NATIONAL QUALITY BOARD MINUTES

08 November 2023 10:00 – 12:00

Care Quality Commission offices, Redman Place, London

PRESENT:

- Stephen Powis - National Medical Director, NHS England, CHAIR
- Allison Streetly - Head National Public Health Team, NHS England
- Matthew Style - Director General for NHS Policy and Performance, Department of Health and Social Care
- Rosie Benneyworth - Chief Investigator, Health Services Safety Investigation Body
- Sue Ibbotson - Head of Clinical Excellence and Quality, UK Health Security Agency
- Stella Vig - Medical Director for Secondary Care and Quality, NHS England
- Wendy Reid - Acting Chief Executive, Health Education England
- Adam McMordie - Deputy Director Quality, Patient Safety and Maternity, Department of Health and Social Care
- Prem Premachandran – Emergency Medicine Specialist, Care Quality Commission
- Erika Denton - Interim National Medical Director for Transformation, NHS England
- Nicola Wise – Head of Hospital Inspection, Care Quality Commission
- Kate Terroni – Deputy Chief Executive, Care Quality Commission

IN ATTENDANCE:

- Daniel McDonnell - Quality Strategy Lead, NHS England (Secretariat)
- Dominique Black - Strategy Manager, CQC (Secretariat)
- Fiona Butterfield - Quality Policy Manager, NHS England (Secretariat)
- Meera Sookee - Head of Quality Strategy, NHS England
- Sonia Sharma - Clinical Fellow, shadowing Stephen Powis
- Alex Crowe - Deputy Director Safety and Learning, NHS Resolution
- Jonathan Benger - Chief Medical Officer and Interim Director of the Centre for Guidelines, National Institute for Health and Care Excellence

APOLOGIES:

- Aidan Fowler - National Director of Patient Safety, NHS England
- Deborah Sturdy - Chief Nurse for Social Care, DHSC
- James Bullion - Interim Chief Inspector of Adult Social Care and Integrated Care, CQC
- Jamie Waterall - Deputy Chief Public Health Nurse, OHID
- Anna Severwright - Lived Experience Expert
- Charlotte McArdle - Deputy Chief Nursing Officer, NHS England
- Clenton Farquharson - Lived Experience Expert
- Lyn Romeo - Chief Social Worker for Adults, DHSC
- Ruth May - Chief Nursing Officer, NHS England
- Sean O'Kelly - Chief Inspector of Hospitals, CQC
- William Vineall - Director, Acute Care and Quality, DHSC

AGENDA
1. Welcome and introductions
2. NICE Prioritisation Process
3. Collaboration across ALBs in safety and risk recommendations
4. NQB discussion on quality stocktake – next steps
5. Any other business

1 Welcome and Introduction to Amanda Pritchard

1.1. STEPHEN POWIS (chair) welcomed all to the fifth National Quality Board (NQB) of 2023. Attendees and apologies were noted as above.
1.2. The minutes of the previous meetings on 7 June 2023 and 11 October 2023 were agreed as an accurate record and will be published in due course.
1.3. It was agreed that Jayne Chidgey-Clark will be invited to become a formal member of NQB going forwards.

2. NICE prioritisation process

2.1. JONATHAN BENGER updated NQB on NICE prioritisation. NICE has a new vision for responding to challenges in the health and care system and to understand what is happening. The core purpose is to help practitioners get the best care to people fast, while ensuring value for the taxpayer.
2.2. NICE is evolving in three ways, actively contributing to support commissioners to deliver care. Producing relevant guidance that is more useful and usable, focused on greater demonstrable impact. Ensuring guidance is implemented correctly is important.
2.3. The NICE Improvement Board is in year 2 of the 5 year strategy. Going forward NICE will develop relevance particularly around prioritisation and how topics are selected. Some topics are statutory. A common prioritisation framework will be published and applied consistently to topics, delivered through an integrated single prioritisation board.
2.4. A review of NICE prioritisation will be published. Horizon scanning in NICE has been helpful in identifying unified definitions and understand what the system wants now.
2.5. NQB discussed multimorbidity, how that is tackled through guidance and how to incorporate cross system prevention, public health, and primary, secondary and social care aspects. Multimorbidity is being looked at currently, consulting with stakeholders to tackle this. Research is coming which will be helpful in working out areas of common overlap and combining guidance, e.g., type 2 diabetes and obesity.
2.6. NICE has a role in social care and recognises the importance of the challenge for penetration into the system, ensuring guidance is used. Interface is key, focusing on where health and care interface rather than writing pure social care guidance. In terms of public health NICE keen to revisit this being cognisant about delivery.
2.7. CQC have done some work and understood that guidance that is accessible and deliverable and along with legislation can work, NICE guidance can work, the focus of accessibility and measuring impact is important.
2.8. NQB discussed having an agreed set of areas to focus on in terms of quality and for that to be reflected in NICE guidance. Four areas for guideline activity focus are currently Mental Health, Women's and Maternal care, Cancer, and metabolic disease. Better dialogue is needed on what the system needs and now NICE can assist with that.
2.9. Research studies often exclude Health Inequalities questions, greater datasets are more inclusive than randomised trials, bias in evidence is being looked at, research evidence if not representative means guidance is also not representative.

2.10. Citizen panels are core but many recommendations from NICE need population behaviour change which is not costed and not in recommendations, can that be incorporated into impact standards? Economic modelling is challenging, it has often been criticized. Opportunity cost and can often mean diverting resources.
2.11. NICE writes guidance that is accepted and cross cutting, important topics that are hard rather than topic specific guidance with strong evidence bases such as that produced by the Roal Colleges.
2.12. Presenting recommendations is not on a two-tier basis, and can be challenging to the system, but is about recommending excellence in care.
2.13. Sponsor teams will still be able to commission guidance, as was the case with coronavirus.
2.14. CQC quality statements are underpinned by 6 evidence categories but signpost to best practice and guidance, including NICE guidance. There is a good opportunity to ensure that relevant guidance in signposted.

3. Collaboration across ALBs in safety and risk recommendations

3.1 ROSIE BENNEYWORTH and ALEX CROWE updated NQB on the collaboration work started in November 2022, following Secretary of State direction to ALBs to collaborate more. One area of work was safety and risk, looking at opportunities for safety and risk recommendations. It is a cross ALB piece of work.
3.2 Group findings confirmed organisations are drowning in recommendations and are unclear where to focus effort, unclear on mandatory or optional recommendations, and sometimes are without a clear set of principles. Costs of recommendations is not always clear, and not clear how to measure the impact. Impact is measured across the system in a range of different ways. Accountability is not always clear, and following big inquiries some of the important work done is put out to the whole system whereas some other work should clarify if it is relevant for all or not.
3.3 The work is in an early stage with four potential areas to support, an agreed set of principles that are measurable, supporting NHS Resolution work, a shared repository of work for ALBs to avoid duplication of work, and a workstream looking at measuring impact of safety recommendations. The Health and Care Select Committee are also doing some work about this at an early stage.
3.4 The ALB group has allowed NHS Resolution to develop and evolve this workstream. Being cognisant of the fact that implementation of recommendations reduces harm, the consequence is a huge number of recommendations and how to process that.
3.5 The Recommendation to Implementation Emergency Medicine Tool has been developed to reduce burden of information overload and was shared with the NQB. Proof of concept uses the recommendations on emergency medicine. 14 trusts have expressed interest in the tool, with provided wrap around dialogue with the trust leads, complete by the end of this year.
3.6 NQB were asked to consider sponsoring the work in terms of oversight and governance. The 3 areas to focus on are Emergency Department, Maternity and Mental Health. NQB agreed to bring this under the umbrella of NQB providing sponsorship. The issue is widely recognised at all levels.
3.7 it was recognised that the drug pipeline from NICE is a gold standard, what can we draw from the way that this works in terms of principles, for example evidence base,

and being clear about that to underpin recommendations. For the cost effectiveness question NICE sets a ceiling for methodology for not being cost effective, considering if the cost will reduce harm to the same effect that spending that money elsewhere would? The audit trail for recommendations isn't always clear.

3.8 Improving quality saves lives as does improving performance, NQB considered how to we tie up quality and performance recommendations and how to incorporate other recommendations in a way that is not duplicative.

3.9 Clinical audits create recommendations commissioned by NHSE through HQIP, work is ongoing to tighten up the recommendations, manage coroners process and looking to get a process around those.

3.10 NQB discussed concerns about recommendations not being implemented as well as things done with no impact when they have been implemented, the Health and Care Select Committee should question this. Harm is important, can we prioritise things that are producing harm. Prioritising better will reduce harm and cost.

3.11 NQB agreed to feed into work on an achievable aim – a set of principles for those producing recommendations that NQB adheres to, so that there is confidence that recommendations have gone through a process of sense checking. The process of pre-recommendation phase, live phase and post phase to enhance the possibility of recommendations being carried out.

4. NQB discussion on Quality Stocktake – next steps

4.1. Following the NQB meeting on 11 October 2023 it was agreed that a further discussion would take place on next steps on work NQB can do to improve quality across health and social care with open discussion on what more NQB can do for quality policy, policy gaps and exploring future priority areas going forward.

4.2. NQB agreed to identify work going on already in these areas, new NQB guidance and the suite of guidance already in existence, policy alignment required between organisations and to agree future agenda items and a sense or priority. NQB discussed alignment on quality policy and governance, report and review recommendations, and how to improve this across the member organisations. Quality productivity and finance, the recommendation to implementation tool, economic / cost impact, quality governance structures. An NQB policy leads forum will be set up to help facilitate this work and join up.

4.3. NQB agreed to the direction of travel, to understand via the policy leads call and develop an agenda planner for 2024, with a sense of priority from NQB members.

5. Any Other Business

5.1. NQB chair asked if members had any other business to raise. No further business was raised. The next NQB meeting is scheduled on 21 February 2024.