# 8.2

## NHS DORSET CLINICAL COMMISSIONING GROUP

## GOVERNING BODY MEETING

## QUALITY REPORT

| | |
|---|---|
| **Date of the meeting** | 20/11/2013 |
| **Author** | S Shead, Deputy Director of Quality, M Wain, Head of Patient Safety and Risk and V Read, Head of Quality Improvement |
| **Sponsoring GB member** | T Goodson, Chief Officer<br>Presented by S Rastrick, Director of Quality |
| **Purpose of report** | To provide an update on key quality issues relating to providers with whom the CCG commission services.<br><br>Issues identified in the report either relate to areas where the Trusts are performing below target or where there are 'live' quality concerns. |
| **Recommendation** | The Governing Body is asked to **Note** the report. |
| **Resource implications** | Budgeted |
| **Link to strategic principles** | • Services designed around patients<br>• Preventing ill health and inequalities<br>• Sustainable healthcare services<br>• Care closer to home |
| **Risk assurance**<br>Impact on high level risks | Any risks relating to the quality of services are documented in the organisational assurance framework/risk register. |
| **Outcome of equality impact assessment process** | EIA completed and not applicable. |
| **Actions to address impact** | N/A |
| **Legal implications** | None. |
| **Freedom of information** | This report is not restricted |
| **Stakeholder engagement** | Patient representatives are part of the Quality Group which reviews all quality issues in detail. Patient surveys and a range of patient feedback are used to inform the review of the quality of services provided. |

| | |
|---|---|
| **Previous Committees/Governing Body** | Regular updates are provided to the Quality Group (quarterly), Audit and Quality Committee (quarterly), Governing Body (quarterly) and Directors (monthly). |

## 1. Introduction

1.1 This report provides information and assurance on the quality of services provided within Acute, Community Mental Health Services and Care Homes that are commissioned by NHS Dorset Clinical Commissioning Group.

1.2 Specific quality matters relating to detail arising from, or comprised in this report, are considered in more detail at the Quality Group which reports through the CCG's Audit and Quality Committee.

1.3 The Appendices outline the main indicators for quality, which have been included within the main provider contracts, and are based on National Guidance and Best Practice.

1.4 In addition to analysis of the scorecard quality indicators, a range of activities are undertaken on a day to day basis to gain intelligence on the quality of service provision, to identify any 'early warning' signs of service failures and to work with partner agencies towards quality improvements.

1.5 As part of this process, unannounced visits are undertaken to provider organisations on a planned programme basis throughout the year, as well as in response to any alert of a concern in a specific area. In addition, regular one to one meetings are held between the Director of Quality and the provider Directors of Nursing. Medical Directors are now also invited to these meetings.

1.6 All information relating to quality concerns, which is received through either the Customer Care, Safeguarding Adults and Children, Risk Management, Medicines Management or Care Home Teams is collated and stored in the Ulysses Safeguard system. This allows for triangulation of the information, which the Quality Sharing Information Group (QSIG) examines regularly.

1.7 An important part of the team's function is to ensure that lessons are learnt and that professional practise and processes are improved after identifying concerns or that the care provided falls below the high standard expected.

## 2. Provider Contractual Performance

### Dorset County Hospital NHS Foundation Trust (DCHFT)

2.1 The CQC report has now been published and is publicly available. The CQC reviewed eight standards and found the Trust to be non-compliant with moderate concerns in six of these areas. These have been summarised overleaf:

| | |
|---|---|
| **Respecting and involving people who use services** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✗ Action needed |
| **Meeting nutritional needs** | ✓ Met this standard |
| **Management of medicines** | ✗ Action needed |
| **Staffing** | ✗ Action needed |
| **Supporting workers** | ✗ Action needed |
| **Assessing and monitoring the quality of service provision** | ✗ Action needed |
| **Records** | ✗ Action needed |

The Trust also received a warning notice in relation to Management of Medicines as issues had been highlighted in this area at both previous visits.

The Trust had to submit an action plan to the CQC by 16 October 2013 and this will be monitored by the CCG via the contract monitoring process.

2.2 Year to date the Trust has reported one MRSA bacteraemia and 17 C-diff against an annual trajectory of no more than 18. The Trust will now not meet their annual trajectory and this puts the CCG at risk of not achieving the quality premium in this area (performance of other providers remains good which may bring the CCG total under trajectory at year end if this is sustained). A contract query has been issued in relation to this and subsequently an action plan has been put in place. The Trust has requested that the CCG works in collaboration with them to address any community issues which may impact on the incidence of C Difficile.

2.3 There is concern in relation to the percentage of staff who are compliant with safeguarding children's training required for their role. The lead nurse for the Trust has been off sick for a significant period and although has now returned to work the amount of training has been affected. The Named Doctor has been providing additional training but the amount of training has decreased to unacceptable levels. In the last report the Trust reported 78% compliance with staff having undertaken level 1, 2 or 3 training, but only 50% were compliant with the level required for their role. The information has not been available by staff group or percentage compliance by level. The CQC report has also highlighted that "*approximately 51% of staff had received safeguarding children level one training, in the surgery division, 40% in the medical division and 36% in the family services division."* A contract query has been issued in relation to this and other issues highlighted in this paper. An action plan is now in place to address this.

**Dorset HealthCare University NHS Foundation Trust (DHUFT)**

2.4 The Trust's warning notices for Blandford Hospital in relation to Outcomes 4 and 13 have now been judged compliant by CQC. However, the Trust has been issued with a Warning Notice for Outcome 21 (records) at Blandford Hospital. There are still a number of non-compliant areas with moderate impact at Forston Clinic Waterston Unit and at Bridport Hospital.

2.5 In September, Monitor imposed an additional condition on the trust's license due to concerns that the Trust was failing to improve sufficiently on quality and governance concerns. After receiving the independent review from Deloitte, Monitor became concerned the trust was not acting quickly enough. The condition requires the Trust to ensure its board and council of governors are functioning effectively. The Chairman has stood down and a new Interim Chairman has been appointed by Monitor. Paul Sly has also stepped down as Chief Executive and an Interim CEO is in place, Ron Shields. The new Director of Nursing and Quality, Paul Lumsdon commenced in post on 30th September.

2.6 The Betty Highwood Unit has moved to Chalbury Ward temporarily, until additional staff recruitment can take place. A number of safeguarding alerts have been raised in relation to patient assaults, mostly patient on patient. A high number of patients with challenging behaviours are being managed on the ward. It was also reported at the last contract meeting that the number of falls assessment and number of pressure ulcer risk assessments are low on this ward. As a result of all these concerns, new clinical leadership is in place and the trust is working collaboratively with the CCG and Dorset County Council to improve the situation.

2.7 During the past 2 months, unannounced visits have been undertaken to Blandford Hospital, Portland Hospital, Shaftesbury Hospital and Wimborne Hospital. These have generally been positive visits, with patient feedback being overwhelmingly positive. However, some issues were identified around lack of activities on the wards, safeguarding information not being available, care planning not always complete and some minor infection control issues. All of these have been fed back to the Director of Nursing and will be followed up via the 1:1 meetings with the Director of Quality.

2.8 The introduction of SystmOne led to some patient safety incidents being reported in relation to relevant documentation not being available for community staff to enable them to provide continuity of care. This was raised with the Trust and has now been resolved.

2.9 The Trust has introduced the Friends and Family Test across all units. The response rate for inpatients has been very good, in August it was 41%, and for Minor Injury Units 12%. The score was + 83.

**Poole Hospital NHS Foundation Trust (PHFT)**

2.10 A contract query was issues to the Trust in relation to the following issues:

- Safeguarding Children training
- Safeguarding Adult arrangements and training
- Serious incident process
- Never Event
- Neonatal Incidents
- Compliance with National Patient Safety Alerts

Progress against each of the elements of the contract query are summarised in the following sections of this section. The Trust have completed an action plan to improve all of these areas, the plan is monitored through quality meetings and monthly contract meetings.

2.11 The Trust has submitted a plan to their Trust Board which details the actions that are proposed to achieve compliance with safeguarding children training by March 2014. The CCG have asked for a trajectory plan to be submitted to next contract meeting.

2.12 Following a recent higher incidence and the potential severity of safeguarding alerts raised in relation to PHFT, Poole Social Services have launched a pathway four safeguarding investigation. A strategy meeting was held in July 2013 and Poole Social Services have now conducted a thematic review of the cases involved. A follow up meeting held on 17 October scrutinised the review report. An action plan is now being developed with key areas for action including strengthening the safeguarding and complaints process, instigation of three monthly safeguarding meetings, reviewing the adult safeguarding lead post and agreement to improve communication regarding safeguarding. There was also a discussion regarding the change of culture within the organisation which will require openness and transparency of safeguarding.

2.13 Following the unannounced visit to NICU in June 2013 the CCG wrote to the Trust asking to carry out a review of their serious incident process. This review was conducted on the 12 August and highlighted a significant number of incidents that should potentially have been raised as SIRIs. The Trust has retrospectively added these incidents on to the reporting system. The Head of Patient safety and risk will be re-checking this process around six months after the initial review.

2.14 The Trust reported a never event relating to a patient who underwent a laparoscopic hysterectomy. The panel meeting following the RCA was held on Monday 14 October 2013 which concluded that a Standard operating procedure had not been written and there was variation in practice between surgeons.

The procedure is now in place and all staff have been trained. They have introduced an additional fail safe to record the use of vaginal packs in future.

2.15 The Trust has revised the risk assessment in relation to high risk injectable medicines in the neonatal unit. The Trust has been asked to provide assurance that this process has been embedded in all clinical areas across.

**Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust (RBCH)**

2.16 The Trust has reported a never event in relation to the use of wrong sized prosthesis. The patient had to undergo further surgery to rectify this error. A full RCA is awaited.

2.17 The CQC is due to conduct a visit to RBCH towards the end of October. The visit is to be conducted following the Keogh style review. The visit is prompted by the higher than expected HSMR and SHMI mortality data.

2.18 The Trust has been issued with a mortality outlier alert in relation to Chronic renal failure. The Trust have been asked to response to the alert by 8 November 2013, the review should include individual case analysis and also to review if any of the patients had been admitted from a nursing or care home and if they would have been better remaining at home rather than be admitted to hospital.

2.19 The Trust has had a MRSA bacteraemia that was reported during August. The Trust has 28 days to complete a Post Infection Review. A full RCA will be submitted to the Pan-Dorset RCA group highlighting any lessons learnt and recommendations.

2.20 The Director of Quality undertook a clinical day on 11 September with the Director of Nursing focusing on the elective pathway.

2.21 The CCG carried out an unannounced visit to the Trust on 30 September. During the visit there were some drug and food refrigerators that did not have a record of temperature checks being conducted. There were some commodes that were found to be dirty. It was noted that the Trust had introduced a new patient meal system on the day of the visit which was creating some problems. Generally there was a lack of storage in the wards visited. We noted that flooring to the main corridor to AMU had been replaced, which had been identified on a previous visit, but the flooring in the main ward still required updating. A letter detailing the issues identified in the visit has been sent to the Director of Nursing and her response is awaited.

**Salisbury Hospital NHS Foundation Trust (SFT)**

2.22 Performance has improved in relation to stroke care with 100% of patients spending 90% of their time on a dedicated stroke unit. There has also been improvement in the % of people who received a CT scan within 12 hours of

admission, which has improved to 80% in August. The Trust reported 100% compliance with TIA referrals seen in less than 24 hours during August

2.23 During the first two quarters of year the Trust has had one case of MRSA and 9 cases of C-diff against an annual trajectory of 21. There was concern that due to the number of cases of c-diff during quarter one that it would present a challenging remainder of the year for the Trust in achieving the target at year end. There has been good performance in quarter two which has brought performance back under trajectory. MRSA screening remains consistent at above 90% for non-elective and elective cases.

**Yeovil District Hospital NHS Foundation Trust (YDH)**

2.24 The Trust performance in relation to stroke ward admission has dipped with quarterly compliance for at 60% against a target of 90%. TIA performance has also dipped with 70 of high risk patients receiving treatment within 24 hours against a target of 80%. It is recognised that the number of patients per month is low so one patient missing out on the 24 hour timeframe can skew the results. There is also variance between the length of stay for Dorset and Somerset patients and the Quality Team are currently reviewing this with the Trust to see how the issue can be rectified.

2.25 The Director of Quality undertook a clinical day with the Director of Nursing and participated in collection of “Safety Thermometer” information and data at ward level.

**South Western Ambulance Services NHS Foundation Trust (SWASFT)**

2.26 In relation to the Dorset Out of Hours service, Dorset had 6304 cases in September, a decrease from 7177 in August. GP Shift cover for September was below target at 92% - year to date is 92%. The target for Urgent: Clinical assessment (triage/telephone) to be initiated within 20 minutes was non-compliant at 89.53% for September and 91.88% for the year to date. The target for Less Urgent: Clinical assessment (triage/telephone) to be initiated within in 60 minutes was compliant at 95.98% for September and 95.86% for the year to date. Urgent consultations started within 2 hours was compliant at 95.03% for September and is now partially compliant at 90.75% for the year to date. Urgent home consultations started within 2 hours was non-compliant at 85.22% for September and 84.23% for the year to date.

2.27 In relation to the Dorset 111 service the percentage of calls answered in 60 seconds in September was compliant at 96.57%. Year to date is currently non-compliant at 88.17% but is an improvement on last month and projected to further improve. The service received 17,286 calls in September a decrease over previous months. In September the per cent of calls abandoned was compliant at 0.26%. Year to date is compliant at 3.41% (target of no more than 5%).

2.28 In September the percentage of emergency calls passed to 999 ambulance control in 3 minutes 80.9% which is non compliant and the year to date to is 88.87%. The service concentrates on providing clinician input when a 999 disposition is reached by a call advisor, which is why some calls extend beyond the 3 minute time frame. However, this results in reduced unnecessary 999 callouts. In September the per cent of patient call backs within 10 minutes was 49.97% bringing the year to date to 47.58%. This is non-compliant and SWASFT are working on plans to address this through service modelling.

**Care Homes**

2.29 The Care Home Quality Assurance Team has now completed visits to over 85% of nursing homes within the CCG area and continues to work closely with the three local authorities.

2.30 The visits have identified common themes within the care home sector including difficulty in access to supportive primary/community care services, lack of training opportunities, lack of registered managers and, most challengingly, recruiting appropriately qualified competent staff, particularly registered nurses.

2.31 Each team member has an identified caseload of homes and the initial visits have generated a high number of return visits to support and facilitate improvements in care standards.

2.32 Following a joint quality assurance visit and safeguarding investigation, significant concerns have been identified in one care home. The GP locality team has been made aware and a joint Local Authority and CCG plan has been developed to both assess and mitigate the risks to individuals within the home. Contingency plans are being put in place should the need arise to move individuals out of the home. The CQC have been fully informed throughout the process and have undertaken an unannounced inspection, the outcome of which is awaited.

2.33 The development of a CCG quality assurance tool is almost complete and a business case has been submitted to the Directors to fund the development of an application and the equipment needed to support the tool.

2.34 Information regarding individual care homes is being shared with the CHC commissioners, Section 117 commissioners and safeguarding. Work is ongoing to develop a quality assurance process for domiciliary care services. The Care Home Quality Assurance team is currently responsible for monitoring care in 83 care homes with nursing and 11 residential facilities where people with learning difficulties reside, across the geographical location of Dorset, Bournemouth and Poole.

**Safeguarding Adults**

2.35 There are currently nine pathway 4 whole scale investigations across the Dorset, Bournemouth and Poole.

2.36 There have been a number of alerts that have implications for Dorset Healthcare University Foundation Trust (Community Services) with the main themes being holistic assessments and delivery of task orientated care and the implementation of the Mental Capacity Act.

2.37 Community and inpatient Mental Health Services have seen an increase in the number of alerts, these are being managed on an individual basis, and information to inform a thematic analysis is being gathered.

2.38 Two safeguarding alerts have been directed onto the Area Team, for their involvement, a meeting has been held to ensure there is an agreed process for the management of safeguarding that requires the Area team involvement as the commissioner.

2.39 There is a case audit organised for November to discuss the serious case that was CHC funded and received residential care from both Dorset County Council and Poole Borough Council.

2.40 Interagency work continues across all local authorities and the links with safeguarding leads in the main providers continues to be developed and enhanced.

**Prevent**

2.41 As part of the Government's revised counter terrorism strategy of June 2011 (CONTEST), the NHS has committed to support initiates to reduce the genuine risk we face from terrorism so that people can go about their lives freely and with confidence. It is made up of four work streams, or four Ps:

- Protect – strengthening our borders, infrastructure, buildings and public spaces;
- Prepare – where an attack cannot be stopped, to reduce its impact;
- Pursue – to disrupt or stop terrorist attacks;
- The fourth P is Prevent which aims to stop people becoming terrorists or supporting terrorism. It has been described as "the only long term solution" to the threat we currently face from terrorism. The Prevent strategy will specifically focus on three broad objectives, known as the three I's:
- Respond to the ideological challenge of terrorism and the threat from those who promote it;
- Prevent individuals from being drawn into terrorism and ensure that they are given appropriate advice and support;
- Work with institutions where there are risks of radicalisation that we need to address.

2.42 The Prevent strategy places an onus upon the health sector to support the work of counter-terrorist activity because of the volume of people who come into contact with healthcare workers on a daily basis and high profile cases associated with the NHS.

2.43 Healthcare workers have the potential to:

- Prevent someone from becoming a terrorist or supporting terrorism as it is substantially comparable to safeguarding in other areas;
- Receive information that allows them to correctly identify signs that someone has been or is being drawn into terrorism;
- Identify people who could be considered “at risk of exploitation”;
- Be aware of the support which is available and be confident in referring people for support;
- Meet and treat people who are vulnerable to radicalisation.

2.44 In Dorset the CCG are an active partner in delivering the Prevent agenda through reviews of potentially vulnerable individuals via ‘Channel Panels’. Channel Panels are multi-agency risk identification and mitigating meetings that review information from all agencies involved and create an action plan to ‘channel’ the vulnerable individual away from engagement in extremist acts.

2.45 The CCG works with partners including Dorset Police, Social Services, Probation, Safeguarding and third sector organisations. A gap that has been identified relates to the awareness of Prevent at a GP practice level. As a CCG we need to be promoting reporting from GPs in relation to individuals they believe are at risk of being radicalised, promoting the (appropriate) sharing of information to inform the Channel Panel process and actively participating in Chanel actions.

2.46 A structured process is planned to raise GPs awareness of the Prevent agenda, with a two tiered approach. All GP practices will receive information relating to Prevent via the Practice Managers and it is proposed that the new safeguarding lead GPs attend a Workshop to Raise Awareness of Prevent (WRAP) training which is a two hour session that will be delivered by Dorset Police.

**3. Children’s Safeguarding**

3.1 Interagency work remains busy, both Local Safeguarding Children Boards (LSCB) chairs are retiring with the interviews taking place on the 21st October with a view to appoint one chair for both boards, which will aid a consistence approach across Dorset Bournemouth and Poole. All sub groups off the LSCB have health representation ensuring fulfillment of the CCG statutory role.

3.2 One Serious Case Review relating to the death of a 15 year old boy from an overdose of un-prescribed medication is underway. Themes highlighted so far include mental health of father and child, hard to reach family, out of

education, drugs and alcohol misuse, missed referrals to social care and social isolation.

3.3 In the last three months two other teenage boys have died, one from hanging; current investigation has identified concerns regarding drug taking, but he was not known to health or social services. This is being considered as an accidental death.

3.4 A second young person had been experimenting with drugs, his behavior had escalated over a matter of weeks, again was not known to health services.

3.5 The themes above including teenage neglect and risk taken behaviors are being explored within a case audit led by the Local Authority, in addition to the Serious Case Review in November 2013.

3.6 Although child maltreatment due to abuse or neglect is pervasive within our society, less is known about fabricated or induced illness by carers (FII) which is considered to be a rare form of child abuse. The term FII was introduced in the UK by the Royal College of Paediatrics and Child Health (RCPCH) in 2001 and subsequently adopted by the Department of Health. The terminology is useful in helping to describe and respond to various types of abuse which involve a child being presented for medical attention with symptoms or signs which have been fabricated or induced by the child's carer. Currently within Dorset we have six cases that are under investigation, these cases are investigated under strict adherence to policy in which the designated nurse has direct involvement to ensure the cases are fully explored. One case has necessitated direct contact with the family to ensure the safety of the child. The mother has agreed to fully engage in the child protection process.

3.7 On a positive note the current Drinking Head campaign has been very well received with a positive uptake on training, awareness by other agencies and front line workers. There was a positive response to the radio interviews and interest across the region. The campaign was presented at an international conference with a positive response.

3.8 A mapping exercise is underway to determine training needs for GPs and medical staff and Board members at Training levels 2 and 3.

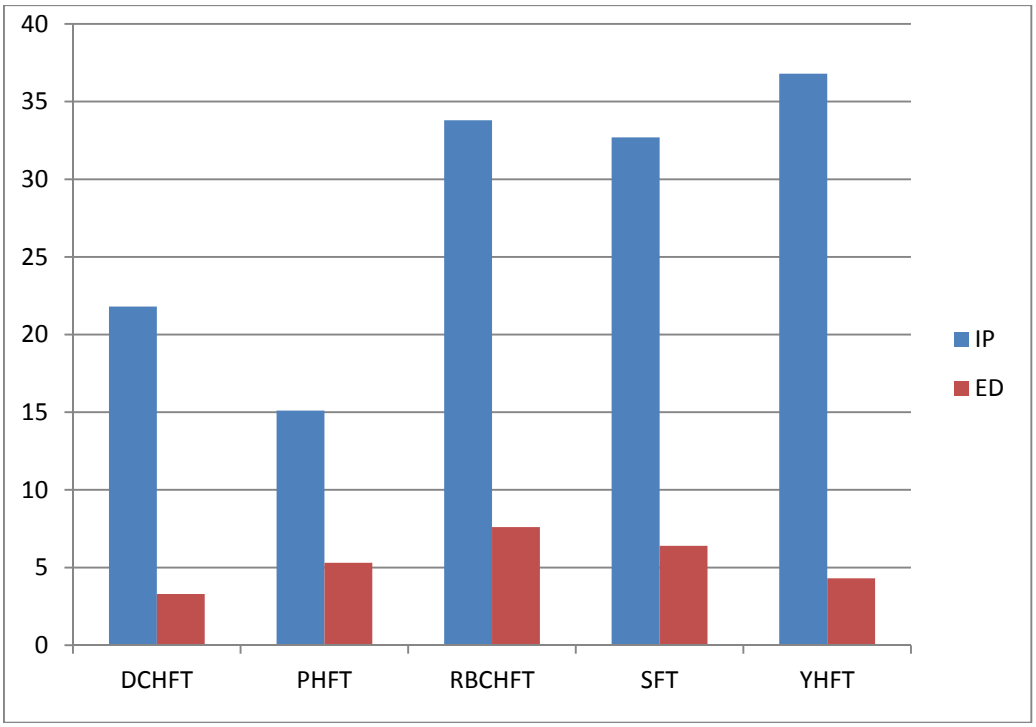
## 4. Friends and Family Test

4.1 On 30 July 2013 the NHS published the first round of Friends and Family data for Acute Inpatient and Emergency Departments. The data covered the period from April to June 2013 and for the purposes of this report I have provided an average for the three months combined.

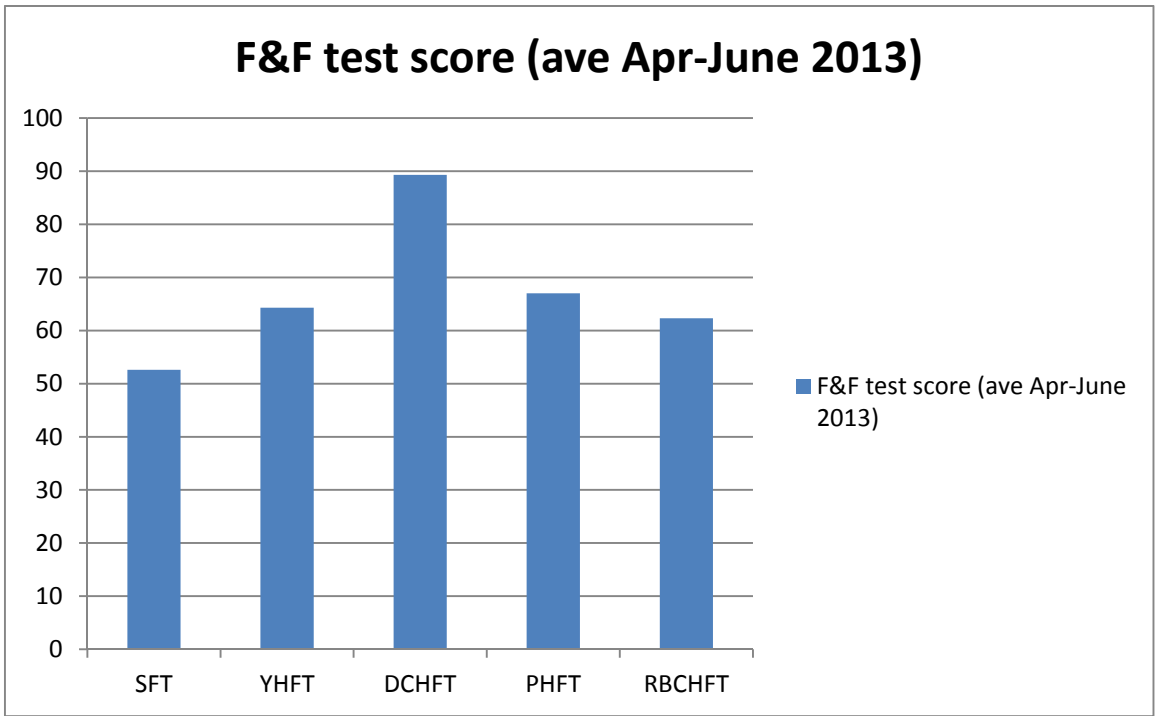
4.2 The overall Trust score which has been widely publicised in the media relates to a net promoter weighted question. The net promoter score is calculated by counting only "extremely likely" as a positive confirmation, taking away points

for both “unlikely” and “extremely unlikely” responses. Other responses are counted as neutral and thus attract no weighting.

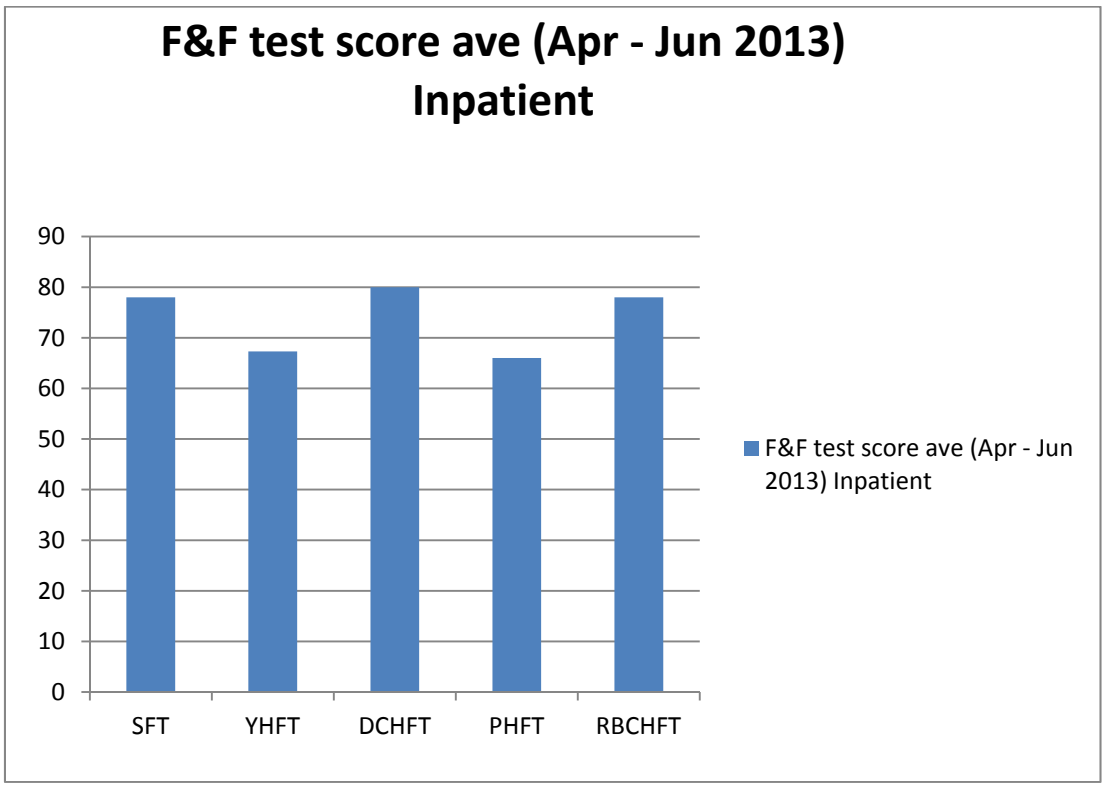
4.3 Response rates have varied from provider to provider and from ward to ward. The biggest are of difficulty in obtaining sufficient responses is in Emergency Departments. The other challenge in relation to low return rates is that at ward level results can be skewed e.g. five responses with one being very unlikely could give a low score and consideration should be given to validity of such low numbers. The chart below demonstrates the response rates for local acute Trusts in both Inpatient and Emergency Department areas:




4.4 The chart below summarises the average of the three months averaged (net promoter) score for Emergency Departments of local acute Trusts. The average rate across all Trusts in England for Emergency Departments is **53**.




4.5 The chart overleaf summarises the average of the three months averaged (net promoter) score for Inpatient wards of local acute Trusts. The average for England is **72**.



## 5. Information Governance

### Section 251 and Accredited Safe Haven Status

5.1 In order to ensure that the CCG can continue to process data, and remain lawful, the Health and Social Care Information centre (HSCIC) announced that provisional arrangements have been put in place under s251, which allow all CSUs, and those CCGs with in-house data processing facilities, to access personal confidential data from the SUS data system. This approval is only temporary for a period of six months and is subject to stringent conditions which include preventing individuals from being identified and the CCG achieving Accredited Safe Haven (ASH) status.

5.2 An ASH may process data that is only 'weakly pseudonymised', which means the data has the potential to identify an individual if handled outside the controls of the ASH environment. Weakly pseudonymised data may contain the NHS number or the postcode, which on its own will not directly identify the individual, but outside of the controls of the ASH would make the data identifiable.

5.3 In order to achieve ASH status the HSCIC required the CCG to submit the IG Toolkit, attaining level 2 in all requirements, on or by 31 October 2013. Under normal circumstances submission of the IG Toolkit would take place annually by the 31 March.

5.4 Post submission, the IG External Delivery Team will review Version 11 status and examine the evidence submitted.

5.5 Once the toolkit and evidence has been reviewed and approved by the Data Access and Information Sharing (DAIS) Team they will instigate the process of agreeing the request for the CCG to access data and sign the Data Sharing documentation.

5.6 The IG toolkit was submitted late on the 31st and level 2 was achieved in all the requirements. The CCG has now been provisionally recorded as 'Satisfactory' for the submission. (Please note that an organisation is recorded as either satisfactory or unsatisfactory). The percentage score achieved is 67%.

5.7 The submission will not be ratified until the review of the evidence is complete. Part one of ASH status should then be agreed.

### IG Task Force

5.8 The Health and Social Care Act 2012, and the Caldicott2 review, changed the levels of access to person identifiable data for CCGs and CSUs, causing a number of significant challenges. In response, NHS England states that they have established a task force to work on ensuring that secondary users of data have access to the data that they require for checking invoices, identifying high-risk patients, and following up the outcomes of patients.

5.9 Work around invoice validation is currently a key priority for NHS England. The issue is apparently complex and is taking time to clarify and resolve. NHS England hopes to publish interim guidance shortly, with further guidance to follow a few weeks later.

5.10 NHS England has advised that they are currently discussing the s251 exemption with the Confidentiality Advisory Group (which advises the Secretary of State) and further information is expected shortly.

**Caldicott2 Review**

5.11 In December 2011 the government commissioned a review of information issues across the health and social care system. This resulted in the report 'Caldicott2' *To Share or Not to Share*. A full copy of the report can be obtained from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

5.12 A government response to that report has recently been released (September 2013) in which the Caldicott2 report is ratified.

## 6. Customer Care

6.1 A number of reports have recently been published including the *Francis Report*, the "*Designing good together: transforming hospital complaint handling"* report and "*A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture"* report by Ann Clwyd, MP.

6.2 The above mentioned reports contain a number of recommendations in relation to improve complaint handling within the NHS. These include but are not limited to:

a. Governing Body led scrutiny
b. Clear standards for complaint handling
c. Encourage positive and negative feedback
d. Offer complainants the option of a conversation at the start of the complaints
e. process
f. Openness and transparency on learning from a complaint
g. Commissioners should establish clear standards for hospital complaint handling

6.3 As a result of these recommendations the Customer Care Team is reviewing and revising the current process that is in place for handling complaints.

6.4 The Professional Practice Lead and members of the Customer Care Team met with relevant senior managers from the four major service providers. The purpose was to establish clear standards for complaint handling and how the learning from complaints would be disseminated and acted upon. The

Professional Practice Lead is to attend relevant meetings where learning from complaints is discussed by providers. She will also undertake "deep dive" exercises into five consecutive closed complaints from each provider. This will be followed by visits to wards as appropriate to check that learning has been disseminated.

6.5 Each of the four major service providers will make available to their Trust Board and, to the public, anonymised summaries of closed complaints.

6.6 The Customer Care Team have received 17 formal complaints since mid September. These include issues relating to service providers, Individual Patient Funding processes and decisions, and NHS Funded Continuing Care processes and decisions. Of these 7 relate to services provided by Dorset Healthcare University NHS Foundation Trust.

6.7 The Customer Care Team handled 17 concerns and complaints during the first two weeks of the newly commissioned transport service.

6.8 The Team continue to receive a number of complaints relating to GPs and other Independent Providers which are the responsibility of NHS England.

## 7. Research Governance

7.1 The CCG is a member of the Western Comprehensive Local Research Network (WCLRN). The governance for research being undertaken within the CCG is managed on our behalf by Salisbury NHS Foundation Trust.

7.2 Analysis of recruitment performance for research in the first quarter of 2013/14 gave rise for cause for concern. The proportion of the total research activity in England undertaken by trusts in the WCLRN has continued to fall and the network as a whole recruited only 78% of its target in Q1. Given the current position, the CCG has been asked to take every opportunity to continue to develop its research capacity and capability with the support of the WCLRN.

7.3 There are currently 46 ongoing open studies within the Dorset CCG area.

## 8. Medicines Optimisation

8.1 In primary care prescribing, the Medicines team continue to work with the GP prescribing locality leads to implement a strategy of quality improvement and reduction in variation in prescribing using national and locally derived measures in prescribing e.g. NICE medicines management options for local implementation.

8.2 All first practice prescribing visits have either taken place or been booked, and the locality pharmacists are starting to book second visits for practices struggling to achieve budget for the new year. The majority of visits are accompanied by the locality prescribing lead GPs which allows the peer support and challenge on prescribing practice, and this has been very

positive. The Medicines Optimisation Group (MOG) has also agreed an escalation plan for managing potentially poor performance in prescribing, with GP leads able to refer practices into the process.

8.3 A multidisciplinary project has been underway with the aim of reducing the impact of patients seeking repeat medicines on the out of hours service. Practices have undertaken an audit on patients accessing the out of hours service for routine medicines at weekends and have received notification about patients seeking several medicines or repeatedly seeking medicines. Community pharmacies are receiving referrals for emergency supplies of medicines and there have been communications to the public encouraging patients to order repeats in plenty of time. As a result of the audit and flagging up of the issue, a number of practices have changed their messages on websites and reviewed their processes for when medicines are requested on Friday afternoons etc. The result of this approach has been for SWAST to report a one third decrease of patients needing referral to an out of hours GP, releasing at least 8 hours of GP time to deal with urgent cases.

8.4 Current forecasting suggests a potential underspend of approximately £2m. Some of this may be affected by movement of services to specialised commissioning, the full impact of newer anticoagulants is still yet to have a significant impact on spend as their usage, though rising exponentially is still very low. Clarity has been gained over what we can expect will be funded through specialised commissioning, with the publishing of a defined list of medicines and indications. There are still some questions over other indications. Modelling is about to begin on a new way to set practice prescribing budgets following a meeting with GP prescribing leads to explore relevant elements.

8.5 Work is underway to repatriate non medical prescriber prescription codes to their employing organisation, and to ensure that clinic costs and prescription pads are within contracts with providers.

8.6 The Health Technologies Forum has been re-named the Dorset Medicines Advisory Group (DMAG) and the format, terms of reference and sub groups are currently being realigned.

## 9. Conclusion

9.1 Key areas of concern remain around Dorset HealthCare's compliance with CQC Standards and Monitor's requirements, Poole Hospital's Safeguarding systems and Serious Incidents, and Dorset County Hospital's rates of C Difficile, safeguarding children training and CQC compliance.

9.2 The CCG quality team continues to work towards providing assurance to the Governing Body around the quality of care provided within Dorset and to improve quality in the future.

**Author's Name and Title:** Sally Shead, Deputy Director of Quality
Vanessa Read, Head of Quality Improvement
Matt Wain, Head of Patient Safety & Risk

**Date:** 31 October 2013

**Telephone Number:** 01305 368071

## Appendices

| | |
|---|---|
| **Appendix 1** | **Quality and Performance Integrated Scorecard** |