes

4.1. Stephen Powis invited Michael Marsh to talk to this item. The NQB were asked to comment on the processes in place relation to Prevention of Future Deaths (pfd) reports, a statutory instrument coroners have and issue when a death may have had factors contributing to it that processes and systems can change to prevent future deaths. Pfd reports are not meant to be punitive but do feel difficult to deal with, the object is to identify learning.

4.2. In recent years it has been difficult to comment on whether numbers of pfd reports received at NHSE are going up due to pandemic disruption. The Chief coroner is trying to encourage more reporting to maximise learning.

4.3. On receipt of pfd reports NHSE coordinate and contact relevant policy departments who can contribute to the response, legal opinion is gained, and the national Medical Director will review and sign off prior to sharing with coroner. The Working group looks at and considers the pfd reports and review and look at learning and actions. Sometimes this will identify additional learning. The working group has also moved towards looking at commitments given by NHSE in responses to see if those had been actioned for internal audit.

4.4. Colleagues in DHSC also receive pfd reports and deal differently to NHSE. The DHSC response is signed off by the minister. Increasingly what happens is DHSC seek advise from NHSE to coordinate a response to ensure consistency.

4.5. Learning patterns are seen with often the same issues raised repeatedly. The NHSE working group recently started collating those that are a common pattern and re-review at a future time to identify if any learning been missed and help reinforce learning.

4.6. Points for consideration for NQB:

- Reporting – observation that low use of pfd reports is not a bad or good thing but may reflect a higher level of trust with coronial system/ response of health system. There is a marked variation in numbers received between regions which will be discussed with the Chief Coroner. Neither NHSE nor DHSC have

oversight of all pfd reports and this is dependent on where the coroner chooses to send the report.

- Benefit seen from trying to look at and review pfd reports more widely, but there are occasions when pfd should have been dealt with locally not at NHSE.
- Coroners don't always send to appropriate organisation which can cause delays.
- The working group proposes to look at additional information, which could identify features relating to health inequalities.

4.7. An offer was put forward for public health input in the working group to provide public health expertise and insight, particularly relevant to place-based elements to prevent suicide. There is opportunity to look on a grander scale across the system at health inequalities, what would a multi- system review look like? Mental Health is the strongest theme coming through the pfd reports, particularly suicides.

4.8. Data collection could look at structural inequalities, the inequality gap and how to we disaggregate data to tell us a bigger picture, what alternative action could aid learning and remind and support the accountability to system to keep equity as a high priority. Inequalities are contributing to deaths.

4.9. Parallel working between DHSC and NHSE was discussed and could be more joined up. Both are good at responding but need to focus on looking forwards. Common cause and governance across both organisations would allow themes to be seen more clearly. Ministers are very interested in pfd reports.

4.10. Multiple stakeholders often involved in responses and programmes of care such as CYP should be involved in this process.

4.11. The annual report can be shared with NQB members. It is important to consider the role of ICBs. Habib Naqvi at The Race and Health Observatory is interested in pfd coding, recent work has been done in this space.

4.12. NQB summarised there is a great deal of variation in when and where pfd reports to NHSE originate come which is up to the individual coroner. The Working group should look at these thematically not as individual responses and ensure that we should do what we say we will – accountability.

5. Update on Children and Young People's Transformation Programme

5.1. Sean O'Kelly invited Richard Owen and Simon Kelly to update NQB on the Children and Young People's (CYP) programme delivery and operational matters. NQB were asked to support the work on deterioration in CYP.

5.2. There have been many challenges affecting CYP in the wake of the pandemic, as well as increasing inequalities. The cost-of-living crisis is also having long lasting effects on CYP health.

5.3. CYP programme established in 2020 via the NHS Long Term Plan and has several workstreams, a CYP programme board, and a delivery model with small regional teams and ICBs. CYP is a population group not a workstream or a pathway and has a close role with other programmes, e.g. Mental Health, Safeguarding, and across health and social care. 7 young people sit on the programme board, which has strong clinical input.

5.4. The CYP programme published a document for asthma in 2021, based on evidence and findings of national inquiries into avoidable child death, serious of interventions for systems, system focused to make changes across diagnosis. Children's interventions are dotted through UEC Recovery Plan, including a paediatric clinical assessment service in 111.

5.5. Programme leads support intervention and there is a huge opportunity for prevention leads to work on health inequalities. Each ICB should have an executive lead for CYP on the board and the team are working to support ICBs to bring together community practice, support the plans and share what good looks like. Core20plus5 for CYP published November 2022.

5.6. The pfd mortality discussion (agenda item 4) flows through into areas of CYP policy and integration of care. The programme is also involved in unseasonal winter viruses, strep A infections, RSV and influenza, provision of support for Ukrainian CYP, medicine supply, contaminated milk supplies, and more.

5.7. Elective recovery for CYP is a subgroup of elective recovery board, using data to show children were being treated to a disadvantage in terms of wait times. It is hard to understate potential impact of community waits also, which include speech and language therapy.

5.8. There can be difficulty in identifying a sick child, the window of opportunity to detect deterioration is narrow. The team are working on the Paediatric early warning score (PEWS), different scoring systems are currently being used across England. There is a group set up to move towards a CQUIN to incentivise adoption. PEWS is now in implementation phase, phase 1 launch in April 2023. This is about a culture of recognising the deteriorating child, not just a score. No evidence yet that PEWS scores impact child mortality but they do identify a deteriorating child earlier.

5.9. The risk profile around a child may possibly identify higher risk children, vaccinations, asthma review, deprivation, hospital admissions are all risk factors. NHS 111 is the glue of UEC working closely with them to corral that information. Research and experience from Australia on PEWS include a loop to bypass for parental concern. Systematic review doesn't bring parental concern out, but it is included and is vitally important.

5.10. PEWS is important especially with care closer to home in the community. Parental concern, there is a nursing led worrying concern group looking at ways relatives / parents can share concerns and how to escalate if not listened. SK will invite CMc to liaise with the CYP Board.

6. Quality in ICSs

6.1. Stephen Powis invited Daniel McDonnell and Kate Terroni to talk to this item.

6.2. Paper 6a provides a summary of all the NQB guidance to date, including in development work. NHSE expects all ICBs to fulfill their quality duties.

6.3. ICB annual assessment guidance is a potential future lever through legislation on system level quality accounts, joint forward planning guidance. All these levers signpost back to NQB quality guidance, with softer levers available including peer support and learning.

6.4. The paper outlines the current quality governance landscape – System Quality Groups (SQG) are the main forums for quality issues at ICS level. There is escalation between place, Provider Collaboratives, and SQG level up through the NHSE Executive Quality Group and the NHSE Board Quality Committee. Regional JSOGs are not specifically included in the diagram of governance as many are included in SQGs. Regulators attend the regional SQG meetings.

6.5. Risk escalation and management is expected to be as close to the point of care as possible with escalation processes in place.

6.6. There are 5 ICS Quality programme priorities with specific deliverables outlined in the paper. The future deliverables include a National ICS Survey to understand implementation of the NQB guidance, case studies and webinars, a national peer learning programme, ICS quality data group and delivery of further guidance and frameworks. Common issues systems and regions have been experiencing aim to be addressed through these deliverables and wider work NHSE and partners are conducting.

6.7. Outputs in development include a quality analytical framework, RASCI framework, and Quality Early Warning Signs Framework. Clarity is needed in relation to the transition of commissioning relationships.

6.8. Kate Terroni updated NQB on CQCs approach to assessing Local Authority and ICSs, set out in paper 6b. This provides an opportunity to shine a light on the prevention and population health agenda. CQC are working with Yvonne Doyle to take this forward.

6.9. The Single assessment framework includes quality statements referred to as ‘we’ statements. The framework has six evidence categories for assurance, specific evidence, and quality indicators, outlined in the paper.

6.10. Priorities or ICSs are set by the Secretary of State (SoS) in 3 categories, with 17 quality statements to look at. ICSs have been involved in testing. Priorities or assurance for Local Authorities are in 4 areas, based on the Health Act Part 1.

6.11. Establishing a baseline is expected to commence in April 2023, pending sign off by the SoS Once signed off CQC will communicate with ICSs and LAs and build relationships prior to any visiting and assessing. ICS assessment will take into account provider information but this will not involve aggregating up provider ratings. CQC are keen to share best practice and innovation.

6.12. NQB recognised the challenge of bringing together a quality approach across local government and the NHS, all partners start from different places. Good examples are emerging locally of a hybrid of those quality models. SQGs are the vehicle for this looking at the whole pathways, prevention, and public health. Developing case studies will be beneficial. A further update will be shared at a future NQB meeting.

7. Any other business

No further business was raised.

Actions

- Yvonne Doyle will work with CQC to gather intelligence and examples of good practice for intermediate care.

- Aidan Fowler and Rosie Benneyworth (HSIB) will link in to review what went well or not so well in the pandemic as part of a wash up.
- UKHSA will provide good modelling data for respiratory infections by region as there are differences.
- Healthwatch offered to assist with communicating to the public on virtual wards.
- NQB secretariat would circulate the Professional Judgement guidance to members and request written comments for consideration prior to NQB publication. A case study should be included with the guidance.
- Public health to input into the pfd working group to provide public health expertise and insight.
- The pfd annual report will be shared with NQB members.
- Charlotte McArdle agreed to liaise with the CYP Programme Board, specifically in relation to the Nursing led worrying concern group.
- Future update to be scheduled at NQB on CQCs approach to assessing Local Authority and ICSs.