NHS England and NHS Improvement Board meetings held in common

Paper Title: Learning processes for NHS England and NHS Improvement

Agenda item: 6 (Private session)

Report by: Stephen Powis, National Medical Director
Ruth May, Chief Nursing Officer

Paper type: For discussion

Summary/recommendation:
This paper sets out

- the roles and responsibilities across the system for quality, safety and learning
- the role NHS England and NHS Improvement has taken in investigation, review and quality surveillance, and
- work that is underway to ensure the new operating model has a focus on quality, safety and learning.

Background

1. This paper has been produced following a discussion at the November 2019 Board meeting about the handling of investigations into poor care and how NHS England and NHS Improvement can learn from them. A list of investigations can be found in Annex A. There are a number of processes and frameworks already in existence for quality and safety in the NHS, with NHS England/Improvement having distinct roles within many of those processes. The integration of NHS England and NHS Improvement as well as wider changes in the policy landscape, now provides us with an opportunity to consider and update our own existing processes to ensure a strategic and coherent approach to learning and improvement.

Considerations

Responsibilities for quality

2. NHS England and NHS Improvement have statutory duties to continually drive improvement in quality whilst delivering their functions. They also have specific duties to collect information about the safety of services, and improve the safety of services through issuing advice and guidance and supporting improvement activity. However, providers of NHS services are ultimately responsible for the quality of the care and treatment they deliver. Local, regional and national organisations (both regulators and commissioners) monitor the quality of care and take appropriate action to protect the interest of patients. This can be through targeted support to improve but also through regulatory actions to prevent unsafe and harmful care from a service or professional.

Key roles and responsibilities in the system

Organisation	*Role*	*Specific functions for safety and investigation*
Providers	Ultimate responsibility for the safety of patients and the quality of the services provided.	• Upholding robust processes for recognising and reporting incidents • Arranging and resourcing serious incident investigations, identifying root causes to produce focussed recommendations and ensuring actions are implemented to prevent recurrence. • Liaising with providers, commissioners and regulators and using mechanisms to share learning. • Early, meaningful and sensitive engagement with patients, families and carers, including duty of candour. • Feed into national reporting systems.
CCGs	Commission services with a view to continuous improvement in quality	• Assuring the robustness of providers' serious incident investigations, including patient/family involvement and action plan implementation. • Commissioning investigations into serious incidents where they meet certain criteria (see para 7) • Monitoring and updating reporting on serious incidents locally. • Using and sharing details of serious incident reports to continuously improve services. • Working with providers and other commissioners to ensure a coordinated response to incidents that involve one or more organisations.
NHS England	NHS England provides national leadership in commissioning NHS services. It oversees the planning, budget and operation of the NHS commissioning system with a view to improving the health and care outcomes for people in England.	• Ensuring that CCGs have appropriate oversight of SI management. • Assuring the robustness of NHS England commissioned providers' serious incident investigations, including patient/family involvement and action plan implementation. • Oversee Regional and Local Quality Surveillance. • In some instances national teams may be asked to commission or oversee an investigation where it has not been possible to successfully

		conclude the investigation at regional level. • Commissioning investigations where appropriate. • Monitoring and updating investigation reporting locally. • Working with partners to support the sharing of learning. • Overseeing processes to ensure the effective management of controlled drugs. • Conducting independent investigations into mental health homicides
NHS Improvement	NHS Improvement provides strategic leadership and practical help to the provider sector, supporting and holding providers to account to achieve a single definition of success through the single oversight framework.	• Providing system wide leadership for patient safety in the NHS. • National oversight of incident reporting. • Supporting Trusts to improve their practice in serious incident management.
Care Quality Commission	The CQC is the independent regulator of quality for health and adult social care in England. It provides assurance and encourages improvement by registering providers, monitoring, inspecting and rating their quality, taking enforcement action and using its independent voice to share information and insight.	• Making judgements on the quality of health and care services according to whether they are safe, effective, caring, responsive and well-led, and taking action where necessary • May use details of serious incident reports, investigations and action plans to monitor organisations' compliance with essential standards of quality and safety to assess risks and respond accordingly. • Receives reports of specific types of serious incidents from providers.
Health and Safety Investigation Branch	Conduct Independent Investigations of patient safety concerns across the NHS	• Undertaking up to 30 investigations per year on incident types that signal systemic or apparently intractable risks in local healthcare systems. • Acting independently and making local and national recommendations to a range of NHS bodies. • Championing good quality investigation across the NHS • Leading every maternity serious incident according to pre-defined criteria.
NHS Resolution	Administering NHS indemnity schemes & enabling the pooling of	• Reducing the focus on claim management to proactive, earlier interventions to support families,

	expenses arising from claims	while providing advice to help the NHS learn from mistakes. • Earlier interventions in maternity related cases, with a focus on brain injuries at birth. • Resolving concerns and disputes quicker with more use of mediation and dispute resolution, to reduce the number of costly court cases. • Administering NHS indemnity schemes & enabling the pooling of expenses arising from claims.
Department of Health and Social Care	The Department of Health helps people to live better for longer. It leads, shapes and funds health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.	• Commissions Reviews and (including independent Inquiries) into NHS services on behalf of the Secretary of State.
Professional Regulators	Professional regulators like the Nursing and Midwifery Council and General Medical Council support clinicians to deliver high quality, safe care through professional standards,	• Professional regulators such as the General Medical Council and Nursing and Midwifery Council provide support and guidance to registered clinicians and investigate individuals when a referral is received.
Professional membership bodies	Professional membership bodies such as Royal Colleges are responsible for development, training and clinical leadership in specialty areas	• Sometimes commissioned to carry out reviews in some instances where there are service or individual quality issues.
Medical Examiners	NHS England and NHS Improvement are implementing the non-statutory medical examiner system in England. Initially this will provide scrutiny of non-coronial deaths in acute hospitals. Scrutiny will later be extended to other non-coronial deaths.	Medical examiners (with medical examiner officers) review medical records and interact with qualified attending practitioners and the bereaved to address three key questions: • What did the person die from? (ensuring accuracy of the medical certificate of cause of death) • Does the death need to be reported to a coroner? (ensuring timely and accurate referral) • Are there any clinical governance concerns? (ensuring the relevant

		notification is made where appropriate)
Parliamentary and Health Service Ombudsman	The PHSO makes decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.	• Reviews complaints which have been escalated.

3. The National Quality Board's role is to assist with aligning roles and responsibilities for quality across the national organisations [1].

How do we investigate when things go wrong in the NHS?

4. The 2015 Serious Incident Framework sets the current expectations for when and how the NHS should conduct safety investigations into 'Serious Incidents' with the vast majority of these investigations undertaken by providers. However, compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations sometimes struggle to deliver good quality safety investigations. This was due to a lack of skills and a focus on processes rather than improvement.

5. A new framework for responding to patient safety incidents, (including by undertaking a safety investigation where appropriate but also advocating other types of response such as case record reviews) is being developed which, if approved, will replace the Serious Incident Framework. This ''Patient Safety Incident Response Framework (PSIRF)'' will be tested with a small number of 'early adopter' local systems over the course of 2020, with the findings being used to inform a final version of the PSIRF for wider roll-out to the rest of the NHS in 2021. Key features for the new Framework that will be tested include:

    - a broader scope, describing principles, systems, processes, skills and behaviours for incident management as part of a broader system approach, moving away from a focus on current thresholds for 'Serious Incidents' and effectively removing that designation.
    - a risk-based approach where organisations develop a 'patient safety incident response plan' that bases the selection of incidents for safety investigation on the opportunity they offer for learning and helps providers allocate sufficient local resources for incident responses and improvements that address safety investigation findings.
    - clarifying the purpose of safety investigation and insulating it against inappropriate use, so that safety investigations are no longer asked to judge 'avoidability', predictability, liability, fitness to practise or cause of death
    - increased emphasis on transparency and support for those affected: setting expectations for always informing, involving and supporting patients, families,

[1] The National Quality Board brings together the clinical leadership for quality for NHSE, NHSI, CQC, PHE, NICE, HEE, NHSD, DHSC and Healthwatch

carers and staff affected by patient safety incidents where they wish to be involved.

- a different approach to the oversight and assurance provided by commissioners, rather than the current process of commissioner oversight of every single investigation, emphasising instead the role of provider boards and leaders in overseeing individual investigations.
- a new suite of standards and templates for investigation informed by best practice and HSIB's approach.

6. The 'early adopters' have been identified with at least one in each region. They will work under the PSIRF to generate insight into how the new expectations are best implemented. Subject to approval this early adopter phase will begin from March 2020 and will inform the publication of a final PSIRF in early 2021 for national implementation by Autumn 2021.

How has NHS England/Improvement been involved in independent investigation or reviews?

Serious Incidents

7. In terms of serious incidents, NHS England has played a role in independent investigations largely through our role as a commissioner. CCGs and NHS England acting as a commissioner oversee independent investigations where:

   (i) It is very difficult for the provider to be **objective and impartial** – for example where there is clear evidence of bias or significant failings in the handling of the incident.

   (ii) The serious incident relates to a **systemic issue** such as the configuration of services, a very complex multi-agency investigation or is very complex and affects multiple patients.

   (iii) The serious incident is likely to cause **widespread public concern** or significant media interest leading to widespread public concern.

8. The vast majority of these types of investigations have historically been conducted by CCGs, who would normally be identified as the lead commissioner. NHS England has also commissioned some other types of independent serious incident investigation where the criteria above are met and a single CCG is not best placed to be the commissioner.

9. However, NHS England commissions independent investigations in all cases where a **homicide is committed** by an individual who is, or has been, subject to a Care Programme Approach (CPA), or under the care of specialist mental health services, in the past 6 months prior to the event.

10. In September 2017, NHS England published 'Applying the Serious Incident Framework' as internal guidance to clarify its own processes for its role on serious incidents. This guidance covered NHS England's role in serious incidents as both the overseer of CCGs and as a commissioner of services

itself, giving further clarity beyond the 2015 Serious Incident Framework. It also sets out NHS England processes for reporting independent investigations that had been commissioned by NHS England and how to escalate serious incidents where national involvement is deemed necessary [(see Annex ?)].

National Reviews or investigations

11. National reviews or investigations can be commissioned by NHS England/NHS Improvement where there have been systematic failings and calls for in depth investigation from patients. These can go beyond individual 'serious incidents' and consider wider or systemic service problems. These can be commissioned by the Secretary of State, largely for the reasons highlighted in paragraph 7, but where the complexity and level of harm requires a national approach. Over the last 2-3 years, these requests were directed towards NHS Improvement, who then commissioned independent investigations from a range of sources. Many of these are not yet concluded, and their progress is reported into the Quality and Innovation Committee (see Annex A for list of national investigations, and para 15 for more information on the Committee).

12. Although not used to date, Health and Safety Investigation Branch (HSIB) provide a potential avenue for conducting national investigations in the future, ensuring independence as well as ensuring the use of HSIB's consistent approach. The intention of HSIB was to ensure more national consistency when it came to national investigations, this could be explored further with DHSC in terms of addressing roles in the system.

Quality Surveillance

13. Quality Surveillance Groups (QSGs) were established by NHS England to bring together different parts of the health and care system, to share proactively intelligence about risks to quality. Initial guidance was published in January 2013, and a network of QSGs was established across England, bringing health economies together locally and in regions on the then NHSE footprint. Given the changes in the NHS since then, the guidance has been reviewed and revised in both 2014 and 2017.

14. QSGs review a wide range of hard and soft intelligence (including investigations and review), escalating concerns and taking action where necessary. A review of QSGs has begun with a focus on how they fit with the new operating model and how we can ensure that there is consistency across the system on how concerns are shared and action is joined up across local, regional and national bodies.

National Medical Examiners

15. NHS England and NHS Improvement are implementing the non-statutory medical examiner system in England. Initially this will provide scrutiny of non-coronial deaths in acute hospitals. Scrutiny will later be extended to other non-coronial deaths.

Medical examiners (with medical examiner officers) review medical records and interact with qualified attending practitioners and the bereaved to address three key questions:

- What did the person die from?
  (ensuring accuracy of the medical certificate of cause of death)
- Does the death need to be reported to a coroner?
  (ensuring timely and accurate referral – there are national requirements)
- Are there any clinical governance concerns?
  (ensuring the relevant notification is made where appropriate)

Benefits of the medical examiner system include:

- provide bereaved people with greater transparency, by giving opportunities to ask questions about care and raise concerns
- improve the quality and accuracy of medical certification of cause of death
- ensure referrals to coroners are appropriate
- support local learning and improvement by identifying matters for clinical governance – medical examiners will "detect and pass on" concerns to processes such as Structured Judgement Reviews
- greater safeguards for the public through improved and consistent scrutiny of all non-coronial deaths
- align with related systems such as the 'learning from deaths' framework

Learning Disability Mortality Review (LeDeR)

16. The purpose of the Learning Disability Mortality Review (LeDeR) programme is to drive improvements in the quality of service delivery for people with a learning disability and help to reduce premature mortality and health inequalities in this population: it aims to drive improvement in the quality of health and social care service delivery for people with LD and to help reduce premature mortality and health inequalities in this population.

    The objectives are to:

    - Influence practice change at individual professional/clinician/allied health professional level, such that it will contribute to improving service provision for people with LD and their families
    - Influence change in policy and service provision at national level with Government, NHS England, Public Health England and Local Government Association, such that it will contribute to improving service provision for people with learning disabilities and their families
    - Support commissioning and service redesign by helping commissioners understand opportunities to improve service delivery, reduce variation and learn from best practice
    - Contribute to a move towards equality of treatment and parity of esteem for people with learning disabilities and help tackle the systemic contributors to the health and access inequalities they face.

CCGs have responsibility for completing all reviews of deaths of people with a learning disability aged 4 and above within 6 months of notification of death. They must be part of a local LeDeR steering group to deliver action from learning, have an identified SRO for the LeDeR work and publish an annual report setting out learning and progress on service improvements.

NHS England and NHS Improvement is responsible for the national delivery of the LeDeR programme to review the deaths of all people aged 4 and above with a learning disability across England. With over 3,000 deaths reviewed to date; the programme now has the largest body of evidence from reviews of the deaths of people with a learning disability, reviewed at an individual level, in the world. LeDeR. In 2019 the first Action from Learning Report was published with the second due in 2020. We have led on a series of campaigns to translate learning into action including: resources to address key health inequalities faced by people with a learning disability such as: sepsis, constipation, respiratory issues and diabetes. In May 2019 NHSE/I issued a letter to clinicians to reinforce that 'learning disability; is not an acceptable rationale for a DNACPR or an acceptable primary cause of death.

National Clinical Audit and Patient Outcomes Programme (NCAPOP)

The NCAPOP is funded by NHSEI and Welsh Government and includes a number of confidential inquiries into patient outcomes, including the National Confidential Enquiry into Patient Outcome and Death (NECPOD) and others.

Learning processes for NHS England and NHS Improvement

New structures for quality governance

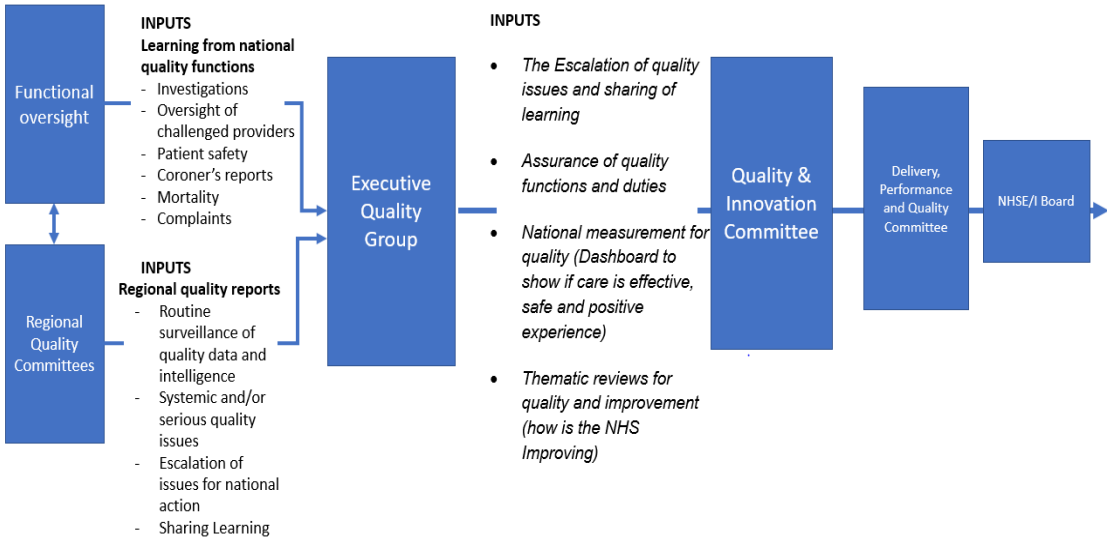
17. NHS England's and NHS Improvement's new operating model provides an opportunity for us to work together more effectively and efficiently so we can better support the NHS to maintain and improve the quality of patient care and health outcomes. Since April 2019, the organisations have combined their quality governance and structures. This has included the establishment of the Quality and Innovation Committee, a sub-committee of the Delivery, Quality and Performance Committee, with agreed purpose and duties that cover:

    - The escalation of quality issues and sharing of learning
    - Assurance of quality functions and duties
    - National measurement for quality
    - Thematic reviews for quality and improvement

18. The Committee facilitates the sharing of data and intelligence about quality risks and issues and the sharing of learning and best practice at national level. The Committee is supported by the Executive Quality Group, which is co-chaired by the National Medical Director and Chief Nursing Officer and brings together the Regional Medical Directors, Regional Chief Nurses and senior national colleagues. It considers regional reports and intelligence on quality issues, shares risks and learning, and agrees national action and escalation where it is needed. This builds on and combines the arrangements that have

been in place for several years in NHS England and NHS Improvement prior to the joint venture. The diagram below illustrates how flow of information and governance in the new combined structure.

NHSE/I Quality Governance and Oversight



19. Working in conjunction with the Executive Quality Group the Quality and Innovation Committee will:

- Oversee the identification and deployment of appropriate resources to tackle escalated quality risks and issues and support quality improvement activities at national level.
- Escalate quality risks and issues to the Delivery, Quality and Performance Committee if required.
- Refer national cross-system quality risks and issues to the National Quality Board

20. The Quality and Innovation Committee has also been considering quality measurement. This has so far focussed on national outcomes measures that align with the Long Term Plan, which have been developed into an outcome monitoring dashboard that the Committee will refer to and evolve over time. However, the Committee also wants to understand how quality measurement by NHSE/I has been aligned with the Care Quality Commission. A working group is currently being established.

21. The Joint Corporate Risk Register includes the following risk on quality '*The Joint Organisations' systems and processes do not effectively minimise the risk of quality failures and enable us to intervene appropriately when failures occur'.* The Quality and Innovation Committee holds the oversight of this risk on behalf of the Delivery, Quality and Performance Committee and reviews the risk rating based on the inputs it receives.

Work to refine and improve our learning processes

22. We are now undertaking a rapid exercise to combine and update processes for investigation and learning so that they are fit for purpose in our new operating model. A number of actions are being taken:

    - Full roll out of the Patient Safety Incident Response Framework, including learning from the early adopters.
    - Updating internal guidance for commissioning and overseeing our investigation processes by end March 2020, particularly to ensure that there is a standard approach to sponsorship, ensuring that regions are in the lead as far as is possible, and that there is appropriate governance of decision making
    - Updated guidance on Quality Surveillance so that the system is fit for purpose in our new operating model.
    - An analytical group is being established to consider quality measurement across NHS England, NHS Improvement and the Care Quality Committee.
    - Work with the National Quality Board to update the Shared Commitment for Quality – reaffirming the definition of quality and the roles and responsibilities of national organisations
    - Ensure there is a clear escalation decision tree with a ceiling to enable decision making about when no further investigation or enquiry is appropriate or worthwhile.

23. This work will be progressed at pace, with new processes being developed and rolled out by the end of 2020/21. Work will involve national and regional teams, with oversight by the Quality and Innovation Committees.

Annex A – Summary update on National Investigations and Reviews
Annex B – Applying the Serious Incident Framework – NHSE Internal guidance, including the processes for escalation