NATIONAL QUALITY BOARD MINUTES 08 July 2024

Microsoft Teams Virtual Meeting

PRESENT:

- Prem Premachandran –Medical Director, Care Quality Commission, CHAIR
- Stephen Powis - National Medical Director, NHS England, CHAIR
- Allison Streetly, Deputy National lead for Health Care Public Health, NHSE
- Anna Severwright - Lived Experience Expert
- James Bullion - Interim Chief Inspector of Adult Social Care and Integrated Care, CQC
- Jamie Waterall, Interim Chief Nurse, OHID
- Jayne Chidgey-Clark – National Guardian, National Guardians Office
- Mark Radford – Chief Nurse of HEE and Deputy Chief Nursing Officer, NHS England
- Matt Inada-Kim
- Radhika Dube – Director of Community Services, NHS England
- Rosie Benneyworth – Interim CEO, HSSIB
- Sarah Price - Director of Public Health, NHS England
- William Vineall - Director, Acute Care and Quality, DHSC

IN ATTENDANCE:

- Dominique Black - Strategy Manager, Care Quality Commission (Secretariat)
- Fiona Butterfield – Quality Policy Manager, NHS England (Secretariat)
- Kate Lupton – Quality Strategy Lead, NHS England
- Katherine Bowman – Clinical Fellow
- Martha Martin – Clinical Fellow
- Mary Cridge – Director of Adult Social Care – CQC
- Matthew Mansbridge – Senior Investigator, HSSIB
- Meera Sookee - Head of Quality Strategy, NHS England (Secretariat)
- Peter Skinner – Programme Director, Digitising Social Care, NHS England

APOLOGIES:

- Aidan Fowler - National Director of Patient Safety, NHS England
- Charlotte McArdle - Deputy Chief Nursing Officer, NHS England
- Clenton Farquharson – Lived Experience Expert
- Deborah Sturdy – Chief Nurse for Social Care, DHSC
- Erika Denton – Interim
- Jonathan Benger, Chief Medical Officer and Interim Director of the Centre for Guidelines, NICE
- Louise Ansari – National Director, Healthwatch England
- Ruth May – Chief Nursing Officer, NHS England
- Stella Vig – Interim National Director for Secondary Care and Quality, NHSE
- Sue Ibbotson - Head of Clinical Excellence and Quality, UKHSA

AGENDA
1. Welcome and introductions, Minutes of previous meeting
2. Digitising Social Care
3. Local Authority and Integrated Care System Assessment Update
4. Social Care discussion
5. HSSIB safety recommendations work
6. Any other business

1 Welcome and Introductions

1.1 PREM PREMACHANDRAN (chair) welcomed all to the third National Quality Board (NQB) of 2024. Attendees and apologies were noted as above.
1.2 Chris Dzikiti appointed new CQC Chief Inspector of Healthcare. Ian Trenholme stood down and Kate Terroni is in post as Interim Chief Executive of CQC.
1.3 The minutes of the previous meetings on 17 April 2024 were agreed as an accurate record and will be published in due course.

2 Digitising social Care – Peter Skinner.

2.1 PETER SKINNER shared with members the work of the Digitising Social Care programme and defined terms for social care for this update as provision of adult social care, not care packages managed by local authorities. Only half of care packages are provided by local authorities and not all people come into contact with these. A lot of social care is also privately funded by service users.
2.2 The programme has put in place digital social care records, 70% of providers have these with approx. 79% of people covered by the care record providing a restricted view of the primary care record and allowing people to have access to info they need to provide best quality care.
2.3 Social care technology supports people to live independently in their own home, care or own home, for as long as possible. Taking control of their own care supporting high quality personalised care, allowing us to track care without creating huge burden.
2.4 Different technologies were discussed such as:
- falls monitoring techniques,
- use of smart meters which can track changes in routine,
- hydration monitoring,
- pain levels technology can help avoid over or under medicating,
- wearables such as smart socks,
- virtual reality to calm people with dementia,
- augmented reality is assisting domiciliary staff by providing expertise to support, and
- the robotic seal, Paro, is a therapy seal, designed to reduce stress levels and to reduce stress behaviours.

2.5 These technologies can help people live independently, provide safe care, reduce demand on NHS services through early interventions and reducing admissions and readmissions. Building tech into a care package can also speed up hospital discharge.
2.6 Pilots have been small scale in care homes and individual care settings, funded by technology suppliers, looking at the benefit and cost for part of a system, rather than system wide cost.
2.7 Falls technologies have a huge benefit to the NHS but less so for social care, the evidence suggests technology can cut falls by at least 25%, but it is not clear how much this is reflected in reduced demand in the NHS as this is difficult to track. Falls in social care costs the NHS approx. £1.25m each year. Good practice evidence pack for falls prevention to be published in summer.

2.8 Evaluation framework in development, aiming for a single evaluation framework for everyone to use and to ensure data is sufficiently robust to share with others.

2.9 NQB discussed concerns re lack of on the ground user testing causing safety issues, interoperability, and issues with implementation leading to safe use. The programme is looking at implementation support. The interoperability challenge is huge with some potential proposals awaiting decision. The digital social care record has interoperability built in. HSSIB looking at electronic prescribing and medicines admin systems.

2.10 In the context of how to set our benefits and priority for this work, public and population health prevention across the system is important. We must understand what is happening to ensure approaches aren't exacerbating health inequalities. From a public health approach, what are the top causes of people becoming ill and dying early, e.g. extreme weather events.

2.11 Technology focused on health and social care is much more than its impact on the NHS, people's well-being and prevention is most important. Are we asking people/ families what they want? Are we utilizing the technology that is already out there?

2.12 CQC have an expectation of Local Authorities that even if not funding care they should be connecting people with these technologies. It should be free and universal. Predictive models allow us to build profiles, but there are ethical issues in how we operate. Are there clear standards in place for tech that CQC can assess against?

2.13 There is something about understanding the reason for the fall in the first place, falls will happen, but what can be done to prevent them to reduce impact and frequency. Training staff, patients and carers / families to identify critical illness such as infection.

2.14 CQC working with the programme team to build expectations into the inspection regime. These will be a primary mechanism for prevention and population health work.

3 Local Authority and Integrated Care System Assessment update – James Bullion

3.1 James Bullion shared an update with members on CQC's Local Authority (LA) and Integrated Care System (ICS) Assessments. Social care here means people with levels of needs including Learning Disability and Autism, Mental Health and is about living a good life as well as formal personalised care provided by social care providers.

3.2 CQC have commenced assessments of 44 LAs. Engaging over a 2-year period to set a baseline provision of social care under the Care Act. Initial feedback is that most LAs have found it useful, anticipated impact and begun to examine themselves and make improvements in line with the Care Act.

3.3 CQC will notify a LA who then complete a self-assessment subject to CQC review, there is then wider engagement deliberately targeting efforts on providers, service users, NHS colleagues at senior and local level, to gather info and examine data and carry out an onsite review process. This feeds into a draft report and allows CQC to determine a rating based on national policy from government, a process of calibration and consideration against best practice. This is an absolute measure, not comparing one LA to another. Reports are published on CQC website.

3.4 ICSs assessments are not yet at the same stage, CQC piloted an approach in Birmingham and Solihull ICS and Dorset ICS and evaluated and developed tools for conducting process and reporting. Agreement needed from government about the approach before election was called. Approach looks at 3 areas: legislation, leadership integration, quality and safety as well as the 4 aims of the ICS and some key intersections. Intersections relate to how the system works together on a particular area, e.g. MH care, CYP transitions. The process is aligned with NHSE oversight of the ICB element of an ICS.

3.5 Views from patients and people using health and social care in an area, community groups, voluntary sector groups, and the experience of the sector itself from Exec reviewers, DASS's in LA, public health expertise are all invaluable.

3.6 Social care issues across systems seen are workforce issues, calls for a social care workforce strategy. Commissioning issues affecting sufficiency, capacity and flow. Differing approaches to integration and social care models. Quality issues present in systems work in LAs and ICSs e.g. medicines optimisation, dementia support, MH crises, LD and autism.

3.7 Importance of looking at public health, the model would be strengthened by including PH in that reviewing team for learning.

4 Social Care discussion – All

4.1 STEPHEN POWIS opened up a discussion on social care, following on from the presentations received, the new government manifesto for social care, and a focus on concerns NQB member ALBs may have.

4.2 NQB discussed opportunities for focusing more on technologies for the future, using these in people's own homes e.g. Alexa, google radar system, smart lights, and the opportunity to think how to use these in community settings as part of prevention. ICSs may be seen as the moderating influence on alignment between digitising social care and the NHS.

4.3 NQB discussed expectations for the new government including care closer to home, combining health and social care (H&SC), delegating some health tasks to social care, social care workforce reform, a commitment to reform the means test which might affect the number of people supported. A national care service from the Labour manifesto was considered but it is not clear what this means in practice. NQB expressed high expectations for the new government.

4.4 Quality and safety should be paramount in a national care service. Corridor care in UEC highlights the importance of integration. HSSIB UEC work found no accountability for patient safety across the whole H&SC pathway. HSSIB are looking at safety management systems as part of this across the whole system.

4.5 NQB discussed supporting OHID work with the Royal Society developing a Public Health training package for the workforce contribution to public health, with real potential and opportunity to work alongside the workforce to strengthen that with new resource for social care colleagues and insights work to understand how to further that work.

4.6 Activity monitoring prevention work, e.g. how often boiling kettle, opening fridge – early detection, was agreed as being really important, as well as retaining and attracting

social care workforce. '*One health approach'*, is a holistic approach looking after people when well and managing infection, managing deterioration and outcomes figures. Corridor cases are often driven by a lack of access to urgent primary care which can be avoided using appropriate community management and improving the quality of the system as a whole.

4.7 Early findings show support for Carers needs to be better. Dementia strategy at CQC, aiming to agree a cross sector definition of what good quality dementia care looks like with guidance that CQC would regulate, and commissioners would commission. A lot to learn from and how to support family members through primary care settings.

4.8 Social care did a lot of work to encourage Labour to move away from a model of building an NHS structure. Social care leadership needs to be local and community based rather than provided by a service. People should be allowed to take risks in life, and some prevention work seems to take that away. One budget, one team of people working towards a person's overall health and wellbeing would be ideal.

4.9 The culture in social care white paper from 2 and a half years ago looked at improving access to National Guardians, NGO hope the new government can reinvigorate that, looking at systems and culture.

4.10 One of biggest challenges in the digitising social care programme is a lack of clarity of the role of ICSs in delivery of social care. NHSE is operating under delegated powers from DHSC, then delegated to ICBs, which is not sustainable to join up care at a local level.

4.11 NQB agreed to assess the new government position on social care. NQB chairs to meet with the NQB secretariat and assess how to navigate and ensure NQBs collective voice is heard as there is a real appetite for inputting into the social care agenda.

5 HSSIB safety recommendations work – Rosie Benneyworth

5.1 ROSIE BENNEYWORTH updated on NQB on HSSIB led work on cross ALB safety recommendations following a request from SoS about ALB collaboration. Work identified a list of areas and agreed to look at recommendations made into the system. The work is dual reporting into NQB and ALB Chairs and Chief Execs and is looking at recommendations made by national organisations. Discussions are happening with families from Grenfell, the infected blood inquiry, and highlight their concern for the recommendations to be implemented. Change on the ground does not always match ambitions of recommendations.

5.2 Working with reps from NHSE, NHS Resolution, CQC, HSSIB, MHRA, NICE, provider organisations, DHSC, NGO, PHSO, families and others. Conversations have been held with NHS Confed and NHS Providers who are supportive of the work, as well as meeting with coroners and HQIP.

5.3 Providers report drowning in recommendations, not clear what is mandatory, optional, how to prioritise, and no common set of principles. Patient safety team at NHSE have created a set of principles used in some cases but not widely adopted across system.

5.4 Recommendations are not cost assessed, some are duplicative, and often have a variable evidence base. Without a consistent measure of impact, providers are developing their own which may change the context of recommendations.

5.5 Across ALBs there is a lack of understanding what is happening across organisations, how do we work together better as a national system for visibility of work going on. Lack of clarity of oversight of recommendations and who is accountable? How to share recommendations from investigations to other sectors. Also seeing healthcare staff potential for moral injury and the impact on staff when recommendations can't be implemented / not leading to the change.

5.6 Some recommendations are not considering inequalities and impact and unintended consequences. Significant numbers of recommendations made need a national response for policy change and financial support for implementation.

5.7 Five potential next steps were outlined with NQB:

- Publish an interim report with findings to date in Autumn 2024
- Develop guidance for organisations to adopt when making recommendations
- Develop guidance for the system to support implementation of recommendations
- Continue to explore potential of a recommendations repository
- Explore potential of a cross agenda 'recommendations coordination panel' to reduce duplication, confliction and ensure providers have high quality recommendations to follow.

5.8 NQB discussed the large number of bodies that can make recommendations. NHSE met recently with the coronial system to try assist coroners with recommendations they make as part of learning from deaths, this is variable and often asks for guidance that is already developed. For public inquiries each chair will need to take a view, consider work with the cabinet office to agree this as part of inquiry ToRs. Target audience for this work is important to clarify.

5.9 NQB agreed that a repository would be huge across every area but considered if DHSC could have one for public inquiries.

5.10 Four nations recommendations also feed into this.

5.11 NQB welcomed this work and broadly supports the proposed next steps. Accountability for this work needs further exploration and links to HSSIB work on safety management systems, but quality and reliability of care should also be considered in the round. Where does assurance come from that recommendations are monitored?

5.12 It was noted that there is a risk in this work, from a public and patient perspective, if it inadvertently limits recommendations made by public bodies, that are legitimate and appropriate. Good engagement with patient groups is vital perhaps including Healthwatch, patients' association alongside the clinical voice and front-line workers.

5.13 NQB agreed to view the draft interim report before publication, the report will be hosted as HSSIB with engagement from the system.

5.14 Members agreed this work should be socialised with the new government, advising that NQB has been a shaping board.

6 Any Other Business

6.1 MEERA SOOKEE updated NQB on the draft refreshed NQB Terms of Reference, reviewed annually. No major changes were proposed, but changes include the

membership, with a proposed larger cast list from NHSE reflective of the merger of wider NHS organisations. NQB were asked to consider:

- Expanding membership to include social care, LGA and/ or ADASS?
- How NQB can ensure strategic direction of topics covered, impact of NQB work how to measure and review
- NQB agenda items prioritisation and selecting topics to address.
- Addressing potential conflicts of interest
- Use of quantitative data.

6.2 NQB members agreed to share comments on ToR for update and ratification at the next meeting.

6.3 The next meeting is scheduled for 18 September 2024.