Surrey Downs CCG Clinical Quality and Patient Safety Report

Reporting Period: April 2013

Introduction

This report is to inform and provide assurance to the Governing Body about the quality and safety of service provision commissioned by NHS Surrey Downs CCG (SDCCG), including hosted services.

The report extracts areas of progress, concerns and actions taken from SDCCG Clinical Quality and Patient Safety Report (April 2013) overseen by SDCCG Clinical Quality Committee.

1.0 SYSTEMS AND PROCESSES

Systems and processes are now in place to provide early warnings on the quality of service provision to be used to support improvement which include:

1.1 Risk Register

As risks in the quality and safety of services are identified, they are risk assessed and added to the register. This is providing a focus on the areas of highest risk and will enable the quality team to prioritise its work across all CCG commissioned services. Following an initial meeting, the Head of Clinical Quality and Head of Corporate Services and Board Secretary have scheduled monthly meetings to review progress and update the risk register.

The risks that are currently being prioritised as a result of transition from NHS Surrey are:

- Lack of assurance around the capacity within the Safeguarding Children Service hosted by Guildford and Waverley CCG. A review of the service will take place during the summer and any actions that are recommended will be taken forward through the Surrey CCGs Collaborative

- Capacity within the Continuing Health Care Service which is hosted by Surrey Downs CCG. There is a risk that the high number of outstanding continuing care assessments could mean that clients are not receiving the most appropriate care to meet their needs. A full service review has been commissioned to start June 2013 with recommendation expected in September 2013. These will be reported through the Surrey CCGs Collaborative for agreement and action.

Additional risks that have been identified are:

- The performance of NHS Commissioned providers around Infection Prevention and Control – particularly Health Care Acquired Infections (HCAIs). Health Care Acquired Infections are a risk to patient safety and adversely affect patient experience. There is also a risk that this will affect the CCG's ability to attract the National Quality Premium with resultant financial and quality implications.

  Actions taken: See Section 2.3

- The CQC have undertaken unannounced inspections of a number of providers with whom NHS SDCCG commission services and have identified:

  Serious failures at BMI Mount Alvernia Hospital in Guildford which have put patients at serious risk, at times life threatening. Surrey CCGs only commission adult services. Of a total of 250 patients, SDCCG had of last week only 50 patients (90% private, 10% NHS) attending.

Actions taken:

- All referrals suspended by host commissioner (Guildford & Waverley CCG) until significant improvements made. Helpline set up by G&W CCG for patients and public

- Letter to all GP practices to inform of issues and suspension of referrals (attached)

- Confirmed that no SDCCG were inpatients at Mount Alvernia

- SDCCG to review all provider sub-contracting arrangements, specifically Royal Surrey County Hospital

- CCG collaborative response to CQC.

Minor to moderate failings at St Georges Hospital in Tooting which have an impact on patients using these services. These failings related to certain departments within the hospital. In other areas of the hospital, the Trust was judged to meeting those standards.

Actions taken:

- Wandsworth CCG as lead commissioners are monitoring St Georges Hospital action plan through the contracting process.

- A meeting has been arranged between the Quality Lead at Wandsworth CCG and SDCCG's Head of Clinical Quality to discuss.

1.2 Clinical Audit Programmes

A Clinical audit programme will be carried out during the year across a range of providers and services. This programme is currently being informed by concerns raised through provider clinical quality review meetings, quality accounts and dashboard and through soft intelligence from a number of sources.
Key priorities will be:

- The review of discharge processes within acute providers, specifically Epsom and SaSH. This is as a result of the Trusts' performance around the patient journey including the provision of timely written discharge summaries and also because of soft intelligence around patient experience in this area.

- Theatre procedures at SaSH, as a result of the 'Never Event' there which is described in Section 2.4

- Infection Prevention and Control at Epsom Hospital particularly focussing on Healthcare Associated Infections and the role of the infection control team.

- Continence Services within Central Surrey Health. We have decided to progress this piece of work, outside the potential Surrey wide review, in response to feedback from patients and professionals about the level of service provision that is currently available. The review group will be made up of a mixture of both Service Users, Lay members and Healthcare professionals

- Additionally we will be including audits by the medicines management team such as a review of antibiotic prescribing within both acute and primary care.

The programme will be drafted for the Clinical Quality Committee in May before being presented to Governing Body for approval in June 2013.

1.3 The management of Incidents and Serious Incidents Requiring Investigation

Serious Incidents is now managed jointly between CSU South and SDCCG. Additionally, the Quality Leads for each of the 6 Surrey CCG set up a monthly Patient Safety Assurance Review Group which held its first meeting on the 18th April. Terms of Reference requires agreement by SDCCG Governing Body with the overall aim of scrutinising all Serious Incidents across all Surrey commissioned providers and share trends and learning more widely.

CSU South will produce and report for the Clinical Quality Committee on all notified Serious Incidents across SDCCG Commissioned services and the emerging trends. Action plans will be managed formally through each Clinical Quality Review meeting.

Action: The Governing Body is asked to approve the Terms of Reference of the Patient Safety Assurance group in Appendix 1 and agree a delegation of authority to the group**.**

1.4 Stakeholder Feedback

All stakeholder feedback is being co-ordinated and managed through SDCCG Patient Advisory Group and PALS service with leadership from our Lay Panel members for Patient and Public and Quality Team. The CCG is engaging with stakeholders to reshape the way that we communicate with them as an organisation, encouraging feedback, concerns and comments. This work will be linked with existing membership practice and locality patients groups. Examples of patient feedback and actions taken are contained in Section 3.0

2.0 PATIENT SAFETY

2.1 Safeguarding Children – key areas to note

At the point of authorisation, it was identified that there were 3 practices within SDCCG where there was no identified lead for safeguarding children. Following liaison with each practice, the CCG is now 100% compliant in this area.

The action plans in response to the inspection conducted in Surrey in September 2012 on key aspects of a child's journey through the child protection system was presented to the Surrey Safeguarding Children Board (SSCB).

The revised Working Together document published in March 2013 makes it clear that safeguarding is everyone's responsibility and includes more detail on the roles and responsibilities of partner agencies.

Actions required by SDCCG working with NHS Guildford & Waverley CCG as host commissioners:

- Ensure that our safeguarding systems are reviewed to comply with the revised Working Together document and will need assurance that commissioned services are compliant.

- Provider Independent Management Review (IMR) action plans are progressed and change evidenced.

- Lessons learned from case reviews are cascaded effectively and responded to.

2.2 Safeguarding Adults – Key areas to note

2.2. The Designated Nurse for Safeguarding Vulnerable Adults had identified that the level of Safeguarding Adults training and awareness within practices across Surrey does not meet the level required for assurance. This has been recognised by the CCG as a potential risk to patient safety and therefore has been logged on the CCG risk register.

Action: Safeguarding training has been provided to the CCG Governing Body and Locality representatives. In addition, a training timetable has been planned, for all staff employed by the 6 CCG's in Surrey, together with all staff employed by GP

Surgeries in Surrey, to attend level 1 and level 2 training. This timetable will run fortnightly from June 2013 to the end of March 2014. Details will be sent out to practices shortly.

Unfortunately, Safeguarding Adults is not afforded the same attention nationally as that given to Safeguarding Children. However, Surrey Downs CCG has recognised the need to prioritise all vulnerable groups within Surrey and so, as the host of this service, is taking the lead in developing and embedding good practice across all our commissioned services.

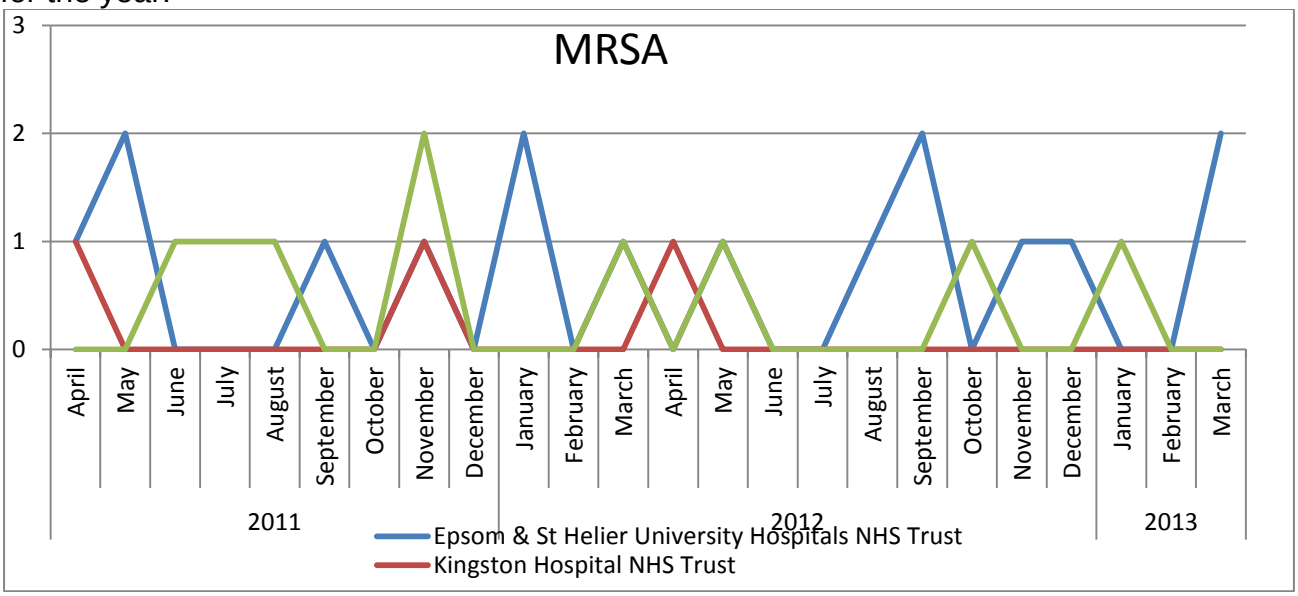
2.2.2 A Care Home in the Surrey Downs area which had been closed to admissions is now open on a phased admission plan. They will admit no more than 2 residents per week, looking forwards; they have developed an action plan identifying training needs around nursing competencies, to include tissue viability, wound care, diabetic care, and medicines management. The safeguarding actions have now been closed.

***Actions taken*:** The Designated Nurse for Safeguarding Adults and the Clinical Quality Lead for SDCCG have conducted an arranged visit to the home and during this time, discussed the action plan and met with residents and staff. A follow up visit will be undertaken in 3 months.

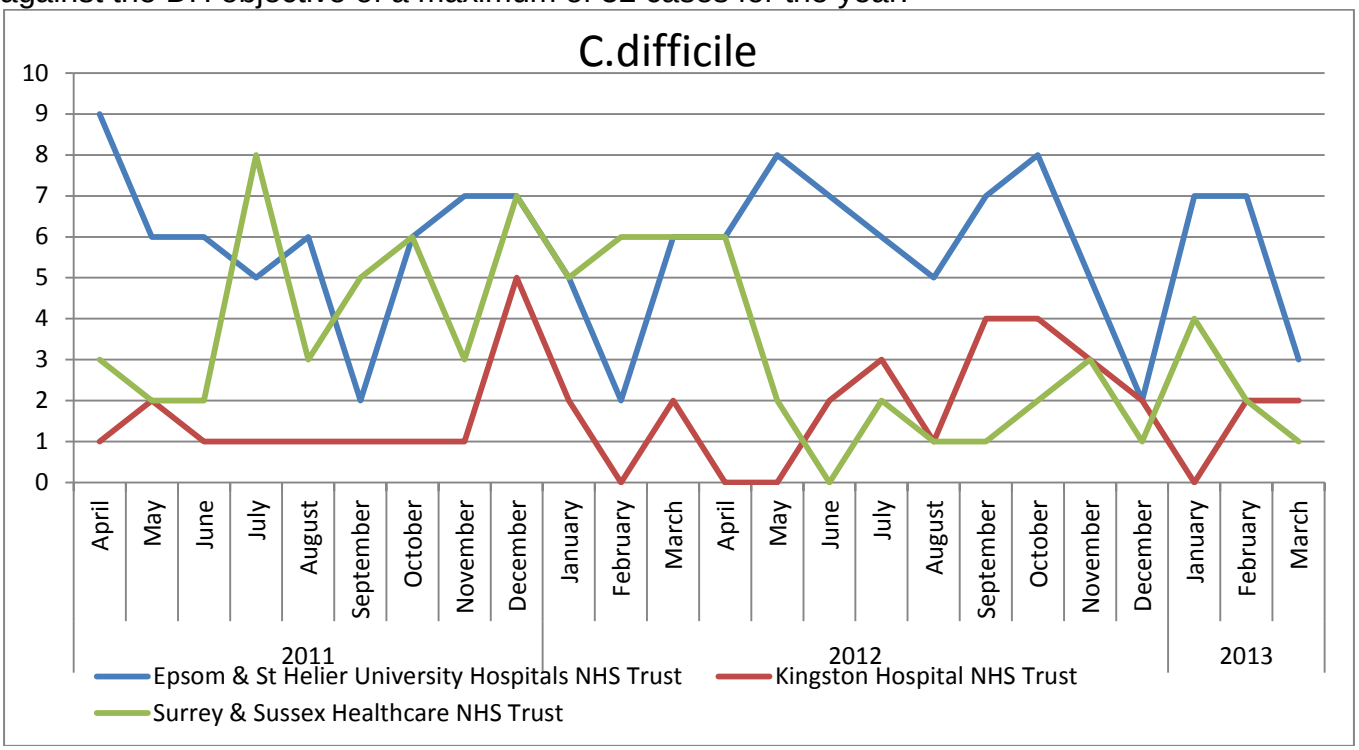
2.2.3 The Serious Case Review commissioned by the Surrey Safeguarding Adults Board is now underway. The Panel are next due to meet to review the Independent Management Reviews from all agencies involved, on 22 May.

2.3 Infection Control – Key areas to note

There continues to be concerns about the performance of Epsom and St Helier Hospitals University Trust (ESHUT). The position at the end of March 2013 was that the Trust had had 8 cases of MRSA bacteraemia against the DH objective of 4 cases for the year.



In addition to this, the final position for the year 2012-13 was 71 cases of Cdiff against the DH objective of a maximum of 52 cases for the year.



The graphs above show the deteriorating position of the Trust particularly in 2012/13 and when compared to our other local acute Trusts

The Department of Health sets an annual improvement objective for every organisation around Healthcare Associated Infections – particularly MRSA bacteraemia and Cdifficile. A target of zero has been set for MRSA bacteraemia and maximum number of 73 cases of Cdiff for Surrey Downs CCG patients is the limit for 2013/14.

Actions:

- Antibiotic prescribing audits will form part of the clinical audit plan for 2013-14
- "Deep dive" either in partnership with Sutton CCG or within the Epsom site regarding Infection control will be undertaken as part of the Clinical Audit Plan.

Concerns have been discussed with the Surrey and Sussex Area Team within a number of forums.

2.4 Serious Incidents

The reporting, investigating and management of Serious Incidents continue to be in line with similar organisations within Surrey Downs CCG directly commissioned providers.

- **Central Surrey Health**: week beginning 8th April reported 2 Serious Incidents open, 1 of which is awaiting the results of a Serious Case Review before closure, the other still being investigated. There are no overdue incidents and no 'never' events
- **Epsom and St Helier University Hospital**: 2 new Serious Incidents reported by Epsom Hospital during March 2013. These related to Community acquired Pressure Ulcers and will be investigated by the relevant community provider before being scrutinised for closure. They currently have 5 open incidents under investigation, none of which are overdue. There have been no Never Events reported.

- **Cobham Day Surgery**: 1 reported Serious Incident in March which related to anaesthetic gases. The provider has conducted a robust investigation and the outcome has been quality assured by the Head of Clinical Quality during a planned visit to the day surgery unit. It is expected that this incident will be closed within agreed timescales.

- **SASH:** 1 **'**Never' event on 7th March which was an incident of wrong site surgery. The Investigation of this event has been undertaken with full involvement of the patient and is now complete. The report will be scrutinised internally before being confirmed to the Area Team for closure. Lessons learned will be shared across Surrey and Sussex.

- **Kingston Hospital:** have reported a 'Never' event on 15th April which was the "Sub-optimal Care of a deteriorating patient". The investigation is in progress and will be scrutinised internally alongside any action plans before being confirmed for closure by the Area Team. Further information will be brought back to the Governing Body in July.

2.5 NHS 111

Following the launch of NHS111 on the 3rd April 2013 there have been a number of hard and soft intelligence concerns raised about operational and patient access issues, particularly at weekends. This has had a detrimental impact on clinical safety and patient experience

Actions: In addition to the daily 111 SITREPs, SDCCG has taken a number of steps to ensure that any risk to patient safety is identified and minimised:

- All membership practices were contacted and encourage to forward feedback on 111 to Head of Clinical Quality. As a result one of the issues raised is now being investigated as a serious incidence with the provider.

- All feedback collated by the Head of Quality has been taken by Steve Loveless, SDCCG 111 lead, to the Surrey 111 Governance meeting.

- SITREP reports will be disaggregated to CCG level by end of May 2013

3.0 Patient Experience

3.1 PALs

The SDCCG PALs service had received 6 PALs enquiries and 4 complaints since 1st April. All issues have been responded to and dealt with where possible. One example of support is the story of Mr A whose wife is suffering from depression and he didn't feel she was being effectively treated. Following disclosure of other issues relating to Safeguarding and confidentiality, we were able to discuss the case with the general practice and the Designated Nurse for Safeguarding Adults and together, with the consent of the family, implemented a number of actions which improved the situation. These improvements will be reviewed within three months.

3.2 Patient Led Assessments of the Care Environment (PLACE) Inspections

PLACE assessments which have replaced the old PEAT inspections focused entirely on the environment where care is delivered including Privacy and Dignity, cleanliness, food and general building maintenance. Patients and their representatives will make up at least 50% of the team making these annual assessments and results will be reported annually.

Central Surrey Health is undertaking these assessments within all four of their Community Hospitals and has recruited SDCCG patient representatives for this.

The Head of Clinical Quality will monitor this process and that carried out by other providers and will report back to the Governing Body through the Clinical Quality and Safety Committee.

4.0 Integrated Quality Plan

The CCG will hold a quality seminar for the Governing Body in June 2013 and during this will discuss and agree the priorities for the quality team during 2013-14. These priorities will be developed into an Integrated Quality Plan which will also be used to monitor and report progress to the Governing Body against key areas. The Plan will be presented to the Governing Body in July for their consideration and agreement.

Appendix 1

Patient Safety Assurance Review Group-
Draft Terms of Reference

For the Following Clinical Commissioning Groups: North West Surrey, Surrey Heath, North East Hampshire & Farnham, Guildford & Waverley, Surrey Downs, East Surrey.

1. Purpose:

A group comprised of Surrey CCG representatives that meets collectively to exercise their individual responsibilities with respect to robustly scrutinising and performance managing Serious Incidents (SIs).

2. Accountability

The Patient Safety Assurance Review Group is accountable to the respective individual CCGs Governing Bodies for the management of SIs via their respective quality leads. The group has delegated responsibility for scrutinising NHS Commissioned Provider Organisations' SI arrangements and escalating failures in the process to protect patients.

The Governing Body for each CCG will give delegated authority for closure of SIs to their respective Quality Lead who will report back to the Governing Body for assurance and accountability.

3. Objectives

3.1 Review final investigation reports to ensure that all appropriate actions have been taken.

3.2 Confirm and challenge where SIs has been investigated formally and fully in accordance with policy & procedure to enable closure.

3.3 Consider and agree further action (closures, clarification, re-submissions & escalation to Boards).

3.4 Identify lessons learned to be shared with other NHS commissioned providers via meetings with individual organisations and with the NHS Commissioning Board for sharing with the whole health economy as necessary.

3.5 Triangulate information arising from SIs with intelligence from members own specialist areas and Health Watch.

3.6 Identify themes and trends arising from SI investigations and alert CCG's enabling further scrutiny by commissioners with commissioned service providers.

3.7 Identify and agree key lines of enquiry for wider follow up with provider organisations through contract and/or Care Quality Review Group (CQRG) meetings.

3.8 Consider the commissioning of independent or external reviews or investigations if required. All recommendations to commission external investigations or reviews must be preceded by a formal emergency item to the relevant CCG Board/s.

3.9 Where necessary, gain expert advice regarding SIs from respective CCGs, Local Authority, subject expert and/or NHS Commissioning Board, or professional body.

4. Membership

The SI Assurance & Review Group consists of the following members:

- Senior Quality Representation/ Accountable CCG Director from Respective CCG (rotational chair)
- GP Lead
- CCG/ CSU SI Lead
- Patient Representative/ Health Watch Representative
- Subject Experts
    - Regular (Safeguarding Adults, Medicines Management, Mental Health
    - Ad Hoc (Infection Control, Safeguarding Children, Maternity, Estates, Health & Safety, Information Governance)

Members of the Group may be represented at meetings by deputies as appropriate, but the CCG Representatives should have an approved scheme of delegation by each individual Board.

5. Quorum

The group is quorate by the attendance of at least three different CCG representatives and one representative from each CSU.

6. Confidentiality and Freedom of Information

Given the confidential subject matter, these meetings will be held in private. The minutes of the meetings will be written in a way that confidential person identifiable information is anonymised in such a way that the minutes could, if appropriate, be made available under the Freedom of Information Act

7. Reporting Arrangements

The Patient Safety Assurance & Review Group will report to CCG Quality Committees. Each CSU is responsible for producing monthly and trend reports for their Individual CCGs.

This report will focus on:

Monthly: Clinical Quality Review Group / CCG Quality Assurance Committees

- New and closed SI Performance
- Individual High Risk, High Media Interest Incidents
- Themed SI report, by incident type and commissioned service
- Evidence of scrutiny and analysis of themes from SIs (including analysis of contributory factors identified within reports)
- The escalation of trends
- Reflective SI service improvements
- Sharing learning from SI investigations

Quarterly:

- Action plan implementation updates including lessons learnt

8. Administration

Administration of the meetings will be managed jointly by South London CSU, CSU South and CSU Surrey and Sussex. The CSUs will agree the process.

9. Frequency

Monthly

10. Revision of Terms of reference

The Patient Safety Assurance Review Group will review its Terms of Reference in September 2013.