Public Health England

Protecting and improving the nation's health

Minutes

Title of meeting	Quality and Clinical Governance Committee	
Date	Monday 25 January 2016	
Time	10:00 – 12:00	
Venue	Wellington House, 133-155 Waterloo Road, London SE1 8UG	
Present	Rosie Glazebrook	Non-executive member of the PHE Board
	Viv Bennett	PHE Chief Nurse
	Andrew Blakeman	External Independent Adviser
	Sue Cohen	PHE, National Screening Lead (*for Kevin Fenton)*
	Paul Cosford	PHE Medical Director
	Anthony Kessel	PHE Director of International Public Health
	Amal Rushdy	PHE Consultant in Public Health
	Rashmi Shukla	PHE Regional Director, Midlands and EoE
	Alex Sienkiewicz	PHE Corporate Affairs Director
	Imogen Stephens	PHE Consultant in Public Health Strategy
	Pauline Watts	PHE Deputy Director, Nursing Directorate
	Mike Yates	PHE Corporate Affairs Directorate (Secretary)
Guests	Ben Anderson	PHE East Midlands Centre
	Susanne Howes	PHE East Midlands Centre
	Meng Khaw	PHE East Midlands Centre
	Michelle Lawrence	PHE West Midlands Centre
	Barbara Paterson	PHE East of England Centre
	Giri Rajaratnam	PHE Midlands and East of England Region
Apologies	Kevin Fenton	PHE Director for Health and Wellbeing
	George Griffin	Non-executive PHE Board member
	Sue Ibbotson	
	John Newton	PHE Chief Knowledge Officer

Introduction and apologies; Chair's opening remarks

15/044 The Chair welcomed those in attendance to the meeting. She congratulated Viv Bennett and Paul Cosford on their New Year honours.

Minutes of the last meeting: 9 November 2015

15/045 The minutes of the previous meeting (Enclosure QCGC/16/01) were accepted as an accurate account of the previous meeting.

Matters arising

15/046 Enclosure QCGC/16/02. Pauline Watts was asked to provide an update on the sharing of best practice (ref: 15/022). An intranet site was being developed to share good practice. The Quality and Clinical Governance Steering Group, which had now met, was also scrutinising examples. The Chair asked that these specifics be written into this matter arising.

Action: Mike Yates to amend matter arising 15/022 to reflect additional measures being taken to identify good practice.

15/047 Viv Bennett reiterated how important the sharing of good practice would be in getting a consistent approach, and this would be a key element for the communications strategy being developed for quality and clinical governance.

SECTION 1 – MONITORING PROGRESS

Progress report from the Chair of the Quality and Clinical Governance Steering Group

15/048 Viv Bennett, Chair of the Quality and Clinical Governance Steering Group, provided a general programme update.

15/049 The Quality and Clinical Governance Steering Group had met on 11th January.

Programme management

15/050 Good programme management was in place, with regular team meetings occurring, a live delivery tracker and a full risk register regularly updated. Terms of reference were being finalised for both the Quality and Clinical Governance Committee and the Quality and Clinical Governance Steering Group (the latter would be shared with the Committee in due course).

Action: Liz Scott/Mike Yates to circulate the terms of reference of the QCG Steering Group when signed-off.

Quality Plans

15/051 The list of Quality Hubs had been finalised and a lead identified for each. There had been very good engagement with all Quality Hubs, but particularly so from the Centres who should be congratulated for their hard work and the content of their draft Quality Plans.

15/052 Draft Quality Plans from the Early Implementer Sites were now being received and reviewed. The team did not impose a strict template for Quality Plans, but would introduce a standard cover sheet and checklist to aid consistent analysis. All Early Implementer Site Quality Plans were due by the end of January, with all other plans by the end of March.

Guidance and communications

15/053 Full guidance documentation was being drawn up for the Quality Hubs and Quality Component leads, and a communications strategy was being refined and finalised.

Reporting and monitoring

15/054 Future Quality Hub reporting and monitoring arrangements were also being considered. Importantly, these should not add unnecessary additional burdens to Quality Hubs, particularly Regions and Centres, and current information collection mechanism should be utilised as much as possible (including information collected for the Public Health England balanced scorecard). The process needed to be systematic and disciplined.

15/055 It was suggested that a future meeting of the Committee consider reporting in more detail. The information, reporting and monitoring requirements of the Committee and other Public Health England audiences should be determined. Pertinent information already collected through other processes (including that for the Public Health England balanced scorecard) should be mapped against these. Finally, a gap analysis should be conducted with suggestions made for collecting information to fill the gaps.

Action: Amal Rushdy and Trisha Hymas to produce a paper for the March QCGC meeting, with a full proposal for identifying the QCGC and other audience reporting needs, mapping of current information collected, gap identification and gap filling.

Feedback from senior colleagues

15/056 Viv Bennett fed back comments from a presentation she made to the Public Health England Senior Leadership Forum. Although a lot of the recent work in developing this agenda had been around compliance, equally important was i) getting the necessary commitment from all parts of Public Health England, and ii) ensuring that future delivery was based around innovation.

Roadmap to move from Sound Foundations to business-as-usual

15/057 A full roadmap plan describing the transition from *Sound Foundations* to business-as-usual was being drawn up. This would include:

- On-going communications and engagement with Quality Hubs;
- Identifying future programme resources and support;

- Clarifying leadership and governance (e.g. the roles of the SROs, the Committee and the Steering Group; what each Committee should oversee/scrutinise; links with the PHE Board and Audit and Risk Committee; links with sub-programme committees, boards, groups and teams);
- Defining and putting in place monitoring and reporting processes, and defining how information is translated and shared with the Committee, Steering Group and elsewhere in PHE (as described above);
- Building network delivery and engagement (particularly how the Quality Hubs and Quality Component teams should work together);
- Setting future aims and objectives, and tracking delivery;
- Embedding quality and clinical governance through business planning (across PHE).

15/058 A draft roadmap would be shared with the Committee at its next meeting.

Action: Mike Yates and team to share draft roadmap with Committee at its March meeting.

Internal Audit reviews and actions

Preparation for the Internal Audit review in February

15/059 Pauline Watts gave a brief update on the preparations in place for the Internal Audit review in February.

15/060 Three portfolios of papers were being prepared:

- Those relating specifically to clinical governance;
- Those relating to improving quality; and
- Those relating to how *Sound Foundations* would be embedded across the system.

15/061 An initial interview schedule had been agreed. Interviews would start in week commencing 1 February, with others to be added in due course. A meeting had been arranged for 1 February to brief Early Implementer Sites on what might be expected from them as part of the review.

Internal Audit actions

15/062 Imogen Stephens provided a brief update on the status of the actions arising from the previous reviews (Enclosure QCGC/16/03). 95% of all audit actions had been completed.

15/063 There were some outstanding tasks, most significantly those associated with safeguarding children and vulnerable adults (particularly ensuring that mandatory training took place). However, good progress was being made and an information paper had been shared with the Committee (Enclosure QCGC/16/11).

15/064 Rashmi Shukla explained that Centre-based work was taking place to support some of the actions arising from the Internal Audit reviews. It was suggested that this information be collected from a sample of Centres and documented. Rashmi suggested this be done with Centres who were not currently committing resource to other audit work taking place.

Action: Rashmi Shukla and Pauline Watts to identify, collect and document Centre-based work supporting the Internal Audit report recommendations and actions.

15/065 The Chair suggested that if a draft review report were available before the next Audit and Risk Committee, that this should be shared as an information paper.

Action: Mike Yates to check status of review prior to the February Audit and Risk Committee meeting, and share a draft report for information if available.

15/066 The Chair thanked the team for their considerable efforts in meeting the actions and recommendations arising from the reports, and recognised the excellent progress made.

SECTION 2 – SCRUTINY

Alignment: Papers for the Committee to consider/ scrutinise v papers for the Audit and Risk Committee to consider/scrutinise

15/067 A discussion took place on the reports to be received by the Committee. An incident report, covering clinical incidents (Enclosure QCGC/16/04), and the Public Health England full strategic risk register (Enclosure QCGC/16/05) were viewed as examples of the kind of information that might be put to future meetings of the Committee.

15/068 Paul Cosford suggested that the Committee concentrate primarily on themes and systematic concerns rather than the detail. Public Health England's governance and delivery networks ensured that detailed scrutiny in many of the Quality Component areas did take place with issues and concerns reported.

15/069	The scrutiny role of the Quality and Clinical Governance Steering Group also needed to be considered as part of this discussion. It was felt that if additional scrutiny between the Quality and Clinical Governance Committee and Public Health England's wider corporate and clinical governance processes was needed, this might be done by the Steering Group. Getting the balance right between the respective scrutiny roles would be key to avoiding duplication.	
15/070	Some detailed quality and clinical governance information was currently being provided to the Audit and Risk Committee as part of an integrated governance report. The Audit and Risk Committee also received the full strategic risk register for scrutiny. At its November meeting, the Audit and Risk Committee said this should continue.	
15/071	It was suggested that a piece of work be conducted, through the Quality and Clinical Governance Steering Group and the Quality Component leads, to map what reports currently go where, for each of the Quality Components, with a view to identify whether beneficial changes might be made (this would include how clinical governance issues are reported across the Quality Components if not currently done). The work would also address when and how issues arising from scrutiny would be escalated from the Steering Group to the Committee.	Action: Pauline Watts, Imogen Stephens and Liz Scott to work with Quality Component leads to map which boards, and committees they currently report to and what is reported. A map will be provided to the May meeting of the Committee with proposals for change if appropriate.
15/072	Viv Bennett said it would be important to recognise the development of effective scrutiny between the various levels of the organisation as a strong mitigating action for heading off specific quality and clinical governance risks and incidents in the future. The programme risk register should reflect this.	Action: Mike Yates and Imogen Stephens to amend the strategic risk wording to reflect how full scrutiny was being developed.
15/073	In the meantime, it was suggested that as well as deep dives on Quality Hubs at each meeting of the Quality and Clinical Governance Committee, Quality Component deep-dives wiith one or two Quality Component teams also take place. It was suggested risk and adverse incident management be the first focus area, with the timetabling of others discussed and agreed at the March Committee meeting.	Action: Mike Yates to add a risk and adverse incident management deep-dive to the agenda for the March meeting of the Committee, and draw up a proposed list for future deep dives.

SECTION 3 – QUALITY PLAN DEVELOPMENT AND REPORTING

Quarterly reporting

15/074 Covered in detail above (15/054 and 15/055).

Quality Hub deep-dives

15/075 Enclosure QCGC/16/06 set out a schedule for Quality Hub deep-dive sessions at future Committee meetings. It was thought that the list circulated might not be the complete list and this should be checked.

Action: Pauline Watts/Liz Scott to check that the list of Quality Hubs on the deep-dive schedule is complete.

Quality Hub presentations

15/076 The Chair welcomed colleagues from the Midlands and East of England region and its Centres.

Midland and East of England region

15/077 Giri Rajaratnam began by giving a brief overview of the regional draft quality plan (Enclosure QCGC/16/supp i).

15/078 The draft regional quality plan indicated how quality was being embedded through the regional team's business and provided examples of the quality improvement areas they would be working on in the immediate future. This included supporting NHS England's assurance process. Smoking in pregnancy was also highlighted as a key target area.

15/079 The plan emphasised the need for the regional team to make connections in order to share and learn. The regional quality lead would also ensure that Centre leads are brought together to enable issues to be identified and escalated, as well as enable further sharing of experience and lessons.

15/080 Paul Cosford asked what quality-related issues the team was particularly concerned about, but also what aspects of their work they were most proud of and which others could learn from.

15/081 Giri said the recent local changes to teams had been a particular challenge. There were lots of examples where he felt the team was making particular progress including those already mentioned, and there was a clear plan for sharing and learning.

East of England Centre

15/082 Enclosure QCGC/16/ supp ii. The Centre team confirmed that a quality framework had already been in development prior to the call for all parts of Public Health England to draw up and submit quality plans.

15/083 The team recognised the value of the engagement with and support from the national team, particularly Pauline Watts. Pauline confirmed that good engagement had taken place with the team and it was clear that the work they were doing was making people think differently about quality.

15/084 Paul Cosford also asked the Centre team i) what kept them awake at nights, and ii) what and how might others learn from the quality work being done by the Centre.

15/085 The team mentioned that tracking mandatory training and ongoing professional registration was a big issue, and could expose the whole organisation if not done effectively. Plans were in place to address this, including through annual appraisals and through agreement of personal development plans.

15/086 The team also reiterated the importance of links being made between national teams, regions and centres to ensure consistency and the sharing of ideas and learning.

15/087 The team were most proud of the integration work that they had taken forward in areas such as liver disease.

15/088 Barbara Paterson said there were three current overarching priorities:

- Integration;
- Devising a suite of quality and clinical standards aligned with national standards; and,
- Review and improvement of quality practices across all of the operations of the Centre.

15/089 It would be important to assure that local delivery was aligned with what Public Health England was required to deliver nationally on the quality agenda. The quality improvement plan would be adapted and updated accordingly. There also needed to be a clear link with future business planning processes and the enclosure illustrated how the quality agenda was doing this.

15/090 Overall, it was agreed that very positive progress was being made.

West Midlands

15/091 Enclosure QCGC/16/supp iii). The team highlighted the good progress being made. Local quality and clinical governance 'deep-dives' were taking place, quality leads for all areas had been identified and teams were aware of what they should be doing to meet the quality and clinical governance standards set.

15/092 The recent *Sound Foundations* focus and engagement had helped link and align work in this area across the region. Sharing good practice had become systematic and teams were ensuring that quality was everyone's business.

15/093 The draft quality plan listed the Centre's priorities clearly.

15/094 The Chair asked how easy it had been to embed the principles being driven by the *Sound Foundations* programme. The team felt it had been relatively straightforward to map the work they had been doing onto the framework. There was a lot of familiarity already with the *Sound Foundation* areas, but the recent drive had provided the Centre with an opportunity to push the agenda forward.

15/095 Paul Cosford was pleased to see performance across the piece (by professionals, teams, the organisation as a whole and through partnership), and that this was a key building block for achieving better values and outcomes.

15/096 The Centre team suggested their key challenges would be:

- Dealing with variation across the system; and,
- Engagement and partnership delivery with major stakeholders.

East Midlands

15/097 (Enclosure QCGC/16/supp iv). The Centre had a clear vision of how to provide high quality, safe and effective local public services. The development of a strong quality and clinical governance culture would be important to drive this agenda.

15/098 The Centre had adopted an integrated governance approach to quality.

15/099 A full and clear quality improvement plan had been provided as part of the quality and governance framework covering all the key areas of the programme. Assurance on meeting the objectives would be evidence-based.

Summary

15/100 It was agreed that these were four very strong draft quality plans. Centres were at different stages of development, but they had all engaged fully with the process and recognised the opportunities that the new quality and clinical governance drive offered.

15/101 For future iterations of reports, the following was suggested:

- Have in mind the two challenge questions posed by Paul Cosford (issue and risks; and, sharing best practice with others);
- Summarise the context of the Centre upfront (its work coverage and its stage of development);
- Describe what regulatory compliance is needed and show the evidence to demonstrate compliance; and,
- Explain fully what data and evidence will be used to measure assurance in quality and clinical governance across the piece.

SECTION 4 – OTHER BUSINESS

Any other business

15/102 Imogen Stephens spoke to the update paper on safeguarding children and vulnerable adults (SCAVA) (Enclosure QCGC/16/11). The Committee agreed it was a priority for the Chair of the SCAVA group to be appointed as quickly as possible. The Committee asked for a further report on progress in due course.

Action: Paul Cosford, Viv Bennett and Imogen Stephens to ensure appointment of SCAVA chair as quickly as possible.

Action: Imogen Stephens to provide SCAVA progress report to May meeting of the Committee.

15/103 The meeting ended at 11:57.

Date of next meeting

Monday 21 March 2016 at 10:00 am, Wellington House

Mike Yates
Quality and Clinical Governance Committee Secretary
January 2016