National Quality Board

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Dear Jonathan

STRENGTHENING THE CLINICAL EXCELLENCE AWARDS: ADVICE FROM THE NATIONAL QUALITY BOARD and THE NATIONAL LEADERSHIP COUNCIL

The National Quality Board (NQB) and the National Leadership Council (NLC) would like to thank you for the opportunity to provide collective advice on sharpening the assessment criteria in respect of the next round of the Clinical Excellence Awards.

The NQB and NLC are pleased that their recommendations for the 2010 scheme were taken into account and welcomes this opportunity to provide the ACCEA with further advice for the year ahead on the operation of the 2011 scheme.

Both the NLC and the NQB have deliberated on and participated in enthusiastic discussions on the scheme in general and specifically the requirements set out in *Part 4: Assessment Criteria* in the *ACCEA Guide for Applicants*. Both bodies agree on the importance of transparency and are of the view that there is no greater quality control than scrutiny by peers. We strongly encourage the ACCEA to introduce even greater transparency in the application process and recommends that all successful applications are published in full. This greater transparency will minimise the risk of exaggeration and misrepresentation. We appreciate that the timing of our advice may preclude the introduction of full transparency for the forthcoming awards round. However, we would recommend that for beyond 2011 applications should be fully transparent.

There is an argument that for even greater transparency all applications, successful or otherwise should be published. Indeed the NLC are strongly in favour of this. They recognise that the publishing of merely the successful ones may have some undesired side effects, but if everyone's applications were

published this would allow more transparency as to why Applicant A was successful but not Applicant B.

As a further transparency mechanism, the NQB recommends that applications should provide evidence of how clinicians have changed their practice, based on patient feedback. The guide should make clear that this would be looked upon favourably.

The **National Quality Board** has provided further advice on quality with regard to the awards as follows.

The NQB was pleased to see the improvements to the domains in Part 4 were in line with its previous advice. It felt that there were several minor areas where the domains could be strengthened further.

The NQB recommends that there is greater alignment between the delivery of national quality improvement priorities and the awards made under this scheme. For example,

i. strengthening the expectations on the use of robust quantified measures, with recognised denominators and numerators, as part of evidence;
ii. emphasise the value of providing evidence of delivery of national priorities, for example, VTE prevention, where appropriate;
iii. give far greater prominence to the critical importance of participation in clinical audit and implementation of quality improvement as a result;
iv. demonstrate how applicants have risen to the quality and productivity challenge, given the financial pressures in a constrained NHS, and
v. reference to accreditation schemes should be recognised. Consultants should be encouraged to clarify if their service was accredited and how they had contributed to the development of the service.

Detailed wording suggestions are at **Annex A**.

More generally, the Board commented on the sustainability and feasibility of the awards scheme. It was recognised that there may be questions on this in future years taking into account the current financial environment. It was also noted that there may be an argument for such incentive schemes for other professional groups, e.g. non-academic GPs and nursing personnel. The Government has now announced (on 20 August) that there is to be a UK wide review of compensation levels, incentives and the Clinical Excellence and Distinction Award Schemes for NHS consultants, led by the DDRB. I would be grateful if you could make reference to the views set out in this letter when you give evidence to the DDRB. The DH evidence to the review will include a copy of this letter.

The National Leadership Council has provided advice in respect to the leadership element of the awards scheme with a view to ensuring that leadership is recognised as critical to the awards.

The NLC feels that the proposed criteria are much improved, however, more work could be done to align them with QIPP and the values expressed in the NHS Constitution. The specific recommendations from the NLC involve ensuring that

leadership is referenced in the awards criteria in terms of leadership impact, personal leadership qualities and commitment to self development.

Leadership Impact
The key question that could be asked is 'How has the nominee's leadership behaviour impacted on the delivery of high quality care?' Nominators could be asked to list specific outcomes in response to this question.

Personal Leadership Qualities
With regards to qualities, the NLC recommends that the following question is asked 'What makes the nominee stand out as an individual leader?' Nominators in answering this question could be asked to describe the nominee's leadership behaviours.

Commitment to Self Development and the Development of Others
More specific requirements around participating in ones own leadership development and the development of others could be included. Nominators could use examples such as participation in formal or informal mentoring, coaching activities, participation in fellowships/schemes/courses and evidence of developing the next generation of talent.

Thank you for the opportunity to provide advice on strengthening the criteria of such an important lever for improving quality in the NHS. I hope the ACCEA finds the above helpful.

Yours sincerely

Sir David Nicholson KCB CBE
Chair, National Quality Board and **Chair, National Leadership Council**

Annex A: Detailed suggestions from the National Quality Board

Strengthen the expectations on the use of quantified measures as part of evidence

1. In **Domain 1,** an example should be given of an application in which the quality evidence has been structured according to the three dimensions of quality, patient safety, effective clinical outcomes and good patient experience. The wording should be strengthened (suggested changes in bold) to say that:
   " your evidence should include quantified measures if these exist, that reflect the whole service that you (and if relevant, your team) provides, using Indicators for Quality Improvement or Quality Standards and other referenced data sources in England.... the evidence on patient safety should refer where possible to the new quality indicators and the evidence on patient experience should indicate how you have addressed the issues of dignity, compassion and integrity with patients."

2. In **Domain 1**, the following example should be included:
   "I have set up a short stay programme which has the lowest length of stay for hip replacements in England, 2.7 days as against the England average of 6.1 days….. 67% patients are home after two nights….. 98.5% patient satisfaction service….. readmission rate of 5.1% as compared to the regional average of 7%"

Emphasise the importance of VTE prevention

3. In **Domain 1** a reference could be made to VTE prevention as a specific example of addressing clinical priorities. The following example could be included:
   "As a Clinical Director of Acute Services I have rationalised our current approach to VTE prevention as a part of the Trust's overall clinical governance, audit and performance data set; I have ensured that each patient on admission undergoes a VTE risk assessment using the national tool and NICE guidance through out electronic patient admissions system, with integration to the hospital at night service and our online pharmacy records. This comprehensive change in risk assessment has moved our performance from ....% patients

assessed on admission to ....% and is accompanied by .....% receiving appropriate NICE compliant prophylaxis compared to ...% one year ago"

4. In **Domain 2**, the following example of VTE prevention could be given.
   "From an orthopaedic consultant: I have developed a continuous patient pathway with GP services for all preadmission clinics, and day case surgery patients ensuring the following; VTE risk assessment, appropriate thromboprophylaxis (including an extended duration component) with bleeding and VTE incidence, prevalence and follow up data. This is already improving our understanding and awareness of the issue but also stimulating us to work with GP colleagues to streamline the process. We estimate that, in the area piloted, ...bed days have been saved over the 6 month period of the pilot. "

Give more prominence to participation in clinical audit and implementation of quality improvement as a result

5. In **Domain 2**, more prominence should be given to participation in clinical audit and implementation resulting in quality improvement. The CEA guidance should specifically request information on the clinician's involvement in relevant national clinical audit and in local clinical audits. This could include a request for specific examples of action taken in the light of audit findings. Some audits may highlight quality improvements that require organisational change, rather than a change effected by clinicians (which it often is) and the criteria CEA should seek information on how the applicant had tried to achieve organisational change.

Emphasise the importance of delivering quality and productivity given the financial pressures on the NHS

6. The preamble to Part 4 should include the following:
   "Clinical excellence is about delivering high quality services to the patient in front of you. However it is also about ensuring that you are able to treat as many patients as possible by using resources efficiently and improving the productivity of the services you offer. Assessors will expect to see evidence of a contribution to improving the productivity and efficiency of services of the NHS whilst simultaneously improving quality. "

7. Wording about improving productivity and efficiency of services could also be added to the criteria for the various Domains.

8. In **Domain 2** the following example should be used:
   "I used multi disciplinary team working to effect systemic change throughout our unit saving nearly 1,000 bed days. This reduced the requirement for elective beds by 25%....I developed two half session theatre days. This has greatly improved theatre efficiency….. I helped set up and develop the Orthopaedic Outreach Team which greatly reduced length of stay and was highly commended in the 2006 HSJ Awards."

Strengthen the innovation components

9. In **Domain 4**, the wording about innovation should be strengthened. Consultants should be asked to say how they have supported innovation by developing the evidence base for the measurement of quality improvements. They should also be asked what work they may have done to:
   - further develop techniques for public engagement;
   - encourage the systematic uptake of innovation to improve the quality of patient services; or
   - an example of innovative practice should be added to the criteria.

10. In **Domain 5** the criteria should be expanded to include developing innovative teaching methods to equip the next generation of clinicians to understand and improve the quality, productivity and efficiency of patient services. Evidence should include some on being trained to teach, evaluated formally and informally on teaching quality, with demonstrable improvements in the quality of teaching.

National Nominating Bodies

11. In order to support the changes to the assessment criteria, ACCEA might ask the National Nominating Bodies (NNBs) how they could best give weight to indicators of quality relevant to their specialties in NNB assessments of CEA applications.