NHS
Calderdale
Clinical Commissioning Group

Agenda Item: 13 b

Report To:	**Governing Body**
Date:	**13 October 2016**

Title of Report:	**Quality & Safety Report/Quality Dashboard**

FOI Exemption Category:	**Open**

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Executive Summary: (to highlight if applicable) • **Risk assessment** • Legal implications • **Health benefits**	This report provides the Governing Body with a copy of the Quality Dashboard for September 2016, with progress against recent quality and patient safety activities including: • Care Quality Commission report on Calderdale and Huddersfield NHS Foundation Trust (CHFT) • Maternity Services Report • Improving Healthcare Quality through the National Clinical Audit and Patient Outcomes Programme • Primary Care Safeguarding Standards Self-Assessment 2016 • Medicines Management update from the quarterly report
Resource Implications	CQuINs has a financial value attached to outturn contract value
Risk Assessment	Risk is managed in line with risk management policy and procedures, included in the corporate risk registers and Board Assurance Framework as relevant. There are a number of risks on the risk register relating to quality and safety including health care associated infections, patient experience, CQuINs

Legal Implications	None identified
Health benefits	**Health benefits** - the Quality and Safety work positively affects the Outcomes Framework.
Staffing/workforce implications	None identified
Outcome of Equality Impact Assessment:	Not applicable
Sub Group/Committee:	Quality Committee
Recommendation (s):	It is recommended that the Governing Body: Receive the updates and note any actions being taken on the dashboard.

1.0 Purpose

1.1 This report provides the Governing Body with an update on progress against recent quality and patient safety activities.

2.0 Quality Measures

2.1 The quality measures including healthcare associated infections, eliminating mixed sex accommodation, Venous Thromboembolism (VTE), National Patient Safety Alerts (NPSA) and Safety Thermometer have been incorporated into a quality dashboard, together with an exception report.

2.2 Further information on these can be found in the Quality Dashboard Exception Report, Appendix 1.

3.0 Care Quality Commission report on Calderdale and Huddersfield NHS Foundation Trust (CHFT)

3.1 The final overall rating for the Trust was “Requires Improvement”, although over 70% of service areas were rated as good.

3.2 The inspection found variation in the quality of the services provided by CHFT. At both hospitals; accident &emergency (A&E), medical care, surgery, outpatients and end of life care were rated “Good”. However maternity, critical care, and children and young people’s services were rated as “Requires Improvement” at both hospital sites.

3.3 The Trust’s community services were rated “Good” across the board – especially the work being done in the community to reduce A&E attendances and GP callouts by effectively caring for people in their own homes.

3.4 There were some examples of outstanding practice this included the Engagement Support Workers in surgical services who provided engagement, socialization and companionship to patients with dementia or delirium.

3.5 The full report can be found at: http://www.cqc.org.uk/provider/RWY

3.6 The CQC final report is being used to inform a Trust Action Plan. This is based on the 19 must do and 12 should do actions detailed in the report which also feature in the requirement notices issued to the Trust. The action plan contains **all** must and should do actions, some of which impact on all divisions and others which are specific to a core service.

3.7 In order for the Trust to manage their response an action plan has been formulated to include the following:

- *The associated CQC domain and whether the action is relevant for all services or a specific core service.*
- *The issue / issues raised by the CQC that led to the action*
- *The expected outcomes (measurable)*
- *The executive director responsible for the action*
- *The manager responsible for delivery of the action*
- *The group / committee / board with responsibility for the governance oversight of the action*

3.8 A BRAG rating will be applied to each of the actions within the plan, using the framework below:

B - Delivered and sustained
G - Action complete
A - On track to deliver
R - No progress / Not progressing to plan

In order for an action to be considered complete (green), robust evidence is required as assurance that:

- *The action has been completed*
- *The action will achieve the intended impact*
- *Any identified risks are captured on the Trust's risk register*
- *There is a plan in place to monitor the effectiveness of the actions, including the impact for patients / staff*

In order for an action to be considered delivered, sustained and embedded (blue), a period of monitoring / measuring must be completed which demonstrates a sustained delivery of the expected outcome.

3.9 Work is still on going in terms of populating the full action plan and will not be complete until after the Quality Summit which will be held on 17th October 2016.

3.10 The Trust has established robust governance arrangements, in order to monitor, manage and challenge performance against delivery of the action plan. The CCGs will monitor progress through the Clinical Quality Board reporting by exception to Quality Committee on progress.

4.0 Maternity Services Report

4.1 The CCG has discussed concerns on a number of metrics within the maternity dashboard for a number of months. The CQC inspection as reported above identified that Maternity Services required improvement.

4.2 In response to the CQC findings the CHFT commissioned the Royal College of Obstetricians and Gynaecologists to undertake a review of the service. The review took place at the end of July and the Trust is awaiting the report. The Local Supervising Authority Audit Report for 2015/16 was also published in August and the action plan resulting from this report will form part of the overall improvement plan.

4.3 A robust CQC Maternity Action Plan has been developed which includes three focused areas for improvement; post-partum haemorrhage, third and fourth degree tear and improving the quality of midwifery preceptorship. The Trust had already begun to address the three areas prior to the CQC inspection visit.

4.4 The Trust has also developed an action plan in response to The Local Supervising Authority audit.

4.5 The National Maternity Review Better Births was published in this reporting period, the report is based around seven key themes:

- Personalised Care: based around the needs of the woman, her baby and her family, with genuine choice informed by unbiased information. This includes the opportunity for woman to have a personal budget for maternity care.
- Continuity of Care: to ensure safe care based on a relationship of mutual trust. This includes continuity of midwife care through the ante-natal, birth and postnatal period. The aim is to have a new model of care in place from 2018/19.
- Safer Care: with professionals working together across boundaries and a safety culture within organisations. All provider organisations should have a board level champion for maternity services who is responsible for monitoring quality and safety issues.
- Better postnatal and perinatal mental health care: including investment in specialist services for perinatal mental health, and in additional post-natal support.
- Multi-professional working: breaking down barriers between midwives, obstetricians and other professionals, with an emphasis on shared training, improved electronic record keeping and multi-professional peer review.
- Working across boundaries: to provide and commission services. This includes the idea of providing maternity services in community hubs, co-located with other services, and establishing maternity systems for populations of between 500,000 and 1.5 million.
- A fairer payment system: that fairly and adequately compensates providers for delivery of efficient, high quality care**.**

4.5 The report sets out the key delivery actions required over the next five years. Some actions need to be implemented centrally by NHS England, other recommendations require actions from providers, commissioners and arm's length bodies. The Head of Midwifery at CHFT is working with the CCGs and an initial scoping exercise and draft action plan has been completed. Further work is planned following the Yorkshire and Humber Clinical Network Event on Implementing the Better Birth Report.

4.6 As described above there are currently a number of action plans that have been developed in response to different reviews of the service and current performance against a number of clinical measures. In order to effectively monitor progress against these and provide a forum to support improvement it has been recommended that a maternity quality meeting is established with CHFT, CCG and Public Health involvement. This will report into the Quality Committee and Clinical Quality Board.

4.7 Next Steps

- To establish a maternity quality meeting to monitor progress against the action plans and work together to support improvement.
- Monthly maternity dashboard analysis presented in the CCG quality dashboard, areas of concern will be escalated to the Quality Committee.

5.0 Improving Healthcare Quality through the National Clinical Audit and Patient Outcomes Programme

5.1 The Quality Team has reviewed its use of audits published as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP) to determine how it can most effectively exploit the information for quality assurance / quality improvement purposes.[1] This is an iterative process.

5.2 The current process focuses on audits that relate to CCG priorities and Provider key performance measures and areas of concern. The Quality Team produces a brief summary of these audits including key findings and recommended action (for Provider Trusts and CCGs). Information is used with the Providers at relevant Commissioner / Provider forums, for example, Commissioner / Provider Quality Boards. Areas of concern are communicated to the Quality Committee via a quarterly report on National Audits and, where appropriate, a report from the service leading on a particular area of concern.

5.3 Internally, the Quality Team triangulates data with other sources including the Quality dashboard. In addition to NCAPOP audits, the Quality Team is also looking at the use of clinical audit more widely and will review the Provider Trusts' annual clinical audit programme twice yearly and their outcome reports annually.

5.4 The Quality Team is assured that the main Providers participate in 100% of audits relevant to their Trust and that they have internal governance processes in place around participation, review of findings and actions taken. The CCG monitors outcomes in relation to those actions.

5.5 In Quarter 1 the Quality Team reviewed the following audits:

- Falls and Fragility Audit Programme; (FFFAP) National Audit of Inpatient Falls - Commissioners Report 2015
- National Paediatric Diabetes Audit Report 2014-2015, Report 1: Care Processes and Outcomes
- Mental Health Clinical Outcome Review Programme Suicide by children and young people in England
- Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2014

[1] Under the standard terms of contract between commissioners and providers of NHS services, all trusts must participate in NCAPOP national audits. In order to meet the risk management standards set by the NHSLA, Trusts must have a clear documented plan for prioritising both national and local clinical audits.

5.7 Next Steps: The Quality Team will continue to strengthen links with providers and will ensure that clinical and programme leads are aware of audit findings aligned to the CCG priorities. The Quality Team will maintain oversight of the NCAPOP audits in order to obtain quality assurance / quality improvement. In particular, the Quality Team will be reviewing outcomes of Trust Action Plans to monitor improvement as it occurs.

6.0 Primary Care Safeguarding Standards Self-Assessment 2016

6.1 In 2014-2015 NHS England developed and circulated the Safeguarding Standards to General Practices via the CCG Designated Nurses for Safeguarding. Practices were asked to respond with their completed self-assessments directly to NHS England (NHSE). NHSE then passed on the responses to the CCG safeguarding team to develop actions to support GP practices. The data showed that NHS England sent the self-assessment to 26 Calderdale General Practices and received 69% (18/26) completed responses for 2014-15.

6.2 Following the introduction of co-commissioning in April 2015 Calderdale CCG safeguarding team took responsibility for the development, implementation and evaluation of the GP safeguarding standards.

6.3 This provided the CCG Safeguarding Team with a new opportunity to review and amend the previously developed self-assessment to enable it to be up to date with current legislation (including the Care Act 2014).

6.4 Process:

- The standards were revised by the CCG Safeguarding team and presented to Calderdale Quality Committee in January 2016 and the Local Medical Council (LMC) in March 2016 for support and approval. The Primary Care Practice Managers Group also had to opportunity to discuss and prepare for the standards in November 2015.
- The standards were circulated to Practice Managers on April 2016 along with an accompanying letter explaining the document and a submission/self-assessment template to complete and return.
- A timeframe of 6 weeks was given for returned documentation and a further 2 weeks was given to practices who had failed to submit within the original timeframe. During this 2 week period 2 reminders were sent to practices which had not provided a return.

6.5 Summary of Findings

A greater number of practices completed the self-assessment compared to the previous year. In 2014 69% (18/26) of practices responded and in 2016 88% (23/26) of practices responded. This may be as a result of improved partnership working between the CCG safeguarding team and GP practices.

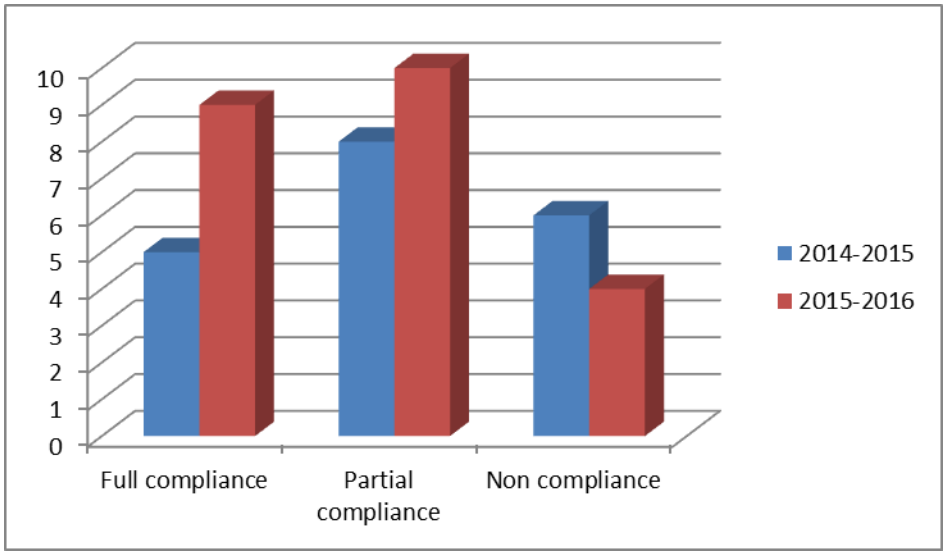
Table 1 demonstrates improvement practices have made since 2014/15 in relation to compliance.

- Full compliance means that the practice has met all the standards fully.
- Partial compliance means the practice has some areas of partial compliance and full compliance but no areas of non-compliance.

- Non-compliance means the practice has at least one area in which they have declared non-compliance but is compliant / partially compliant in other areas.

The table shows that the number of GP practices declaring full compliance with all the standards has increased from 2014-15. The number of practices declaring partial compliance has also increased whereas the number of practices declaring non-compliance in at least one area has reduced.

Table 1 – The number of GP practices declaring levels of compliance



Key areas of improvement by practices since the 2014 audit include:

- All practices now have an identified lead for safeguarding
- All practices having safeguarding policies in place and can evidence that staff are familiar and work within these policies.
- All records clearly identify children in need or children on protection plans
- All staff are familiar with the process for referring concerns to children'
- All practices robust recruitment processes
- Robust training records for staff

In the 2014 audit undertaken by NHSE, the key areas of non-compliance were:

- Governance arrangements, policies and procedures and systems – not having policies in place or requiring updating
- No Prevent lead for the practice
- Infrequent meetings between practice and Health Visitors

In the 2016 audit undertaken by the CCG, the key areas of non-compliance were:

- Updated policies to include: Female Genital Mutilation, Child Sexual Exploitation and Human Trafficking
- A Prevent policy including referral to Chanel process.
- Identification and recording of patients subject to Deprivation of Liberties Safeguards

All of the key areas of non-compliance in 2015-16 were either new standards for 2015-16 or required a higher standard to reach compliance.

6.6 Compliance in relation to children's safeguarding issues had been declared as higher than declared adult compliance in both 2014 -15 and 2015-16.

6.7 Practice responsibilities in relation to PREVENT need development.

6.8 Noted areas of good practice include:

- All practices have a named safeguarding lead for both adult and children
- All practices have and can evidence that safeguarding training records are kept for staff

6.9 2 practices that failed to engage in the 2014 audit also failed to engage and submit returns for the 2016 audit.

7.0 Medicines Management update from the quarterly report

7.1 The Quality Committee received a quarterly update on Medicines management at the September meeting areas to note from the report were:

7.2 Polypharmacy Service: A polypharmacy review service was commissioned by the CCG from member practices in September 2015. The service specification was previously approved by Quality Committee.

7.3 The service provides structured reviews of patients aged 75 and over on 10 or more medicines; with a view to ensuring patients are continuing to benefit from all treatments, and are happy and able to take them. 1329 polypharmacy reviews have taken place since the beginning of the service.

7.4 Practices have been asked to encourage patients to complete patient feedback forms. 268 forms have been returned, a response rate of 20%. These have provided positive patient feedback on the service. Feedback from practices who have not participated in the service is largely that they have not had the capacity to provide this service to date.

7.5 An evaluation of clinician opinion of the benefits from and satisfaction with the polypharmacy service will be developed in 2016/17 and form part of the overall service evaluation to inform decisions on future commissioning.

7.6 Antibiotic prescribing quality premium 2016/17

The CCG achieved its quality premium in 15/16 to promote appropriate antibiotic prescribing in primary care. The CCG was required to reduce cumulative antibiotic prescribing in 15/16 by 1% from baseline level of prescribing in 13/14 and reduce or maintain prescribing of broad spectrum antibiotics below the England median level of prescribing. This was supported last year by two antibiotic audits and an antibiotic campaign across CKW in autumn 2015.

7.7 The CCG achieved an excellent reduction of 8% in items/STAR PU (a benchmarking prescribing measure for comparison of different practices taking into account demographics and practice size) in 2015/16 versus the baseline.

7.8 The CCG continued to prescribe less broad spectrum antibiotics than the England median. Only a couple of Calderdale practices prescribe above this level and this is has been addressed with them at their practice visits.

7.9 It should be noted that the CKW CCGs won an award in the collaborative stewardship category at the Antibiotic Guardian Awards in 2016. This acknowledged the joint working across the health economy and our co-ordinated actions. The CCG is continuing with its collaborative approach to antibiotic stewardship and is formalising the original antibiotic campaign task and finish group into a primary care antibiotic stewardship subgroup of the Area Prescribing Committee so that we benefit from sharing work and knowledge across the health economy.

7.10 The CCG will work to achieve the 16/17 antibiotic quality premium which requires a 4% reduction in cumulative antibiotic prescribing in 16/17 versus baseline in 13/14 and to maintain broad spectrum antibiotic prescribing below 10% of all antibiotic items. The CCG is on track to achieve both of these indicators. An antibiotic campaign is planned for autumn 16 across CKW. This will promote the three key messages from last year for GPs and primary care prescribers:

1) become an antibiotic guardian
2) don't prescribe for self-limiting illnesses
3) promote self-care

Materials and resources will be shared with practices and community pharmacies to aid the campaign Resources were shared with community pharmacies and the campaign will be supported by a communications plan.

8.0 Recommendations

8.1 It is recommended that the Governing Body:

Receives the updates and note any actions being taken on the dashboard.

9.0 Appendices

9.1 Appendix 1 – Quality Dashboard