Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 1st May 2018
Time: 1.30pm
Location: The Winter Gardens Pavilions, Weston College, 2 Royal Parade, Weston Super Mare BS23 1AJ

Agenda item: 8.1

Report title: Quality Assurance Report

Report Author: Marie Davies, Associate Director of Patient Safety (Patient Experience)
Report Sponsor: Anne Morris, Director of Nursing and Quality

1. Purpose

The purpose of this report is to provide the Governing Body with the key issues of quality work discussed at the BNSSG Quality Committee in April 2018 and areas of emerging quality issues.

2. Recommendations

To note the area of work undertaken; note assurances received and actions agreed.

3. Background

The first Quality Committee of the Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) took place on the 19 April 2018. The Quality Committee was established in accordance with the BNSSG Clinical Commissioning Group Constitution, Standing Orders and Schemes of Reservation and Delegation.

The BNSSG CCG is responsible for ensuring that there is a cohesive and comprehensive structure in place for the oversight and monitoring of:

- The quality of commissioned services including patient safety, patient experience and clinical effectiveness
- The clinical effectiveness of commissioned services
- Performance against constitutional standards

4. Quality Committee Assurance

4.1 Pressure Injury Strategy Launch

The Multi-Agency Strategy for the Management and Prevention of Pressure Injuries was launched across Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group at the West of England Wounds Annual Conference on the 19 April 2018. The Strategy is the culmination of 2 years work undertaken with Care Providers across BNSSG to develop a consistent approach to pressure injury management.

Nationally, nearly 700,000 people are affected by pressure injuries each year with approximately 187,600 patients developing a pressure injury in hospital. Pressure injuries occur in all provider care settings including patients' homes. Each pressure injury that occurs in hospital is estimated to add an additional £4000 to care and represents a major burden of sickness and reduced quality of life for people and their carers (NHS Improvement Stop the Pressure 2017) http://nhs.stopthepressure.co.uk/. Pressure injuries account for a significant proportion of all incidents reported across the Bristol, North Somerset and South Gloucestershire area.

The Pressure Injury Programme Board was established in October 2017 to ensure delivery of the strategy. The Programme Board consists of representatives from acute and community providers, local authorities and commissioners.

The aim of the strategy is to influence the reduction of Grade 2, 3, and 4 pressure injuries across Bristol, North Somerset and South Gloucestershire regardless of care setting. The strategy sets out clear standards and expectations for all care providers to prevent, manage and detect pressure injury.

The strategy reflects the aspiration of the participating agencies to have a consistent approach to preventing pressure injuries across all care settings. It focuses on the key areas of Communication, Documentation, Education and Training of Staff, Patient and Carer Support and makes recommendations for providers of care to measure and monitor outcomes that are shared with all front line staff to drive improvement.

Alongside the strategy a set of standards have been developed that will enable all providers to undertake a consistent approach to audit against the strategy to drive forward improvement across BNSSG. The strategy will also be published on the BNSSG CCG website and the work will continue to be overseen by the Programme Board chaired by the CCG Director of Nursing and Quality.

4.2 MRSA Update April 2017 – March 2018

Between April 2016 and March 2017, the Public Health England (PHE) Mandatory Surveillance data tool identified that 38 cases of Methicillin Resistant Staphylococcus Aureus (MRSA) Blood Stream Infection (BSI) were initially apportioned to Bristol, North Somerset, and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and their acute providers. These cases accounted for 44% of the total apportioned CCG cases across the South West.

Forty nine cases of MRSA BSI have been apportioned to BNSSG CCGs and their acute providers for the period April 2017 – March 2018.

NHS England expects Clinical Commissioning Groups (CCGs) and providers to have a zero tolerance to healthcare associated MRSA bloodstream infections. Healthcare associated infections including MRSA cost the NHS approximately £1billion per year (NHS England 2015). Every case of MRSA BSI is subject to a comprehensive post infection review (PIR) to identify learning and actions to prevent the same circumstances recurring and attribute responsibility.

In 2014/15 Bristol CCG saw an increase in MRSA bacteraemia. Review of the cases identified a significant rise in intravenous drug users. At this time an MRSA task and finish group was established and funding was secured from NHS England for a fixed term Infection Prevention and Control (IPC) nurse post. The IPC nurse worked with acute providers and Bristol Drugs Project (BDP) to put in place actions for intervention and education of intravenous drug users and cases were seen to decrease in 2015/16. A further rise in MRSA cases was also seen in 2016/17.

BNSSG CCG hosts a Bristol, North Somerset and South Gloucestershire (BNSSG) wide Healthcare Associated Infection (HCAI) Group held bi-monthly. Membership is drawn from commissioners (CCG and NHS England) acute, MH and community providers, primary care and Local Authority and NHSE Public Health across the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group areas. The aim of the group is to ensure that the appropriate governance systems and processes are in place to prevent avoidable healthcare associated infections. MRSA is a standing agenda item and regular updates and assurances on performance, identified trends and associated work for improvement including sharing best practice and lessons learned from post infection reviews takes place at each meeting.

In July the findings of the Elizabeth Blackwell study were verbally shared with the BNSSG HCAI group. The study identified that there was a high MRSA colonisation rate and a large increase in the number of invasive MRSA infections in Bristol that held a close genetic relationship (i.e. unique to Bristol). Three factors were associated with the increase in MRSA infections. These are:

- injecting intravenous drugs outside,
- Hospital contact in the past month, and
- injecting in groups of more than three.

The first meeting of the MRSA task and finish group was held on 14 September 2017. The group includes representatives from BNSSG CCGs, PHE, Local Authority, Primary, Secondary and Mental Health Providers and third sector agencies. The findings from the Elizabeth Blackwell Study were discussed again and from this the group identified short and long term actions to address the factors associated with, and reduce MRSA bacteraemia in patients who inject drugs.

BNSSG CCGs have seen an increase in reported cases of MRSA bacteraemia in intravenous drug users. The rise in MRSA infections has been recognised as both a public health and healthcare issue, and therefore the membership of the task and finish group is representative of the wider health community. This group is meeting monthly to identify, evaluate and implement actions to reduce MRSA bacteraemia in patients who inject drugs and action has been put in place to address these issues.

The introduction of new post infection review guidance by NHS Improvement has currently taken away the requirement for UH Bristol and WAHT to undertake formal post infection review and may impact on the whole system approach to tackling MRSA bacteraemia however the CCG is currently in discussion with NHS England in relation to this proposed change.

4.3 Serious Case Review

Working Together to Safeguard Children 2015 states that it is mandatory to carry out a SCR when a child dies or is murdered and abuse or neglect are known or suspected. Becky was reported missing on 20 February 2015 and her body was found on 3 March 2015. Becky's step-brother was found guilty of the murder of Becky and his partner was found guilty of manslaughter. Both are serving custodial sentences of 33 and 17 years respectively.

The SCR was carried out by 2 lead reviewers using the Social Care Institute of Excellence (SCIE) systems methodology between September 2015 and September 2016. The publication of the report has been delayed due to the recommendation of the review panel to the Bristol Safeguarding Children Board (BSCB) that a Domestic Homicide Review (DHR) be undertaken given the circumstances of Becky's death. This was referred to the Safer Bristol Partnership Board who agreed with this recommendation and this led to delays in the SCR being completed.

The SCR review panel comprised of senior representatives from local agencies, including the Named GP for Safeguarding Children in Bristol and the Deputy Designated Nurse in Bristol. The report covers a three and a half year period between 2012 and Becky's death in March 2015. The report is 32 pages long and has identified 5 key findings highlighted below:

a) Services need to be focussed on an evidence based understanding of the needs and circumstance of adolescents; the absence of this can lead to adolescents inappropriately becoming the focus of concern and being seen as 'troublesome' rather than 'troubled' because of their circumstances.

b) The inconsistencies within intra and inter-agency approaches to recording, analysis, planning, coordination and review makes joint working for children and their families less effective.

c) Children in receipt of specialist services from Hospital Education Services (HES) have complex needs and some require a multi-agency response to meet these needs. Despite this HES are often working alone in providing services to children; such lone working does not meet the needs of all children.

d) The propensity for professionals to take parent/carer perspectives at face value without triangulating information from other sources, including observations of how a child or young person appears, can lead to a limited understanding of a child or young person's needs.

e) Professionals are less challenging of the lack of engagement of fathers in child welfare practice leaving the risks they may pose unassessed and the contribution they could make to children's lives unknown.

The Quality Committee received the first draft of the action plan for the health components of the findings of the SCR and will continue to oversee this alongside the BNSSG Safeguarding Governance Group with oversight from the Director of Nursing and Quality as Executive Lead for Safeguarding. The Quality Committee will receive any exception reports if the action plan is not progressing as planned.

4.4 Avon Wiltshire Mental Health Partnership

The Quality Committee received a paper which outlined the approach required to ensure that quality metrics on AWPs service delivery provide the necessary information to support early identification of any issues before they become significant concerns.

Bristol, North Somerset and South Gloucestershire (BNSSG) CCG is the lead commissioner for AWP. This is a complex contract across 4 CCGs and 2 STP footprints. Following recent changes to the NHS England South sub-regions the AWP geography is now covered by one sub-region, but any concerns raised for wider discussion with other commissioners, regulators and CQC are still held at two separate NHS England led Quality Surveillance Groups.

Contracting and Quality support for this contract transferred on the 1 April to the CCG from the South Central and West Commissioning Support Unit (CSU). However the CSU will still provide some provider management support for the B&NES, Swindon & Wiltshire CCGs. .

The CCG receives monthly data from AWP on quality metrics to demonstrate compliance with the requirements as detailed within the quality schedule of the NHSE standard contract, which has been agreed by all 6 CCGs. These metrics are produced at corporate level and provide both Trust and locality level data. The presentation of these metrics has been revised on multiple occasions by AWP during 2017, following individual requests from commissioners.

It is recognised that further work is required in order to gain the necessary assurances required by the CCG and to support AWP to improve service provision. This will include:

- A meeting with AWP to confirm the content of the monthly dashboard in line with the quality schedule requirements – End of May 2018
- Greater understanding of the Risk Oversight Process and clarification regarding the CCG notification of any early identification of problems – End of Quarter 1 201819.
- Agree outcomes and next steps following update of the QRP tool – End of April 2018
- A schedule for further quality observation visits will be drafted – End of Quarter 1 2018/19

The Quality Committee was asked to note the next steps planned for gaining assurance regarding the AWP quality metrics.

4.5 Continuing Healthcare Internal Audit Report

The Quality Committee received the BNSSG final report into a recent internal audit process examining the management of Continuing Healthcare (CHC) services in each of the previous three Clinical Commissioning Groups and associated action plans.

NHS CHC is a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a primary health need. Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness. As part of the 2017/18 Internal Audit Plan an audit was undertaken of CHC management within the BNSSG CCGs.

The Quality Committee received the individual reports from the three previous CCGs which have been agreed by the CCG's Audit, Risk, and Governance Committee and agreed that the action plans can be merged for a BNSSG approach. The Committee is scheduled to receive an update on the merged action plan in June 2018.

5. Financial resource implications

There are no direct financial implications for the CCGs in this paper

6. Legal implications

There are no legal implications to the CCGs from this paper.

7. Risk implications

Risks and mitigation where required are described in this paper.

8. Implications for health inequalities

High quality care is a requirement for all.

9. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Not applicable

10. Consultation and Communication including Public Involvement

Not applicable

Glossary of terms and abbreviations

Continuing Health Care	Continuing health care describes a situation where, following a thorough assessment of needs, a person's overall health needs are judged to be so great that the NHS will manage and pay for all the care they need. An NHS professional will supervise the agreed care plan and care can be provided in any setting, for example the person's own home, a hospice, a care home or a hospital. In this situation, no charges are made for care services that are arranged as part of a care plan.