# NATIONAL QUALITY BOARD

**25 April 2022 13:00 to 15:00**

Virtual Meeting

**MINUTES**

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| **PRESENT** | | |
| Steve Powis (Chair) | Rosie Benneyworth (Chair) | |
| Aidan Fowler | Anna Severwright | Chris McCann |
| Clenton Farquharson | Gail Allsopp | William Vineall |
| Kate Terroni | Mark Radford | Samantha Illingworth |
| Victoria Vallance (on behalf of Sean O'Kelly) | Viv Bennett | Yvonne Doyle |
| Graeme Dewhurst (on behalf of Wendy Reid) | Shera Chok (on behalf of Jonathan Benger) | |
| **IN ATTENDANCE** | | |
| Cathy Hassell | Clare Foreman | David McNally |
| Dawn Hodgkiss | Dominique Black (secretariat) | Jane Sproat |
| Kathryn Lupton | Marian Holliday | Sarah Jones |
| Stephanie Somerville | Helen Causley | Johanna Hulme |
| Danny McDonnell (secretariat) | Fiona Butterfield (Secretariat) | |
| **APOLOGIES** | | |
| Matthew Style | Wendy Reid | Ruth May |
| Jonathan Benger | Tim Ferris | Susan Hopkins |
| Jenny Harries | | |

**AGENDA**

1. Welcome & Minutes of Previous Meeting. NQB Terms of Reference.
2. National Virtual Ward Programme
3. National Recall Framework – Paterson Inquiry

4. Update on Refresh of Quality Accounts
5. Mortality Governance
6. NQB Experience of Care Guidance
7. Any Other Business

## 1. Welcome & Minutes from Previous Meeting

1.1 ROSIE BENNEYWORTH (Chair) opened the second National Quality Board (NQB) of 2022. Rosie Benneyworth confirmed she is now co-chair of NQB following Ted Baker's retirement from the CQC. The following members will also join NQB membership:

- Jenny Harries, Chief Executive, UKHSA
- Susan Hopkins, Chief Medical Adviser, UKHSA
- Dr Timothy Ferris, National Director of Transformation, NHSE/I
- Louise Ansari, National Director, Healthwatch

1.2 The refreshed NQB Terms of Reference (Paper 1) was approved with an amendment required to Viv Bennett's job title, Chief Public Health Nurse, OHID.

1.3 Attendees and apologies were noted as above.

1.4 The minutes of the meeting on 07 February 2022 were approved and agreed as a true and accurate record. The minutes will be published in due course, alongside the associated agenda and papers.

## 2. National Virtual Ward Programme

2.1 STEPHANIE SOMERVILLE provided the NQB with an overview of the Virtual Ward Programme (Paper 2), which is being delivered by NHSE/I.

2.2 The programme represents a big shift in the way acute care will be delivered from being hospital based into peoples' homes:

- Virtual wards support people who would otherwise be in hospital thereby freeing hospital beds, creating potential staffing efficiencies and providing safe and more convenient care for patients. This will extend hospital capacity by reducing avoidable admissions and supporting earlier discharge from hospital.
- Virtual Wards were set up in 96% of trusts during the pandemic. The programme is moving on from the early adopter phase and providing funding to developing at scale, engage with clinicians and build staff confidence.

- NHS Operational Planning 2022/23 guidance set a national ambition for virtual ward capacity of 40 – 50 virtual wards beds per 100k population and provides £450m additional funding over two years. Each ICS has committed to developing virtual wards in their area, intending to create 18,500 beds by mid-2023.
- In December 2021 core guidance was published to support roll out of virtual wards, containing detailed guidance on two key pathways for acute respiratory infections and people living with frailty / undergoing acute exasperation of a condition. Systems should develop a blended model of remote monitoring with face to face support for those patients who require it.
- Best practice is being reviewed via pathways currently in existence. The NHS At Home team and NHSE/I are leading on this. Regional and ICS networks are being brought together to look at the correct infrastructure and support required to ensure care is delivered safely with quality.
- Developing correct data architecture and oversight to allow monitoring and evaluation of virtual wards is crucial.
- ICS plans are due in June 2022. Plans should include collaboration across providers, evidence that clinicians are involved in the process, and clear workforce models and staffing requirements. Once plans are evaluated a further update will be provided to NQB.

MARK RADFORD questioned the level of involvement of patients and people drawing on services in the programme. He highlighted the complexity of providing joined up virtual ward services where other services exist (e.g. discharge teams). He also highlighted that more engagement is needed within some professional communities, given that some teams (e.g. District Nursing Teams) have been doing this work for some time but have not had the same level of investment.

2.3 KATE TERRONI raised the point that the communications for the programme should focus on the benefits for peoples' outcomes, rather than hospital capacity. She also suggested it would be good to draw out how learning from existing virtual wards was developed into the principles. Social care and the Voluntary Sector should be considered.

2.4 CHRIS MCCANN asked how patients are being educated and given the skills needed to ensure virtual wards work for them and are inclusive.

2.5 GAIL ALLSOPP offered support from NICE in relation to guidelines, to ensure safety and evidence, and extended an offer from NICE to sit on the national Clinical Reference Group. This offer was accepted.

2.6 STEPHANIE SOMERVILLE added that virtual wards currently operating provide excellent examples of onboarding and educating patients, case studies will be used as exemplars to support patients.

2.7 CLENTON FARQUHARSON asked to clarify communication to patients and communities about use of virtual wards, engagement with patients and whether this is suitable for patients with long term support needs, older patients and how this will close the inequity gap.

2.8 VIV BENNETT commented on District Nursing and recognising leadership of that workforce who are experts in providing care in people's homes. She also highlighted the impacts of virtual ward programmes on carers, and asked that carers are involved and supported through the programme.

2.9 SHERA CHOK offered support from a Digital perspective. It is worth considering that Virtual wards may require a larger workforce with a need to consider building teams to successfully deliver virtual wards and the upskilling of staff.

2.10 JANE SPROAT confirmed that The Carers Trust are involved in this programme, carer burden benefits and challenges to Virtual Wards are also being considered.

2.11 STEPHANIE SOMERVILLE added that communication with patients is being considered, good examples of engagement with patients in local roll out exist and will be built upon. Inequalities is crucial and this should not exacerbate quality of care. Once system plans are returned in June 2022 this will allow deeper analysis.

2.12 A further update on the Virtual Ward programme will be received by the NQB later in 2022.

## 3. National Recall Framework – Paterson Inquiry

3.1 WILLIAM VINEALL introduced to the NQB the National Recall Framework (Paper 3) which was developed following a recommendation from the Paterson Inquiry report published in 2021.

3.2 MARIAN HALLIDAY presented the framework which is patient centred and contains overarching principles if a recall is to be carried out and is applicable to both the NHS and Independent Sector. The Framework outlines scope of patient inclusion, exclusion criteria, patient engagement, the process for a recall and the need for learning for continuous improvement.

3.3 The scope covers the process of carrying out a recall but not the earlier review of patient care to understand if a recall is required and covers hospital-based care only.

3.4 STEVE POWIS stated that an explanation on origin of the framework is required in the communications released during the launch of the framework. Constituent members of the NQB should carry out relevant communications, coordinated through NQB secretariat. Steve also asked that an update on the implementation of the Framework be brought back to a future NQB,

given it will be is important to understand how the Framework is being utilised.

3.5 ROSIE BENNEYWORTH questioned how learning would be shared cross-sector. WILLIAM VINEALL clarified that the Framework was generated in the acute sector and applicability could be considered for other sectors in future.

3.6 CLENTON FARQUHARSON asked to clarify communications to the public explaining outcomes that patients can expect. MARIAN HALLIDAY confirmed this is not a patient communication. If a patient enters a recall process the organisation has a duty to explain the context of the specific recall. STEVE POWIS asked that this requirement be added to the Framework.

3.7 NQB agreed that the Framework would be NQB branded and published. The Framework will be brought back to the NQB in 2023.

## 4. Update on Refresh of Quality Accounts

4.1 KATHRYN LUPTON updated the NQB on work to refresh Quality Accounts. NQB agreed to review Quality Accounts following an engagement and consultation exercise with providers and other key stakeholders in 2021. Paper 4 summarises key changes proposed to Quality Accounts, pending the legislative process being followed and testing with providers and systems.

4.2 The expected timescale for updates to regulations will mean that changes to Quality Accounts will be expected for the 2024/2025 reporting cycle.

4.3 Proposed changes fit into three core themes:

- Purpose – refreshed to highlight the importance of public accountability and system collaboration for quality
- Content – updated mandatory reporting, quality indicator refresh
- Development and oversight – streamlining processes for production and scrutiny of Quality Accounts.

4.4 An advisory group will take work forward and test with three ICSs, alongside the CQC Assessment Framework.

4.5 VIV BENNETT highlighted the opportunity to focus on the health inequalities dimension. An update is scheduled at NQB in June on Quality in the Public Health System which should be joined up with this work. Representation in design teams from Public Health is important to reflect inequalities.

4.6 KATE TERRONI queried the ambition for systems to converse transparently with the public about quality. KATHRYN LUPON confirmed this is to be tested with systems and a clear account of system quality priorities. All systems must have core priorities for quality improvement.

4.7 CLENTON FARQUHARSON asked how system Quality Accounts would align with local authority strategies. KATHRYN LUPTON confirmed that this would be considered in the work.

4.8 NQB agreed to move forward in testing and refining proposed changes.

## 5. Mortality Governance

5.1 AIDAN FOWLER updated the NQB on Mortality Governance (Paper 5). The paper builds on the former Learning from Deaths programme, and summarises the status of mortality governance across England.

5.2 AIDAN emphasised the significant changes that have been made in recent years, including the introduction of the Medical Examiner system and improvements in patient safety reporting systems. These are summarised in the paper.

5.3 Quality Accounts are also an opportunity for providers to report what they have learnt from deaths occurring under their care in the previous year which should be linked together with learning. Processes for reviewing mortality have developed in regions and systems. The proposed changes to improve mortality reporting in Quality Accounts are summarised in the Paper.

5.4 CATHY HASSELL added that whilst individual mortality programmes have governance in place, work is required to join up all learning from deaths processes, health inequalities and must avoid duplication. Next steps are set out in the paper and the NQB are asked to comment on scope of the process in terms of governance and joining up learning.

5.5 STEVE POWIS commented on next steps; specifically, the need for the group to join up work, identify themes and gaps in learning, and advising on improvements to programmes/ organisations to act. He asked that the Mortality Group should report back to NQB on a periodic basis.

5.6 YVONNE DOYLE and AIDAN FLOWLER discussed the data profiles the Mortality Review Group will consider. Bringing data together as a report to NQB will identify the mortality opportunities for improvement of care.

5.7 STEVE POWIS closed the discussion and NQB agreed to amend the terms of reference for the Mortality Review Group, with an update to the next NQB meeting. Patient Safety Team to coordinate.

## 6. NQB Experience of Care Guidance

6.1 SARAH JONES presented the Experience of Care Guidance (Paper 6). The refreshed guidance provides an updated view of improving experience of care for those working in health and care systems and partnerships. The task and finish group included people with relevant lived experience.

The Beneficial Changes Network commissioned independent research into the accelerated changes made in Health and Social Care during the pandemic and identified critical ingredients for change. This research was approved by the Quality and Innovation Committee. The number one recommendation was co-production as default and is a key principle for improving experience of care. Reducing inequalities and supporting unpaid carers feature in the guidance.

6.2 ROSIE BENNEYWORTH highlighted the need to change cultural barriers to ensure people embrace working and co-producing with people using services. DAVID MCNALLY confirmed this important aspect of the guidance. Delivery depends on other programmes taking the guidance onboard.

6.3 ANNA SEVERWRIGHT asked how coproduction will be measured and accountability will be held to account

6.4 KATE TERRONI highlighted the CQC single assessment framework where the balance will be individual experience coupled with outcomes and safety which aligns with this guidance. CQC will ask to see evidence of engagement and coproduction.

6.5 CHRIS MCNALLY echoed the comments and the need for systems to put in place capacity to deliver on the aims and evaluation of delivery.

6.6 DAVID MCNALLY stated that the framework is a starting point for a simple checklist self-assessment approach for systems to use ahead of regulatory input.

6.7 The NQB agreed that the Framework could be published on the NQB webpage.

## 7. Any Other Business

7.1 **NQB Guidance on Quality Risk Response and Escalation** (Paper 7) KATHRYN LUPTON presented the updated NQB Risk Summit guidance, which has been refreshed for ICSs. The updated guidance is a more streamlined flexible framework setting out the expected approach to the management of quality risks within systems according to three tiers of assurance and support, and the roles and responsibilities of different partners.

NQB were asked for final comments on the guidance and an agreement to publish. Further conversation will be undertaken to align with the System Oversight Framework prior to publication. The NQB agreed that the guidance could be published on the NQB webpage.

7.2 **Social Care Quality Matters Framework** – KATE TERRONI raised Quality Matters, developed in parallel to NQB to focus on quality issues in Social Care. The Quality Matters Board was stood down a couple of years ago and KATE asked whether it should be picked up by the NQB; such that the NQB would cover health and social care (and public heath). STEVE POWIS

agreed the approach of formally standing down Quality Matters for inclusion within NQB. The NQB secretariat will speak to KATE and colleagues about ensuring future meetings and work reflect this scope.

7.3 **Beneficial Changes Network** (Paper 8) – an update on the annual cycle of Beneficial Changes, shared for information.

7.4 The next NQB meeting is 21 June 2022.