BOARD PAPER – NHS ENGLAND

Title: Quality and Clinical Risk Committee
Clearance: Bruce Keogh – National Medical Director Cyril Chantler – Chair, Quality and Clinical Risk Committee
Purpose of paper: • To update the Board on the last two meetings of the Quality and Clinical Risk Committee.
Key issues and recommendations: • To note the work undertaken by the Committee in the last two meetings in relation to: ○ the process of medical revalidation; ○ patient safety; ○ managing winter pressures; ○ the quality and clinical risks within the Board Assurance Framework (BAF); ○ the role of measurement in improving quality and identifying quality/clinical risks; ○ Quality Surveillance Group (QSG) meetings; and ○ the Committee's meeting schedule for 2014.
Actions required by Board Members: • To note the work of the Quality and Clinical Risk Committee, and to consider the committee's recommendations made in relation to the topics outlined above.

Quality and Clinical Risk Committee

1. The Quality and Clinical Risk Committee has met twice since the last update to the Board, on the 16 December 2013 and the 24 February 2014. The minutes from the meeting held on 16 December are attached at Annex A.

2. Since the last update to the Board, the Committee's membership has been extended – Geoff Alltimes, Associate Director of the Local Government Association, has joined the Committee, along with two interim patient and public voice representatives – Neeta Mehta and Linn Phipps. Recruitment for permanent patient and public voice representatives is underway.

16 December 2013

3. At the meeting on 16 December, the process of Medical Revalidation, patient safety, preparation for winter pressures and the Board Assurance Framework (BAF) were discussed.

Medical Revalidation

4. The process of medical revalidation was initially discussed at the Committee's meeting in October 2013, from the perspective of NHS England as Senior Responsible Owner (SRO) for the system-wide revalidation programme. In December, the Committee considered medical revalidation from the perspective of NHS England as a designated body.

5. Given that NHS England Area Team Medical Directors were responsible for carrying out appraisals and making recommendations to the General Medical Council (GMC) for around 42,000 General Practitioners (GPs), the Committee felt it was vital that there was sufficient resource made available to support the programme. The Committee was concerned to hear that there was uncertainty around the continuation of funding for 2014/15, as there was a risk that without sufficient support and resource, a GP may be revalidated locally by NHS England, and subsequently found to be unsuitable.

6. The Chair highlighted the importance of securing resource immediately to mitigate this risk at December's Board meeting, and actions are now underway to secure resource and employ staff to provide the support needed for this process.

Patient Safety

7. The Committee considered NHS England's responsibilities in terms of patient safety at its meeting in December – many of these responsibilities had been transferred to NHS England following the abolition of the National Patient Safety Agency (NPSA) in June 2012.

8. Committee members felt that the work underway to improve the functioning of the National Reporting and Learning System (NRLS) – the system for reporting harm in England – was vital. The NRLS received a large amount of information, and it would be important to ensure that it was properly dealt with and analysed going forward – Committee members did not feel this was happening at present.

9. Equally important was the focus on understanding and improving the low reporting rates from primary care to the NRLS. Currently, just 0.4% of reports received by the NRLS came from primary care, with 99% coming from acute, mental health, learning disabilities and community services.

10. The Committee concluded that it would be important to consider patient safety on an on-going basis – six monthly agenda items have been scheduled.

Winter Pressures

11. Prof Sir Bruce Keogh gave the Committee a verbal update on the plans put in place to cope with winter pressures. The Committee felt that the plans – which included the establishment of Urgent Care Working Groups and the transfer of £400 million to support the system – appeared to be comprehensive, and represented real progress on previous years. The Committee will return to this topic at a future meeting, reflecting on lessons learned this winter, with a view to informing plans for 2014/15 and beyond.

Board Assurance Framework (BAF) - discussed on 16 December 2013 and 24 February 2014

12. The BAF was initially discussed in December, and was introduced as the framework used by NHS England to identify and manage strategic risks. There were a number or risks included in the BAF that were directly related to quality, however, the Committee felt that all of the risks included had the potential to impact on quality and outcomes.

13. A revised BAF, containing fewer risks (17 as opposed to 35) was discussed on 24 February. The Committee agreed that where the risk was the responsibility of the Medical or Nursing Directorate, the Committee should audit that risk and the mitigating actions put in place in detail, beginning with risk 1 – major quality problems.

14. The Committee should also audit other risks where there was a quality dimension and quality-related mitigating actions – for example, the risk on information and data sharing. The development of the BAF would be an iterative process and the Committee would continue to advise and contribute to its development on an on-going basis, working with the Audit Committee as necessary.

15. The Committee had two particular points to feed in to the development of the BAF at this stage:

- An important issue that was not captured in the BAF was the relationship between NHS England and professional bodies. The Committee agreed that in order to harness professionalism within the NHS, it would be necessary to work in partnership with professional bodies, involving and engaging with them in a more meaningful manner at present. The Committee will consider NHS England's role in providing clinical and professional leadership at a future meeting, and this topic may need to be reflected in the BAF.

- Of particular concern to the Committee was the risk around complaints listed in the revised BAF. 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 as people did not know where else to go. It would be important to ensure a clear, system-wide process for dealing with patient complaints in an efficient and timely manner was established. The National Quality Board (NQB) was considering this topic at their meeting on 25 February, and the Committee will seek an update on conclusions made by the NQB. Within NHS England, 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 are handled in the system.

24 February 2014

16. In addition to the BAF, the Committee discussed the role of measurement in improving quality and identifying quality/clinical risks, a report from Midlands and East Quality Surveillance Group, and its meeting schedule for 2014. A seminar on measuring quality was held prior to the meeting to inform the Committee's discussions going forward.

The role of measurement in improving quality and identifying quality/clinical risks

17. The ability to identify and monitor risks in the NHS was contingent on being able to measure quality. The Committee considered a number of problems associated with measurement of quality, which had the potential to compromise NHS England's ability to identify quality/clinical risks and to drive continuous quality improvement. These included a lack of alignment of activity in the system; gaps in knowledge about quality in key clinical areas and care settings; and the deficit in commissioners' skills to confidently use and scrutinise data. The Committee was particularly concerned that NHS England did not have sufficient knowledge about the quality of certain services it commissioned – particularly specialised services and primary care.

18. In specialised services particularly, the Committee identified the lack of knowledge of the quality of services as a significant risk. The Committee will consider this risk in further detail at a future meeting.

19. In primary care settings, where around 90% of patient contact occurred, there was little information available on the quality of services provided, and it was thought there was widespread variation in quality. The Committee will 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.

20. The Committee felt that within NHS England, there was a lack of alignment in the work underway related to measurement for quality. Working within available resources, it would be necessary for those working on measurement for quality across the organisation to work more collaboratively than at present. It would be beneficial to develop a strategy to guide the organisation's work and that of its partners, which would seek to systematically address the issues that had the potential to compromise NHS England's ability to meet its responsibilities in terms of quality.

21. The skills and capabilities needed at Board level in provider and commissioner organisations to use data to drive quality improvement and identify quality/clinical risks was discussed. The Committee was concerned that there was a deficit in the skills required at 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 for this purpose. A further discussion on how the skills required could be instilled at Board level throughout the NHS will be held at a future meeting.

Report of the Midlands and East Quality Surveillance Group (QSG)

22. QSGs went live across the country from 1 April 2013, with the aim of facilitating the sharing of hard and soft intelligence on provider quality between different parts of the NHS system, such as commissioners, regulators and local government. They operate at two levels: locally, on the footprint of the NHS England's 27 area teams, and regionally, on the footprint of the four regional teams.

23. Further to the Committee's request that Chairs of regional QSGs pilot a process of providing reports based on regional QSG meetings to NHS England's Board via the Committee, a sample report from the Midlands and East Regional QSG meeting was considered on 24th February.

24. From the report, it was apparent that the QSG was functioning well, had identified quality risks and had taken the steps necessary to mitigate these. The Committee remained very positive about the role of QSGs in supporting the wider system to identify potential or actual quality failures, and in supporting commissioners to fulfill their responsibility for assuring the quality of commissioned services.

25. The Committee Chair had recently met with the Chair, Chief Executive and hospital inspectors from the Care Quality Commission (CQC), and they had emphasized 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 QSGs were a good forum in which to discuss these matters at local, regional and national levels. NHS England should continue to engage with the National Quality Board (NQB) to ensure that cross-system issues related to quality were discussed and addressed at a national level.

26. Going forward, Committee members felt that NHS England should continue to enable the network of QSGs to function effectively, but that it should avoid adding another level of formal reporting requirements or bureaucracy at a national level. Instead, the Committee would audit the functions of QSGs, seeking assurance that:

- The four regional QSGs were operating effectively;
- The four regional QSGs were auditing the effectiveness of local QSG meetings;
- The regional QSGs were sharing concerns amongst each other, and escalating issues for national action where appropriate.

27. The Committee could provide a forum for regional QSGs to raise issues that required national attention.

28. A paper covering these aspects of the operation of QSGs will be considered at a future Committee meeting.

Meeting schedule for 2014

29. The Committee agreed a meeting schedule for 2014 – this is attached at Annex B. This is based on topics identified by the Committee for further exploration at meetings held to date. Members also agreed that the Committee should audit the progress made in implementing the 8 ambitions outlined in Prof Sir Bruce Keogh's review into fourteen hospitals with elevated mortality rates, given NHS England's role as system-leader for quality (these are outlined at Annex C).

30. The next meeting of the Committee is on 15 April, and will consider the plans for assurance, aggregation and promotion for setting levels of ambition for improving outcomes, and the CCG assurance process.

Sir Cyril Chantler
Chair, Quality and Clinical Risk Committee
6 March 2014

ANNEX A

QUALITY AND CLINICAL RISK COMMITTEE
Minutes of the meeting held on Monday 16th December, 9:00 – 11:00am
Maple Street MR1

Attendees

Cyril Chantler - Chair, Quality and Clinical Risk Committee
Bruce Keogh - National Medical Director, NHS England
Jane Cummings - Chief Nursing Officer, NHS England
Ciaran Devane - Non-Executive Director, NHS England
Ed Smith - Non-Executive Director, NHS England
Mike Bewick - Deputy Medical Director, NHS England
Brigid Stacey - Director of Nursing and Quality, Shropshire and Staffordshire Area Team, NHS England
David Haslam - Chair, NICE
Terence Stephenson - Chair, Academy of Medical Royal Colleges
Juliet Beal - Director of Nursing, Quality Improvement and Care, NHS England
Nick Black - Professor of Health Services Research, London School of Hygiene & Tropical Medicine
Mike Durkin - Director, Patient Safety
Jenny Simpson - Clinical Director, Revalidation
Neeta Mehta - Patient and Public Voice Representative (interim)
Paul Taylor - Interim Regional Finance Director (South)
Secretariat: John Stewart, Lauren Hughes, Elizabeth Modgill (Quality Framework team)
Jon Schick (Head of Governance and Board Secretary)

Apologies

Liz Redfern - Deputy Chief Nursing Officer, NHS England
Victor Adebowale - Non-Executive Director, NHS England
Paul Watson - Regional Director, Midlands and East, NHS England
Peter Melton - CCG Lead /Commissioning Assembly President
Paul Husselbee - CCG Lead, Southend CCG / Commissioning Assembly Quality Working Group Co-chair
James Mountford - Director of Clinical Quality, UCL Partners
Linn Phipps – Patient and Public Voice Representative (interim)
Sam Higginson - Director of Strategic Finance

1) Welcome and introductions
Apologies for absence • Apologies had been received from Liz Redfern, Victor Adebowale, Paul Watson,

Peter Melton, Paul Husselbee, James Mountford, Linn Phipps and Sam Higginson.

2) Minutes of the previous meeting

- Attendees approved the draft minutes of the meeting held on 28th October and 4th November (Paper 1)

- Attendees noted the report of the Quality and Clinical Risk Committee that would be presented at the NHS England private Board meeting on 17th December (Paper 2)

3) Board Assurance Framework (BAF)

- Jon Schick introduced the BAF - the framework used by NHS England to identify and manage strategic risks. The BAF was being revised to broaden the scope of the document, and to remove some issues that were no longer considered to be risks. The aim was to have a revised version of the BAF in early 2014.

- The Committee's role in considering risks identified in the BAF was discussed. Whilst there were certain risks included in the BAF that would fall within the remit of the Committee, all the risks had the potential to impact on quality, and the Committee would need to establish a way of prioritising risks, and identifying those issues that should be considered by the Committee. Additionally, there were other Committees responsible for managing risks with potential implications for quality – it would be important not to duplicate their work, but to maintain close dialogue on the work undertaken – for example, by the CCG Assurance Committee.

- The Chair suggested that the Committee would have an interest in risks 3, 4, 6, 9, 12, 13, 18 and 26 of the current BAF (as at 28th November). Risk 17 on public participation also required attention – it was important that NHS England had a way of knowing where the pressures in the system were, and where they were impacting on patient care. This highlighted the importance of the Committee, on behalf of the NHS England Board, piloting an approach to receiving reports from regional Quality Surveillance Groups (QSGs), as discussed at the previous meeting. Ideally this would start at the next Committee meeting.

- One area not currently covered in the BAF was the relationship between NHS England and the professional bodies. Within the NHS, different staff groups had allegiances to several different bodies, for example, to their professional body, to a specialist association, to the department/practice they were working in, to a

specific hospital, and to a Trust. This was particularly the case for medics where there were specialist associations. The result was that often, healthcare professionals would not feel a strong sense of loyalty or belonging to their employer.

- In order to harness professionalism in the NHS, it would be necessary to work in partnership with the professional bodies, involving and engaging with them in a more meaningful manner than at present.

- The relationship with nursing professional bodies was relatively positive – the Nursing Directorate were working with the professional arm of the Royal College of Nursing (RCN) to embed professionalism, and were leading some values based work involving professional bodies.

- Whilst engaging with the various professions, it would be important to avoid the establishment of a culture of 'tribalism' in the NHS. There needed to be a truly multi-professional approach with better flows of communication between professional groups, allowing intelligence and risks to be identified and escalated. Clinical Senates could provide a vehicle for building multi-professional relationships and consensus across an area.

- Concluding the discussion, Ed Smith highlighted the importance of being clear about the extent of NHS England's responsibilities and the role of the Committee in relation to quality and clinical risk. Through its audit function, the Committee would provide advice to the Board on where the greatest quality and clinical risks were, with all risks identified being the responsibility of one member of the Executive team. Though the Committee would provide advice on the development of policies and strategies from a quality perspective in addition to its audit role, it would be important to respect the responsibilities of the executive team.

- The Committee should provide advice from a quality and clinical risk perspective on the BAF over the next 2-3 months to inform its revision, both in terms of the issues currently included, and whether there were any gaps. The Committee would consider the BAF in detail at a future meeting (February) and a risk expert from Deloitte would attend the April meeting to help the Committee think about its role in managing risks, and how it should discharge its duties as an audit committee.

Actions for the Committee:

- The Committee to receive regular reports from regional QSG meetings.
- The Committee to consider the BAF in more detail at the February meeting, and provide advice to inform the revision of the BAF.

4) **Revalidation**

- Building upon the discussion at the first meeting, where the role of NHS England as Senior Responsible Owner (SRO) for the revalidation programme was considered, the role of NHS England as a designated body was discussed.

- NHS England Area Team Medical Directors were responsible for carrying out appraisals and making recommendations to the General Medical Council (GMC) for around 42,000 General Practitioners (GPs). This was a significant task, and required substantial support at Area Team level. There was currently uncertainty around the continuation of funding for the revalidation programme for 2014/15, as it was being considered as part of NHS England's overall business planning process. This was problematic as contracts of staff working on revalidation at Area Team level could not be renewed in time to provide certainty for the next financial year. Additionally, the Revalidation Support Team (RST) would cease to exist from 31st March 2013, and it would be beneficial to employ some of the staff working on the programme, to ensure that expertise and knowledge of the programme could be retained. Without confirmation of funding, this was not possible.

- Furthermore, anecdotal evidence suggested that revalidation was dominating Area Team Medical Directors' time. There was a risk that Area Team Medical Directors did not have sufficient time and capacity to focus on other key areas and provide clinical leadership across their area. This would be compounded if there was less support available in 2014/15.

- It was particularly important to ensure that resources were made available (predominantly at Area Team level) to support revalidation as there was a reputational risk that locally, a GP may be revalidated by NHS England and subsequently be found to be unsuitable (for example, if identified thorough the Care Quality Commission's (CQC) inspections). The importance of securing resource immediately to mitigate this reputational risk would be raised by the Chair at the forthcoming Board meeting. Mitigating this risk would require confirmation of funding for 2014/15 as soon as possible in January, potentially out with the wider business planning process.

Actions for the Committee:

- Chair of the Committee to highlight the importance of securing resources to support the revalidation programme in 2014/15 at the NHS England Board meeting on 17th December 2013.

5) **Patient Safety Steering Group**

- Mike Durkin outlined NHS England's responsibilities with regards to patient safety. Many responsibilities for patient safety had been transferred to NHS England following the abolition of the National Patient Safety Agency (NPSA) in June 2012, and Jane Cummings and the Patient Safety Team within NHS England had responsibility for ensuring that NHS England executed these responsibilities.

- A key responsibility of the Patient Safety Team was running the National Reporting and Learning System (NRLS), the system for reporting harm in England. Reports from across the health service, primary care, mental health and community services were collated nationally, with around 99% of reports coming from acute, mental health, learning disabilities and community services. 0.4% of reports came from primary care – this figure appeared to be very low. Work was underway to understand the low reporting rates from primary care, and to enhance reporting from this sector.

- The Committee discussed the risk that the NRLS was not operating effectively in that it was not systematic, nor did it encourage the spread of learning. The NRLS received a large amount of information, and it would be important to ensure that it was properly analysed – attendees did not think this was the case at present. There was a quality risk that analysis of the information received through the NRLS was insufficient to flag up recurring themes or major problems. Work was underway to mitigate this risk, which the Committee felt was vital – the NRLS and analysis of the information they received should be a key lever to improving patient safety.

- Reporting patient safety incidents from primary care happened mainly through the Significant Events system, though findings from these were not shared regionally. The culture for reporting incidents of harm was often set by the practice or organisation that clinicians practised in, and it was important that staff working on the front-line had a way of analysing and monitoring the quality of care delivered by that organisation – including incidents of harm. One potential way of doing this would be to have Chief Quality Officers on Boards of organisations, who would take responsibility for quality in the same way that a Finance Director was accountable for the financial performance of the organisation.

- Attendees agreed that though the remit of this Committee was to focus on NHS England's responsibilities in relation to quality and clinical risk, it was important that information on quality across the whole system together was assimilated and triangulated. This was the role of QSGs locally and regionally, but there remained a question about whether this should also happen nationally and where. The National Quality Board had a role in overseeing the effectiveness of the QSG network, and there was a role for the national support centre in NHS England in supporting Regional and Area Teams in facilitating QSGs.

- Another key function of the patient safety domain included the re-launch of the Patient Safety Alert system, and specific programmes of work around priorities identified to date. These included medication errors, pressure ulcers, venous

thromboembolism (VTE), healthcare associated infections (HCAI) and never events.

Actions for the Committee:

- The Committee to have further discussions about the potential role of Chief Quality Officers.
- The Committee to consider patient safety at future Committee meetings on a regular basis.

6) Preparation for winter pressures

- Bruce Keogh explained that winter pressures and the performance of Accident and Emergency services (A&E) continued to attract politicians' and the media's interest. The ability of the NHS to meet the target of 95% of patients being seen within 4 hours was key.

- Preparation for winter planning this year had begun in May, which was significantly earlier than in previous years. Urgent Care Working Groups (UCWGs) – which brought together the local health economy, and local authorities – had been established to develop plans to sustain the delivery of A&E performance through the winter. There was a recognition that the solution to sustaining A&E performance through winter depended on the wider health system, in particular, on the quality and capacity of general practice and social services.

- In addition to the local plans developed by UCWGs, a total of £400 million had been made available to support the system - £250 million in the first tranche announced in September, and £150 million in the second tranche announced in November. £371m had been allocated to local systems to support delivery of the A&E standard, and was being spent across acute, primary, community, mental health and social services, as agreed by local partners. £15m had been allocated to NHS 111, £14m to ambulance services and £7m to specialist services.

- These plans were more comprehensive, and were expected to be more effective, than in previous years. Two key risks to maintaining A&E performance were: 1) the risk of an outbreak of norovirus or flu, and 2) the operational implications of the Better Care Fund. In relation to the latter, there were concerns in the NHS that the £3.8 billion that would be transferred from existing NHS budgets to local authorities to support improved social care provision resulting in reduced admissions to, and effective discharges from, hospital, would be used for other purposes.

• Concluding the discussion, the Chair commented that plans put in place to cope with winter pressures appeared to be comprehensive, and that the Committee would return to this issue at a future meeting, reflecting on lessons learned from this winter with a view to informing plans for 2014/15 and beyond.
Actions for the Committee: • The Committee to consider winter pressures in more detail at a future meeting.

ANNEX B

Meeting Schedule

This meeting schedule is indicative and will need to remain flexible

Meeting date	Agenda Items
24th February (Seminar on measuring quality immediately before meeting)	Future work programme
	Role of measurement in driving continuous quality improvement
	Report from regional Quality Surveillance Group, Midlands and East
	Board Assurance Framework
15th April (Developmental session on the Committee's role in managing risk before meeting – risk expert from Deloitte attending)	Strategic framework for the commissioning of primary care
	CCG Assurance Framework
	Levels of ambition for improving outcomes – plan for assurance, aggregation and promotion
	Standing item: Report from regional Quality Surveillance Group
	Winter planning –reflections on last winter, plans for coming winter
	Review of incentives, rewards and sanctions for 2014/15

9 June	Better Care Fund
	Six-monthly standing item: Patient Safety
	Standing item: Report from regional Quality Surveillance Group
1 September	Specialised services commissioning
	Medical Revalidation
	National Performers List for primary care doctors
	Local Supervising Authorities for midwives
	Standing item: Report from regional Quality Surveillance Group
13th October	Strategic and operational planning
	NHS England's role in providing clinical and professional leadership
	Standing item: Report from regional Quality Surveillance Group
1 December	*Six-monthly standing item: Patient Safety*
	Standing item: Report from regional Quality Surveillance Group

ANNEX C

Ambitions from Prof Sir Bruce Keogh's review into 14 hospitals with elevated mortality rates

Ambition 1

We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

Based on

This review has shown the continuing challenge hospitals are facing around the use and interpretation of aggregate mortality statistics. The significant impact that coding practice can have on these statistical measures, where excess death rates can rise or fall without any change in the number of lives saved, is sometimes distracting boards from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals.

Mortality outliers are characterised by the sub-optimal way in which emergency patients are dealt with, particularly at the weekend and at night.

Action

• All trusts should rapidly embed the use of an early warning system and have clinically appropriate escalation procedures for deteriorating, high-risk patients - in particular at weekends and out of hours. Commissioners and regulators should seek assurance that such systems are in place.

• I have commissioned Professor Nick Black at the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi at Imperial College London to conduct a study into the relationship between 'excess mortality rates' and actual 'avoidable deaths'. This will involve conducting retrospective case note reviews on a substantial random sample of in-hospital deaths from trusts with lower than expected, as expected and higher than expected mortality rates.

• This study will pave the way for the introduction of a new national indicator on avoidable deaths in hospitals, measured through the introduction of systematic and externally audited case note reviews. This will put our NHS ahead of other health systems in the world in understanding the causes of and reducing avoidable deaths.

Ambition 2

The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

Based on

This review found that providers and commissioners are struggling to understand and take full advantage of the enormous and very rich set of data available on quality, as it is held in a fragmented way across the NHS and difficult to use to benchmark performance. We also found a deficit in the high level skills and sophisticated capabilities necessary at board level to draw insight from the available data and then use it to drive continuous improvement.

Too often, boards were honing in on data that reassured them they were doing a good job, rather pursuing data that revealed inconvenient truths, thereby missing opportunities for improvement.

Action

• All those who helped pull together the data packs produced for this review must continue this collaboration to produce a common, streamlined and easily accessible data set on quality which can then be used by providers, commissioners, regulators and members of the public in their respective roles. Healthwatch England will play a vital role in ensuring such information is accessible to local Healthwatch so that they and the consumers they serve can build a picture of how their local service providers are performing. The National Quality Board would be well placed to oversee this work.

• Boards of provider organisations - executives and non-executives - must take collective responsibility for quality within their organisation and across each and every service line they provide. They should ensure that they have people with the specific expertise to know what data to look at, and how to scrutinise it and then use it to drive tangible improvements. Over the last decade, many hospitals in the United States have recognised the importance of this by creating board level Chief Quality Officers. Creating a new board role is not essential, but having someone with the breadth of skills required is.

• NHS England, the NHS Trust Development Authority and Monitor should work together to streamline efforts to address any skills deficit amongst commissioners,

NHS Trusts and NHS Foundation Trusts around the use of quantitative and qualitative data to drive quality improvement.

• I will ensure that the requirements for Quality Accounts for the 2014-15 round begin to provide a more comprehensive and balanced assessment of quality.

Ambition 3

Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

Based on

Involving patients and staff was the single most powerful aspect of the review process. Patients were key and equal members of review teams. Well-attended listening events at each trust provided us with a rich understanding about their experiences at the hospitals. Accessing patient insight in this way need not be complex, yet many of the trusts we reviewed did not have systematic processes for doing so, and all have actions in their action plan to improve in this area.

Action

• Realtime patient feedback and comment must become a normal part of provider organisations' customer service and reach well beyond the Friends and Family Test.

• Providers should forge strong relationships with local Healthwatch who will be able to help them engage with patients and support their journey to ensuring more comprehensive participation and involvement from patients, carers and the public in their daily business.

• The very best consumer-focused organisations, including some NHS trusts, embrace feedback, concerns and complaints from their customers as a powerful source of information for improvement. Patients and the public should have their complaints welcomed. Transparent reporting of issues, lessons and actions arising from complaints is an important step that the NHS can take immediately to demonstrate that it has made the necessary shift in mindset.

• Monitor and the NHS Trust Development Authority should consider the support, development and training needed for Non-Executive Directors and Community, Patient and Lay Governors to help them in their role bringing a powerful patient voice to Boards.

• All NHS organisations should seek to harness the leadership potential of patients and members of the public as they fulfil their respective responsibilities whether as providers, commissioners or as part of future inspections by the regulators. Patient

and public engagement must be central to those who plan, run and regulate hospitals and each has improvements to make in this respect.

Ambition 4

Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

Based on

The methodology we used for this review has worked well, uncovering both good practice as well as previously undisclosed problems requiring immediate attention and urgent action.

The multidisciplinary nature of the review teams - involving patient and lay representatives, junior doctors, student nurses, senior clinicians and managers - was key to getting under the skin of these organisations. The review teams were not constrained by the limitations of a rigid set of tick box criteria. This allowed both cultural and technical assessments to be made, informed by listening to the views and experiences of staff, and particularly patients and members of the public.

Action

• The new Chief Inspector of Hospitals has agreed to adopt and build on this review methodology as he takes forward the Care Quality Commission's new inspection regime for hospitals.

• In the new system, the place that data and soft intelligence comes together is in the recently formed network of Quality Surveillance Groups. These must be nurtured and support the Care Quality Commission in identifying areas of greatest risk.

• Provider boards might wish to consider how they themselves could apply aspects of the methodology used for this review to their own organisations to help them in their quest for improved quality.

Ambition 5

No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

Based on

The trusts reviewed tended to be isolated in terms of access to the latest clinical, academic and management thinking. We found many examples of clinical staff not following the latest best practice and being 'behind the curve'. They - and other trusts not included in this process - need to be helped to develop culture of professional and academic ambition.

Action

• NHS England should ensure that the 14 hospitals covered by this review are incorporated early into the emerging Academic Health Science Networks. We know that the best treatment is delivered by those clinicians who are engaged in research and innovation.

• Providers should actively release staff to support improvement across the wider NHS, including future hospital inspections, peer review and education and training activities, including those of the Royal Colleges. Leading hospitals recognise the benefits this will bring to improving quality in their own organisations. Monitor and the NHS Trust Development Authority should consider how they can facilitate this.

Ambition 6

Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

Based on

The review teams found inadequate numbers of nursing staff in a number of ward areas, particularly out of hours - at night and at the weekend. This was compounded by an over-reliance on unregistered support staff and temporary staff.

Action

• As set out in the Compassion in Practice, Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.

• The National Quality Board will shortly publish a 'How to' guide on getting staffing right for nursing.

Ambition 7

Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

Based on

The contribution of junior doctors and student nurses to the review process was hugely important. They are capable of providing valuable insights, but too many are not being valued or listened to. Junior doctors in particular were receiving inadequate supervision and support, particularly when dealing with complex issues out of hours. They often felt disenfranchised. In some trusts we visited junior doctors are not included in mortality and morbidity meetings because they were considered 'not adult enough to be involved in the conversations'.

Action

• I strongly advise Medical Directors to consider how they might tap into the latent energy of junior doctors, who move between organisations and are potentially our most powerful agents for change. Equally, I would strongly encourage Directors of Nursing to think about how they can harness the loyalty and innovation of student nurses, who move from ward to ward, so they become ambassadors for their hospital and for promoting innovative nursing practice.

• Junior doctors must routinely participate in trusts' mortality and morbidity review meetings.

Ambition 8

All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

Based on

From talking to people in the 70 focus groups we conducted as part of the review, it was clear that staff did not feel as engaged as they wanted or needed to be: yet academic research shows that the disposition of the staff has a direct influence on mortality rates.

Action

• All NHS organisations need to be thinking about innovative ways of engaging their staff.

• Addressing this issue is part of the action plans for all of the 14 trusts which provides them with an opportunity to lead the way on this.