

Attachment 08

**North East Lincolnshire CCG**

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| **Report to:** | NEL CCG Partnership Board |
| **Presented by:** | Jan Haxby, Director of Quality & Nursing |
| **Date of Meeting:** | 10th March 2016 |
| **Subject:** | Quality Report from Clinical Quality Committee |
| **Status:** | OPEN  CLOSED |
| **Agenda Section:** | STRATEGY  COMMISSIONING  OPERATIONAL ISSUES |

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| **OBJECT OF REPORT:** |
| The report informs the Partnership Board of key metrics for quality and safety of the services it commissions and in doing so provides assurance that North East Lincolnshire CCG is fulfilling its responsibility and commitment to commission safe and effective services that meet the needs of the population of North East Lincolnshire.  The report is delivered in 3 sections:   1. Effective Care 2. Patient Safety 3. Patient Experience |

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| **SECTION 1. EFFECTIVE CARE** |
| 1. **External Reviews** 2. An announced CQC inspection of St Hughes Hospital was undertaken in August 2015. The final CQC report has given St Hughes a “requires improvement” rating and a summit meeting is planned in March which the CCG will be attending. St Hugh’s have shared some of the high level findings with the CCG and the main concerns are regarding the hospitals ability to evidence areas through documentation of meeting minutes etc, which St Hugh’s have already started to address. The Summit meeting will enable a plan to be developed with support from key stakeholders. 3. We are still awaiting the final report from CQC in respect of the announced and unannounced inspections of NLG. Anecdotally we are aware that the CQC are considering their final view and that they have raised a number of concerns including mixed sex accommodation and OPD follow-up. *See further in Section 2 D – Risks related to NLG.* 4. We are still awaiting the CQC EMAS report for the inspection during November. This is expected to be published end of March 16. Commissioners haven’t had any further updates on the CQC position. 5. **Clinical Effectiveness**   The two Quality Committees at NL CCG and NEL CCG have agreed to establish a Research & Development Working Group reporting to both Quality Committees, which will aim to promote:-   * + Opportunities for high quality and relevant research and making links to local health and care need or clinical practice.   + Good research that leads to innovation and provides a strong evidence base for clinical decision making.   + The promotion and conduct of research embedded in the CCG.   + A developing and evolving knowledge base is established to improve health outcomes and reduce inequalities.  1. **CQUINS**   The Commissioning for Quality & Innovation (CQUIN) is a payment scheme that encourages care providers to share and continually improve how care is delivered. Commissioners are able to allocate up to 2.5% of the provider’s whole contract value to the CQUIN scheme to develop specific quality initiatives during the year. The scheme is split into two sections; the local indicators and the national indicators (the national indicators are defined by NHS England). The national indicators have not yet been defined but it is expected that these will be published by mid-March 2016.  Commissioners have been working closely with NL&G since November 2015 to negotiate and agree local quality CQUINs for 2016/17. Agreement has been reached between all 4 commissioners, and the proposed local CQUINs are summarised below:   |  |  | | --- | --- | | CQUIN Title | Summary | | Adults at risk within hospital settings due to cognitive impairment or decline | This indicator requires the Trust to undertake a comprehensive review of processes and practices in place in relation to the identification of adults at risk, across all Trust sites.  These patients will be considered to be at risk due to their cognitive impairment or decline (the loss of intellectual function), cognitive impairment to include patients with or who develop any of the following conditions:   * dementia * delirium * learning disability * neurological condition * acquired brain injury * impairment due to substance/alcohol abuse   The review will focus on action taken by the Trust to identify, promote/disseminate and improve good practice in respect of the care, support and overall clinical management provided to this vulnerable client group. | | Chronic Obstructive Pulmonary Disease (COPD) Care Bundle (Specifically the discharge element) | Inclusion: All patients discharged from hospital after admission for acute exacerbation of COPD.  This indicator has been proposed in order to support effective implementation of the British Thoracic COPD care bundle, specifically the patient discharge element. | | Dementia and Delirium CQUIN: discharge summary and follow on recommendations | The overall aim of this CQUIN indicator is to demonstrate partnership working between the Acute Trust and mental health providers, specifically focusing on the effectiveness and the efficiencies that these partnerships have on care.  In North East Lincolnshire, this partnership specifically relates NAViGO with particular reference to the effectiveness of the Home from Home service at Diana Princess of Wales Hospital.  In North Lincolnshire, this CQUIN indicator will relate to the partnership between NL&G FT and RDASH Mental Health Trust.  NL&G FT is also required to demonstrate effective partnership working with mental health providers in the Lincolnshire East area and the East Riding of Yorkshire area.  The proportion of patients aged 65 and over, following an episode of care with a length of stay over 72 hours, who have been identified with dementia or delirium, and who have a discharge summary including follow up recommendations that is shared with the patient’s GP. |   NL&G and the Quality Team are now working closely to negotiate the final versions and the next steps. The final versions agreed can be shared at the next board.  We intend developing a new process for the development of CQUINs commencing in the autumn 2016 and this will be shared and approved by the Quality Committee.   1. **Summary Hospital-level Mortality Indicator (SHMI)**   SHMI measures deaths both in and out of hospital (deaths within 30 days of hospital discharge) and reflects on all care provided to patients. Recent SHMI data showed that we have returned to the “as expected” range at 109.7, for the period of July 2014-June 2015, with the latest official SHMI release expected within March 2016 (for the period: Oct 14-Sept 15). Using an NLAG purchased indicator (HED from University Hospitals Birmingham) which provides a ‘provisional’ proxy of the ‘official’ SHMI, attempting to give an indication as to what the ‘official’ indicator will look like demonstrates that there has been an increase in out of hospital SHMI in NEL. This data is from the period November 14 to September 2015  cid:image004.jpg@01D1748E.09DDBD80  The NEL out of hospital increases (see chart above from the most recent NL&G Mortality report) shows a huge drop in October. We are working with NL&G to better understand the data and NL&G consider the October drop could be due to a number of scenarios: the number of out of hospital deaths for DPOW in the latest month (Oct-15) was low, or it could be because of delays in recording deaths, or could be that DPOW simply had lower out of hospital deaths that month. We may see the number of deaths for Oct-15 go up in next month’s data refresh, which may result in a less dramatic line on the graph.  The CCG is working closely with NL&G towards developing one strategic approach, with a number of delivery plans for all partners from the same strategy. NL&G has a number of internal work streams which we are now proposing focus on the whole patient pathway and not just acute services. These work streams are linked to the following specialties which are considered to be priority areas due to their high levels of crude mortality: Respiratory, Cardiology, deteriorating patients including Sepsis, Gastroenterology, End of Life & Stroke.  The CCG continues to hold its own Mortality Steering group who monitor delivery of the CCG’s contribution to any agreed plans and work streams, and in addition has its own actions. This group has developed a dataset that will help to show the journey towards improving mortality rather than relying only on SHMI as the indicator of a change in mortality in NEL.  A recent education session delivered for primary care staff was jointly delivered by the CCG and NL&G and focused on SHMI data and intelligence and seeking ways of improving patient pathways. There are plans to hold a similar larger workshop in the summer for a wider audience of providers.   1. **Examples of Good Practice**   NL&G Tissue Viability Nurses have developed a new toolkit to assist nursing and care staff to prevent and treat pressure ulcers called the PUG, and this has achieved national recognition. The Trust have delivered training alongside providing nursing staff with access to a toolkit and are attributing the reduction in grades 3 and 4 pressure ulcers over the last 12 months to the impact of this piece of work.  **SECTION 2. PATIENT AND CLIENT SAFETY**   1. **Safeguarding**   In line with the Prevent Duty guidance, the Board will receive its training at the next Board workshop. Prevent training is creating a demand on our resources but the Safeguarding Designated Nurse is delivering it with colleagues across the patch.  NHS England provided a briefing on the Goddard Enquiry and the Myles Bradbury (Addenbrookes’ Paediatric Haematology Consultant) case. The Designated Nurse for Safeguarding Children attended the briefing and will produce a report for the Quality Committee and relevant partnership boards. There is an expectation from NHSE that all NHS governing bodies will receive a briefing (and discussion) on the implications of the Goddard enquiry, and it is therefore proposed that this is included as part of the already planned safeguarding annual update to the Partnership Board workshop in June.  The 2 Designated Nurses are working on a new dashboard for reporting to both the Quality Committee and the CCG Partnership Board and will be agreed by the Quality Committee.   1. **Infection Control**   Clostridium Difficile  A total of 30 cases have occurred to date in the period April 2015 to February 2016 against the annual 2015/16 target of 35, on current trend the forecast position would be 32. Of the 30 cases, 18 were Community acquired infections and the other 12 were Acute.  Systems across both primary and secondary care are in place to undertake post infection reviews of all C Diff cases. We are continuing to monitor NL&G action plans and Infection Control Policies in the Quality Contracting Committee and Yorks and Humber Hospital Acquired Infection Strategy Group.  MRSA BSI  We had 2 cases of MRSA BSI in April 2015/16, this measure has a zero tolerance as the target and as such the 2015/16 target will not be achieved. Post Infection Reviews (PIR) were undertaken as per guidelines and results sent to NHS England. It was deemed that all procedures were handled correctly. Action plans are formulated for all cases and are monitored.   1. **Incident Reporting**   iThe CCG has introduced a new Incident reporting process through an App (replacing Datix) accessible through the CCG network. This App will be used by the CCG and by Primary Care staff and during 2016 we will be working with care homes to improve their incident reporting, hopefully also through this App. The Patient Safety Lead provided CoM with a presentation on the new App at the February 2016 meeting which was well received. All but 2 general practices have now been trained to use the App. The App will be accessible on all CCG and practice staff, including GPs, desktops from 31st March and looks like this:   * For the reporting period April – Dec 2015 (Q1-Q3) we note that 10 out of 31 practices in NEL had not yet reported any patient safety incidents. Although increased reporting has been seen after recent training sessions with the App, this is not across all practices and we will be analysing the data following production of the Q4/year-end report to identify practices still not reporting, and agree a plan within the Quality Committee to approach practices about this.   Historically, GP Practices were not sent the quarterly incident reports provided by the Quality Team. However, the CCG has now agreed to send this out and the Quality Team will be following up with those practices not reporting, or in relation to key themes, and will be working during 2016 to encourage the use of Risk Registers in all practices. The Patient Safety Lead is attending the Practice Managers meeting on the 8th March 2016 to showcase the incident reports, explain their meaning and assist with interpretation, specifically the new section of “So What, What’s changed” (i.e. the learning for all).  In relation to incidents reported, please see below 4 areas highlighted as key themes for April 2015-December 2016:   1. **Discharge Letter Issues**   All incidents reported on DATIX re discharge letters from services provided by NLAG are now being collated and reviewed with CCG and NLAG senior reps at QCR. GP Practices are being encouraged to continue to report issues on DATIX to enable us to understand if this service is improving, and also to feedback to NLG through a recently added “feedback” button at the end of the discharge letter. This helps NLG to learn from the feedback Primary Care provides.   1. **Cytology Incidents**   Pathlinks have submitted a total of 9 incidents during the last quarter with reference to cytology samples being either incorrectly or unlabelled.  All have been sent to respective GP Practices for investigation with the main theme being human error and the patient will be recalled in 3 months.  The CCG are awaiting further feedback from the Immunisation and Screening Team (NHS England) as to next steps.   1. **Medication Incidents**   Across Q1-Q3 we received 65 incidents related to medication specific issues/errors. This is the highest reported category of errors.  Out of those 65 incidents, a total of 29 specifically related to pharmacy errors and are sent to NHSE to investigate. We are working with NHSE to improve the mechanism in place for them to feedback to us on pharmacy related issues.   1. **Key Risks within Main Providers**   **Key risks -** Northern Lincolnshire & Goole NHS Foundation Trust  *Ophthalmology Service Issues:*  The Trust has confirmed, via the NL&G Executive Contract Board, that all of the Ophthalmology patients identified from the earlier validation process, whose appointments were showing on the system as overdue, have all now been seen.  The NLCCG and NELCCG Patient Safety Team have confirmed that no additional SIs or incidents that relate to this issue have been reported following completion of the validation exercise at the end of December 2015.  This remains an area of concern until the SI action plan is complete; the action plan is not due to be completed by the Trust until 01/12/16. Commissioners are also aware that there could be additional incidents/serious incidents that arise as part of the implementation of the new Specialist Administration Teams structure.  *Mixed Sex Accommodation Breaches in December 2015*  A mixed sex occurrence is defined as a patient in a clinical setting (specifically defined) that is occupied by a patient of the opposite sex or the patient has to pass through an area designated for the opposite sex, unless this can be justified for clinical reasons. NL&G is required to report any breaches to the mixed sex accommodation (MSA) policy. In December 2015 they reported 28 breaches. These occur mostly in HOBS beds (High Observation beds) due to the environmental layout of the bay.  In December, 5 separate incidents of mixing were not justifiable as they were in response to bed capacity issues and A&E pressures. There were 28 patients affected by these breaches in total, 25 of which were in NEL area, the other 3 from Lincs East. NLG report that from a patient experience point of view NL&G have had no related complaints and staff tried their very best to maintain privacy and dignity within these MSA breaches.  Root Cause Analysis was undertaken to identify key issues and action plans developed. The CQC noted the breaches at their unannounced inspection in January. Since January NL&G have undertaken the following actions:   * A review of the MSA policy. This will be agreed by the both CCG’s before final sign-off at NLG to ensure there is clarity about the policy and about the approach NL&G adopt. * A new alert process has been put in place that alerts senior managers before the breach occurs to see if senior staff can make decisions that can avoid a breach. * The Web-V IT system now visually identifies all male and female patients and therefore empty beds in male/female bays. It also shows all patients that are “ward ready” and therefore can be moved out of HOBS beds. This helps to manage and avoid MSA breaches. * Weekly challenge by the CEO regarding breaches and “near misses”.   *Clinical Admin Review – CAR.*  Following the SI’s related to Ophthalmology, NLG implemented a Clinical Admin Review – the CAR. The CAR creates new admin and typing teams that NLG consider will streamline the admin function, making it more efficient and a more personal service to patients, giving patients a named person to contact for any queries. The Trust has advised that the Clinical Admin Review (CAR) is now complete. However, an element of risk remains whilst the Specialist Administration Teams are being established.  A number of incidents reported are connected directly or indirectly to the CAR; we are also aware of concerns raised by NLG admin staff (through anonymous letters) regarding the process of the CAR. NLG have put robust monitoring of the CAR review into place, led by the CEO and reported to the CQC, and also shared with commissioners through Executive Contract Board meetings, and meetings between the NLG Director of Risk and CCG Director of Quality & Nursing.  The Quality Team are currently reviewing all incident data and intelligence available and we are closely monitoring investigation responses by NLG to all related incidents. The Quality Team are producing a timeline of issues and will clarify our specific concerns in respect of the CAR which will then be taken to the Quality Committee to agree a way forward.  *CQC inspection*  The Trust has formally responded back to the CQC following the recent inspection, the draft outcome report is expected to be published imminently. The Trust has advised Commissioners (via the NL&G Executive Contract Board) that, following the 2015 CQC visit, the CQC had asked for some additional information and assurance from the Trust – the two main areas being in respect of Out Patient Department (OPD) follow-up appointments and how the Trust is managing ligature risks in A&E at SGH.  The Trust has circulated the latest version of its CQC action plan to Commissioners. The action plan is shared weekly with the CQC and is submitted to the NL&G Executive Contract Board on a monthly basis.   * OPD Follow-up   In respect of OPD follow-up, the validation of the 19,127 patients on the priority waiting list (i.e. patients identified on the system as being overdue their follow-up appointment) is now complete. Revised booking rules have also been introduced, to minimise the number of repeat appointment cancellations. The Trust continues to report on-going capacity issues in general surgery and ophthalmology, the Trust has agreed to share the recovery plans for these services with Commissioners via the established contractual mechanisms. No incidents of harm have been identified from the above validation exercise.   * Ligature risks at SGH   All actions related to ligature risks within the CQC action plan are either complete or are on track.  The CQC also requested additional information in relation to Mixed Sex Accommodation; this is covered in more detail above.  **Key Risks** - Hull & East Yorkshire Hospitals Trust   * Single item QSG took place in January 2016 to discuss on-going Commissioner concern regarding patient safety and quality of care, and on-going work streams have been established to work through these concerns. * The Trust continues to report decline in performance in the following areas: * Cancer 62-days wait and 2-week wait targets * RTT * A&E 4 hour wait * Cancer 62-day waiting lists: the Trust report they are conducting clinical reviews of all patients on their waiting lists. To date, no harms have been identified but the robustness of these reviews is currently under review. The Trust has advised that individual SI investigations will be conducted should any instances of patient safety / harm identified. To date 3 individual SI’s have been potentially linked to this issue.   **Key Risks** - East Midlands Ambulance Service   * We have no information in relation to new risks within EMAS.   **SECTION 3. PATIENT AND CLIENT EXPERIENCE**   1. We are working with the Community Forum to develop our thinking about how we measure quality as a CCG that embraces the service users’ view. We will be collecting feedback from Community Forum members at their event on 31st March. This will inform the development of our Quality Strategy and will shape how and what data and feedback we request from providers and will sit alongside other reporting requirements in terms of quality deliverables. 2. During 2016, and through the development of the Quality Strategy, the Quality Team aim to improve not just the way we use FFT information but all patient experience and feedback information and from across a range of commissioned providers. 3. Friends and Family Test (FFT). See below the most recent data showing uptake of FFT and those who would recommend the service.  |  |  |  |  | | --- | --- | --- | --- | |  | **2015/16** | | | | **Target** | **Value** | **Status** | | FFT - Ambulance - % Who would recommend 'PTS' service | 90.42% | 95.14% |  | | FFT - Ambulance - % Who would recommend 'SAT' service | 94.27% | 96.07% |  | | FFT - AAE % Who would recommend service | 88.10% | 84.74% |  | | FFT - Inpatient % Who would recommend service | 95.73% | 96.24% |  | | FFT - Outpatient - % Who would recommend service | 92.20% | 90.14% |  | | FFT - Community (CPG) % Who would recommend service | 95.32% | 96.76% |  | | FFT - MH % Who would recommend service (NAVIGO) | 87.35% | 93.33% |  | | FFT - Maternity - Combined % Who would recommend | 95.64% | 92.33% |  | | FFT - Employee score | 77.89% | 50.31% |  |   ***‘% Who would recommend service’***  The year to date performance shows we are below target for A&E, Outpatient, Maternity and Staff who would recommend service but above target for Ambulance, Inpatient, Community and Mental Health when looking at how others are performing nationally.   |  |  |  |  | | --- | --- | --- | --- | | **Indicator** | **2015/16** | | | | **Target** | **Value** | **Status** | | FFT - Ambulance Response (PTS) | 0.46% | 0.49% |  | | FFT - Ambulance Response (SAT) | 0.17% | 0.53% |  | | FFT - AAE Response (NLAG) | 14.8% | 12.9% |  | | FFT- Inpatient Response (NLAG) | 27.0% | 21.2% |  | | FFT - Outpatient Response | 5.86% | 0.69% |  | | FFT - Community Response (CPG) | 3.55% | 1.36% |  | | FFT - MH Response (NAVIGO) | 2.41% | 13.5% |  | | FFT - Maternity Response (NLAG) Birth | 22.7% | 11.1% |  | |  |  |  |  |   ***‘Response rates’***  In respect of response rate currently year to date we are below target for A&E, Inpatient, Outpatient, Community and Maternity (Birth) when looking at how others are performing nationally. |

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| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT:** | |
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|  | Members of the Board are asked to note the content of the report. |
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|  |  | **Yes/**  **No** | **Comments** |
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|  | Does the document take account of and meet the requirements of the following: |  |  |
| i) | Mental Capacity Act | n/a |  |
| ii) | CCG Equality Impact Assessment | n/a |  |
| iii) | Human Rights Act 1998 | n/a |  |
| iv) | Health and Safety at Work Act 1974 | n/a |  |
| v) | Freedom of Information Act 2000 / Data Protection Act 1998 | Y |  |
| iv) | Does the report have regard of the principles and values of the NHS Constitution?  [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613) | Y |  |