Paper 15051413

BOARD PAPER – NHS ENGLAND

Title: Quality and clinical risk committee
From: Bruce Keogh – National Medical Director Jane Cummings – Chief Nursing Officer Cyril Chantler – Chair, Quality and clinical risk committee
Purpose of paper: To update the Board on the discussions of the 15 April 2014 meeting of the Quality and clinical risk committee.
Actions required by Board Members: To note the work of the Quality and clinical risk committee, and to consider the committee's key points/recommendations made in relation to the topics outlined in the attached report.

Report of the Quality and clinical risk committee

1. The fifth meeting of the Quality and clinical risk committee was held on 15 April 2014 – this paper updates the Board on discussions held and the key points made during the meeting.

2. The committee approved the minutes of the meeting held on 24 February 2014 – these are attached at Annex A for information.

3. Recruitment of permanent patient and public voice representatives was underway - they were expected to be appointed by mid-May. The committee was also seeking another CCG representative to join the committee, given that the previous member had tendered his resignation. Revised Terms of Reference for the committee will be submitted to the Board for approval in due course, to reflect updated membership.

4. The committee had invited David Noon, Senior Partner at Deloitte and Head of NHS England Internal Audit to attend the meeting, to discuss approaches to risk management and the role of this committee.

5. David outlined the approach to risk management that had been widely adopted since the financial crash of 2007/8. This approach was increasingly being adopted by organisations outside of the corporate world, and comprised of four key steps:

    1) Identification of risks;
    2) Establishment of a mitigation process: a set of core principles should be established, under which different mitigation steps could be taken depending on the different types of risk within an organisation;
    3) Assurance that steps were being taken to mitigate risks;
    4) Monitoring risks on an on-going basis, dealing with them as necessary.

6. The committee felt that there were significant parallels between good risk management and a culture of continuous quality improvement in the NHS, as called for in recent reports by Don Berwick & Prof Sir Bruce Keogh. Both risk management and continuous quality improvement required openness and transparency, where people and organisations were truthful and realistic about the risks and potential harm involved in activities. Additionally, continuous quality improvement involved a sound understanding of quality delivered, and a relentless focus on improving quality irrespective of the baseline; risk management relied on seeking continuous assurance that risks were under control, and finding better ways to mitigate these risks. In risk management, it was vital that risks were not simply recorded, but actively managed and mitigated; this was similar to continuous quality improvement,

where simply measuring or auditing activities was not sufficient to drive improvements – clinical audit needed to be used as part of a process to drive quality improvement. The committee felt that it would be important for NHS England to model this connection between good risk management and driving continuous quality improvement in its role as system leader for quality.

7. Substantive items that were discussed at the meeting were complaints, Quality Surveillance Groups (QSGs), primary care, and the process of CCG assurance. The key points made that the committee wishes to draw to the Board's attention are as follows:

Complaints

8. The Chair had raised the need to establish a clear process to handle patient complaints and concerns a) across the health system, and b) within NHS England, at the March Board meeting. The current complaints process was confusing and inefficient, as people did not know how or where to complain. Additionally, some complaints had been made directly to members of the executive team; whilst they were not ultimately responsible for these complaints, the lack of a clear process for handling complaints left them in a difficult situation from a professional and ethical perspective.

9. The committee remained concerned that the lack of a clear process around complaints constituted a significant reputational risk for the NHS and for NHS England. A clearer process needed to be established urgently to make the system more timely and responsive for patients, and to ensure that NHS England and members of the executive team were not compromised in the absence of a robust system (both within NHS England, and across the health system).

10. Jane Cummings outlined that she was now the Senior Responsible Officer (SRO) for complaints, and that work was underway to clarify and improve a) how the NHS England Customer Contact Centre dealt with complaints, and b) how action could be taken to improve patient care following receipt of complaints. It would also be necessary to improve the technology platform used for complaints, although this could take some time.

11. In addition to establishing clear systems and processes for dealing with complaints, cultural change was needed in the NHS to ensure that when a complaint was made, people reacted in a timely and appropriate manner. A greater sense of professionalism in the NHS would encourage people to take more responsibility for their actions, and to react better to complaints made by patients.

Quality Surveillance Groups (QSGs)

12. As part of a pilot to test the reporting of regional QSGs to NHS England, the committee had received a report from the Midlands and East regional QSG at the previous meeting. The committee had felt that rather than receiving regular reports from regional QSGs, it would be more appropriate for the committee to seek assurance that processes were in place to ensure the effective operation of QSGs at a regional and local level, and that there was a mechanism for issues to be escalated to a national level where quality issues identified required national action.

13. The committee was content that the processes outlined in the paper provided assurance that the regional QSGs were operating effectively, that the regional QSGs were assuring the effectiveness of local QSGs, and that the regional QSGs were sharing concerns amongst each other.

14. In particular, the committee felt that the establishment of a mechanism to report concerns from regional QSGs to the national support centre in NHS England would be a significant step forward in ensuring that NHS England is able to mitigate quality/clinical risks identified through QSG meetings at a national level when necessary.

15. The committee felt that the network of QSGs had probably not yet achieved its full potential, but that it had a vital role to play in identifying quality/clinical risks and in driving continuous quality improvement. The committee would continue to engage with those responsible for QSGs, with the aim of maximising the potential of the network.

Primary Care

16. The committee considered a paper outlining NHS England's approach to assuring and improving the primary care services it commissioned, with a particular focus on general practice.

17. Whilst all directorates within NHS England had a role to play in commissioning high quality general practice services, three directorates led on particular aspects of this; the Operations Directorate, the Commissioning Development Directorate, and the Medical Directorate. Additionally, there were three groups overseeing the work on primary care commissioning – the Primary Care Oversight Group, the Primary Care Strategy Oversight Group, and the National Network of Quality in Primary Care.

18. The committee was concerned that responsibility for primary care was fragmented in this way. The committee felt that in order to ensure a coherent

approach to commissioning primary care and developing policy in this area, and to facilitate the effective identification and mitigation of risks, it would be important to rationalise the number of groups overseeing this work, and to ensure clarity around the roles of the different directorates involved.

19. Though there was a fairly common misconception that there was a lack of data about the quality of primary care services, the committee felt that there was a wide range of information available; the Quality and Outcomes Framework (QOF), GP High Level Indicators (GPHLI) and GP Outcomes Standards (GPOS) were all used to measure outcomes achieved from primary care.

20. The committee felt that the Primary Care Web Tool could be particularly powerful. This platform registered all GP practices in England, and could be used by GP practices for peer review, benchmarking and quality improvement, by CCGs to identify local areas for quality improvement, and by NHS England Area Teams and Regional Teams to use as part of their assurance processes.

21. The committee felt that in order to maximise the potential of this information for the purposes of driving quality improvement, it should be more widely available to members of the public – access to the Primary Care Web Tool was restricted at present. Much of the information held in the web tool was displayed in the accountability section of the NHS Choices website, though the committee felt that this part of the website should be improved to ensure that people were able to access, understand and use the data easily.

22. CCGs were under a statutory duty to contribute to driving continuous quality improvement in primary care, and were increasingly working with Area Teams to achieve this. CCGs were taking an active role in interrogating data on the performance of GP services, and on leading peer-review and challenge. The committee felt that NHS England should encourage CCGs to work with Area Teams in this way, and that the CCG Assurance Framework could be used as a lever to influence CCGs behaviour in this respect. Going forward, NHS England should support CCGs to understand and use the wide range of data available to them, recognising that it needed to be used as part of a wider range of tools available to help them to understand the quality of services, including soft data and intelligence.

23. Many CCGs were exploring how to commission care across an integrated pathway, which was a key ambition for the NHS going forward. Being able to commission care from the perspective of ‘a year in the life of’ patients, involving primary care, secondary care, social care, mental health and

community services, would improve patient outcomes, reduce the pressure on secondary care, and lead to financial gains for the NHS.

24. Currently, there were a number of barriers in place making this process very difficult. The organisational structures in place created a barrier to commissioning integrated care, as responsibilities and budgets were fragmented between CCGs and NHS England. Despite this, some CCGs and Area Teams were working together to find ways to pool resources and responsibilities, enabling them to commission across primary and secondary care services. The committee felt that NHS England should support CCGs and Area Teams to find innovative ways to commission integrated care and that NHS England should remove as many barriers to this process as possible, recognising that this would need to be done within existing organisational structures.

CCG Assurance

25. The committee considered the role of CCG Assurance in helping commissioners to better understand quality, and as a key lever in driving quality improvement and identifying quality/clinical risks.

26. Where indicators, measures or issues were identified in NHS England planning guidance as integral to CCG plans, this afforded the assurance process a line of sight into those issues at CCG level. There was the potential to better align the planning and assurance processes, and the committee felt that going forward, NHS England needed to be very clear on the most important issues for inclusion in the planning guidance so that CCG Assurance could be used as a tool to drive quality improvement and to identify quality/clinical risks in key areas.

27. The committee felt that it would be important to strengthen the alignment between the NHS England Direct Commissioning Framework and the CCG Assurance Framework. As the previous discussion on primary care had highlighted, it was vital that NHS England had the ability to consider quality of care and outcomes for patients across services and over time. The committee felt that the assurance frameworks needed to better align and complement each other, including the same requirements around quality/clinical risk, to enable this to happen.

Sir Cyril Chantler
15 May 2014

Annex A

QUALITY AND CLINICAL RISK COMMITTEE

Minutes of the meeting held on Monday 24th February, 15:15 – 17:15

Skipton House room 140B

Attendees

Cyril Chantler - Chair, Quality and Clinical Risk Committee

Bruce Keogh - National Medical Director, NHS England

Victor Adebowale - Non-Executive Director, NHS England

Ciaran Devane - Non-Executive Director, NHS England

Juliet Beal - Director of Nursing, Quality Improvement and Care, NHS England

Mike Bewick - Deputy Medical Director, NHS England

Sam Higginson - Director of Strategic Finance

Terence Stephenson - Chair, Academy of Medical Royal Colleges

David Haslam - Chair, NICE

Nick Black - Professor of Health Services Research, London School of Hygiene & Tropical Medicine

James Mountford - Director of Clinical Quality, UCL Partners

Paul Husselbee - CCG Lead, Southend CCG / Commissioning Assembly Quality Working Group Co-chair

Paul Watson - Regional Director, Midlands and East, NHS England

Linn Phipps – Patient and Public Voice Representative (interim)

Neeta Mehta - Patient and Public Voice Representative (interim)

Geoff Alltimes – Associate Director, Local Government Association

Secretariat: John Stewart, Lauren Hughes, Elizabeth Modgill (Quality Framework team)

Linda White (Head of Governance and Board Secretary)

Rachel Souter – Head of Programme Management Office, NHS England

Apologies

Jane Cummings – Chief Nursing Officer, NHS England

Brigid Stacey - Director of Nursing and Quality, Shropshire and Staffordshire Area Team, NHS England

Liz Redfern – Deputy Chief Nursing Officer, NHS England

1) Welcome and introductions
• The Chair welcomed attendees to the fourth meeting of the Quality and Clinical Risk Committee, and thanked them for their participation in a seminar on measuring quality, which was held immediately before the meeting. • Apologies had been received from Jane Cummings, Brigid Stacey and Liz Redfern.
2) Minutes of the previous meeting and actions arising
• Attendees approved the draft minutes of the meeting held on 16th December. • The actions from the previous meeting were either underway or in progress. Action 2.1 required further investigation – the Chair had highlighted the importance of seeking better alignment between GP and consultant contracts and the revalidation process in the Committee's report to the NHS England Board in December 2013, and an update on the resulting actions was required at the next meeting. • Since the last meeting, the Chair had met with the Chair, Chief Executive and the Hospital Inspectors from the Care Quality Commission (CQC), and they had all emphasised the importance of sharing intelligence on quality at all levels of the system. Professionalism, commissioning and regulation all played a vital role in delivering high quality care, and intelligence on and from these functions needed to be brought together in a coherent manner. Quality Surveillance Groups (QSGs) were a vital forum for holding these discussions at local and regional levels, and ways of sharing information nationally were being considered by the Committee. • Attendees felt that a clearer approach to quality was required across the system – in particular with regards to the regulators, where the roles, responsibilities, and interactions

remained unclear. The National Quality Board (NQB) had previously produced a report entitled *Quality in the New Health System* which aimed to clarify roles of organisations across the health and care system in terms of quality, and the NQB was due to update this report in the near future. The need for clarity around the role of regulators would be fed in to the development of the updated report.

Actions for the Committee:

- *The Committee to seek update on actions underway to achieve greater alignment between Consultant and GP contracts, with the aim of fostering professionalism in the NHS*
- *The Committee to provide comments to the NQB on the need to clarify roles of regulators in their updated report on quality in the health system*

3) Future Meeting Schedule

- The Chair outlined that a meeting schedule for 2014 had been devised based on topics that the Committee had identified for exploration during discussions in previous meetings. Dates for meetings in 2014 had already been agreed and would be recirculated to attendees for information.

- Additionally, attendees agreed that the Committee should audit the progress made in implementing the eight ambitions outlined in Prof Sir Bruce Keogh's report into fourteen hospitals with elevated mortality rates. Realising these ambitions would reduce the amount of quality/clinical risk in the system, and would allow quality/clinical risks to be more easily identified than at present. The ambitions provided a useful way of theming discussions at future Committee meetings.

- Bruce Keogh (BK) outlined that the report deliberately contained a small number of ambitions to maximise the chances of implementation, and the review process had promised to support those organisations that needed to implement changes based on the findings of investigations. Though a degree of performance management may be required to ensure changes were implemented, it would be important to ensure that the supportive spirit of the investigations was maintained and that organisations were supported and enabled to improve, as opposed to being subjected to high levels of performance management by either NHS England or the regulators.

- Junior doctors involved in the reviews had demonstrated a tremendous amount of energy, enthusiasm and dedication to driving quality improvements, and it would be important to harness their input into improving systems in the NHS going forward. A way of facilitating the sharing and dissemination of good practice and ideas across the system needed to be identified – the Committee would consider this at a future meeting.

Actions for the committee:

- *The Committee to consider progress made in implementing the eight ambitions outlined in Prof Sir Bruce Keogh's report into fourteen hospitals with elevated mortality rates*
- *The Committee to theme discussions at future meetings based on the ambitions*
- *The Committee to consider how the spread of best practice across the system can be facilitated at a future meeting*

4) **Role of quality measurement in driving continuous quality improvement and identifying quality/clinical risks**

- John Stewart (JS) outlined that the ability to identify and monitor risks in the NHS was contingent on the ability to measure quality. Currently, there were a number of problems associated with quality measurement, which had the potential to compromise NHS England's ability to identify quality/clinical risks and to drive continuous quality improvement. These were:
    - Alignment of activity: there was a range of activities related to measuring for quality underway, both within NHS England and across the system, however, there was a risk that these activities were not aligned and did not have a common purpose;
    - Gaps in knowledge in some clinical areas and care settings such as primary care and mental health;
    - The skills and capabilities at board level in provider and commissioner organisations to handle data confidently to identify risks and drive quality improvement;
    - Accessibility: data tended to be held in a fragmented way across the NHS and was difficult to use to benchmark performance. Additionally, data was not thought to be widely accessible or understandable by patients and the public;
    - Data quality: poor data quality undermined the confidence in information used to plan and commission services, and to assess quality of care. Though there were parts of the NHS where good quality data was routinely collected – particularly in secondary care – there was large variability in the quality of data across the system; and
    - Appropriate use: indicators were developed for a specific purpose, yet there was some doubt over the extent to which they were used for their intended purpose. Using indicators for the wrong purpose may not provide an accurate assessment of the topic being measured.

- Attendees were particularly concerned with gaps in knowledge in key areas such as primary care and specialised services, which were directly commissioned by NHS England. Specialised services had previously been commissioned by specialised commissioning groups, and NHS England had taken over this commissioning function on establishment of the organisation. Attendees were concerned that there was little data available to measure

quality of services, and that the outcomes achieved from these services were unknown – this constituted a significant risk which required further exploration by the Committee. The Chair would highlight this issue in his forthcoming report to the Board.

- In primary care settings, where around 90% of patient contact occurred, there was little information available on the quality of services provided aside from that collected by the Quality and Outcomes Framework (QOF), and it was thought that there was widespread variation in quality. The Committee would consider these issues as part of the agenda item on the development of the Strategic Framework for Commissioning of General Practice at a future meeting.

- Measuring the quality of individual services or interventions tended to be relatively straightforward; however, measuring quality for treatment of chronic, long-term conditions was more difficult. The National Institute for Health and Care Excellence (NICE) was currently considering how this could be done, potentially incorporating the social aspect of how care affects a patient into measurement of effectiveness. This would build on work on-going in the system to commission and pay for a 'year of care' for certain patients.

- Quality measurement and reporting for provider organisations tended to refer to performance within individual provider organisations only. However, what mattered most to patients and commissioners was quality across the whole system (including how well providers interacted between themselves). Additionally, Committee members felt that the focus of quality measurement was not always on those elements of care that mattered most to patients, and that there was significant potential to improve measurement to ensure it was focussed on those outcomes that were most relevant and important to patients.

- Committee members were concerned that there was a deficit in the skills required at provider and commissioner Board level to understand and use data to improve quality, which could compromise the system's ability to meet its responsibilities relating to quality. Some organisations in the United States had appointed Chief Quality Officers at Board level to address this issue. It was important that the skills and capabilities required to use data properly to drive improvement and mitigate quality/clinical risks were present in the NHS, however it was recognised that this would be challenging. A further discussion on this would be held at a future Committee meeting.

- Committee members agreed that within NHS England, there was a lack of alignment in the work underway related to measurement for quality and outcomes. It would be beneficial to develop a strategy to guide the organisation's work and that of its partners, which would seek to enable commissioners and providers to harness the power of measurement to drive improvement in quality and outcomes. This would require staff across NHS England working on related matters to work collaboratively towards a common purpose, and for resource to be committed.

Actions for the Committee:

- *The Committee to consider how NHS England can be assured of the quality of services provided in primary care and specialised services at future meetings*
- *The Chair to recommend that NHS England develops a strategy for measurement to improve quality and outcomes with its partners at the March Board meeting*
- *The Committee to consider at a future meeting the skills and capabilities at Board level in provider and commissioner organisations to use data to drive quality improvements and to mitigate risks*

5) **Report from Midlands and East Regional Quality Surveillance Group (QSG)**

- At a previous meeting, the Committee had heard about the network of QSGs and was very positive about their role in supporting the wider system to identify potential or actual quality failures, and in supporting commissioners to fulfil their responsibility for assuring the quality of commissioned services. The Committee felt that it would be important to ensure that there was a way to escalate issues identified through QSG meetings that required national attention to the NHS England Board, and agreed to pilot an approach to receiving reports based on regional QSG meetings.

- The Committee considered an initial report from the Midlands and East regional QSG meeting, which highlighted some of the key issues identified and actions agreed. The report also outlined areas of good practice and learning, as well as issues that required communication to other QSGs, or further dissemination. Attendees felt that the report demonstrated that the QSG was working well, had identified quality risks and had taken the steps necessary to mitigate these.

- There was a discussion about whether, and how, NHS England nationally should continue to receive QSG reports. Attendees felt that it would be important not to over-formalise arrangements, or to create a 'tick-box' process, but that it was important that issues were escalated when national action was required to mitigate any quality/clinical risks identified. Attendees concluded that rather than receiving reports from regional QSGs on a routine basis, the Committee should audit the functioning of QSGs.

- The Committee would seek assurance that:
  - the four regional QSGs were operating effectively;
  - the four regional QSGs were auditing the effectiveness of local QSGs; and
  - the regional QSGs were sharing concerns amongst each other, and escalating issues for national action where appropriate.

- The National Quality Board (NQB) had established the network of QSGs, and further

consideration was required around their role in considering information on quality from QSGs at a national level, across the health and care service.

- Where it was necessary to escalate issues identified through QSGs for national attention by NHS England, the Committee could provide a forum where those concerns could be raised. A further paper outlining these aspects of the operation of QSGs was required.

Actions for the Committee:

- *The Committee to consider a further paper on the operation of QSGs and the Committee's role in auditing operation of the QSG network at a future meeting.*

6) Board Assurance Framework (BAF)

- John Stewart (JS) outlined that the BAF had been revised since the last Committee meeting – the number of risks in the BAF had been reduced from 35 to 17, and it was presented in a new, simplified format. It was also being considered by the Audit Committee, and it would come into effect on 1 April.

- Attendees agreed that the BAF should contain risk 1 (major quality risks), and that the Committee should take a lead in overseeing this risk, and other specific risks within this broad area.

- Attendees also agreed that the Committee would take responsibility for auditing those risks that were the responsibility of the Medical or Nursing Directorate. Given that all of the risks included in the BAF had the potential to impact on quality, the Committee may need to be involved in auditing other risks from a quality perspective, such as the risk around Information, which had the potential to impact on quality.

- Committee members were particularly concerned about the risk on complaints. Currently, there was confusion and inefficiency in the health and care system as people did not know how or where to complain. Complaints were often made to NHS England – either directly to members of the Executive Team or to the organisation in general - as people did not know where else to go.

- Going forward, it would be vital to ensure a clear, system-wide process for dealing with concerns and patient complaints in an efficient and timely manner was established. The National Quality Board (NQB) was considering this topic at their meeting on 25th February, and the Committee would seek an update on conclusions made by the NQB.

- Though NHS England was not set up or equipped to deal with complaints, attendees felt

that a process for dealing with complaints needed to be established – this should ensure that the complainant received a timely response and helpful information on how complaints were handled in the system. The Chair would raise this issue in his report to the Board in March.
Actions for the Committee: • *Committee to seek update on conclusions reached by NQB with regards to handling complaints across the health and care system* • *The Chair to highlight need to establish a process within NHS England for handling concerns and complaints* • *The Committee to contribute to the development of the BAF on an on-going basis, and to oversee the risks on quality, and those owned by the Nursing and Medical Directorates.*