Trust Policy

Worcestershire Acute Hospitals NHS Trust

National Confidential Enquiries into Patient Outcomes and Death Policy

Department / Service:	Clinical Governance & Risk Management
Originator:	Heather Webb, Compliance & Effectiveness Manager
Accountable Director:	Dr Mike Hallissey, Chief Medical Officer
Approved by:	Clinical Governance Group
Date of Approval:	6th October 2020
Review Date: **This is the most current document and should be used until a revised version is in place:**	13th April 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Clinical Departments
Target staff categories	All Clinical Staff

Purpose of this document:

This document outlines the process for National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) for the Trust and details the aims, accountabilities, responsibilities, resources and processes designed to establish a coordinated and effective approach to the studies.

The implementation of the policy will also enable study outcomes and recommendations to be monitored for effectiveness and provide assurance that national recommendations related to the studies are being met and improvement measured.

Key amendments to this document:

Date	Amendment	By:
8 July 2018	Transferred from a policy pathway to a policy format. Updated to reflect current governance structure and process. Changes to the following sections: • 3. Duties & Responsibilities • 4. NCEPOD Study Process • 5. Reporting and shared learning of results Addition of: • Appendix 1: Quick reference flow chart for Divisions on reporting NCEPOD activities	H Webb/ S Wardle
21 September 2020	Changes to section 4; NCEPOD Study Process to reflect that questionnaires are often electronic rather than paper, and to note the requirement to comply with the national data opt-out rules.	H Webb/ Holly Page
Oct 23	Document extended for 6 months whilst review undertaken	Jo Howden
April 24	Document extended for 6 months whilst review is undertaken	Elaine Chapman
Nov 24	Document extended for 6 months whilst review and rewrite is complete	Elaine Chapman
13th October 2025	Document extended for 6 months whilst review and rewrite is complete	Elaine Chapman

Contents

1. Scope of the Policy

This policy describes the management arrangements, responsibilities and processes for National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) within Worcestershire Acute Hospitals NHS Trust.

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

Statutory and mandatory requirements

Under the National Clinical Audit and Patient Outcome Programme (NCAPOP) participation in the Clinical Outcome Review Programme is mandated. The General Medical Council (GMC) states that clinicians should take part: Good Medical Practice states "you must work with colleagues and patients to maintain and improve the quality of your work and promote patient safety".

In particular item (g) states "contribute to confidential enquiries and adverse event recognition and reporting, to help reduce risk to patients" (Para 14 Good Medical Practice 2006). Additional guidance from the GMC on confidentiality also states "There are circumstances in which you should disclose relevant information about a patient who had died" item (c) states that this should be disclosed "for National Confidential Enquiries or for local clinical audit". The DH documents cover NHS Trusts and the GMC document covers clinicians working in both the NHS and the independent sector.

The NHS standard contracts for acute hospital services covers agreements between Worcestershire commissioners and hospitals. The contract terms apply to new agreements for services provided by Worcestershire Acute Hospitals NHS Trust and require the Trust to participate in the National Clinical Audit Patients Outcome Programme (NCAPOP) audits and outcome review programme (NCEPOD) which are relevant to the services they provide and must implement all relevant recommendations of any appropriate studies

Under the Health Act 2009, the Trust is required to produce an annual Quality Account, which must include information on participation in NCEPOD, and the actions which have been taken as a consequence to improve the services we provide.

Improvement and Assurance

The Trust supports the view that NCEPOD plays an important role in providing assurances about the quality of services.

In addition, the Trust is committed to ensuring that:

- It participates in all eligible NCEPOD studies
- Published reports of all studies undertaken within the Trust are reviewed to provide assurance to the speciality, directorate, division and board that the findings have been reviewed, areas of concern are raised and recommendations for which the Trust is eligible are progressed.

2. Definitions

Clinical Outcomes Review Programme (CORP)

The Clinical Outcomes Review Programme (CORP) also known as Confidential Enquiries are designed to help assess the quality of healthcare and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data.

Clinical Governance Group (CGG)
The Clinical Governance Group (CGG) is a sub-group of the Quality Governance Committee (QGC).

National Confidential Enquiries into Patient Outcome and Death (NCEPOD)
The aim is to ensure that a wide variety of medical and surgical studies are undertaken, reviewing the quality of care received by patients in hospital

NHS England Quality Account List
The NHS England Quality Accounts List is made available each January. It comprises of national audits, clinical outcome review programmes and other quality improvement projects that NHS England advises Trusts to prioritise for participation during the forthcoming financial year.

QGC – Quality Governance Committee
The Quality Governance Committee (QGC) is constituted as a standing committee of the Trust's Board. The QGC is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for, or expedient to, the exercise of its functions.

3. Duties and Responsibilities

The Clinical Governance Group (CGG) oversee the Trust's activities on NCEPOD.

3.1 All Trust Clinical Staff

To comply with the requirements of this policy.

All clinical staff have the responsibility to participate in studies which are relevant to them and for which they have been requested to participate as outlined in this policy.

3.2 Chief Executive

The Chief Executive is responsible to the Trust Board for the statutory duty of quality.

3.3 Chief Medical Officer

The Chief Medical Officer is the executive lead for NCEPOD and is responsible for ensuring the provision of an NCEPOD Policy.

The Chief Medical Officer may delegate the following responsibilities:

- That this policy is implemented across all clinical areas.
- That NCEPOD Study reports and recommendations are considered and implemented where relevant.

3.4 Head of Clinical Governance & Risk Management

The Head of Clinical Governance and Risk Management has the responsibility to ensure a consistent approach to implementing the organisational arrangements for clinical governance across the Trust, including clinical audit and NCEPOD.

3.5 Compliance & Effectiveness Manager

The Compliance & Effectiveness Manager is responsible for ensuring corporate level systems and processes are evidenced and implemented within the Trust, to support NCEPOD studies. Has a line management responsibility for the Clinical Audit Manager.

3.6 Local Ambassador

They will act as the voice of the Trust to improve participation rates in the work of the enquiry and enhance the implementation of the lessons of the reports provided by NCEPOD. They will also provide support to the NCEPOD Local Reporter. The Chief Medical Officer delegates the role of Local Ambassador to a Clinician.

3.7 Local Reporter

Local reporters act as a link between the non-clinical staff at NCEPOD and individual hospitals: The role includes compiling and sending datasets requested by NCEPOD and acting as a named contact for information sent by NCEPOD. A member of the Clinical Audit Team is named as the Local Reporter

3.8 Individual Clinician/Study Lead

The individual lead is responsible for completing the questionnaires and returning in a timely manner to NCEPOD.

3.9 Divisions

Key individuals (Divisional Management Team, Heads of Divisional Governance, Clinical Directors, Divisional Governance Teams) within the Division must:

- Ensure that this policy is effectively implemented within their directorates/specialties.
- Identify a named clinical lead for each study.
- Ensure that clinicians within their specialty that are required to complete an NCEPOD study are supported to do so
- Ensure that there are clear mechanisms for assuring the quality and appropriateness of NCEPOD activity.
- Ensure that there is a systematic approach for monitoring the agreement and implementation of recommendations and action plans resulting from NCEPOD studies.
- Ensure that there are appropriate forums to enable presentation and discussion of NCEPOD results
- Ensure that on publication of the report that the NCEPOD recommendation checklist is completed and a management summary is produced as part of the review process.
- Provide assurance to the Clinical Governance Group that NCEPOD studies are reviewed. Escalate any areas of concern, or adverse outcomes that highlight risk of patients care/treatment not being safe/effective. See Appendix 1 guidance for reporting on NCEPOD

3.10 Clinical Audit Team

The role is to:-

- Manage and oversee the process for the Trust's participation in NCEPOD studies.
- Support the Chief Medical Officer in carrying out their responsibilities.
- Develop and implement a process to record NCEPOD study activity.
- Monitor that published NCEPOD study reports have been reviewed and that the recommendation checklist and a management summary report have been completed.

3.11 Divisional Governance Teams

The Divisional Governance Team's include:

- Head of Divisional Governance
- Quality Governance Team

The role is to support NCEPOD within the divisions and act as liaison, where necessary, between the divisions and the corporate Clinical Audit Team**.** Facilitate and support the Divisional responsibilities as outlined in 3.9.

4. NCEPOD Study Process

The process for completing NCEPOD studies is described below:

- NCEPOD send notification of the study to Chief Medical Officer, NCEPOD Ambassador and Local Reporter.
- The Local Reporter will ask the relevant Divisional Medical Director to assign a Clinician/Study Lead who will coordinate the data collection.
- NCEPOD request the dataset. Local Reporter requests data from Information Department, ensuring that sample complies with the Data Opt-out requirements.
- Local Reporter returns encrypted data set to NCEPOD.
- NCEPOD update the online portal with the selected patients.

- The Local Reporter then assigns the questionnaire to the relevant clinician.
- Clinicians complete the questionnaires online and submit to NCEPOD when completed.
- Clinical Audit Team track questionnaires online and ensure all questionnaires are submitted.

5. Reporting and shared learning of results

The NCEPOD team provide local Trusts with individual reports on their compliance and performance along with a recommendation checklist. The requirement is that the recommendation checklist is completed and returned to the Clinical Audit Team whereby a management summary report and action plan is formulated to implement the recommendations as part of the quality improvement process. The management summary report and action plan is overseen by the Divisional Medical Director(s) and the Clinician/Study Lead(s).

Sharing learning from NCEPOD studies is an important part of the process. It offers the opportunity to identify common themes across other work streams such as incidents, risks, complaints and facilitates organisational learning.

The following methods are examples of opportunities for sharing learning;

- Specialty audit meetings
- Directorate meetings
- Divisional Governance meetings
- Ward team meetings
- Grand Rounds
- Doctors training sessions

6. Ethics & Consent

By definition, NCEPOD Studies should not require formal approval from a Research Ethics Committee. However one of the principles underpinning NCEPOD is that the process should do good and not do harm. NCEPOD must always be conducted within an ethical framework.

The ethical framework should consider the following four principles:

1. There is a benefit to existing or future patients or others that outweighs potential burdens or risks.
2. Each patient's right to self-determination is respected.
3. Each patient's privacy and confidentiality are preserved.
4. The activity is fairly distributed across patient groups.

7. Equality & Diversity

The process for determining choice of NCEPOD Studies, and the manner in which project patient samples are drawn up, should not inadvertently discriminate against any groups in society based on their race, disability, gender, age, sexual orientation, religion and belief. Any person who has concerns regarding the ethics of NCEPOD activity within the Trust should refer them in the first instance to the Clinical Governance Group, who may require equality impact assessments to be undertaken and / or equality data to be collected as part of Studies in order to determine whether any particular groups of patients are experiencing variations in practice. It should be noted that NCEPOD govern the process for how studies are undertaken and patients are selected.

8. Information governance: collection, storage and retention of data and confidentiality

All NCEPOD Studies must adhere to NHS Information Governance policies and standards. Studies should pay special attention to the Data Protection Act (1998) and the Caldicott Principles (1997). This means, for example, that data should be:

- adequate, relevant and not excessive
- accurate
- processed for limited purposes
- held securely
- not kept for longer than is necessary

- comply with the requirements of national data opt-out rules.

9. Equality requirements of this Policy

The content of the policy has no identified adverse impact on equality and diversity. A copy of the completed checklist form is found in supporting document 1.

10. Financial risk assessment

The content of the policy has no identified adverse impact on finance. A copy of the completed checklist form is found in supporting document 2.

11. Consultation

Details of those consulted during the development of this policy are outlined below:

Key individuals involved in developing the document.

Designation
Chief Medical Officer
NCEPOD Ambassador
Compliance & Effectiveness Manager
Clinical Audit Manager

Circulated to the following individuals for comments during development

Designation
Deputy Chief Medical Officer
Divisional Medical Directors
Heads of Divisional Governance
Quality Governance Team
Clinical Audit Facilitators

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12. Approval process

This policy is approved by the Clinical Governance Group.

13. Implementation

In order to implement and evaluate the NCEPOD policy the Clinical Audit Team will:-

- Ensure that the policy is effectively communicated across the Trust. This will be achieved through the dissemination process described below.
- Continually monitor the implementation of the policy and achievement of stated aims.
- Review and revise the policy within specified timescales.
- Facilitate studies identified by NCEPOD for which the Trust is eligible to participate

14. Dissemination

A copy of the policy will be provided on the Trust's intranet.

Communication with staff through the Trust intranet communications.

- Discussion at Divisional Governance meetings
- Consultation with stakeholders
- Circulated to all Clinical Directors, Directorate Managers and Divisional Management Teams.

15. Policy Review

The policy will be reviewed three years after approval or sooner in the event of any significant changes in the Trust structure or processes that require amendment

16. Monitoring and Compliance

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
4	The Trust will ensure that they will participate in all eligible studies	Clinical Audit Team to liaise with specialities/divisions.	Annual	Clinical Governance Group	Clinical Governance Group & Quality Governance Committee	Annual
4.	NCEPOD Studies are carried out in accordance with Trust Policy, including completion of actions identified within action plans	All NCEPOD activity is monitored at directorate and divisional level.	At least bi-monthly	Divisional Governance Group	Clinical Governance Group	At least bi-monthly
4.1	The Trust participates in all NCEPOD Studies it is eligible to participate in.	The Clinical Audit Team works with Divisional Medical Directors to ensure a Clinical/Study Lead is identified and that questionnaires are returned.	Monthly/as required	Clinical Audit Team	Clinical Governance Group	Quarterly

Appendix 1 Quick Reference Flowchart for Divisions on reporting NCEPOD activities

Specialty/Directorate Meeting Level

NCEPOD
- Participation in NCEPOD studies.
- Gap analyses and action plans.
- Risks arising from NCEPOD studies.
- Lessons to be shared.

Divisional Governance Meeting Level

NCEPOD
- Obstacles to participation in NCEPOD studies and how these can be overcome
- Review NCEPOD reports and action plans
- Any risks relating to participation in or outcome of NCEPOD studies
- Lessons from NCEPOD studies

Clinical Governance Group Level

NCEPOD
- Review risks relating to participation in or outcome of NCEPOD studies, as part of routine risk management process.
- Assurance/ corrective action statements for NCEPOD reports.

Guidance for Divisions on reporting NCEPOD Activities
This guidance is designed to provide a framework for divisions to manage and report on NCEPOD activities within specialties, directorates and divisions each month, and how assurance should then be provided to the Clinical Governance Group.

Activity	Specialty/ Directorate meeting level	Divisional Governance Level	Clinical Governance Group
NCEPOD	• Report to include participation in NCEPOD studies relevant to specialties. • Review gap analyses and action plans following publication of NCEPOD reports. • Identify any risks arising from NCEPOD studies and ensure these are assessed in line with the risk management process. • Report to include any lessons to be shared across the directorate/division/ trust, and ensure lessons are shared appropriately. **Escalation/ onward reporting to divisional governance meeting;** • Any instances of non-participation in NCEPOD studies. • Any instances where action plans are not progressing to the agreed timescales, with plans for improvement. • Any lessons for sharing more widely.	• Report to include obstacles to participation in NCEPOD studies, as reported by specialties/directorates, and consider how these can be overcome to support the specialties/directorates. • Review NCEPOD reports and action plans, and ensure action plans are monitored to completion. • Manage any risks relating to participation in or outcome of NCEPOD studies, as part of routine risk management process. • Ensure any lessons from NCEPOD studies have been shared appropriately. **Escalation/ onward reporting to Clinical Governance Group, as part of routine Quality & Safety Report/Presentation;** • Report to include any NCEPOD reports where the trust is performing poorly, with assurance that an action plan has been developed and is being monitored at divisional governance meetings. • Report to include an outline of any NCEPOD reports for which an action plan is overdue, or where action plans are not progressing to the agreed timescales.	• Review risks relating to participation in or outcome of NCEPOD studies, as part of routine risk management process. • Receive assurance/ corrective action statements for NCEPOD reports where the trust is performing poorly, or where no action plan has been developed, or where actions are overdue, with assurance that this is being managed within the division. Exception reporting to QGC.

Supporting Document 1 - Equality Impact Assessment Tool

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire and Worcestershire Safe and effective health and care services

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Mr Mike Hallissey, Chief Medical Officer**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Heather Webb	Clinical Effectiveness Manager	wah-tr.ClinicalAudit@nhs.net
Date assessment completed	19th February 2020		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** NCEPOD Policy
What is the aim, purpose and/or intended outcomes of this Activity?	This document outlines the process for National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) for the Trust and details the aims, accountabilities, responsibilities, resources and processes designed to establish a coordinated and effective approach to the studies. The implementation of the policy will also enable study outcomes and recommendations to be monitored for effectiveness and provide assurance that national recommendations related to the studies are being met and improvement measured.

Who will be affected by the development & implementation of this activity?	✓ Service User ✓ Patient ❑ Carers ❑ Visitors		✓ Staff ❑ Communities ❑ Other _____	
Is this:	✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	The Policy follows the national requirements of NCEPOD.			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Consultation described in Section 11 of the policy.			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	N/A	N/A	N/A
How will you monitor these actions?	N/A			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9

protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Heather Webb
Date signed	4th August 2020
Comments:	
Signature of person the Leader Person for this activity	Mike Hallissey
Date signed	4th August 2020
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval