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NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

SAFETY REPORT – COVID-19

Date of the meeting	13/05/2020
Authors	J Swarbrick, Head of Nursing and Quality (Patient Safety and Risk)
Purpose of Report	To provide a summary of safety in commissioned services during the Covid-19 response.
Recommendation	The Governing Body is asked to **note** the report.
Stakeholder Engagement	N/A
Previous GB / Committee/s, Dates	N/A

Monitoring and Assurance Summary

This report links to the following Strategic Principles	• Prevention at Scale • Integrated Community and Primary Care Services • One Acute Network • Digitally Enable Dorset • Leading and Working Differently		
	Yes [e.g. ✓] *Copy & paste tick*	**Any action required?**	
		Yes Detail in report	**No**
All three Domains of Quality (Safety, Quality, Patient Experience)	✓		✓
Board Assurance Framework Risk Register	✓		✓
Budgetary Impact	✓		✓
Legal/Regulatory	✓		✓
People/Staff	✓		✓
Financial/Value for Money/Sustainability	✓		✓
Information Management &Technology	✓		✓
Equality Impact Assessment	✓		✓
Freedom of Information	✓		✓
I confirm that I have considered the implications of this report on each of the matters above, as indicated	✓		

Initials : JS

1. Introduction

1.1. In response to COVID 19 NHS England and NHS Improvement published revised guidance on quality reporting. Dorset CCG agreed that safety was of paramount importance and moved from assurance that Providers are aiming for high quality services to ensuring the services are safe. The overall CCG Covid Strategy aims are: To preserve life; To maintain safe and quality services to support positive physical and mental, health and wellbeing; Dignity for those where life is lost.

1.2 In the absence of usual quality monitoring this report has been drawn from the local reporting and intelligence that continues in relation to key safety incidents, safeguarding and patient experience.

2. Patient Safety Information Cascade

2.1 The Central Alerting System (CAS) is being used nationally to ensure key clinical messages, updates to guidance and safety alerts are shared effectively. All Dorset Provider Trust incident management teams are receiving and acting on these alerts as they are sent.

2.2 To support Primary Care the CCG team is including relevant alerts on the daily communications bulletin which all practice managers are accessing. In some instances, the team is also requesting assurance from Trusts that the actions in response to the alerts are being taken.

3. Patient experience

3.1 The CCG continues to receive and acknowledge complaints and concerns through the customer care and feedback contact points. The aim is to continue to investigate and respond to concerns, however in line with other providers and primary care people are advised that this may not be within usual timescales.

3.2 Where a concern indicates a patient safety or safeguarding issue these are dealt with immediately. An initial theme in contacts was in relation to Covid-19 shielding from people concerned they had not received their letter. All queries are screened and signposted to the most relevant Government guidance or local service to address their needs.

4. Serious incidents

4.1 There has been no change in reporting of Serious Incidents (SIs) through the national STEIS system and each Trust has provided assurance that its internal reporting and initial investigation processes have been prioritised during the pandemic.

4.2 All Trusts have implemented the new standardised report template from 1 April 2020 and currently 72-hour reports are prepared to ensure learning is shared at the earliest opportunity. It is anticipated that there will be delays

(beyond 60 days as in the SI framework) to receipt of completed reports.

4.3 An emerging theme in SIs was identified and shared regionally by the Lead Midwife for the Dorset system in relation to the late presentation of pregnant women to Maternity Services. Action was taken to co-ordinate public messaging and communications regarding the importance of accessing NHS services. Dorset Healthcare is preparing for a potential rise in unexpected deaths and self-harm in mental health patients and have configured services to maintain access to crisis support.

4.4 There have been two Never Events reported at Poole Hospital since last report; wrong implant insertion and a retained object following a procedure. Both incidents are being fully investigated with relevant clinician involvement and immediate actions have been taken.

4.5 From 1 April 2020 the commissioning support functions transitioned to Dorset CCG as co-ordinating commissioner for SWASFT 999 services. A standard operating procedure for the management of SIs has been implemented following agreement with all South West CCGs.

5. Learning from Deaths

5.1 Along with SI and Never Event reporting, established Medical Examiner processes in acute Trusts have been prioritised to continue with retired consultants and medical staff from elective care areas covering the rota to release anaesthetists to support critical care. Learning from deaths remains a key quality priority and continues in accordance with guidance in all Trusts.

6. Safeguarding

6.1 The CCG Safeguarding team is supporting Primary Care in undertaking statutory requirements. Virtual child protection conferences are working well and are both quorate and timely.

6.2 Children on child protection plans have increased this month in both Dorset Council (DC) and Bournemouth Christchurch and Poole (BCP) areas. This is thought to be due to increased pressure and tension in the home and the requirement for shielding. Home visits are still being made to children at highest risk and the top 50 vulnerable families in both DC and BCP are contacted weekly.

6.3 There has been an increase in activity for the Looked After Children (LAC) services due mainly to shielding and the breakdown of placements. Performance in relation to individual health assessments for LAC has improved.

6.4 So far there has been no reported significant increase in domestic abuse, however there are more neighbourhood disputes and family tensions reported. The numbers of reported sexual assaults are much lower than expected and indicate a potential hidden problem.

6.5 Similar to the theme noted in patient safety, late presentations of children and pregnant women hospitals are an emerging concern as well as an increase in reports of self-harm in adolescents. A widespread multi-agency media campaign is being supported to raise awareness of keeping safe and what to do and encourage hospital attendance to urgent care services that are operating as normal.

7. Recommendation

7.1 The Governing Body is asked to **note** the report.

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