



NATIONAL QUALITY BOARD MINUTES

08 December 2025, via Microsoft Teams

NQB Co-Chairs:

[REDACTED]

Penny Dash – Chair, NHS England

NQB Members present:

- Aidan Fowler - National Director of Patient Safety, NHSE

[REDACTED]

[REDACTED]

[REDACTED]

- Duncan Burton - Chief Nursing Officer for England, NHSE

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- Meghana Pandit - Co-National Medical Director, NHSE

- Neil Churchill - Director of People and Communities (Patient Experience), NHSE

[REDACTED]

[REDACTED]

[REDACTED]

- Stella Vig - Medical Director Secondary Care and Quality, NHSE

[REDACTED]

[REDACTED]

Also in attendance:

- Adrian James - National Medical Director for Mental Health and Neurodiversity, NHSE and Severe Mental Illness clinical co-chair, for agenda item 5

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- David Ashby - Director of Digital Products and Improvement Analytics, NHSE, for agenda item 3b.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- Ramani Moonesinghe, National Clinical Director Critical & Perioperative Care, NHSE for item 5

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Secretariat:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Apologies:

Robert Lechler, NED for Quality, NHSE.

Agenda:

1.	Welcome, introductions and apologies, declarations of conflicts of interest
2.	Terms of reference
3.	CQC report on the State of Care / Wider Data
4.	Quality Strategy for the NHS
5.	Modern Service Frameworks
6.	Recommendations Hub – options paper
7.	Any other business
a)	<i>CQC Assessment framework consultation</i>
8.	Paper recommendations for information (not discussed)
a)	<i>10 Year Plan Quality workstream update</i>
b)	<i>Experience of care subgroup update</i>



1. Welcome, introductions and apologies

Members and attendees were welcomed to the meeting. Apologies were noted as listed above.

No conflicts of interest over and above those already stated were declared.

The minutes of the meeting held on the 24 September 2025 were accepted as a true and accurate record with one amendment from point 2 – a recognition that public health is included in scope.

2. Terms of reference

The Board emphasised the importance of maintaining a small working group, rather than a wide and large representative/stakeholder group, to agree actions to improve the quality of care across the system. It is recognised that wider engagement takes place in developing modern service frameworks and at a local ICB and provider level.

It was reaffirmed that the GMC will attend the NQB on behalf of all regulators, with wider regulatory engagement maintained through existing forums.

The Board agreed that participation on the NQB should reflect all three elements of quality: effectiveness (including public health), safety, and patient/user experience. The latter is currently led by NHSE's Director of Communities and Patient Experience. Once appointed, the DHSC Director for Patient Experience will join the Board. They will have responsibility for ensuring that all parts of the system continually collect, review, synthesise and act on the views of all patients/users. They should also ensure that effective processes are in place across the NHS in England to improve patient/user experience.

Despite increased collaborative working across NHSE and DHSC, the Board noted that governance requirements for an NHSE Quality Committee will remain standing until NHSE is abolished. However, the intention is to streamline arrangements with the NQB where possible, to avoid duplication, and for NEDs across NHSE and DHSC to also have membership of the NQB, where appropriate.

Action: Review Terms of Reference for NHSE quality committee and align dates of meetings. Review NED membership across NHSE quality committee and NQB.

3. CQC Report on the state of care / wider data

Paper 3a CQC report on the State of Care

CQC updated NQB on **Paper 3a** which reflects CQC's view of quality of care of all care sectors over the course of a year. Headlines from the published report go across the health and care system.

NQB discussed:



- how best to ensure measures of people's experience of care are adequately represented.
- that CQC inspection findings can show a perceived mismatch between reported staffing shortages (e.g. rota gaps) and available workforce data; CQC triangulates staffing levels with staff survey evidence on wellbeing and welfare.
- the need for further scrutiny of the analysis underpinning workforce shortage assertions, given substantial workforce growth over the last 5–10 years. Members noted reports of rota gaps against safe staffing models and clinical staff perceptions of staff shortages
- that Adult Social Care vacancy rates are provider-reported and may reflect commissioning and service delivery challenges; ensure reporting also reflects people's experience of care.
- how these insights should inform the Quality Strategy and the priorities for future focus.
- practical examples of improvement ('what is working') that are demonstrating measurable impact.
- that reduced inspection activity has affected the profile of this year's report; as CQC returns to a full inspection cycle, a richer evidence base will be available on what good care looks like and where improvement is occurring.

Paper 3b – Improving Quality Metrics

The NQB considered Paper 3b, Improving Quality Metrics. Members noted current fragmentation and duplication in quality data and the need to improve transparency. The paper supports development of the Quality Strategy and proposes a core set of measures. This core set will sit within a wider dataset to supplement the National Oversight Framework and will support transparent publication of metrics. The NQB discussed how to streamline and further refine the core set of metrics in development. Specific points included:

- The Board supported NHS England's proposal to streamline the quality metrics initially scoped. This will focus on a smaller set of actionable measures linked to improved outcomes and effectiveness, safety, equity and experience, measurable at provider and ICB level. Members stressed the need for alignment with the Quality Strategy and the key drivers of life expectancy and quality of life.
- The Board supported simplifying metrics and applying them consistently across NHS and independent sector providers. This will also help to embed principles of actionability and equity-by-default, with the DHSC's health mission as the overriding goal.
- Members agreed on a pragmatic, iterative approach to metric selection, using existing data where possible, starting with one metric per domain. Initial focus should be on the three domains of quality and the priorities set out in the Quality Strategy, for the next one to two years, recognising this would not represent a final or complete scorecard.
- The NQB will agree a set of key quality metrics for regular review.



Key metric issues were noted:

- Primary care metrics should draw on QOF and address life expectancy gaps.
- CVD mortality was seen as a lag indicator, with interest in shifting towards earlier diagnosis and optimal management.
- Mental health measures currently emphasise inpatient suicide, which may under-represent community quality-of-life impacts and prevention opportunities.
- Members cautioned against overly narrow measures that risk missing wider system harms.

Patient experience measurement requires further development, noting the lack of a consistent PREMs definition. Members supported better use of existing patient experience data, analysis by population characteristics and exploring broader, neighbourhood-level measures. Shifting focus from life expectancy alone to healthy life expectancy was also supported.

Data limitations were acknowledged, including trade-offs between frequent, less mature datasets and more robust annual measures.

CQC confirmed it would reflect these considerations in regulatory judgements, alongside inspection evidence. They welcomed the emphasis on safety, experience and outcomes/effectiveness, and supported closer collaboration, including alignment with the National Patient Survey Programme.

NQB welcomed the work to date to build a core set and noted the need to maximise the Federated Data Platform. NQB acknowledged that this work will be agreed and published as part of the Quality Strategy.

4. Quality Strategy for the NHS

The NQB received an update on the Quality Strategy. The strategy does not set out a new hypothesis; rather, it draws on the 10-year plan and the Dash Review to describe what is missing from the system to improve quality. Members will be provided with an early view of the developing draft in due course. Work to date has built on the agreed outline, drawing on existing content and setting the direction of travel for quality.

Engagement is ongoing with stakeholders and with each NQB member organisation to ensure full NQB input. Further engagement is planned in the New Year, including sessions with NHS CEOs and a wider range of stakeholders (including professional bodies). An Expert Reference Group, chaired by [REDACTED] will support this work, and existing NHS England networks (including the ICS quality leads group) will be used to test relevance and resonance. Ministerial discussions on political engagement are underway. Members were asked to use their networks to support engagement and to send any comments back to the team lead.



NQB discussed:

- Purpose and ambition: to agree a clear 'north star' for the strategy, aligned to the Government health mission (including life expectancy and healthy life expectancy).
- Strengthening and simplifying the vision and strategic goals so they are memorable, measurable, meaningful and clearly linked to delivery (not solely a statement of commitment to the 10-year plan), developed through co-creation across NQB members and wider consultation.
- Setting out delivery timescales, measures and clear priorities for the first 12 months.
- Delivery and accountability: being explicit about what is expected of national, system and provider leaders, recognising limited capacity and avoiding unnecessary new 'asks', while allowing local leadership space to lead improvement.
- Regulation and alignment: positioning regulation as a positive driver, with the strategy aligning and reinforcing effective regulation and other system levers.
- Enablers of quality: strengthening the draft on culture, workforce and management capability, and describe what a good Quality Management System looks like, supported by a practical framework.
- Measures and definitions: keeping a small, disciplined set of headline metrics to evidence delivery, and simplify definitions aligned to the three domains of quality (effectiveness, safety and experience), informed by the public, patients/communities and provider voice.

The NQB summarised next steps in development of the strategy:

- Agree the remit and 'north star', grounded in the problems to solve and focused on life expectancy and healthy life expectancy, and ensure the strategy is deliverable with a clear link to resource allocation.
- Position management capability as a key driver of culture and quality, and describe what 'improvement' looks like in practice, including how the system will support delivery.
- Strengthen accountability by setting out the small number of metrics that place clear responsibility on organisations, and ensure regulation reinforces and enables delivery of the strategy.

5. Modern Service Frameworks

The NQB received an update on Modern Service Frameworks (MSF). The 10 Year Plan announced a series of MSFs to accelerate progress where there is potential for rapid and significant improvement in quality of care, with the first three being sepsis, cardiovascular disease and severe mental illness. The NQB was asked for views on the progress of the first three MSFs, the next wave of MSFs under consideration, and the approach for identifying and prioritising future service areas for MSFs.



It was noted that MSFs are not suitable for all conditions. Developing these frameworks is a lengthy and resource-intensive process that requires significant investment. Therefore, alternative approaches, such as commissioning guidance or best practice guidance, should also be considered. An MSF aims to set ambitious long-term objectives through innovative concepts and products and are developed collaboratively with stakeholders. They should be designed with input from people and communities, focusing on integrated, preventive care delivered closer to home. Common methodology will include developing a 'moonshot' goal, consistent application of best practice, identifying promising innovation, considering a feedback loop, digitally led, prevention first, community and neighbourhood health model, delivering and improving value.

NQB discussed:

- The NQB is responsible for determining suitable areas for Modern Service Frameworks, reviewing proposals against clear criteria including the case for change, ambitious objectives, partnership collaboration, and the adoption of digital-first care.
- All new Modern Service Frameworks must be submitted to the NQB for assessment. The NQB will make recommendations to Ministers for final approval.
- Appropriate guidance and governance are essential to preserve the value of Modern Service Frameworks, recognising that they may not be suitable for every condition or pathway.
- Frameworks must be implemented effectively, ensuring quality and system-wide consistency, and avoiding fragmentation within specialties.
- The focus should be on efficient service delivery, maximising healthcare value and outcomes, and balancing all three elements of quality
- Modern Service Frameworks should utilise interactive, digitally-based documents, including AI and ambient voice technology where appropriate, and draw on NICE guidance to improve health outcomes.
- Each Framework should have its own ambitious 'moonshot' goal, guided by defined inclusion criteria and overarching strategic aims.
- To maintain momentum and progress, alternatives to bi-monthly meetings should be considered to support ongoing work.

The expressions of interest in developing Modern Service Frameworks include frailty & dementia, end of life care, mental health, children and young people, musculoskeletal and respiratory. A formal process and criteria will need to be agreed to select these areas.

Cancer is subject to discussion outside of NQB. Musculoskeletal and respiratory may need an alternative approach such as care pathway redesigns. The Children and Young People MSF is not yet agreed. . Children and young people's mental health is tied into the prevalence review.



Frailty and dementia policies currently focus on early diagnosis of dementia, rather than frailty more generally and NQB raised questions regarding scope and how these work together. Respiratory, dementia and cancer are all connected to end-of-life care. Scope should be considered to ensure they work effectively and avoid duplication. NQB may need to agree join up across multiple diseases and pathways.

6. Recommendations hub The NQB considered the proposals for establishing a Recommendations Hub. These included the draft HSSIB principles (co-created across multiple organisations and informed by learning from other industries) intended to improve quality and reduce the volume of recommendations flowing into the system.

In discussion, the NQB emphasised the need to define a clear and manageable scope for the Hub, reflecting the range of sources of recommendations and an appropriate annual volume. Members noted that decisions may be required on a 'must do' and/or topic basis. Members also queried whether medicines, medical products and devices should be included within scope. Members highlighted the importance of assurance and implementation tracking. It was noted that the approach should enable monitoring of national implementation (without a disproportionate local audit burden) and provide Board-level accountability for timely delivery. The hub would need to align with existing programmes and levers, including Modern Service Frameworks, the Quality Strategy, Board accountability arrangements, the national outcomes framework and CQC inspections.

The NQB agreed the following:

- Scope: to begin with mental health as a pilot (including relevant elements of social care) and to use the learning from the pilot to refine proposals.
- Timelines: the board agreed that the new approach would not apply to all historic recommendations but it would be necessary to take some retrospective analysis to understand status and to inform the assessment of new recommendations.
- Prioritisation of recommendations should be underpinned by a robust methodology. This should incorporate cost effectiveness, drawing on learning from NICE and others. The board considered whether patient outcomes should act as an overarching principle.
- Expert groups with the requisite knowledge should be involved in prioritisation decisions, and the Hub should support transparency and accountability to the public as well as provide guidance to the wider system to inform strategy, planning, delivery and improvement.
- Assurance: the board agreed that implementation tracking would be developed, and further information would be brought back following the mental health pilot.
- Alignment: The hub would need to align with existing programmes and levers. The NQB also discussed the need to professionalise the support provided to



inquiry chairs. This includes ensuring appropriate incentives and a 'less is more' approach to recommendations.

- **Resource:** In light of the likely volume and complexity of work, the NQB agreed that the Hub will require additional capacity, including establishment of a new team with dedicated resource as a standing function.
- **Leadership:** the board agreed to establish a subcommittee of the Board to lead the recommendations work.

7. Any other business

The CQC informed members that they are running a consultation for better regulation, better care to evolve and improve CQC's approach to assessing and rating health and care providers. CQC have analysed an initial 1,600 responses with positive feedback. A summary of all feedback will be available in the new year with next steps, to share with NQB members as the process evolves. NQB members were asked to respond directly to the consultation.

[ENDS]