NHS England

Paper NHSE111417

BOARD PAPER - NHS ENGLAND

Title: Report of the Quality and Clinical Risk Committee

From: Prof Sir Cyril Chantler, Chair, Quality and Clinical Risk Committee

Purpose of paper:

- To update the Board on the last meeting of the Quality and Clinical Risk Committee (September), where the following topics were considered:
    - Domain 1 of NHS Outcomes Framework;
    - Medical Revalidation and National Performers List;
    - Local Supervising Authority in England; and
    - Complaints

Actions required by the Board:

- To note the work of the Quality and Clinical Risk Committee, and to consider the Committee's key points/recommendations in relation to the topics considered at the meeting.

NHS England

Report of the Quality and Clinical Risk Committee

1. The Quality and Clinical Risk Committee met for the seventh time on 8th September 2014. This paper updates the Board on the discussions held, and the key points/recommendations made in relation to the topics considered at the meeting.

2. Committee members approved the minutes of the meeting held on 9th June (these can be found at Quality and clinical risk minutes) and 8 September (these can be found at Quality and clinical risk minutes)

Domain 1 of NHS Outcomes Framework

3. Prior to the meeting, Committee members attended a seminar facilitated by Prof Nick Black, considering different ways of assessing performance in terms of the outcomes achieved from health care. This informed the discussion on NHS England's progress against Domain 1 of the NHS Outcomes Framework (NHSOF) – preventing people from dying prematurely.

4. Potential Years of Life Lost (PYLL) was a measure of premature mortality, and was the difference between life expectancy (for a given cohort) and the age at which the person actually died. The overarching indicator in Domain 1 of the NHSOF was Potential Years of Life Lost for causes considered amenable to healthcare. The Committee noted that recent data indicated a softening of the rate of improvement over the last two years, particularly in relation to cardiovascular disease (CVD), which had been the area of greatest improvement over the past 30 years. Members felt that this trend needed to be examined further, to understand the drivers for the softening of the rate of improvement.

5. The Committee considered some international comparisons with the EU in relation to premature mortality. Whilst data collection methods differed between countries, potentially affecting the statistics to an extent, the Committee were particularly concerned that the relative performance of the United Kingdom (UK) on child mortality had deteriorated significantly. Deaths from respiratory diseases and neuropsychiatric causes were the key drivers of the poor UK position.

6. In 10 to 24 year olds, neuropsychiatric causes were the key driver of poor UK mortality rates compared to EU countries. This was a broad category that included epilepsy, self-harm, suicides, and drug and alcohol consumption, amongst other factors. The Committee recommended that it would be helpful to break this category down into individual areas to consider the trends for each, however, clinical advice suggested that for 10 to 24 year old males, drug consumption and self-harm were the causes of the high mortality rate in this group compared to other EU countries.

7. The Committee found the UK's poor position in this area very worrying, and felt that it highlighted the need to focus on prevention and behaviour change to try and reverse this trend. This could be achieved through making every contact count in brief interventions undertaken in primary care and other settings in the NHS, and it would require strong partnership working with Public Health England, Local Authorities and Health & Wellbeing Boards.

8. As an organisation, NHS England needed to coalesce and focus its resources around improving outcomes in key areas such as this, where the UK's outcomes lagged significantly behind those of the EU. Clarifying the improvement architecture in the NHS and aligning the different organisations involved around a set of agreed priorities would be key in ensuring that there was a robust mechanism to drive improvement. Also, it was currently unclear how clinical priorities translated into actions across NHS England, and the Committee felt that the work underway to establish a delivery mechanism for clinical priorities was highly necessary. Furthermore, a sustained national drive on priority areas, with room for local innovation, would be helpful in improving outcomes in this area.

9. Attendees felt that the discussion had been incredibly useful and recommended that performance in each domain of the NHSOF should be regularly considered by NHS England, who should consider publishing an Annual Report on Quality, or alternatively, making the Quality section of the existing Annual Report clearer and more comprehensive.

Medical Revalidation and National Performers List

10. The Committee considered an annual report outlining progress with implementation of the medical revalidation process, and members felt that the process of medical revalidation was going well, with key risks being mitigated. The Committee agreed that subject to approval from the executive team, the report should be presented to Ministers to evidence the overall degree of progress towards full implementation of revalidation across England, as proposed in the paper.

11. The Committee heard that the NHS England Board had decided in principle that NHS England should be divested of its responsibilities for revalidation, and that a programme board, chaired by Karen Wheeler and Charlie Massey (Director General at the Department of Health), had been established to provide oversight of three transferring statutory responsibilities for medical revalidation. The Committee felt that careful handling and strong governance arrangements would be required to mitigate risks associated with divesting NHS England of its responsibilities in this area.

12. Committee members felt that going forward, a clear distinction needed to be drawn between clinical governance and the revalidation process. NHS England

was a proxy employer of GPs, and as such, was currently revalidating GPs. Though this function would transfer to another body going forward, the Committee recommended strongly that NHS England should continue to have a role around the clinical governance of GPs. Without such oversight from NHS England, there was a risk of creating a gap in the system, as GPs were independent contractors to the NHS and therefore did not have a direct employer that could carry out this function.

13. The Committee were advised of the background of the Performers List system which had been established in 2004. NHS England had assumed responsibility for managing the lists following the abolition of Primary Care Trusts (PCTs) in 2013, which involved unifying the separate lists held by PCTs into a single national list. Management of the List afforded NHS England the opportunity to admit doctors, to refuse to admit doctors, to place conditions on a performer's practise, to suspend their practice, and to remove them from the list. In this way the list provided a vehicle to improve quality where needed.

14. Whilst NHS England would soon be divested of responsibilities for Medical Revalidation, Area Team Medical Directors would still be required to manage the NPL, and the Committee questioned the rationale for this. Whilst members understood the advantages of maintaining a NPL in the system, and felt that the current risks associated with it were being well managed, Committee members questioned whether this should be NHS England's role as a commissioning organisation, and recommended that the Executive Team should consider this going forward.

15. Of particular concern was the fact that Area Team Medical Directors would continue to manage the NPL despite being divested of responsibilities for revalidation. Members felt that this could take up a significant amount of their time, which could impinge on their ability to focus on improving quality and outcomes.

Local Supervising Authority in England

16. The Committee were advised of NHS England's statutory responsibility as the LSA for England, and its statutory role and responsibility for supporting and monitoring supervision of midwives. NHS England had assumed this responsibility on 1st April 2013, following the abolition of Strategic Health Authorities.

17. The Committee heard that a recent Parliamentary Health Service Ombudsman (PHSO) report had recommended that the supervision and regulation of

midwives should be separated. A key issue with the current system was that the supervisory arrangements under the LSA often operated outside of employers' clinical governance frameworks, and Committee members agreed that this needed to be addressed.

18. The King's Fund had been commissioned to undertake a review of the arrangements as a result of the PHSO report, and the findings were due in early 2015. Committee members agreed that a decision about the separation of regulation and supervision should be taken in light of that report – the Committee would consider a further update at that stage.

19. Following completion of the Kings Fund report, NHS England will review options for transferring any ongoing responsibility for the LSA function to another organisation.

Complaints

20. The Committee were encouraged to hear that NHS England appeared to be meeting its responsibilities in terms of complaints, and vast improvements had been made to internal systems for handling complaints.

21. Going forward, the focus needed to be on learning from complaints, and using them to improve care. The Committee were optimistic that the new database to be used for the complaints system would allow recurrent themes to be flagged up, and the information could then be used and analysed to identify where problems existed.

22. Committee members felt that it would be helpful to undertake further work to triangulate complaints data with other sources of patient feedback, including across organisations such as Healthwatch. There were other patient feedback mechanisms in the NHS that needed to be aligned with complaints, to ensure that as much information as possible was used to identify patient concerns and drive improvement in services where necessary.

23. The Committee agreed to receive an annual report on complaints, which would cover how NHS England was handling complaints, what lessons were being learned, and provide examples of where complains had led to an improvement in the quality of services delivered to patients.

Prof Sir Cyril Chanter
Chair, Quality and Clinical Risk Committee
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