Oxfordshire Clinical Commissioning Group Current Clinical Assurance Framework

1. Introduction

The first Francis report on the Mid Staffordshire NHS Foundation Trust was published in 2010. It identified extremely poor care being delivered in a number of areas of the trust. The second report was published in February 2013. This report goes further and looks at the wider responsibility of the NHS. The report makes 290 recommendations.

Following the Francis report, the Keogh report was published and looked at 14 hospital trusts, selected for investigation on the basis that they had been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR). Following the Keogh review, 11 Trusts were placed under 'special measures' by the Health Secretary.

The approach used by the Keogh Team offers a blueprint for the Care Quality Commission's new approach to inspections. The CQC's new Chief Inspector of Hospitals, Professor Sir Mike Richards, has already announced that he will lead significantly bigger inspection teams headed up by clinical and other experts and including trained members of the public.

The Prime Minister has commissioned Professor Don Berwick to undertake a review of patient safety. His report makes recommendations for the NHS, its regulators and the government on how to build a robust nationwide system for patient safety based within in a culture of transparency, openness and continual learning with patients firmly at its heart.

This paper describes the systems and processes with which Oxfordshire Clinical Commissioning Group (OCCG) monitors and manages the quality of provider services.

There are three aspects of clinical quality; clinical effectiveness, patient safety and patient experience. This report details the types of clinical quality intelligence collected, the methods used to collect it and the way in which it is analysed by OCCG.

Roles and Responsibilities

The primary responsibility for quality sits with frontline professionals, both clinical and managerial. Frontline staff and are responsible for their own professional conduct and competence and for the quality of the care they provide. They are witnesses when things go wrong and often have ideas about how the quality of care could be improved. It is vital that these staff are able to speak up and are empowered to act to prevent failings in care and to suggest improvements. OCCG has developed an innovative solution to gather feedback from GPs within Oxfordshire. An explanation of how this information is collected and reviewed is described under section 6.

The second line of defence against serious quality failure is the boards and senior leaders of health care providers. Commissioners are responsible for ensuring the quality of care delivered by the services they commission. Provider boards and the CCG Governing Body are ultimately accountable when things go wrong. They should address problems that arise as a result of a lack of systems and processes. It is vital that they are able to monitor the quality of care, take action to resolve issues, and create a culture of openness that supports staff to identify and solve problems. OCCG is fully aware of its role and work closely with providers to ensure an open culture where mistakes are learned from and not punished. This links to the recommendations made by the Berwick report.

The final line of defence against serious quality failure is external structures and systems. These are usually at national level and are responsible for assuring the public about the quality of care. These national bodies require organisations to be transparent and can require them to account of their performance and actions. They can also take action when local organisations fail to resolve issues. The CQC is in the process of developing a more robust and in-depth inspection process for hospitals. The CQC has a range of indicators which it uses to establish quality and conducts inspections when these indicators suggest deficiencies. OCCG monitors these indicators the providers' performance against the indicators to ensure that we are aware of possible issues as soon as they arise. Monitor also reviews the performance of foundation trusts.

2. Clinical effectiveness

In seeking to establish quality there is clearly a desire to look at things which can be measured. This is a relatively new science and methods are constantly changing and being updated.

2.1 Dr Foster, HSMR and SHMI

Oxfordshire commissioners have, since 2008, used Dr Foster software to monitor clinical outcomes at Oxford University Hospitals NHS Trust (OUH) (previously Oxford Radcliffe Hospitals). This was also one of the tools used to identify trusts to inspect in the Keogh review and is one of the triggers for a CQC inspection. The clinical outcomes measured by this software are mortality, readmissions, length of stay and day case rates. Using an algorithm, the software determines whether the expected numbers of negative outcomes (e.g. for mortality, this would be death) are exceeded by the monitored number. When any of these outcomes is statistically significantly higher than expected, Dr Foster will produce a 'red bell'. OCCG review this data and attend clinical governance meetings at the OUH where mortality is discussed.

Dr Foster measures the Hospital Standardised Mortality Ratio (HSMR). The HSMR is an indicator of healthcare quality that measures whether the death rate at a given hospital is higher or lower than would be expected. The OUH is not an outlier for mortality according to their HSMR. The Department of Health has recently introduced an additional mortality measure, the Summary Hospital-level Mortality Indicator (SHMI). This measure also indicates that the OUH has a mortality rate within expected limits.

Mortality data is just one indicator that is used to determine the clinical quality of a healthcare system and it should not be viewed on its own. Focusing on numbers of excess deaths is not, in itself, an accurate measure, as a number of factors can lead to a high HSMR or SHMI (i.e. data quality, if there is a hospice on site, etc.). HSMR is one of a range of indicators regularly reviewed by OCCG when assessing the quality of the clinical services. The OUH and OCCG's ambition is to have one of the lowest mortality ratios in the country.

Commissioners can also use Dr Foster software to monitor the referral patterns of primary care into secondary care. They do this by looking at Standardised Admission Ratios. Oxfordshire is amongst the best in the country according to Dr Foster software. HSMR and SHMI focus only on acute hospitals and are not currently applicable to Oxford Health.

2.2 Audits

Clinical audit is a quality improvement process. It is used to improve patient care and outcomes through the systematic review of care against explicit criteria and the subsequent implementation of change. In Oxfordshire, clinical audits are requested from providers via the contract to assure commissioners that National Institute for Clinical Excellence (NICE) guidance is followed. Performance in clinical audits is reviewed by the Quality Team of OCCG and the evidence from these reports is triangulated with other information collected.

3. Patient safety

3.1 Serious Incidents

There is an established system for reporting and reviewing patient safety incidents. All providers manage incidents internally. Serious incidents (i.e. ones that result in severe harm or death) must be reported to the commissioner. There is a nationally designated list of Never Events which must also be reported to commissioners. The provider must then conduct a root cause analysis for these incidents. The commissioner manages the investigation process and incidents are only 'closed' when commissioners are satisfied that an incident has been thoroughly reviewed, that lessons have been learnt and that steps have been taken to prevent recurrence. As recommended in the Berwick report, to the emphasis is on learning from these incidents in order to prevent recurrence rather than on punishing individuals for mistakes.

Where themes emerge in the investigation of serious incidents providers are required to understand these and to demonstrate that they are being addressed. Issues about the culture of organisations often emerge in the analysis of serious incidents, as well as in the response of trusts to the events. In these circumstances the commissioners may require action to be taken to address these issues, for example, through increased clinical leadership.

We can begin to understand the safety culture of a trust by looking at how they respond to incidents. The ideal culture is one in which staff feel able to voice their concerns, and where patients are always listened to and their concerns attended to promptly. Trusts should be able to receive information which shows that they may have issues with a willingness to understand and investigate further.

3.2 Safeguarding

Commissioners have a statutory safeguarding function. They are notified of safeguarding alerts relating to both adults and children and are instrumental in responding to alerts. This means that safeguarding information can be viewed alongside other quality information to alert OCCG to areas where poor care may be causing harm.

4. Patient Experience

Patient experience is perhaps the fastest growing area of quality information. In order to be assured of quality we need to put feedback from patients at the centre. Patient experience is a good early indicator of where thing may be going wrong.

Patient experience is also the most difficult area to measure. Patient satisfaction can be collected through simple scoring - as in the new 'Friends and Family test', but experience is not measurable. Hospitals in Oxfordshire perform well in satisfaction surveys. OUH has implemented the Friends and Family test which is being extended to include the services provided by Oxford health. Both trusts have a range of other surveys which they use to understand the patient experience.

Methods of looking at experience include scrutinising complaints, PALS and MPs' letters. The Keogh report noted the tendency for some hospitals to view complaints as something to be managed, with the focus on the production of a carefully worded letter, rather than addressing the issues within the complaint or apologising to the patient. The content of the complaint also needs to be understood in order to detect themes and possible trends. We also look at PALS queries for insight into areas where patients are finding difficulties, and to provide us with an indication of how well providers respond to patients' concerns. Crucially, we look at how trusts use the information they receive in complaints to inform the way in which they deliver services and to make improvements.

There is a close correlation between overall patient experience and the quality of nursing care. In both Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Trust the quality of nursing has been a focus for improvement. We continue to work with them on developing leadership in this area.

OCCG has set up a web page to collect patient experience or commissioned services. This survey can be found at www.oxfordshireccg.nhs.uk/patient-survey.

4.1 Patient and Staff Surveys

The views of patients are frequently sought through local and national surveys. The national acute inpatient survey is conducted every year and allows comparison between trusts and within trusts over time. There are also more specific surveys, for example the cancer patient survey and the maternity survey, which provide a view of patients' experiences of individual services. The OUH generally scores well in the national inpatient survey.

It is well known that the wellbeing of staff has a direct impact on the experience of patients. For this reason we look at the results of the staff survey in conjunction with those of the patient survey.

5. Contracts: Quality schedule

Commissioners receive monthly indicators on performance activity and quality. This range of indicators is set out in different schedules of the contract held between the commissioner and the provider. The contents of this schedule are agreed as a part of contract negotiation. The schedule sets out the quality markers expected from providers. It includes limits for healthcare acquired infections such as MRSA bacteraemia and clostridium *difficile*, and national targets, for example those relating to A&E, cancer waits and 18 weeks referral to treatment times. It also includes relevant local indicators such as radiology turnaround times.

For the main providers the quality schedule is scrutinised monthly at performance meetings. Quality is discussed at the same meeting as activity. In this way quality is given the same weight as performance and the impact of each on the other can be understood.

6. Quality Information system

OCCG uses a risk management software package called Datix. This enables a range of quality data to be stored. Datix includes data on complaints, PALS, MP letters, and incidents. Importantly, Datix permits users to search for data – for example to see whether there have been a number of complaints about a particular area.

In 2012 the Datix system was expanded to provide GPs with direct access. They use this to report directly to the commissioners concerns they have about the quality of services. This facility provides the commissioners with a rich source of timely information which can be addressed rapidly to ensure quality is improved. Since being established in June 2012 we have received well over a thousand reports through this system, all of which have been or are currently being followed up.

7. Whistleblowing

OCCG has, on occasion, received ‘whistle blowing’ allegations. When this has happened we always follow up allegations by conducting investigations or ensuring that Providers follow up on the issues raised.

8. Action to address quality concerns

When there are concerns about the quality of services a number of steps are taken. The first step is usually to raise the issue formally at a contract meeting. The provider is then expected to produce a detailed rectification plan. If the commissioner receives an inadequate action plan or the plan is ineffective then a contract query will be issued. If this approach fails or the concerns are significant then the commissioner will issue a performance notice. If OCCG believes a service to be dangerous it will suspend the service immediately. In parallel with

this process provider executive directors and the chief executive would be informed.

OCCG also has the option of commissioning an external review of quality from national experts such as the Royal Colleges. This facility was used by the PCT on a number of occasions to seek additional information and advice on issues of concern.

OCCG has a structure which puts quality at the heart of commissioning. It has established a formal subcommittee of the board to focus on quality and performance. The group is chaired by a lay member of the governing board and has a lay member in attendance.

The Francis report identifies a number of recommendations for commissioners. OCCG will review these and agree a programme of implementation. We have had initial meetings with Healthwatch, and will work closely with Healthwatch, to help strengthen the patient perspective.

9. Quality Surveillance Group

A Quality Surveillance Group has been established by the Thames Valley Area Team and it brings together commissioners, the local authority, Healthwatch, CQC and Monitor to review the quality of healthcare provision within Thames Valley.

10. Conclusion

This paper sets out the range of tools, methods and intelligence which are currently in use in Oxfordshire to provide commissioners with assurance of the quality of the services they commission. OCCG has intentionally placed quality at the centre of the organisation. The Quality Team work closely with providers and have developed a relationship where they are expected to challenge. When necessary decisive action is taken to address situations where quality falls below the standard we would expect.

Providing assurance of the quality of services is complex and no system is infallible. Systems are evolving all the time as information becomes more sophisticated. The uncovering of poor quality within NHS commissioned services frequently leads to increased scrutiny and changes in the way in which we seek to understand the quality of services.

It is the role of provider boards to ensure services are safe and of a high quality and it is the responsibility of the Governing Body of OCCG to seek assurance on quality. As far as possible the systems we use provide this assurance. However, it is always important to be alert to the possibility of poor quality. The acknowledgement that things can and do go wrong is essential and constant vigilance is required.

Where possible we use validated tools to measure the quality of commissioned services. These are not, on their own, sufficient to provide assurance of quality. We also use the ‘soft intelligence’ we receive. Where there have been extreme

cases of poor quality, culture is frequently cited. While it may not be the cause of the poor quality itself, it is a culture of acceptance and of secrecy which prevents the issues being tackled.

It is essential that providers are open in their reporting and consideration of quality issues. The quality team has built good working relationships with provider trusts. This means that we can work together to understand and address potential quality issues while crucially maintaining the critical distance which scrutiny and assurance requires. Importantly, data which suggests poor performance and data which indicates good performance should be afforded the same degree of scrutiny.

Seeing the organisation or service as a whole is also crucial. When viewed individually indicators may not be the cause for a high level of concern. When viewed in the context of a range of other information a high level of concern may be indicated. This whole picture view is achieved through close working within the quality team and across the organisation.

In light of the Keogh, Berwick and Francis Reviews, OCCG will be reviewing its quality framework in the autumn.

Sula Wiltshire, Director of Quality and Innovation, Oxfordshire Clinical Commissioning Group

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Appendix – Recommendations taken from the Keogh and Berwick reviews

Eight ambitions from the Keogh report

1. We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

2. The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

3. Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

4. Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

5. No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

6. Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

7. Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

8. All NHS organisations will understand the positive impact that happy and engaged staff has on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

Ten recommendations from the Berwick report

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.

4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.

6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.

7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.