Paper NHS071413

BOARD PAPER - NHS ENGLAND

Title: Report of the Quality and Clinical Risk Committee
Clearance: Cyril Chantler - Chair, Quality and Clinical Risk Committee Bruce Keogh – National Medical Director Jane Cummings – Chief Nursing Officer, England
Purpose of paper: • To update the Board on the last meeting of the Quality and Clinical Risk Committee, where the following topics were considered: o Operational resilience and capacity planning; o Review of incentives and levers 2014/15; o The Better Care Fund; and o Patient safety.
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.

Report of the Quality and Clinical Risk Committee

1. The Quality and Clinical Risk Committee met for the sixth time on 9 June 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 15 April. These are attached at Annex A for information.

3. Recruitment of patient and public voice representatives had been completed in May; Gillian Adams, Neeta Mehta and Linn Phipps were appointed for an 18 month period, beginning in May 2014.

4. Following the discussion at the previous meeting, the Committee received an update on the process for handling complaints that related to areas of NHS England's responsibility such as dentistry, primary care, and national policy. Performance in handling complaints had improved significantly since the first quarter of NHS England's existence, with the highest level of customer satisfaction about complaints handling recorded in quarter 4 of 2013-14. Backlogs of complaints had almost been eliminated.

5. However, the Committee remained concerned that there was a significant reputational risk to NHS England as the complaints system in the NHS was fragmented and difficult to navigate, with patients unsure of how to complain, and who to. Consequently, NHS England received complaints that did not relate to their areas of responsibility. Though NHS England were not directly responsible for these, it was important that improvements were made in the way these complaints were dealt with.

6. CareConnect was being developed to provide patients with a single way of sharing their experience, asking a question or reporting a problem with any NHS service via Twitter, Facebook, text message or online. Though attendees supported the principle of this, and were supportive of the work to develop and extend the service to cover the whole country, it was felt that the name had little meaning or connection to its purpose, and needed to be reconsidered.

7. The Committee will consider the complaints system across the NHS as a whole, the extent of NHS England's responsibilities, and the systems in place to provide assurance that these are being fulfilled at its September meeting. By this stage, it was expected that NHS England's database of complaints would be fully functional and would better enable recurrent themes and patterns to be identified.

Operational resilience and capacity planning

8. The Committee considered how operational planning to sustain the urgent and emergency care system in 2013/14 had worked, and received an update

on plans for 2014/15. Performance in 2013/14 had been an improvement on the previous year, and performance on the national accident and emergency (A&E) standard had not fallen below 94%. A number of processes had been put in place to sustain performance, including the creation of urgent care working groups and tripartite panels at a regional and national level to sign off and assure plans.

9. For 2014/15, the aim was to move towards year-round system resilience, and plans were required to cover both urgent and emergency, and planned care. The planning process had begun much earlier than previous years, in January 2014. A stratified approach was being taken to performance management of Urgent Care Working Groups, with attention being focussed on the 53 systems where performance indicated there were the greatest risks. 12 top actions for both urgent and emergency, and planned care had been identified, and there would be a requirement to demonstrate how these actions were being embedded in plans.

10. Going forward, the two main risks to sustaining performance were staff shortages in many A&E hospital departments, and also the impact of reductions in social care funding, which could potentially increase admissions to, and delay discharges from hospitals. In order to mitigate the risk around staff shortages, work was underway with Health Education England on the recruitment, retention and training of staff working in A&Es, and locally, with the most challenged providers to identify solutions to staff shortages. Consideration was being given to the implementation of newer clinical models, and the role of other consultants and clinicians in resolving staffing issues. It was anticipated that the introduction of the Better Care Fund would help to mitigate the risk that social care funding reductions could lead to increased pressure on emergency services.

11. The Committee was satisfied that there were systems and processes in place to mitigate the key risks identified, although these would need to be kept under review. The guidance on planning requirements, due to be published in June 2014, included a requirement for urgent care working groups to identify and use dashboards developed locally providing access to real time data – the Committee felt that this would be a powerful tool to monitor performance against a set of local determined metrics, and to drive quality improvement. The Committee were also encouraged that patient experience was included in one of the top 12 actions for urgent and emergency care, and that for 14/15, a working group had been established focussing on ambulance performance.

Review of incentives and levers 2014/15

12. The Committee heard that a review of incentives and levers was underway to inform 2015/16. It was felt that the current set of financial incentives and levers were not particularly well aligned, and the review aimed to identify a configuration of incentives that could help commissioners to change or transform the way that services were delivered, in line with the priorities

outlined in NHS England's planning guidance *Everyone Counts: planning for patients, 2014/15 – 2018/19.*

13. A number of options were under consideration in relation to the structure of incentives, including the creation of a 'single pot' comprised of funding associated with current incentives. It was envisaged that this would allow commissioners to move resources across the system as necessary, shifting care from the acute sector to community services where appropriate.

14. The Committee felt that financial incentives needed to be considered in the wider context of other motivators for improvement; it would be important to analyse and understand the value of financial incentives in terms of the behaviour change achieved per pound spent.

15. The Committee felt that there were several potential risks around the introduction of a single pot of incentives. Firstly, it could let to unintended consequences - for example, stifling local innovation – and these consequences needed to be understood before implementation. Additionally, the potential burden on providers caused by a change in the incentives system would need to be considered.

16. It was possible that the transfer of £3.8bn from the NHS to local authorities under the Better Care Fund could create gaps in existing NHS services. There was a risk that if introduced, funding associated with a single incentives pot could be used to fill gaps in existing services as opposed to being used to transform the way in which services were delivered, or for improvement purposes. Further work would be needed to understand the likelihood of this risk materialising.

17. Given that certain incentives such as CQUINs (Commissioning for Quality and Innovation payments) were often regarded by providers as part of core funding, there was a risk that using this proportion of money differently could destabilise local health economies.

18. The Committee felt it was imperative that the incentives system was explicitly focussed on achieving improvements in outcomes in line with the five domains of the NHS Outcomes Framework. Additionally, any changes to the current system would need to be communicated to commissioners and providers well in advance of them taking effect, to allow time for systems to adapt, in order to avoid the risk of destabilising the system without deriving any improvement from the process.

The Better Care Fund

19. The Committee heard that the Better Care Fund (BCF) was due to start from April 2015, with the aim of protecting social care services, and promoting the integration of care. £3.8bn was due to be transferred from the NHS to local authorities, with half of this funding coming from existing transfers to local government, and the other half coming from existing CCG budgets. £1bn was linked to achieving outcomes against a set of metrics. The Committee felt

that though it was implicit that the scheme was focussed on the elderly and those with multi-morbidities, this should be made explicit and should be more clearly communicated.

20. A key risk associated with the BCF was the potential for funds to be used by local government for purposes unrelated to health and social care. The Committee felt that the processes put in place to mitigate this risk appeared to be robust: the funding had been ring-fenced, and there was a requirement that plans had to be jointly agreed by councils and CCGs, and signed off locally by Health and Wellbeing Boards. Nationally, plans would ultimately be signed off by Ministers in the Department of Health, the Department for Communities and Local Government, and Her Majesty's Treasury.

21. The BCF was based on an untested assumption that it was possible to simultaneously transform services and deliver financial savings. The greatest risk associated with the BCF was that the programme may not deliver its key aim of releasing acute health service capacity, for example by reducing emergency admissions. If this were to happen, NHS commissioners would face a significant risk as the NHS would effectively have to pay twice.

22. Steps were being taken to mitigate this risk, including the requirement for existing service providers to be involved in, and to support the local plan for re-shaping services and taking out capacity associated with services that would no longer be required. Risk-sharing arrangements were also being established between organisations which could be used to fund services if the assurance process demonstrated that emergency admissions were not decreasing. The process for signing off plans at a local and national level would also mitigate this risk.

23. The Committee recommended that two further steps could be taken to mitigate against this risk. Firstly, the BCF could be rolled out over a longer timescale, allowing services to adapt. Secondly, funding to front load the scheme would allow the double running of services where required.

24. The Committee was encouraged to hear that the BCF had led to better engagement and increased partnership working between CCGs, social care and Health and Wellbeing Boards; the development of these relationships would be key to improving services for patients going forward.

Patient safety

25. The Committee received an update on the work of the patient safety domain team. Improvements in key patient safety indicators within the NHS Outcomes Framework had been maintained, and work was underway to develop indicator 5C of the NHS Outcomes Framework, which was defined as hospital deaths attributable to problems in care. A retrospective case record review study had found that around 5% of hospital deaths had a 50% or greater chance of being preventable.

26. By the end of June 2014, the NHS Choices website would provide a hospital level display of patient safety data, enabling patients and the public to see how hospitals were performing on key safety indicators. A direct link would also be provided to each organisation's staffing data presented to their Board on a monthly basis. Whilst Committee members welcomed the move to increase transparency, and acknowledged that publishing data was a key quality improvement tool, there was a risk that the data could be used by some – including the media - to criticise poor performers, rather than to encourage improvement. This could potentially lead to the adoption of more risk-averse attitudes amongst professionals working in the NHS, which could stifle innovation and improvement. The Committee felt it important that the accompanying narrative on the NHS Choices website was clear around the purpose of publishing this data, articulated that it was part of a quality improvement journey, and reaffirmed the commitment to securing improvements in patient safety.

27. Fifteen patient safety collaboratives were being established on the footprint of Academic Health Science Networks (AHSNs), with the aim of tackling leading causes of harm to patients, bringing together staff, users, carers and the public to work together to tackle specific patient safety problems, and to build patient safety improvement capability using evidence-based improvement methodologies. Though Committee members welcomed this focus on patient safety, there was a risk that a nationally led programme could stifle local innovation and prevent improvements in patient safety from occurring. Committee members felt that the current approach of having a national ambition with local leadership must be maintained and respected in order to create the right conditions for improvements in patient safety to occur.

28. The Committee felt that AHSNs were well placed to lead patient safety work, and that they would play a key role in disseminating good practice and driving quality improvements.

Cyril Chantler
Chair, Quality and Clinical Risk Committee
July 2014

Annex A

QUALITY AND CLINICAL RISK COMMITTEE

Minutes of the meeting held on Tuesday 15 April, 10:00 – 12:00

Skipton House room 138B

Attendees

Cyril Chantler - Chair, Quality and Clinical Risk Committee

Bruce Keogh - National Medical Director, NHS England

Jane Cummings - Chief Nursing Officer, NHS England

Victor Adebowale - Non-Executive Director, NHS England

Ciaran Devane - Non-Executive Director, NHS England

Mike Bewick - Deputy Medical Director, NHS England

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

Neeta Mehta - Patient and Public Voice Representative (interim)

Sylvia Knight – Deputy Director, Quality Assurance, NHS England Midlands & East

Sarah Pinto-Duschinsky – Director of Operations & Delivery, NHS England

Ed Smith – Non-Executive Director, NHS England

David Noon – Senior Partner, Deloitte, and Head of NHS England Internal Audit

David Geddes – Head of Primary Care Commissioning, NHS England

Ben Dyson – Director of Commissioning Policy & Primary Care, NHS England

David Haslam - Chair, NICE

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

Jon Schick (Head of Governance and Board Secretary)

Apologies

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

Geoff Alltimes – Associate Director, Local Government Association

Linn Phipps – Patient and Public Voice Representative (interim)

Terence Stephenson - Chair, Academy of Medical Royal Colleges

Sam Higginson - Director of Strategic Finance, NHS England

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

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

1) Welcome and introductions
Apologies for absence • Apologies had been received from Paul Watson, Geoff Alltimes, Linn Phipps, Terence Stephenson, Sam Higginson, Juliet Beal and Brigid Stacey,
2) Minutes of the previous meeting and actions arising
Minutes • Attendees approved the draft minutes of the meeting held on 24 February 2014.. ***Review of actions*** • Action 4.1 was outstanding; an update had not yet been received on the actions underway to achieve greater alignment between Consultant and GP contracts, with the aim of fostering professionalism in the NHS. A further update would be sought in time for the next Committee meeting. • Action 4.10 related to patient complaints – the Chair had highlighted the need to establish a clear process for handling complaints within NHS England, and within the NHS, at the last

Board meeting in March.

- 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.

- It would be useful to understand more about the nature of complaints being made to NHS England, and to identify recurring themes. Some initial analysis had already been done, and would be circulated to attendees for information. Around 72% of complaints were thought to relate to general medical/dental services.

Actions for the Committee:

- Secretariat to seek further update on action 4.1.
- Secretariat to circulate analysis of the complaints received by NHS England Customer Contact Centre.

Risk Management

- David Noon had been invited to provide advice to the Committee on approaches to risk management, in order to help the Committee better understand their role in managing risks across NHS England.

- David outlined the approach to risk management that had been widely adopted by corporate organisations since the financial crash of 2007/8, and that was also being adopted by public sector bodies. Central to the new approach to risk management was the need to be more transparent and clear about organisational risks than many organisations had been in the past. A change in culture would be needed to encourage people to be more open about risks involved in their work.

- 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 and Prof Sir Bruce Keogh. Both risk management and continuous quality improvement required openness and transparency, a relentless focus on improvement irrespective of the baseline, and taking an active approach to improvement, using measurement/clinical audit as part of a wider improvement strategy.

- The Committee felt that it would be important for NHS England to model this connection

between good risk management and driving continuous quality improvement. To do this, the organisation needed to focus not solely on risk, but also on driving improvements in performance.

Quality Surveillance Groups (QSGs)

- At the Committee meeting held in February, a report from the Midlands and East regional QSG meeting had been considered as part of a pilot approach to receiving reports from regional QSGs. Given its primary audit function, the Committee had felt that, rather than routinely receiving reports from regional QSGs, it would be preferable for the Committee to seek assurance that:

    - The four regional QSGs were operating effectively;
    - The four regional QSGs were assuring the effectiveness of local QSGs; and
    - The regional QSGs were sharing concerns amongst each other, escalating issues for national action where appropriate and that action was then taken.

- Sylvia Knight presented a paper circulated prior to the meeting, which outlined the actions underway to provide assurance on the above points.

- Through previous discussions, the Committee had raised concerns that there was no way to escalate concerns from regional QSGs to a national level if required. Attendees were therefore particularly positive about the proposals to facilitate the escalation of concerns to the national support centre in NHS England. As outlined in the paper, reports from regional QSGs would be used to update the monthly Executive Group Meetings (with performance) from April onwards. The reports would be submitted for information as standard, however, it was envisaged that where there was an issue requiring national action, there would be an opportunity for the Executive Team to discuss and agree actions. The reports would also be used to support regular monthly/bimonthly meetings of NHS England with Regional Medical Directors and Directors of Nursing, who would discuss the reports and share additional soft intelligence and concerns that are worthy of note and attention across the network.

- The Committee also felt it important that regional QSGs shared intelligence and concerns, and were positive that the revised guidance on running QSGs, *How to make your Quality Surveillance Group effective,* published in March 2014, set out a requirement for regional QSGs to share formal reports following each meeting.

- Additionally, a resource pack for QSGs had been developed, which would be helpful in terms of spreading best practice and enabling the QSG network to learn lessons from each other on how to make the meetings effective.

- There was some concern that QSGs had the potential to duplicate the role of the Care Quality Commission (CQC), and that they may add an unnecessary level of bureaucracy to the health system. However, QSGs were not statutory bodies and they did not have formal powers. Rather, they brought together commissioners, regulators and those with a system oversight role to share intelligence, and members of the group were accountable to the organisation they represented. The CQC were a key member of QSGs and would take actions away as necessary, as would other organisations.

- Overall, attendees were confident that the processes outlined in the paper were sufficient to provide assurance to the Committee on these elements of the operation of QSGs. The Committee felt that the network of QSGs had 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.

Actions for the Committee

- The Committee to maintain dialogue with those responsible for QSGs, and consider their development at a future meeting.

Quality in primary care

- Mike Bewick outlined the approach that NHS England was taking to assuring and improving the quality of general practice services. The long-term ambition for improving primary care was being set out in a series of strategic frameworks that were being developed. *'Improving general practice – a call to action Phase 1 report'*, which provided a report from phase 1 of the engagement activity to understand the kind of general practices patients want to see in future, had been published in March 2014.

- The report outlined five key areas in which services needed to improve. These were:

    - Providing proactive, coordinated care;
    - Providing holistic, person-centred care;
    - Providing fast, responsive access to care;
    - Providing health-promoting care; and
    - Providing consistently high-quality care.

- The Committee discussed clinical effectiveness in primary care, which was measured through the Quality and Outcomes Framework (QOF), GP High Level Indicators (GPHLI) and GP Outcomes Standards (GPOS). The Committee heard that though there was a fairly

common perception that there was a lack of data about the quality of primary care services, in reality there was a wide range of information available, although this could be improved.

- The Primary Care Web Tool, an interactive tool that registered all GP practices in England and included two sets of pre-analysed data on the 38 GPHLI and the 28 GPOS, 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. The Committee felt that this could be a particularly important source of information about the quality of primary care services, and that access to it should be widened to members of the public – at present, only those working in the NHS could access the tool.

- Much of the information held in the web tool was displayed in the accountability section of the NHS Choices website. The Committee felt that this part of the website required improvement to ensure that people were able to access, understand and use the data more easily.

- The limitations of data were also recognised. Data needed to be used as one source of information when forming a judgement about the quality of services provided by a practice, triangulating it with other information and soft intelligence. Taken in isolation, data alone could provide a false picture of the quality of services provided by a practice.

- 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 going forward NHS England should do more to 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.

- Many CCGs were exploring how to commission care across an integrated pathway, from the perspective of ‘a year in the life of’ patients, involving primary care, secondary care, social care, mental health and community services. Given that commissioning responsibilities and budgets were fragmented between CCGs and NHS England, and that there were many different rules and regulations governing the use of resources and pooling of accountabilities, it was extremely difficult for CCGs to commission integrated care. However, the Committee heard that some CCGs and Area Teams – such as the Integration Pioneers - were working together to find innovative ways to overcome organisational structures and boundaries and to pool responsibilities and resources. There was a real appetite amongst many CCGs and Area Teams to work together in this way.

- The Committee felt strongly 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. The Chair would raise this issue in his forthcoming report to the Board.

Actions for the Committee

- In his forthcoming report to the Board, the Chair to highlight the importance of supporting CCGs and Area Teams to work together to find innovative ways to commission integrated care, and to recommend that NHS England removes as many barriers to this process as possible.

CCG Assurance Framework

- Sarah Pinto-Duschinsky outlined that NHS England was required by law to conduct an assessment of each CCG's performance in respect of each financial year, and the CCG Assurance Framework (published in November 2013) set out a proportionate, risk based approach to this assessment based on the six domains of effective clinical commissioning which underpinned the initial authorisation assessment. The domains were:

    1. Are patients receiving clinically commissioned, high quality services?
    2. Are patients and the public actively engaged and involved?
    3. Are CCG plans delivering better outcomes for patients?
    4. Does the CCG have robust governance arrangements?
    5. Are CCGs working in partnership with others?
    6. Does the CCG have strong and robust leadership?

- Conversations between Area Teams and CCGs took place quarterly. The primary output from the assurance process was the summary of the assurance conversation and assurance domain level and headline rating of whether the conversation left NHS England either 'assured', 'assured with support', or 'not assured, intervention required' on the basis of the discussion. NHS England had not previously had to take action for a CCG that was not assured.

- A number of key challenges were being considered to strengthen the assurance process. These included:

    - Improving the alignment between the CCG Assurance Framework and the NHS England Direct Commissioning Assurance framework;
    - Improving the alignment between the planning and assurance processes;
    - Improving indicators included in the Delivery Dashboard section of the CCG Assurance Framework to ensure they provided a better picture of quality;

- Considering a stratified approach to assurance ;
- Improving moderation discussions – it was important that the CCG assurance process was not used as a way of criticising/performance managing individual providers.

- The success of the assurance process was contingent on ensuring that the right people were involved in conversations between CCGs and Area Teams, and on ensuring that the insight fed into the conversation was of the highest possible quality. NHS England produced planning guidance annually, and where indicators, measures or issues were signalled in the guidance as integral to CCG plans, this afforded the assurance process a line of sight into those issues at CCG level.

- The Committee felt that there was potential to better align the planning and assurance processes; 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.

- The Committee felt that it would be important to strengthen the alignment between the NHS England Direct Commissioning Assurance 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.

Actions for the Committee:

- In his forthcoming report to the Board, the Chair to highlight the need to achieve greater alignment between the Direct Commissioning Assurance Framework and the CCG Assurance framework, and the importance of seeking better alignment between the planning process and CCG assurance framework.