NHS
Surrey Downs
Clinical Commissioning Group

Surrey Downs CCG Clinical Quality and Patient Safety Report

Reporting Period: July 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 (July 2013) overseen by SDCCG Clinical Quality Committee.

1.0 SYSTEMS AND PROCESSES

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. The Head of Clinical Quality and Head of Corporate Services and Board Secretary continue to review progress and update the risk register on a monthly basis.

The risks that are being monitored as a priority are:

- Lack of assurance around the capacity within the Safeguarding Children Service hosted by Guildford and Waverley CCG. The capacity review of the service has now been completed and the report is currently being considered by Guildford and Waverley CCG as host commissioners and will available following discussion at the Children's Safeguarding Board next week and agreed recommendations will be taken forward.

- Capacity within the Continuing Health Care Service which is hosted by Surrey Downs CCG. The CHC reference group is now meeting monthly and there are 3 task and finish groups that have been formed to work on priority areas – Personal Health care Budgets, Procurement for Nursing Home contracts and exploring the options for streamlining the assessment process to clear the backlog of assessments identified. The membership of these groups is from all of the Surrey CCGs. Progress will be reported to the Governing Body in September 2013.

- The full independent review of the service has been specified and is currently being procured. There will be an interim report on key immediate actions in approximately 6 weeks.

Additional risks that continue to be managed 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.

  Further information is in Section 2.3

1.2 The management of Incidents and Serious Incidents Requiring Investigation

Serious Incidents are managed jointly between CSU South and SDCCG and the Clinical Quality Officer employed by CSU South has now taken up her post and is based with the Quality Team at Pascal Place to support this function. Additionally, the Quality Leads for each of the 6 Surrey CCGs continue to meet monthly to discuss Serious Incidents as a Surrey wide forum.

Incidents to note are contained in Section 2.4

2.0 PATIENT SAFETY

2.1 Safeguarding Children – key areas to note

As of June 2013 across Surrey there are currently 4 active Serious Case Reviews and 4 active Case Reviews.

As of June 2013 within the Surrey Downs CCG area there is currently 1 active Serious Case Review in progress. The Named GP and Central Surrey Health (now CSH Surrey) have provided Individual Management Reports (IMR's) and Chronologies. An Individual Management Report is written by each agency that has been involved with an individual child or family and supports the review panel in reaching a clear understanding of the underlying causes of the child's death or injury and any concern about agencies' practices so that lessons can be learnt.

Virgin Care and Ashford and St Peters (commissioned by the North West CCG) also had contact with the family and were therefore also asked to provide IMR's and Chronologies. The serious case review overview report has been produced and a debriefing meeting is planned for 27th June 2013. At this meeting IMR authors will have the opportunity to hear an overview of the lessons learned and the decisions that have been made re publication and the wider distribution of lessons.

One Case, involving a family in the Surrey Downs CCG area was considered at the Strategic Case Review Group on 22nd February. Further information from health was sought and the decision was made that the case did not meet the criteria for a Serious Case Review.

Actions required

- The CCG will need to be assured that provider IMR action plans are progressed and change evidenced. The action plan will be discussed at the Quality Contract meeting with CSH Surrey on 26th July and progress reported to the Governing Body in September 2013.

- We will also need to ensure that when the lessons from the range of case reviews are published these lessons are effectively cascaded and responded to. This will be achieved by ensuring that all providers have access to the reports as they are published and providing corresponding action plans. The CCG seeking assurance through a range of measures that relate to the recommendations such as monitoring the level of training delivered and delivery of caseload supervision.

2.2 Safeguarding Adults – Key areas to note

The Designated Nurse for Safeguarding Vulnerable Adults continues to meet with the Quality Leads in all Surrey CCGs to formalise operational working and reporting procedures across the service. A workshop took place on 8th May which was attended by the Quality Leads, GP and Local Authority Colleagues to agree these arrangements and to develop the work plan for the year. This will be brought to the Clinical Quality Committee in August for agreement.

Serious Case Reviews

There are currently four Serious Case Reviews underway in Surrey, one which relates to a Surrey Downs CCG patient. There are a further 2 cases that are currently being considered to agree whether they meet the criteria for a Serious Case Review.

All reports are currently being written and once published, the themes and action plans will be progressed across providers and change in practice will be monitored and evidenced. The reports and recommendations are anticipated to be available by October 2013.

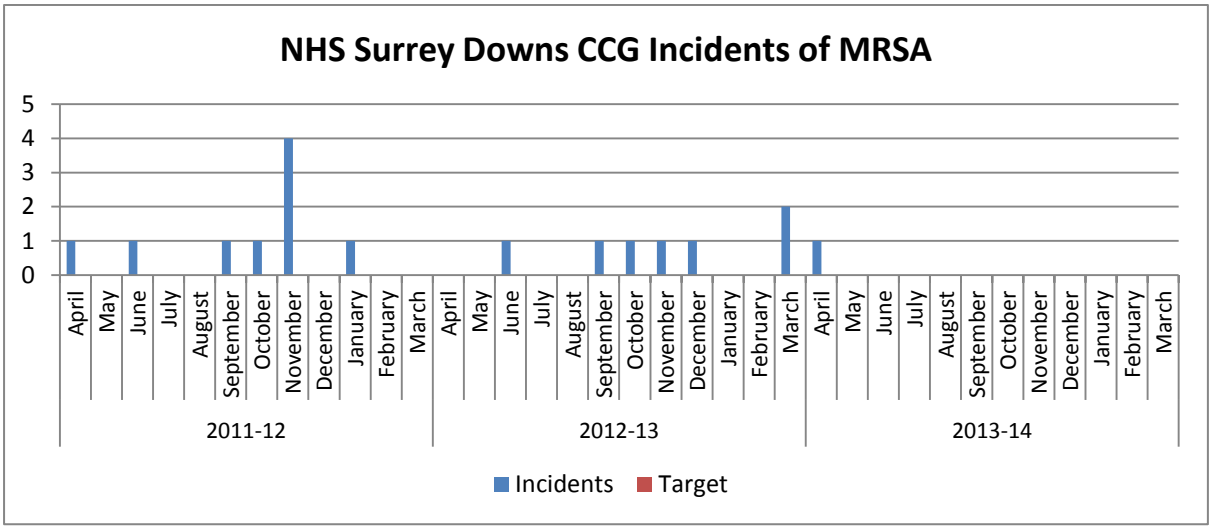
2.3 Infection Control – Key areas to note

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.

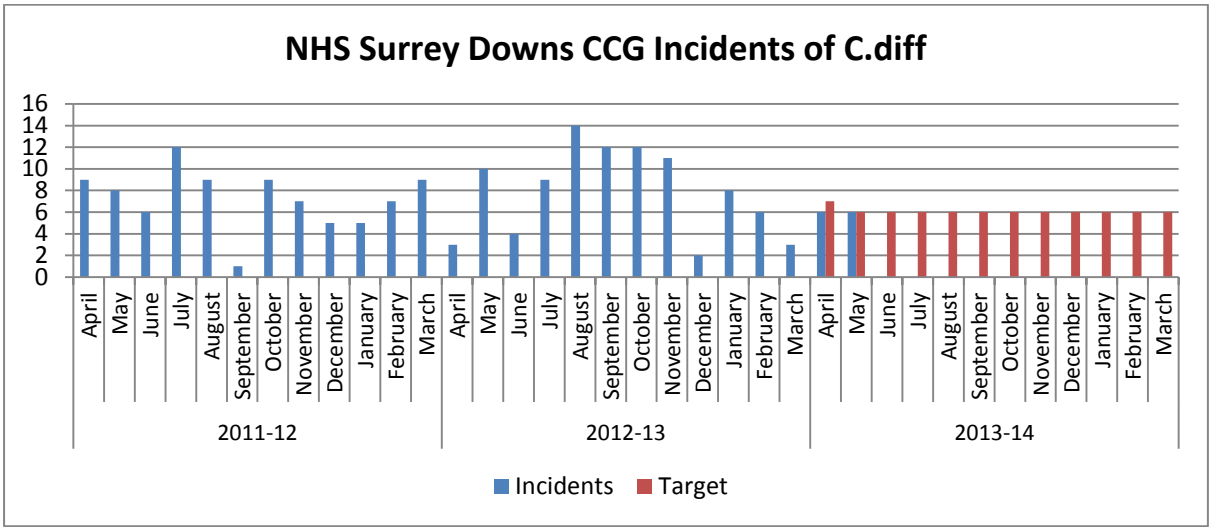
MRSA Bacteraemia

There has been one incident of MRSA Bacteraemia infection acquired by a Surrey Downs CCG registered Patient which occurred on 24th April 2013. Following a Post Infection Review, this infection was attributed to St Thomas' Hospital where the patient was being treated. Following treatment, the patient has now recovered from this infection. The table below shows the incidents of MRSA within the Surrey Downs CCG since 2011. This incident means that the CCG has exceeded the target set for 2013/14 and as a consequence will not receive the associated Quality Premium payment (set at 12.5% of the total amount).



C Difficile (Cdiff cases)

There have been 12 cases of Cdifficile within Surrey Downs CCG during April and May 2013 which is just within the agreed trajectory of 13 for this period in time. The tables below show firstly the incidents of Cdifficile on a monthly basis since April 2011 and secondly, the cumulative total. There have been identifiable peaks both in the summer (July and August) and then again in January and February. By identifying these patterns and understanding the root causes behind these, it should be possible to work with providers to improve the infection rates currently seen.



Further Information

Performance within Surrey Downs CCG commissioned providers to date is within agreed trajectories. The exception is Kingston Hospital which at the time of this report had reported 8 attributable cases of Cdiff against an agreed objective of 16 for 2013/14. It was discovered that the outbreak was probably related to a particular area within one ward and this area has been completely refurbished to ensure that there are no infective spores remaining in the fabric of the ward. The Trust has also held an emergency summit to review their action plan and this will be discussed at the Clinical Quality and Safety Committee in August.

Actions required:

- Review of antibiotic prescribing data at a Practice level to identify areas that may need more support from the medicines management team. This will be presented at the Clinical Quality and safety Committee in August

- Antibiotic prescribing audits will form part of the clinical audit plan for 2013-14 and action plans developed to address areas of concern. These will be monitored through the contracting process

- Continued monitoring of a number of key areas of performance through the Clinical Quality Review Meetings such as Infection Control Training levels, the use of agency staff and hand washing audits

- Gain assurance from providers that the inter-hospital transfer of patients is kept to a minimum and that any movements within the hospital are tracked and recorded to enable the speedy identification and targeting of areas with higher infection rates.

- Commissioner "walkarounds" targeting service areas where there is an identified concern around performance or to challenge when there has been adverse soft intelligence received.

2.4 Serious Incidents

Areas to note are:

- **South East Coast Ambulance NHS Trust**

At the time of this report, the CCG is aware of 32 SIRIs reported by South East Coast Ambulance NHS Trust. Of the 32 on-going cases visible to this CCG, 31 are overdue for closure and 12 reports have not yet been submitted to their commissioners. Future reports will contain further detail around these incidents and the cases in which Surrey Downs CCG patients were affected.

Action:

This level of performance is unacceptable and the lead commissioner is committed to pursuing contractual actions to lever improved performance

- **Surrey and Borders Partnership NHS Foundation Trust**

Surrey and Borders Partnership NHS Foundation Trust (SABPFT) currently has 56 SIRIs open. 39 of these SIRIs have exceeded their deadline (includes 2 cases sent back for resubmission and a further 3 are conditional closures where further assurances are required before closure is agreed).

Of those overdue for closure, 9 are to be closed by the Area Team as they were reported during or before 2012/13 and 5 remain under external investigation.

Action:

The Quality Leads with support from CSU South are currently undertaking a piece of work with SABPFT to analyse their level of reporting of Serious Incidents and the quality and timeliness of their investigations. A full report around the findings and improvement plans will be presented at a future meeting of the Clinical Quality and Safety Committee.

2.5 NHS 111

The CCG continues to monitor the implementation and service delivery of NHS 111. The service is now in week six of its eight week improvement plan and has increased its level of staffing to the level agreed in the plan. Latest data

demonstrates an improvement in performance with the daily abandonment rate target and calls being answered in 60 seconds now being met consistently.

Since its launch, there have been 9 Serious Incidents raised about the service. However, it has been agreed that a number of these were not actual SIs and that the high profile of the service led to a lower threshold in reporting these incidents.

The provider is still not able to produce information at a CCG level and there is no agreed timeframe as yet for producing the information in this way.

However, the CCG is still monitoring concerns and complaints locally and discussing them with the provider through the governance meetings attended by Dr Steve Loveless as SDCCG Clinical Lead.

3.0 PATIENT EXPERIENCE

Friends and Family Test

The Friends and Family Test is being implemented nationally as a tool to benchmark patient experience. Each organisation is currently using the tool within A&E and inpatient services and will be publicising their results from 1st July 2013. A response rate of 15% is required and it has been challenging to achieve this figure – particularly within A&E.

Community Providers are also implementing this tool and appear to be achieving a much higher response rate which is probably due to the smaller numbers and slower throughput within Community Hospital beds.

The first public results will be included in the next Quality and Safety report.

4.0 QUALITY IMPROVEMENTS AND ASSURANCE

4.1 Out of Hospital Providers

Surrey Downs CCG contracts with a number of Out of Hospital providers which include independent hospitals and services commissioned under Any Qualified Provider contracts. These providers include Ramsay Ashtead, EDICS, Dorking Healthcare, Epsom Medical and Princess Alice Hospice. The total contract values for these providers are c. £21,000,000.

The CCG needs to be assured that processes are in place to monitor the quality of service delivery from these providers and that processes are in place for the monitoring of continuous quality improvement.

We also need to ensure that we are aware of any sub-contracting arrangements that these providers have in place and in turn, gain assurance around their arrangements for monitoring those sub-contracting agreements. The Quality team has undertaken a piece of work with each of these providers to develop and agree a Quality Framework that will be monitored through the Clinical Quality, Clinical Governance and Patient Safety Committee.

The framework will include a range of quality metrics and will be monitored on a monthly basis and included in future quality reports.

4.2 Quality Surveillance Networks

The Surrey and Sussex Quality Surveillance Group continues to meet monthly and is a valuable source of early intelligence, particularly soft intelligence, around providers. There has been discussion around the provision of care within Community Providers and Care Homes which has raised concerns around the level of pressure damage that is being reported across the Surrey and Sussex area.

It is planned that the Surrey and Sussex CCG Quality Leads and Directors of Nursing will undertake a “campaign” to raise awareness around skin damage and pressure ulcers to particularly support both paid and informal carers.

The SDCCG Head of Quality will be attending the next NHS SW London Quality Surveillance Group to participate in discussions around these organisations and share intelligence.

4.3 Quality standards across acute services

Since joining BSBV, clinical Governing Body members from Surrey Downs CCG have attended the Clinical Working and Strategy Groups, where they have reviewed the quality standards and supported them as appropriate for the BSBV Programme. In some specialties, these standards propose providing care to what may be regarded as a higher standard than Colleges’.

SD CCG needs to determine the appropriate levels to commission for patients using providers outside BSBV Trusts, ie those outside London. Work is ongoing on agreeing appropriate baseline acute quality standards for Surrey Downs Commissioning. The quality group are in support of recommending to the Governing body quality standards based on College guidelines, particularly consultant presence at peak hours and wherever possible up to 24 hours. The following actions are agreed to take this forward.

- Circulation of the sources of evidence from Obstetrics and Maternity to all Governing body members
- Further work to be undertaken covering stroke, medical and elderly care
- Request for further information and data, currently unavailable on Trust data sets such as time of day of admissions, births, hours of consultant presence and linkage to expectations in College standards
- To seek benchmarking data on outcomes from ONS Comparators and Europe where appropriate
- Discussion with Surrey (and potentially Sussex) CCGs to secure shared approach to acute standards
- Further discussion with Epsom Hospital and relevant Surrey Provider Trusts to understand their current position, then further inform and drive standards
- Based on the above we will propose a pace of change to standards linked to College recommendations on Consultant presence, this appropriate pace will reflect the demographic, needs and circumstances for our population