Surrey Downs Clinical Commissioning Group

Title of paper:	Clinical Quality Report
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Agenda item:	12
For:	Discussion

Executive Summary

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.

Committees and other groups that have considered this paper: Clinical Quality Committee; Executive Committee

Recommendation(s): TO DISCUSS

Implications for wider governance

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

Patient and Public Engagement: The report has been seen by the Patient and Public Engagement lay members on the Executive Committee

Equality analysis: No EA has been carried out on this report

Finance and resources: No implicit financial implications other than quality premium
Workforce: See Section 4.2.1 in relation to DOLS
Statutory compliance: This report is part of the CCGs overall compliance regime. Section 1 covers compliance in relation to safeguarding and section 4 CQC compliance
Conflicts of interest: No known conflicts of interest
Risk and assurance: There are risks on the risk register in relation to quality premium, safeguard, supplier failure and continuing care
Communications Plan: This paper is on the CCG web site
Accompanying papers: Quality report September 2013

Surrey Downs CCG Clinical Quality and Patient Safety Report

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

1.0 SYSTEMS AND PROCESSES

1.1 Risk Register

Whenever risks in the quality and safety of commissioned services are identified, the risk is assessed and the detail added to the register. This continues to give a focus on the areas of highest risk and enables 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:

1.1.2 Safeguarding Children:

There continues to be lack of assurance around the arrangements for Safeguarding Children which is hosted on a Surrey wide basis by Guildford and Waverley CCG. The capacity reviewed that was commissioned by Guildford and Waverley CCG has been presented to the Surrey Safeguarding Children Board and made recommendations around new ways of working to maximise the resource that is available.

The Quality Leads in the Surrey CCGs are working proactively with Guildford and Waverley CCG and the Safeguarding Children Team to ensure that processes are understood and implemented by all providers.

1.1.3 Safeguarding Adults:

Surrey Downs CCG hosts the Surrey wide service for Safeguarding Adults and is continuing to develop the service and embed arrangements with the other Surrey CCGs.

The Designated Nurse for Safeguarding Adults is compiling a database that covers the whole of Surrey. This records details about the identified lead for Safeguarding Adults in each GP practice and also the level of training that each lead has undertaken. A Surrey wide dashboard for Safeguarding Adults has also been developed and will be piloted with providers over the next three months before the final version is agreed by the Quality Leads. This will give CCGs more information that will support performance conversations and enable them to gain assurance around provider's arrangements for Safeguarding Adults.

1.1.4 Continuing Health Care

There continues to be a number concerns which are centred upon the Continuing Health Care Service. Nursing availability at present is limiting the number of routine three month and annual reviews that can be undertaken and this is a risk in terms of CCGs being assured that the provision of care is meeting individual needs. However, reviews are prioritised according to the presenting need and any safeguarding concerns are immediately raised through the multi-agency safeguarding processes.

The team continues to actively recruit Band 6 Nurse Co-ordinators to address the deficit in nursing resources. As an interim measure, CCG colleagues have offered support and this is currently being explored. A task and finish group has been set up to explore all potential short and mid-term solutions in advance of the recommendations resulting from the CHC Review Report which is anticipated to be completed at the end of October.

Additional risks that continue to be managed include the performance of NHS Commissioned Providers around Health Care Associated Infections particularly MRSA and C. Difficile. Healthcare Associated Infections are a risk to patient safety and have an adverse effect on patient experience. Further information about the performance of providers is contained in Section 2.3.2 and in the CCG Performance Report.

2.0 PATIENT SAFETY

2.1 Safeguarding Children – key areas to note

As reported at the July meeting of the Governing Body, a Serious case review is being carried out within the Surrey Downs CCG area. CSH Surrey *(Surrey Downs CCG),* Virgin Care and Ashford & St Peters Hospital Trust *(NW Surrey CCG)*, Surrey GP and Kingston Hospital Trust had involvement with the family so were therefore asked to be part of the process and provide IMR's and chronologies.

The final copy of the Health Overview report was sent to the Director of Quality and Governance (Executive Nurse)- and Surrey wide lead for Children's Safeguarding on 10th May 2013 for sign off and to circulate to CCG's involved for comment, the

signed front sheet was returned and has been forwarded to the Panel where the report was agreed. The overview report was agreed by Surrey Safeguarding Children Board (SSCB) in May 2013 and amendments to the SSCB action plan agreed in July 2013. The findings are currently being disseminated via SSCB SCR workshops and through distribution of a learning leaflet. The report will be published once criminal proceedings have been completed.

In addition there was has been one out of area request for information from a provider commissioned by Surrey Downs CCG in relation to a case review. A request was received from Kingston Safeguarding Board for Epsom and St Helier Hospital Trust to provide an IMR and Chronology for a serious case review. Preparation is underway for publication in early October 2013.

It is the CCG's responsibility to monitor progress of the actions plans of providers they commission; this is done through the SSCB Health Safeguarding Children Group. Providers are also required to evidence progress with these plans during Clinical Quality Review Meetings.

In mapping Surrey Downs CCG position against the main national and local requirements however, the Governing Body can continue to be assured that health trusts in Surrey Downs CCG have the right people and systems in place for safeguarding and are re discharging their safeguarding responsibilities in a way that complies with section 11 of the children Act 2004.

However, there is also a need to continue to review arrangements with organisations from which we commission services to improve oversight of safeguarding particularly with regard to the quality agenda, robust contract and performance monitoring. There is also a need to ensure that General Practitioner practices have adequate and on-going leadership and training.

The Head of Clinical Quality has regular meetings with the Designated Nurse for Safeguarding Children and will shortly be reviewing all contracts for 2014/15 to ensure that they clearly reflect the responsibilities that each provider has for Safeguarding Children.

2.2 Safeguarding Adults – key areas to note

The 4 Serious Case Reviews that are currently underway in Surrey are all in the final stages and are expected to be made public by the end of the year. The case involving the Surrey Downs resident was published on Monday 16th September and actions arising from this will be discussed at the Safeguarding Adults Board (SSAB) on 26th September.

In addition to this, the SSAB will be holding a Surrey wide event that will share the lessons learned from all of the Serious Case Reviews. Surrey Downs CCG will scrutinise all action plans and seek assurance from our providers about the effectiveness of their actions and, as host commissioner for Safeguarding Adults, will support the other Surrey CCGs in seeking the same assurance from their own providers.

2.3 Infection Control – Key areas to note

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

2.3.1 MRSA Bacteraemia

There has been no further MRSA Bacteraemia attributed to our main acute providers that have affected Surrey Downs patients however, another acute trust reported a MRSA bacteraemia on a patient from a neighbouring CCG who had an intravenous tunnel line inserted at St Helier Hospital. The Post Infection Review (PIR) showed that there had been non-compliance with the DH policy on MRSA suppression on a high risk patient. The action plan that has been developed following the PIR has been shared with the lead commissioners for Epsom and St Helier – Sutton CCG – and will be monitored through the provider's Clinical Quality Review Meeting.

2.3.2 C. Difficile

During Quarter 1, there were 16 cases of CDifficile affecting Surrey Downs patients which kept the CCG just within the trajectory for the agreed Department of Health target of 73 cases for 2013/14.

However, there were 14 cases during cases during the month of July, 6 of which were acute and 8 of which were non-acute cases There have been a further 11 cases during the month of August – 6 acute cases and 5 Community Cases (3 GP cases and 2 A&E admissions) which brings the CCG to a cumulative total of 41 cases of Cdiff from April – August against a DH objective of 73 which makes it unlikely that we will achieve our objective for Cdiff in 2013/14.

Next steps are:

- A review of organisational improvement plans through Clinical Quality Review Meetings to gain assurance that agreed measures are being implemented.
- Root cause analyses of all community acquired cases to identify any clinical practice issues or themes around cases. This includes mapping it alongside practice prescribing data to identify antibiotic prescribing which falls outside agreed guidelines
- Work with the localities and practices to publicise themes identified and to support an improvement in practice, particularly where an individual concern is identified.

2.3.3 Serious incidents requiring investigation (SIRI) including 'Never Events'

Areas to note

- Pressure Ulcer damage continues to be the most frequent patient harm that is reported as a Serious Incident. This is due to a number of factors including the frailty and complexity of patients being cared for in the community, often with most of the care being provided by paid or informal carers. The Directors of Nursing and Quality Leads across Surrey and Sussex are undertaking a piece of work to raise awareness around the need for the early detection of skin damage. Updates on this project will be included in future reports.

- There was one SI that relates to the admission of a child less than 18 years of age to an adult mental health ward. There is national crisis relating to access to Tier 4 CAHMs beds and work is being carried out to improve the interface between Tier 3 and Tier 4 services. There is now more information shared around the availability of beds but this means that children can often be placed out of area with the associated problems that this brings. Further information around this issue will be brought back to the next meeting of the Quality Committee.

- There was one Never Event reported by Surrey and Sussex Healthcare Trust which related to a medication incident. This is being investigated and the report will be shared with the CCG.

The Quality Leads in the Surrey CCGs continue to scrutinise the investigation reports and action plans that result from Serious Incidents before the incident can be closed. Action plans continue to be monitored through provider quality contract meetings.

3.0 PATIENT EXPERIENCE

3.1 Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. It is initially for providers of NHS funded acute services for inpatients (including independent sector organisations that provide acute NHS services) and patients discharged from A&E (type 1 & 2) from April 2013.

The Friends and Family Test is based on one question, 'How likely are you to recommend our ward/A&E department to your friends and family if they needed similar care or treatment?' Patients are presented with six responses ranging from 'extremely likely' through to 'extremely unlikely'. Only the response of extremely likely is seen as a positive score.

Organisations have been encouraged to ask follow-up questions at the same time to find out more details that can help drive improvements and also tackle concerns in real time.

The first data was published on 30th July and covered the first 3 months of the survey.

	April rate	May rate	June rate	↑ or ↓
Ashford and St Peters Hospitals NHS Trust	11.7%	14.1%	28.69%	↑
Frimley Park Hospital NHS Foundation Trust	8.4%	10.6%	27.84%	↑
Royal Surrey County Hospital NHS Foundation Trust	13.7%	15.2%	15.44%	↑
Surrey and Sussex Healthcare NHS Trust	6.7%	9.0%	16.34%	↑
Epsom and St Helier NHS Trust	8.2%	15%	26.00%	↑
Kingston Hospital NHS Foundation Trust	3.7%	Not available	18.60%	↑
St Georges Hospital Healthcare NHS Trust	Not available	14.9%	19.15%	↑

All Organisations have improved their response rate over the 3 months lead in time before the data was first published. It has been particularly challenging for all Trusts to collect data in their A&E departments which has been reflected in their scores overall.

There is still needs to be a level of caution around the net promoter scores which are produced as a result of this measure. Epsom and St Helier NHS Trust, for example, achieved an overall Net Promoter score of 74 for the month of June which is positive but organisations need to drill down to individual service and ward levels to understand what the data might be telling them.

There have been issues identified where the response rate is very low (5 & under) and these results cannot be seen as statistically significant giving a skewed result. However, assurance is being sought from providers as to how they will improve response rates and improvements will be monitored through the respective CQRMs over the next quarter.

The Friends and Family Test is being rolled out to maternity services in October. Assurance has been sought from providers that they are prepared for this and this will be reported in future quality reports.

3.2 Patient Advice and Liaison Service (PALS), complaints and compliments

Areas to note:

- Following the expiry of the EDICS contract, the Patient Experience Service has been contacted by around 25 patients regarding their future care. Letters have been sent to all patients who have been affected by the changes and a further updates on this issue will be reported through the Clinical Quality Committee.

- Between April and June 2013 Surrey Downs CCG received 42 PALS queries and 8 general complaints. These have related to a variety of issues and these are detailed in full in a quarterly report which has been scrutinised by the Clinical Quality Committee.

- In addition to these, at the time of the Governing Body meeting held in May, the CCG received around 50 letters and emails around the subject of Better Services, Better Value. All of these concerns were responded to and filed under corporate correspondence.

4.0 Governance of Providers

4.1 Commissioner Walk Rounds

There have been a number of Commissioner Walk Rounds during July and August. These have been planned to give members of the CCG the opportunity to visit service areas, get a better understanding of service delivery and talk to patients and staff about care delivery and their own experiences.

The Walk Rounds have taken place at both Epsom and St Helier Hospitals and have included visits to elderly care wards and a “walk through” the emergency pathway. This visit has informed some of the work that the CCG is carrying out on the Out of Hospital Strategy and a follow up visit has been carried out by the Service Redesign team to observe the discharge pathway.

Following the introduction of a new Radiology computer system at the end of June, SASH developed a backlog in X-Ray reporting, which is having an impact on GPs and their patients. In early August, this backlog reached approximately 4,800 examinations in total, of which around a quarter were requested by GPs. SASH carries out over 160,000 X-ray examinations per year – an average of around 450 every day of the week. The Trust subsequently declared a Serious Incident due to the potential for delayed or missed diagnosis.

It was arranged with the Trust to visit to see the X-ray department and gain an understanding of how it operates but also to discuss the situation, understand why the system had failed and to gain assurance from the Trust around their management of this. This visit was led by Crawley and East Surrey CCGs as lead commissioners and was attended by the Head of Clinical Quality. Following the visit, the visiting team were reassured that SASH were managing a critical issue but agreed that there was further work to do on embedding systems to ensure sustainable improvements in the radiology department.

In addition, there have been visits to CSH Surrey services including visits to Leatherhead Hospital and the Continence Service. During these visits, there were opportunities to talk freely to patients about their experience and also to discuss the services with staff who worked within them. The visits to CSH Surrey have been positive and have also informed the work around the Out of Hospital Strategy.

4.2.1 Care Quality Commission Reports

The Care Quality Commission circulates a weekly publication list to NHS England and other organisations upon request. Previously, this led to each CCG trawling through the lists to identify concerns around local providers and to gain assurance of their improvement plans.

The Surrey and Sussex Area Team have now agreed to shortlist the providers in the Surrey and Sussex area that were non - compliant with 1 or more standards and to circulate this list out to CCGs and partners to enable them to review their areas/services and any implications for NHS funded care/directly commissioned beds.

This has enabled the Quality Team to take a more focussed approach to this work and we have followed up a number of concerns with providers where care is being delivered to our population. This has included recommendations around staffing levels, safeguarding training and advice around DOLs.