NATIONAL QUALITY BOARD MINUTES

7 June 2023 10:00 – 12:00

Virtual Meeting

PRESENT:

- Stephen Powis - National Medical Director, NHS England
- Aidan Fowler - National Director of Patient Safety, NHS England
- Alf Collins – Clinical Director, Personalised Care, NHS England
- Allison Streetly – Head National Public Health Team, NHS England
- Anna Severwright - Lived Experience Expert
- Charlotte McArdle (for Ruth May) – Deputy Chief Nursing Officer, NHS England
- Clenton Farquharson - Lived Experience Expert
- David Johnston - Lived Experience Expert
- Deborah Sturdy - Chief Nurse for Social Care, DHSC
- Devon Elliott – Head of Evidence and Evaluation, Personalised Care, NHS England
- Emma Rourke – Deputy National Statistician, ONS
- James Bullion – Interim Chief Inspector of Adult Social Care and Integrated Care, CQC
- Jamie Waterall - Deputy Chief Public Health Nurse, OHID
- Jason Yiannikou - Director – Systems, Integration and Reform, OHID
- John Newton – Professor of Public Health, OHID
- Judith Richardson (for Jonathan Benger) - Programme Director Clinical Directorate, NICE
- Lynne Reed – National Lead for FNP and Parenting, Quality Strategy, OHID
- Nick Taylor - Deputy Director for Epidemiology and Global Health Analysis, ONS
- Rosie Benneyworth – Chief Investigator, HSIB
- Shahed Ahmad – National Clinical Director for CVD prevention, NHS England
- Sue Ibbotson – Head of Clinical Excellence and Quality, UKHSA
- Susan Hopkins – Chief Medical Advisor, UKHSA
- Vinod Diwakar - Medical Director for Transformation
- Wendy Reid - Acting Chief Executive, HEE
- William Vineall – Director, Acute Care and Quality, DHSC

IN ATTENDANCE:

- Allan Baker – Deputy Head of Population Health Analysis, ONS
- Andrew Sutherland – Head of Quality Mental Health and Health and Justice, NHS England
- Daniel McDonnell – Quality Strategy Lead, NHS England
- Dominique Black – Strategy Manager, CQC (Secretariat)
- Fiona Butterfield – Quality Policy Manager, NHS England (Secretariat)
- Meera Sookee – Head of Quality Strategy, NHS England

APOLOGIES:

- Jonathan Benger - Chief Medical Officer, NICE
- Lyn Romeo - Chief Social Worker for Adults, DHSC
- Ruth May - Chief Nursing Officer, NHSE
- Sean O'Kelly - Chief Inspector of Hospitals, CQC

AGENDA
1. Welcome and minutes of previous meeting
2. Major Conditions Strategy (call for evidence)
3. Personalised Care Quality Framework
4. Excess Mortality
5. Any other business

1 Welcome and minutes of previous meeting

1.1. STEPHEN POWIS (chair) welcomed all to the third National Quality Board (NQB) of 2023. Attendees and apologies were noted as above.

1.2. The minutes of the previous meeting on 19 April were approved and agreed as a true and accurate record and will be published in due course.

2. Major Conditions Strategy (call for evidence)

2.1. DHSC and OHID members updated the NQB about the Major Conditions Strategy, announced in January 2023 by the Secretary of State (SoS), covering the whole care pathway. The strategy focusses on 6 major groups of conditions, cancers, cardiovascular disease (including stroke), diabetes, chronic respiratory diseases, dementia, mental ill-health and musculoskeletal disorders.

2.2. Engagement work included talking to a number of people with lived experience of these major conditions which pointed towards practicalities and experience of living with a major condition.

2.3. Currently there is a call for evidence which will inform the final report. An interim report is due to be published this summer.

2.4. The strategy aims to put improvement at the centre, shifting emphasis from an improvement agenda based on an individual's condition to improvement across the life course, emphasising person-centered care and management of quality and safety.

2.5. A number of points were noted in the discussion:

- that quality improvement (QI) must be a core element for delivery of the strategy ambitions. Improving prevention, diagnosis and management requires a strong focus on quality/ QI across the strategy.
- acknowledgement of NHSE's newly launched NHS Impact approach to developing NHS providers and systems, with a focus on Quality Improvement (QI), aligned leadership behaviours and capacity, working with ICBs and providers and a need to align to this work.
- inclusion of the wider determinants of health such as poverty and obesity.
- alignment with the NQB's Quality guidance for Integrated Care Systems which is focused on improvement across pathways, cross system alignment and leadership. System Quality Groups play a role in implementing this strategy.
- including social care and the opportunities for communication and getting people involved.
- how implementation of the strategy will improve diagnosis experience and how intersectionality, co-production and the voice of people will help decision making? Removing current silo working will improve this, there is a focus on

person centered care and what this means for the way services are delivered, but it must work for people and their families, and is a shift in the way we experience our relationship with ill health.

2.6. NQB were asked to consider how to monitor and evaluate how the strategy is helping patients and the public.

2.7. This is an opportunity for a consistent, coherent approach to cohort management, patients would like a single view to enable better management for the population, with a focus on populations and marginalised groups.

2.8. NQB agreed to discuss the draft final strategy later in the year. Secretariat to coordinate.

3. Personalised Care Quality Framework

3.1. NHS England colleagues with support from lived experience expert DAVID JOHNSTON updated the NQB on NHS England's draft Personalised Care Quality Framework. NQB were asked to:

- Consider the Quality and Outcomes Guidance which is at an early stage of development.
- Consider next steps and support this work.

3.2. The NQB shared commitment to quality is at the centre of this work. It is about whole person health care, biopsychosocial philosophy, and supporting people to manage their own health and care, the 'what matters to me' agenda. Engaging with people and patients and working with them to support them to articulate what is important to them, enabling shared decision making and choice.

3.3. This is a journey to bring quality and outcomes in personalised care to the forefront and aims to bring guidance, tools and resources into one place.

3.4. DAVID JOHNSTON shared his experience of living with this personalised care model. In terms of quality outcomes, simple outcomes measures are needed leading to one version of the truth that can easily be analysed and shared.

3.5. A wider system approach of coordination must be in place. NQB members can help and support to drive this forward to embed and deliver and framework.

3.6. Members supported the work and joining up the personalised care agenda with the NQB. The draft document feels NHS focused rather than inclusive of social care (NHS language). OHID colleagues offered to discuss with the team the key measures to baseline and assess the ICS self-assessment approach included withing the guidance.

3.7. CQC supported the aspiration and wider point about linking across to social care and systems thinking. CQC would want to see the impact of this when assessing systems. The inequalities agenda could be strengthened for setting expectations for ICSs.

3.8. NQB acknowledged that all people all have different starting points, what matters to one may not to another. The assessment process should incorporate flexibility and individualisation.
3.9. NQB supported publication of the document. Secretariat to work with the Personalised Care team to coordinate approval.

4. Excess Mortality

4.1. The Board received an update on ONS excess mortality data and insights since the pandemic, noting that mortality in 2020 was atypical due to the pandemic. From 2022 onwards covid is not seen as the main cause of excess death.
4.2. Age groups see different patterns, 20–34-year-olds main cause of excess death is intentional self-harm. Heart disease features in all over 35 age groups.
Care homes and hospitals saw the highest number of excess deaths during covid.
4.3. Working group across government established to evaluate different methods used to estimate excess mortality.
4.4. NQB then received the OHID excess mortality data explaining the differences between methodologies, data on inequalities and more recent excess death data. Excess mortality allowed us to look at the impact of covid, it is more difficult now to assess the estimated value due to the pandemic. It is a good measure in health protection.
4.5. NHS England's National Clinical Director for Cardiovascular Disease (CVD) shared mortality trends in CVD and the ongoing CVD prevention work. CVD is the largest cause of the excess death gap between the richest and poorest populations, and ethnic minorities.
CVD has a huge impact on social care with est. £4.5b spent per year. Preventing CVD and stroke is vital.
4.6. CVD is included in the NHS Long Term Plan, primary care improvements in blood pressure monitoring could have the biggest impact with the blood pressure at home programme. Engagement and ownership of prevention by ICB leadership teams is critical to allow improvements.
4.7. Pre-pandemic work shows a change in causes of excess mortality, we now have a situation of persistent excess mortality, more people are dying from CVD, diabetes, and alcohol caused disease, these are preventable diseases. The picture emerging from the data is consistent. This is a call to arms for prevention and the data helps us make that argument.
4.8. Deprivation does not appear to have a very great effect on excess mortality.
4.9. NQB need to refocus and drive the quality improvement policy through better use of data through our professional routes, promoting prevention work.
4.10. The Medical Examiner system is scrutinising all in hospital deaths and about 20% of community deaths, it is not clear yet what impact that will have on the data. This may change causes of death over time, a single cause of death is often oversimplification.

4.11. Many expected deaths are also preventable. This is a useful caution. There is bound to be disability as well as preventability.

4.12. Industrial action impact on excess death was not significant and as data is reported weekly there is sometimes a lag.

4.13. NQB members to consider ways to promote ICB Chief Executives to own prevention and drive forward the preventative work and how to get this owned by the whole community beyond leadership. NQB can influence ICB and system leaders, and our wider workforce to take this forward, linking in with the Major Conditions Strategy.

4.14. Public narrative is nuanced in these findings, the public need to understand that there is not one cause of death, it is multifactorial. One ambulance trip is not the cause of death in many deaths.

5. Any Other Business

5.1. NQB chair asked if members had any other business to raise. No matters arose.

5.2. NQB members were informed that the revised Terms of Reference would be circulated, and members were asked to inform secretariat of their nominated leads for the establishment of the NQB policy leads call.

5.3. The next NQB meeting is 6th September 2023.