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'The NCEPOD Method' – How the National Confidential Enquiry into Patient Outcome and Death designs and delivers national clinical outcome review programmes

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Abstract

Introduction: This publication describes the method used by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) to run confidential enquiries. With its history based around the review of surgical mortality, NCEPOD has now grown into a medical as well as surgical review and expanded its remit to review overall quality of care of all patients.

Methods and analysis: The work will describe the qualitative method used by NCEPOD to conduct a national confidential enquiry, starting with how a topic is selected through to report production. Covering all hospitals in the UK and using a network of local contacts, NCEPOD reviews a sample of cases from each hospital and provides in-depth multidisciplinary peer review to give a national picture on the quality of care provided. The peer review data collected is underpinned by quantitative data collected using questionnaires, and all analyses are undertaken using pivot tables in Excel. The paper will highlight the strengths, limitations and challenges of this qualitative method.

Ethics and dissemination: NCEPOD does not interact directly with patients and therefore does not require ethics approval. NCEPOD does, however, gain approvals through the relevant regulations in all UK countries to collect identifiable or anonymised data without consent.

Conclusion: The paper will be useful for those who need a reference document for the general approach to enquiries that NCEPOD now uses. It could also be read by those who would like to undertake their own local enquiry and would like a method to base it on.

Keywords
Confidential enquiry, peer review, case notes, qualitative

Background to the confidential enquiries

The Confidential Enquiry into Perioperative Deaths (CEPOD) was published in 1987 in response to professional concern about perioperative deaths.[1] After the publication of the report the Department of Health announced that it would fund a National Confidential Enquiry to repeat the work, and so NCEPOD as an organisation was established, publishing its first report in 1989.[2] NCEPOD was not the first confidential enquiry to be formed, the method was already well established by the Confidential Enquiry into Maternal Deaths which dates back to 1952 and was the longest running enquiry when it merged in 2003 with the Confidential Enquiry into Stillbirths and Deaths in Infancy. This had been set up in 1993 to address the relatively high stillbirth and infant mortality rates in the UK. These two enquires formed the Confidential Enquiry into Maternal and Child Health (later becoming CMACE (Centre for Maternal and Child Enquiries) in 2009). During this period, in 1999, the Confidential Inquiry into Suicides and Homicides

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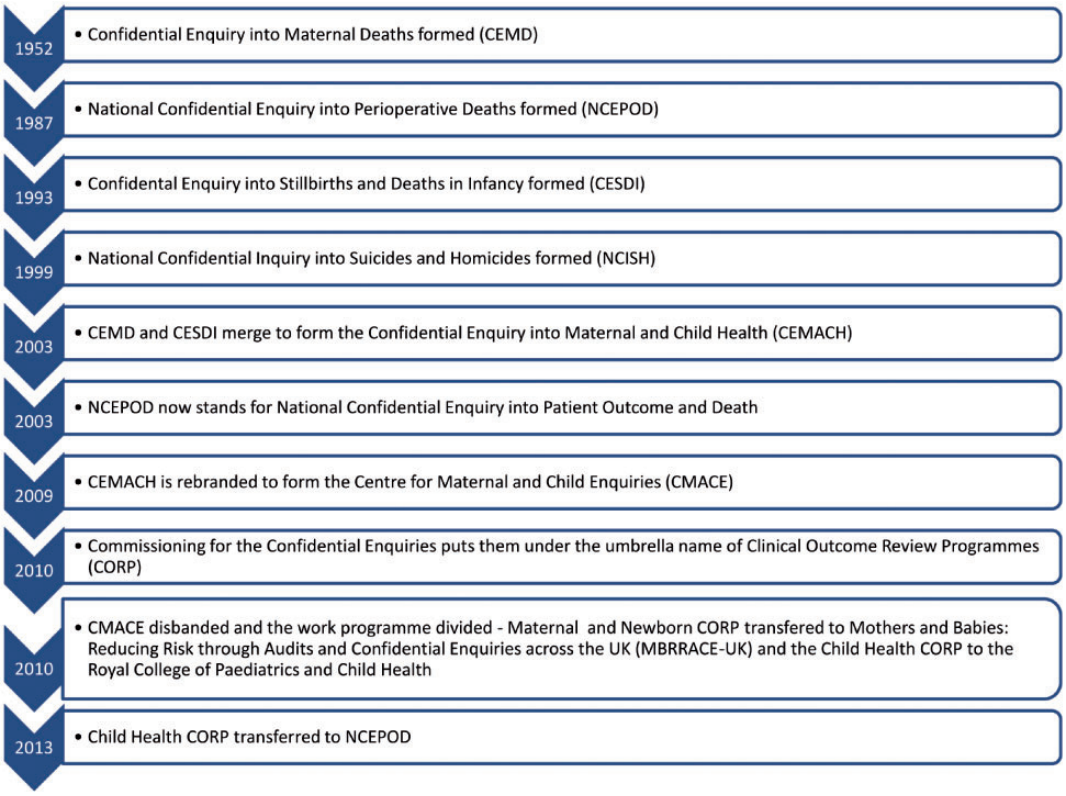

Figure 1. Timeline of the history of the Clinical Outcome Review Programmes/Enquiries.

committed by people with mental illness was established by Manchester University. Additional enquiries have also been undertaken by the Royal College of Physicians of London who provided a National Review of Asthma Deaths[3] and by the University of Bristol who undertook the Confidential Inquiry into Premature Deaths of People with Learning Disabilities.[4]

In 2010, commissioning for these Enquiries came under the National Patient Safety Agency and was tendered under the umbrella name of Clinical Outcome Review Programmes. The commissioning resulted in a change of supplier in some and an expansion of remit in others. The Maternal and Child Health programme was once again divided; the Maternal and Perinatal aspect is now undertaken by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)[5] and the Child Health aspect was run by the Royal College of Paediatrics and Child Health until 2013,[6,7] but is now also run by NCEPOD.

In 2011, responsibility for commissioning was transferred to the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Scottish Government Health and Social Care Directorate, the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS), the States of Guernsey, the States of Jersey and the Isle of Man Government. The majority of independent hospitals also contribute to the programme. HQIP is an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices, established in 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit and outcome programmes have on healthcare quality improvement. Figure 1 shows the timeline of the history of the Enquiries/Clinical Outcome Review Programmes.

NCEPOD method vs. national audit

The national confidential enquiry approach adopted by NCEPOD and national audit are complementary processes. The fundamental differences are that a confidential enquiry takes a sample of cases and reviews them in detail to find out why something went wrong or went well, whereas audit involves including all cases in a larger analysis of data against existing standards. An overview of the two processes is shown in Table 1.

NCEPOD governance

NCEPOD is a clinically led organisation which retains the non-partisan voice of the clinical community.

Table 1. Comparison of NCEPOD method vs. national audit.

National enquiry	National audit
Focus is on qualitative data with additional quantitative analysis	Focus is on quantitative analysis
A random sample of cases is included	Every case is included
Data can only be used aggregated to provide a national picture	Data can be provided at a local level
The sample of cases is reviewed in depth by a multidisciplinary group of clinicians, measuring against, but not limited to, existing standards	The dataset obtained is analysed and measured against existing standards only
Data are analysed and recommendations made – the topic is rarely revisited, impact assessment is more complex	Data are collected annually to identify changes in practice, the routine re-assessment of the data make monitoring changes easier
Cases can be included retrospectively or prospectively	Cases can be included retrospectively or prospectively

This has afforded NCEPOD the full support from relevant Royal Colleges and Specialist Associations, who form an overarching Steering Group for NCEPOD (Figure 2).

NCEPOD steering group

This group comprises nominated members from the Royal Colleges, several professional associations and lay representation.

NCEPOD trustees

This group of clinical and non-clinical members are the Board of Directors of NCEPOD.

NCEPOD lay representatives

This is a core group of lay representatives who work across multiple studies and who support the patient representatives on each specific study.

NCEPOD clinical co-ordinators

This multidisciplinary group of clinicians are seconded from their Trust/Board on a 1–2 session per week basis to clinically lead each project. They develop the design of the study including the protocols and questionnaires along with the wider study team as well as chairing study meetings. They participate in planning the report style and content and to write sections of the report in conjunction with other clinical co-ordinators and the researchers responsible for the study.

Clinical researchers

These are non-clinical staff who are responsible for the data collection and analysis and report content.

Researchers

These assist the clinical researchers.

NCEPOD local reporters

These are our primary contact in every hospital and are the linchpin of the work programmes. They are often based in the clinical audit department.

NCEPOD ambassadors

These are senior clinicians in a Trust/Board who support the Local Reporter by engaging with their colleagues to participate.

Scientific advisor

When required, scientific advice is provided by the Clinical Operational Research Unit at UCL.

Study advisory group

This is a multidisciplinary group formed for each study comprising clinicians from relevant specialties and a patient group who are able to define the areas of greatest concern to be reviewed and highlight where there are guidelines or standards already in place that can be assessed against.

Case reviewers

A multidisciplinary group of clinicians and healthcare professionals who are appointed for each study and are responsible for assessing the case notes returned along with the final dataset. They help develop the recommendations at the end of the study and review two drafts of the report.

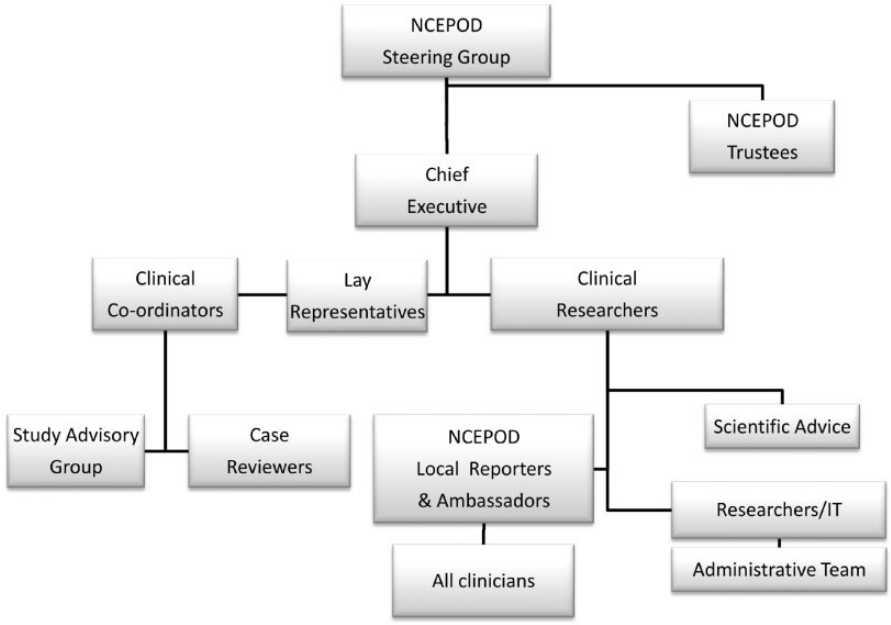

Figure 2. NCEPOD governance structure.

NCEPOD methodology

The process for an NCEPOD confidential enquiry from topic selection to publication is summarised in Figure 3. While each topic under review tends to provide its own unique challenges, such as poor coding, which often requires a modification to the method, the underlying generic process remains consistent. To ensure that the method is reproducible and robust, quality assurance checks are activated at various stages of the process and are highlighted throughout this paper.

Topic selection

An open call for topic proposals is made annually, via direct mailings to all Royal Colleges and Specialist Associations, all hospitals in the UK and to around 200 third-sector and patient representative organisations, as well as an announcement on the NCEPOD website and via social media. An illustrative proposal is provided as guidance on how to complete the proposal form, but other than that all topic suggestions are welcome. While topics in which cases could not be robustly identified, or topics that would be better run as a research study or clinical trial would be excluded, the method does not shy away from challenging topics such as sepsis or tracheostomy insertion where codes for the condition or the procedure are under-used, and case identification has to be supplemented using a prospective approach. Topics are often suggested to NCEPOD because others have found it too complex to assess in another setting, yet the clinical community are still calling out for something to be done. The strength of the open call is that a true variety of concerns can be raised, reflecting those of the profession and the public. However, as there is a limitation to the number of new studies that can be started each year, it does leave many applicants disappointed.

Scoring of the proposals is done using a two-stage process. Initially, the NCEPOD clinical and research team score against a set of pre-defined criteria; focussing on what the enquiry method can add to what is known about the topic, and whether it would still be clinically relevant by the time the report is published two to three years later. A short list of topics is then entered into the second stage, which is presented to the NCEPOD Steering Group for detailed clinical discussion and a second scoring and ranking. Finally, the top four (or five if they are scored closely) topics ranked by the Steering Group are presented to an Independent Advisory Group at HQIP who make the final decision on the two studies that will be undertaken. The significant clinical and lay input to inform the choice of topics is the strength of this process as the aim of the programme is to deliver clinical impact in areas where there are concerns articulated by the profession or the public.

Study development

To ensure that each study is developed by those who have topic-specific experience, NCEPOD convenes a Study Advisory Group (Figure 4).

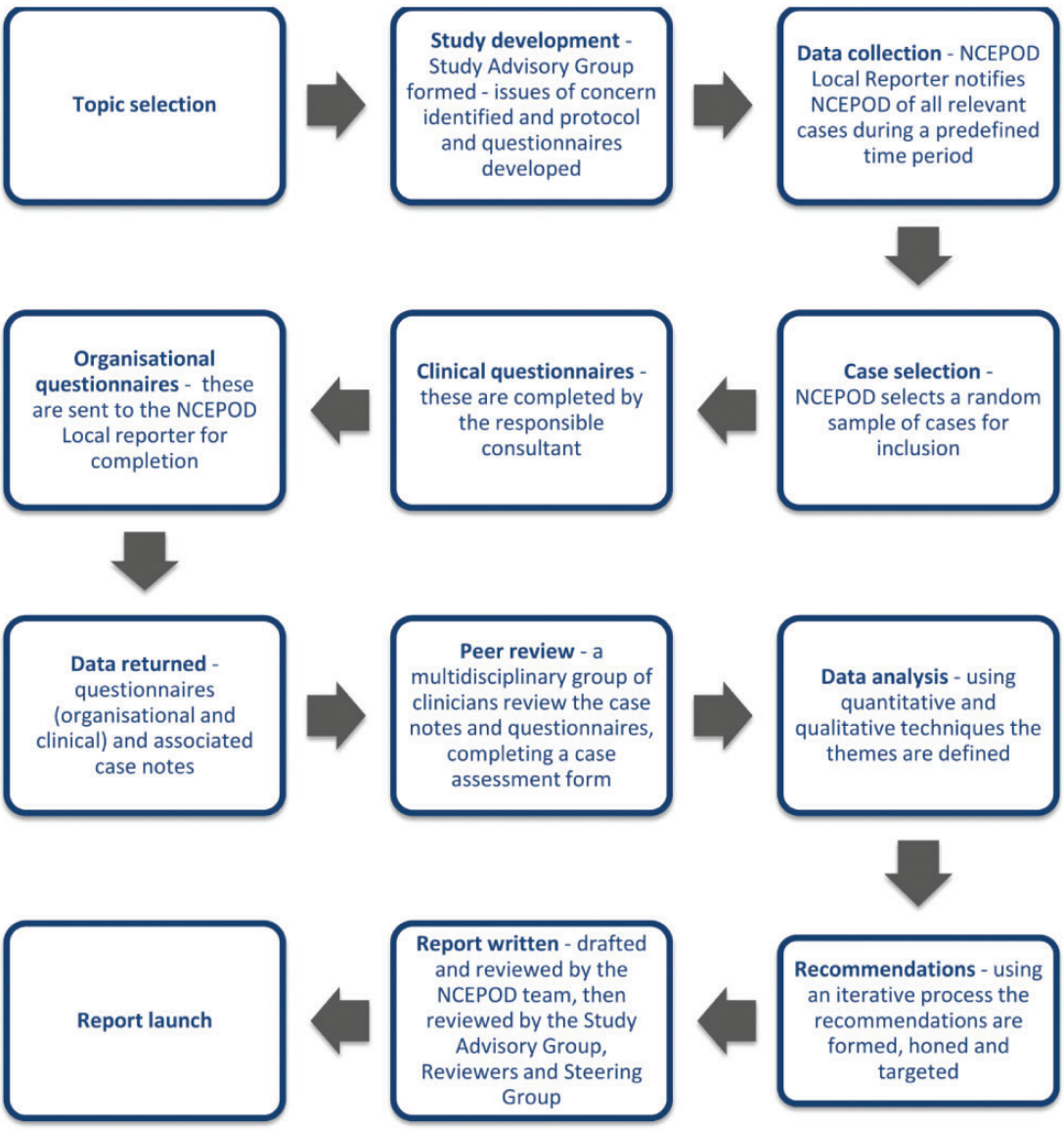

Figure 3. The NCEPOD enquiry process.

This group is led internally by two NCEPOD Clinical Co-ordinators, an NCEPOD Clinical Researcher, a Researcher and a Lay representative. The importance of having this group led by two NCEPOD clinicians is that at least one will be outside of the clinical field of the topic and can provide an unbiased voice in a group who know the subject well. Wider external membership of this multidisciplinary group, including patient representation, is sought by means of open advertisement, nomination by specialist organisations and direct sourcing through online searches and 'word of mouth'.

Members are specific to each topic while ensuring they are in current clinical practice and are a mixed group representing different specialties, hospital types, level of experience and cross-UK representation. This is important as selecting members because of close proximity to the NCEPOD office (i.e. London) for ease or only from large teaching hospitals would give a very biased view of the issues faced by the wider clinical community. The group meet on two occasions approximately two months apart and are contacted by email and phone in between meetings as required. They then meet again at the end of the study once the data have been collected to review the findings.

The group is responsible for:

1. Agreeing the issues of concern to be reviewed (using a consensus exercise if needed[8])
2. Agreeing the aims and objectives of the study
3. Defining the population needed to test the issues of concern (inclusions and exclusions)

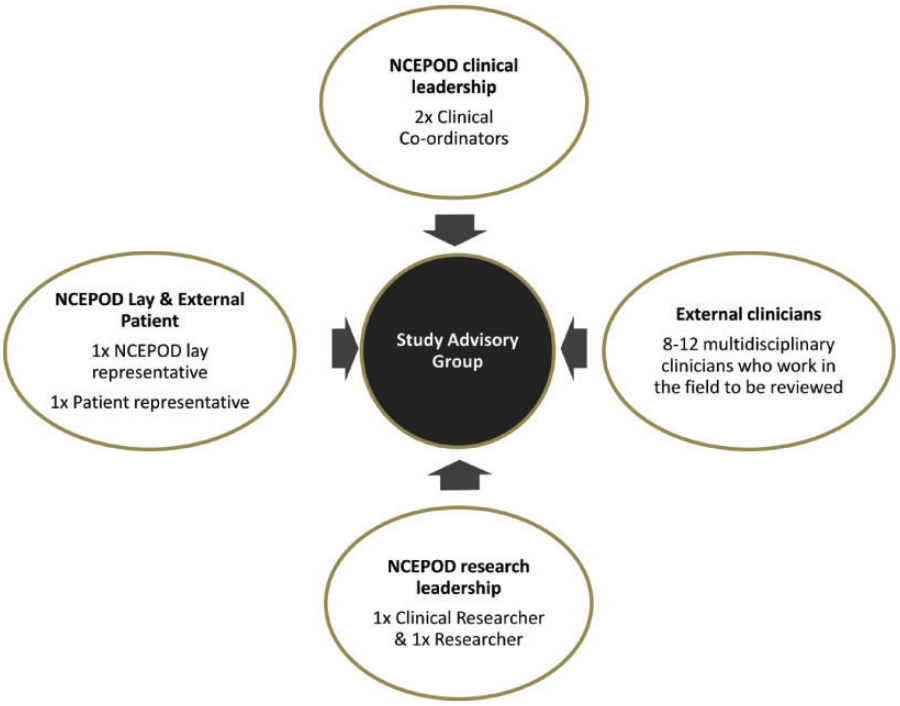

Figure 4. Membership of a Study Advisory Group.

4. Identifying any pre-existing standards/guidelines which should be used to assess against, to ensure a robust review grounded in existing evidence
5. Commenting on the protocol and the project management plan
6. Reviewing the findings of a test data collection and questionnaire completion to determine if the study designed is fit for purpose before it is undertaken
7. Sign-off of the three questionnaires to be used to collect data:
   (a) An organisational questionnaire to assess the policies, guidelines and facilities available at each hospital
   (b) A clinical questionnaire sent to the clinician/s who cared for the patient
   (c) An assessment form used during the peer review of the cases

Data collection

In every UK hospital, NCEPOD has a primary contact known as the NCEPOD Local Reporter. This person, who is most often based in the audit department, is a major strength of NCEPOD as they provide continuity across topics and are critical in ensuring cases can be identified and questionnaires are completed and returned with the case notes. In many hospitals, they are supported by senior clinicians known as NCEPOD Ambassadors. Both the Local Reporters and Ambassadors are invited to NCEPOD to attend training and networking days so that they can meet each other and learn how NCEPOD works.

Stage 1 – Case identification. This initial stage identifies the 'pool' of cases from which a sample will be randomly selected for further review. During the case identification period, NCEPOD Local Reporters are requested to complete and return a pre-defined spreadsheet to include *all* cases in their hospital with the required ICD10 diagnosis code or OPCS procedure code or text field if coding is not always used. The case identification period will vary depending on the commonality of the condition or procedure to be reviewed; examples of different strategies are shown in Table 2. The period for inclusion of cases is set in advance of the study and is based on an estimate derived from nationally available data and by asking Local Reporters to provide an estimate from their local data on the number of cases that would likely be included. This also means that the number of cases expected based on hospital size can be determined, so it would be clear if a hospital was significantly under reporting cases.

Stage 2 – Case sampling for further review. The sampling strategy is based on the following facts:

1. The sample needs to be obtained from across the UK and from as many different hospitals as possible

Table 2. Case identification period.

Incidence of condition/procedure to be reviewed	Initial case identification period	Example
Very high	Very short ≤1 week	High-risk surgery (19,097 patients identified over one week)[9]
High	Short >1 week	Sepsis (3363 patients identified over two weeks)[10]
Moderately high	Long >1 month	Subarachnoid haemorrhage (1457 patients indentified over four months)[11]
Low	Very long >1 year	Sickle cell disease (174 cases identified over two years)[12]

2. To minimise the burden on the hospitals returning case notes
3. To minimise the burden on the case reviewers
4. To have enough cases to identify themes of concern

Cases are sampled when the condition/procedure is common – described as high or very high in Table 2. To sample cases for an in-depth review, either an automated random selection process built in to the database will be used or they are semi-randomly selected if the sample needs to be biased for any reason, such as ensuring an admission to critical care is included in the sample, or if all deaths need to be included. For less common conditions, the sample might simply try to include all cases.

Themes show up after review of around 50 sets of case notes, because the study has been designed to do that – but they do not reflect enough cases to represent all UK hospitals. Therefore, on average a sample of 1150 cases is sampled which limits the number to five cases per hospital. After reported exclusions and some non-return of questionnaires and return of case notes that are complete enough to be reviewed, there is a returned sample of around 700 clinical questionnaires and 500 sets of case notes. Once the final denominator for the study is known, the return rates are in the region of 85% for questionnaires and 60% for case notes.

NCEPOD always undertakes the selection, using only a few patient identifiers so that detailed selection of cases can neither be made by NCEPOD nor by the providing hospital. At this stage, neither the Local Reporter in the hospital nor NCEPOD staff has any detailed knowledge of the cases; hence, NCEPOD cannot select only the 'bad cases' for more detailed review and the hospital cannot provide only their 'good cases'. It is recognised that the flexibility in the sampling process is both a strength and an uncertainty of the method. It allows a freedom to select the 'tip of the iceberg' cases that will truly test the healthcare system; however, it also means that despite having all the numbers in place and a sensible strategy planned, it is only after the data collection starts that its success can be determined. Many years of trying different approaches means that there is now a high degree of confidence in what will work well and what will not work so well.

The random selection of a small number of cases from each hospital means that data cannot be reported back at a hospital or even a Trust/Board level, as the sample of cases alone would not tell a complete story. The random selection also protects the patient involved and the clinicians who cared for them, as they were not selected with any pre-conceived concerns. It also means that if one hospital does not return data, it does not affect the overall findings – although the lack of participation will be noted at the back of the report. The aim of the enquiry is to take a 'snapshot' of data that are representative of the whole country and review it in detail, with the clinicians working in the field providing a narrative to the data. Therefore, it is more effective to have the included sample made up of a minority of cases from the majority of hospitals, rather than having the majority of cases from a minority of hospitals.

Stage 3 – Questionnaire and case note return. Once a sample of cases has been identified, a clinical questionnaire is sent to the clinician/s involved in the care of the patient and an organisational questionnaire is sent to the Local Reporter to complete. The questionnaires are bespoke for each study but built on existing questionnaire templates to ensure the 'style' of questionnaire is maintained across all studies and that the types of questions included are effective and consistent with previous questionnaires. Some question styles do not work well and at worse may encourage unreliable entries. Existing standards/guidelines will be built in to the questionnaires where relevant and all questionnaires are tested before being disseminated. There are limitations to this, as the questionnaire can only be tested so far, and as it is new for each topic, there are inevitably some questions that could have been framed slightly better; this is only ever a minority of questions.

As questionnaires are returned they are checked to ensure they are complete, with follow-up to the clinician responsible if required. Any identifiable information added is removed and photocopied extracts of the case notes are anonymised within eight weeks of receipt at NCEPOD.

Peer review of the case notes

Selection of case reviewers. On average, 30 case reviewers are recruited per study following an open application process and review of CVs. In a similar selection process to the Study Advisory Group, reviewers are selected to achieve a mix of healthcare professionals from across the UK, from a mix of hospitals, i.e. district general hospitals and acute teaching hospitals, a mix of specialties and to include some senior trainee doctors as well as other professions such as physiotherapists where relevant. Reviewers are also encouraged to return for future studies relevant to their specialty as their understanding of the process is incredibly helpful in ensuring the method is reproduced effectively across different topics.

Training of reviewers. A training day is held to ensure quality assurance in the peer review process and to identify individuals with inconsistent clinical assessments. The study protocol is explained to the reviewers and samples of the questionnaires used are presented. After signing a confidentiality statement, all reviewers then review the same two cases and each one is discussed in detail by the whole group. A show of hands at various stages of the discussion, on the quality of care provided, highlights early on in the process any extreme or outlying views that are not supported by the wider group. These members will receive additional guidance and helped closely in their first meeting. The training day also allows development testing of the semi-structured assessment form that will be used by the reviewers for each case they assess.

Case review meetings. Each case review meeting is chaired by an NCEPOD clinical co-ordinator, and each meeting comprises a mixed specialty group of around 8–10 reviewers per meeting who individually review 5–10 sets of case notes each. Reviewers never review any sets from their own hospital and if for any reason feel they recognise a case from elsewhere they are asked to give it a member of the NCEPOD team for reallocation at a different meeting. If the clinical questionnaire and/or organisational questionnaire for the associated case have been returned, then they will be made available to the reviewer. The Chair ensures that all cases once reviewed individually are opened up for a wider discussion by the group.

At first reviewers tend to raise concern over a majority of cases as naturally they are looking for things that went wrong, but after review of the first 50 or so cases and a discussion around each one, the natural baseline is set at a realistic level and reviewers are actually very kind to their peers when highlighting poor care as they familiar with the conditions everyone is working in and may have experienced similar situations. It is important that the overall sample included is large enough to allow this normalisation of a baseline to happen – with those cases from earlier meetings being re-reviewed later in the process. This provides confidence that the data reporting where care can be improved is due to its real existence, rather than as a result of hypercritical reviewers. If the sample is small, such as the sickle cell study mentioned in Table 2, then all the cases are reviewed by more than one person as a standard approach, to allow discussion of the case in more depth and a consensus view of the care to be provided. The cases are then discussed with the wider group as for those reviewed by a single reviewer.

It is known from similar studies that agreement between reviewers can vary in this type of work, as it is opinion based and is therefore subjective.[13,14] NCEPOD has undertaken an assessment of reviewer agreement in a controlled setting across three previous studies and found it to be effective for the purpose of the work undertaken; this is because the sample size of the dataset combined with the number of reviewers is large enough to ensure that a minority of true outlying comments will not affect the whole dataset.

An assessment form for each case is completed by the reviewers. The semi-structured form ensures consistency of review and aids the quantitative analysis, while free text boxes allow the freedom of opinion that underpins case note review. The free text can also be used to merge into case studies for the final report. Like the clinical questionnaires, the assessment form is also designed to include existing guidance/standards on the topic. For each case, the reviewer comments on various aspects of care along the patient pathway, and finally summarises the overall quality of care of each case using a standard grading system set by NCEPOD (Table 3).

During a case review meeting, a case might be classed as a 'cause for concern'. This is when the clinicians identify evidence of behaviour either clinically or organisationally that they think might affect current patients receiving treatment. In such a case they have a professional duty to report their concerns. Therefore, a standard process is followed in which the Chief Executive of NCEPOD notifies the Medical Director at the relevant hospital to review the case and take action where necessary.

Data analysis

A strategy of analysis is developed by the research team at the start of the study. This ensures that all analyses are reproducible and that each objective of the study is linked to specific questions in the questionnaires used to collect data. Any unexpected findings, outside of the original

Table 3. The NCEPOD grading of quality of care.

Score	Grade	Example
1	Good practice	A standard that you would accept from yourself, your trainees and your institution
2	Room for improvement in clinical care	Aspects of clinical care that could have been better
3	Room for improvement in organisational care	Aspects of organisational care that could have been better
4	Room for improvement in clinical and organisational care	Aspects of both clinical and organisational care that could have been better
5	Less than satisfactory	Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution

issues raised are considered with caution and tested during the review of the data with all clinicians involved.

The quantitative data collected in the clinical questionnaires and assessment are aggregated and analysed as are the organisational questionnaires and the assessment forms; this forms three discrete datasets in which cases are linked by a unique NCEPOD number for case level data (clinical questionnaire and assessment form) and by a unique site identification number to link the case data to a hospital or Trust/Board. Analysis of individual questions is done as simple counts or cross tabs using pivot tables in Excel. This quantitative analysis underpins the rich opinion-based answers collected on the assessment from during the peer review of the case notes. The peer review data are also aggregated so that individual cases, clinicians or hospitals are not identifiable. The two elements of quantitative and qualitative data combine to describe nationally occurring themes in the quality of care, on which recommendations to improve them are based.

The data are presented to the case reviewers and the members of the Study Advisory Group for a discussion as to whether the findings are expected or surprising. A month later, the data are presented to the NCEPOD Steering Group to provide a fresh perspective and a sense-check of the findings.

Formation of recommendations. During the drafting of the report, the recommendations are drafted, based on the available data and the original objectives of the study. The list is circulated with the report and comments are discussed. The final list is considered carefully to ensure that the wording truly represents what action is required. Once complete, the reviewers and the Study Advisory Group members are asked to agree the final list.

Report writing. The NCEPOD clinical co-ordinators are the primary authors. They create and work on three drafts in total. Drafts of the report are read by the Reviewers, Study Advisory Group, NCEPOD Steering Group, NCEPOD Board of Trustees, NCEPOD clinical co-ordinators and the research staff at NCEPOD. The Chief Executive has final editorial control.

The report is published and made available free of charge along with a self-assessment checklist for hospitals and an audit tool to measure change locally. Anonymised organisational data are provided to allow hospitals to benchmark their facilities against similar sized Trusts/Boards and patient leaflets are produced, where appropriate, to help patients ask questions about the procedures/services they are accessing.

Discussion

This paper describes the most general NCEPOD method. A process based on clinical peer review of cases could sound like a recipe for over criticism of a healthcare system already under close scrutiny. However, the reports are embraced by the healthcare professionals as they are the ones who want to improve the care they are providing, and the peer reviewers produce a report that will be useful while recognising the limitations that might exist in the healthcare system they work in.

Since 1987, a vast number of changes and quality improvement pieces have been in part underpinned by NCEPOD reports, some examples include:

1. Dedicated emergency 'CEPOD' theatres, reducing the impact on elective surgical lists
2. A reduction in out-of-hours operating by junior staff
3. Appointment of a National Clinical Director for Trauma care
4. A standardisation of guidelines to minimise deaths due to chemotherapy
5. Acute pain guidelines for patients with sickle cell disease (CG143)
6. Guidelines for the recognition of the acutely ill patient (CG50)

7. An wide scale awareness of acute kidney injury (CG169)
8. A surgical outcome risk tool (SORT) to aid clinical risk prediction
9. The National Emergency Laparotomy Audit

The reports are also well received as the method is familiar; it builds on the culture of case review that starts in medical training and which continues in local governance training and in morbidity and mortality reviews. Case note review provides an excellent mechanism to encourage learning from past events in a safe environment and to identify concerns in patient care that are believed to exist. Using it as a basis for local and national quality improvement programmes means that any work is based on a robustly collected dataset representing a wide breadth of hospital participation.

One of the key strengths of case note review is the sharing and discussion of the data. It is therefore just as important the findings are shared early on, beyond the people who are involved in each study. The final report needs to reflect the view of the professional groups as a whole as they will be expected to act on the recommendations made. There is a strong confidence in the method of selecting people to be involved in the study which ensures the final report will not be the views of a select group of people whose opinions are all outside the 'norm'. However, as one final quality assurance the report is shared more widely in advance of the final publication. This enables organisations undertaking work in the same field to be aware of the report. Similarly, working with those organisations on communication strategies also minimises potential confusion for the wider professional group who will be in receipt of findings from the various work streams. The sharing also tests the likely response to the report and ensures that the recommendations will be well received. Early NCEPOD reports showed that it often takes three to five years for recommendations to demonstrate a national change, so they need to be welcomed as soon the report comes out to engender a willingness to act on them. In preparation for the launch of a report, embargoed copies are sent to all relevant organisations so that they will not be taken by surprise, and a media strategy is put in place that will include liaising with their communications departments too.

It is the implementation of recommendations that also allows NCEPOD to measure the impact a report has had. The litmus test in the first instance is the fact that it is well received and this is in part due to choosing topics that are of concern, executing the study with a large amount of clinical input, working with a variety of institutions to ensure they are prepared for the report when it is published and essentially giving back to the healthcare profession a report that states their concerns which they can use to effect change locally. NCEPOD monitors its impact every six months by undertaking a review of all past studies to demonstrate where reports have had a good impact and also to learn from where studies have the most and least impact to see if there are factors that should be incorporated into future studies.

By measuring impact and by assessing the current method, it can be seen that NCEPOD has changed over the last 30 years, often in response to external changes in the healthcare system it's reviewing. It is hard to predict what changes lay ahead but it is important to try and consider what might change in the future. Other than reductions in the budget for the work programme, there are two main challenges.

Firstly, the ability to receive data to review: Advances in IT are likely to result in fully electronic case notes in all hospitals. Where this has already come into effect there is a challenge as the case notes are often split over different systems, the benefit, however, is that data can be transferred to NCEPOD more securely which is something we would encourage. Information governance regulations are becoming increasingly more sensitive which affects not just NCEPOD but all the hospitals that provide data. While our Information Governance Forum constantly assesses new risks to data collections, the inability to receive case notes would render the current method useless, so in thinking about such things we strive to develop new ideas on how the method could be adapted should this happen.

Secondly, the increase in availability of clinicians to take part: The whole point of having case notes is that they can be peer reviewed. With increasing pressures on clinician time, we can only hope that clinicians are able to be released from the hospitals for future studies as without them we would lose the ethos of what NCEPOD is.

Conclusion

NCEPOD uses a robust method of peer review, combined with quantitative data to voice the concerns raised by the medical profession and the public, into the quality of healthcare being provided. By making recommendations and providing evidence in a report, we empower the readers to be able to demand and engender change both locally and nationally.

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Data protection

NCEPOD data are collected in England and Wales with the approval of the Secretary of State for Health obtained by application to the Confidentiality Advisory Group of the Health Research Authority and is mandated in England by Quality Accounts. The data are collected in Scotland with the approval of National Services Scotland. Northern Ireland data are collected under regulations set out by the Privacy Advisory Committee to the Department of Health, Social Services and Public Safety.

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Contributorship statement

Marisa Mason was the sole author of this paper.

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