Open Agenda

Southwark Council

Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

Monday 25 March 2013
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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The Quality Accounts priorities of two foundation trusts: South London and Maudsley (SLaM) and Guy's and St Thomas' (GST) are attached.

To support the scrutiny of all the local hospitals' Quality Accounts a summary of complaints is attached by SLaM, Guy's and St Thomas' (GST) and Kings Collage Hospital (KCH). Summaries of complaints received by Southwark Clinical Commissioning Group (SCCG) are also attached.

More information about Serious Incidents is also attached, that these relate to an (attached) report submitted to the Southwark, Lewisham and Lambeth (SEL) and Bexley Care Trust PCT Board on 29 November 2012. All the hospitals: SLaM, Kings Collage Hospital (KHC) and Guy's and St Thomas' (GST) have submitted reports, particularly concentrating on Pressure Sores. The SCCG have also submitted a report on this.

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Contact
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Date: 19 March 2013

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Our SLAM Quality Priorities 13/14

All NHS Trusts and FTs in England and Wales are required to publish quality priorities for the following year within the quality account. With a number of quality targets and priorities being driven by commissioning and outcome frameworks and quality issues and challenges from our services emerging through governance data as well as CIP/QIPP programme, the aim is to distil priorities down into a small number which are:

- Narrowly defined, with clear targets and measures (with existing data flows if possible)
- Have local relevance and CAG commitment
- Fit with commissioning and outcomes frameworks and key areas of policy development
- Address issues which our stakeholders feel are important

Consultation on the proposed set of draft quality priorities has included: a review of existing priorities (including comments from Stakeholders published in the 12/13 Quality Account) to consider if they are still relevant measurable and whether they should be carried over to 13/14, consultation with CAG Clinical and Service Directors on quality concerns and service development areas for 13/14, a review of proposed CQUIN and Quality Contract indicators and consultation with SLAM Trustwide Involvement PPI group. Further consultation and prioritisation on the following long list of priorities attached is planned at the Trust Senior Leadership Group on 19th March.

DRAFT 13/3/13

SLAM Quality Account 2013 Timetable

Consultation exercise	Jan - March
List data to be published	January
Check with OSC secretaries dates for OSC QA meetings	January
Presentation to Exec	6th Feb
CAG Consultation: Psychosis CAG CAMHS CAG BDP CAG MHOA CAG Addictions CAG Psy Med CAG/MAP CAG	 28.1.13/7.2.13 25.02.13 7.2.13 21..2.13 8.3.13 Awaiting feedback
Service User Consultation: TWIG Strategic Meeting	 12th March 13
Consultation at Senior Leadership Group, Milwall	19th March
Members Council Consultation	Check date- March

DRAFT 13/3/13

1st Draft of Account circulated to Executive	22th March
Draft to Members Council Quality Sub-Group for comment	5th April
Draft to CCGs, OSCs and Healthwatchs' for comment	5th April
CCG and HOSC and shadow Healthwatch feedback meetings	April/May
Draft to SQISC	21st May
External Audit to complete report by	29th June
Final draft to Board	21th May

PATIENT SAFETY

Dimension	Priority areas	Possible Measures	Target
Reducing Severe Harm	Prevention of Violence BDP CAG priority CAMHS priority	• Monthly average of violence incidents with harm (as a % of monthly average of violent incidents) • Reduction in Riddors • Trend analysis of use of 'cohersive (RT, PI,SC)' interventions • Improved availability of monthly violent incident reports to inpatient teams? • Team action plans in response to monthly reports of violent incidents • No. of trained staff on duty that are PSTS trained • Calls to the Police to assist with violent incidents on wards	
	Self Harm and Suicide Prevention	• Monthly average of serious self harm incidents/attempted suicide (SIs) (as a % of monthly average of self harm incidents) • Inpatient suicides and within 14 days of discharge? • Percentage of patients on CPA who were followed up within 7 days of discharge from psychiatric inpatient care **(Quality Contract 13/14)**	
	Falls MHOA priority Implementation of PS Thermometer in all inpatient and CC areas & Falls Review Project	• Reduction in monthly average falls with harm (as a % of monthly average total falls) • CQUIN: PS Thermometer (Falls) – MHOA & ALD	
	Pressure Ulcers MHOA priority Implementation of PS Thermometer in all inpatient and CC areas	• CQUIN: PS Thermometer (Pressure Ulcers) – MHOA & ALD • Datix: SI Pressure Ulcers	
Ensuring patients feel safe		• PEDIC Question: 'Do you/did you feel safe?' (inpatients) • PEDIC Question: 'Have you been offered a crisis plan for emergency mental health situations?' (community)	

DRAFT 13/3/13

CLINICAL EFFECTIVENESS

Dimension	**Priority areas**	**Possible Measures**	**Target**
Preventing People from Dying Prematurely	Physical Health: There is a higher physical morbidity and mortality of service users with schizophrenia with a link to cardio vascular disease and metabolic conditions. As part of the physical health check the following tests (glucose levels, lipids, bp & wt.) are crucial in the early diagnosis of long term conditions: Psychosis CAG priority Addictions CAG priority	• Annual Health Check- % of service users who have been in SLaM hospital/long- term health care for more than one year that have had a physical health check in the last 12 months (**Quality Contract 13/14**) • Reducing Cardio vascular risk and management of Long term conditions (inpatients) i.e i). screening on admission for glucose levels, lipids, bp & wt. ii) ECG prior to antipsychotic prescription and repeat monitoring of glucose levels, lipids, bp and weight at 3-4 and 9-10 months **(CQUIN 13/14)** • Improving SLAM performance in Physical Health Indicators in the 2013 National Re-Audit of Schizophrenia (community patients) (**NHS Contract - National Audit)** • Percentage of inpatients who have a full nutrition screen (95%) **(Quality Contract 13/14)** • ECG monitoring for all patients on >100mg methadone – Pharmacy audit Nov 13 **(Addictions CAG priority)** • Completion of Physical Health Assessment Screen - Insight report (**Addictions CAG priority**)	
Enhancing Quality of Life for people with Long Term conditions	Improved clinical outcomes following contact with mental health services BDP/Addictions CAG priority – HoNOS and team feedback	• Number of Teams given feedback on HoNOS scores and TOPs (for Addictions) • The number of people who are “moving to recovery” (**IAPT KPI 6a/Quality Contract**) • Completion rates of CORE-OM and CORE-10 outcome measure (**Existing QA priority**) • Increase in ‘reliable improvement’ scores on CORE-OM and CORE-10 outcome measures (**Existing QA priority)**	

DRAFT 13/3/13

	Implementation of AMH Acute Care Pathway Model (incl. community Triage) Psychosis/Psy Med/MAP CAGs - ensuring people are treated in least restrictive environment (close to home, choice). MHOA – development and pilot of HTT for Older Adults ensuring tx in least restrictive environment.	• Number and percentage of inpatient admissions gate-kept by the crisis resolution / home treatment team **(Quality Contract 13/14)** • Re-admissions. Reduce the number of patients re-admitted within 28 days of discharge **(Quality Contract 13/14)** • inpatient length of stay • Reduction in use of private sector overspill beds	
Helping People recover from episodes of ill health or following injury	Support and Recovery Care Plan implementation: The Recovery and Support plan is a recovery focussed plan that seeks to place the service user at the centre of the care/support planning process whereby they are supported to define their own goals based on their personal needs and aspirations Addictions (PEDIC copy of care plan/joint development with staff)	• CPA review in previous 12 mths % (**MHMDS)** • Number and percentage of community patients on CPA with a CPA Support & Recovery Plan in place (**CQUIN 13/14)** • Percentage of service users that have 2 or more self-defined recovery goals as part of their care plan (**Quality Contract 13/14**) • PEDIC: 'Have you received a copy of your care/recovery plan?(**Quality Contract 13/14**) • PEDIC: 'Did you jointly develop your care/recovery plan with a member of staff?' **(Quality Contract 13/14**)	

DRAFT 13/3/13

	Integrated discharge recovery planning The GP is an important part of the care plan to facilitate a person's recovery. To promote effective high quality care, s/he should be involved at all stages of care and be involved in the decision of discharge from care together with the user. It is also essential that a user has choice in their recovery and in how and where they can access support when becoming unwell, and hence an advance directive gives clear indication in how care should be delivered and informs the GP of any necessary actions that should be taken.	Numerator: Total number of users on CPA who have had the following completed which has been sent to their GP within 7 days of discharge from SLaM: - a discharge summary with evidence of engagement with the GP(for Inpatients) - a completed Recovery and Support Plan (for discharges from community services) Denominator: Total number of users on CPA discharged from secondary care during the quarter **(CQUIN in 13/14 Contract)**	

PATIENT EXPERIENCE

Dimension	Priority areas	Possible Measures	Target
Improving Staff communication with patients and carers	Releasing Time to Care - Increase in contact time with nursing staff – Productive wards initiative	• Increase in nursing contact time with patients (ongoing monitoring??) • PEDIC: Daily one-one contact with staff on the ward for at least one hour? (inpatients)	
	Improving staff communication with patients Interventions by Education and Training such as Customer Services Training, RCN Leadership programme focussing on Service User experiences at the point of care delivery as well as other SUITE Training which focuses on the Service User Perspective throughout the whole training programme. MHOA – Development of Namaste work in continuing care i.e. providing dignity to patients with end stage dementia Addictions – Purpose and side effects of medication been explained	• Reduction in complaints about staff attitude • PEDIC: 'Did you receive emotional support from this service when you needed it?' (community teams) • PEDIC: Are your individual needs (cultural, spiritual, faith) taken into consideration? • PEDIC: Has the purpose of your medication been explained to you? • PEDIC: Has the side effects of your medication been explained to you?	
	Support for carers Implementation of SLAM carers strategy	• Increase in number of carers offered annual carers assessment • Improved performance in annual community patient survey about carer involvement	
Increasing patient satisfaction, as measured by	Improve our data collection and performance in national and local PEDIC patient satisfaction surveys	• National Patient Survey – Number of areas assessed by National Community Survey to be in the red zone (worst 20% of trusts) <2/9 areas **(Quality Contract 13/14)**	

responses to national and local patient surveys	In addition, in line with a CQUIN target in 13/14 the SLaM PPI Team will support wards to work with patient focus groups to identify the top 5 issues on which they want improvement (in line with the recent Croydon Hear Us report). BDP CAG – bespoke PEDIC for patients with Learning disabilities	• Number of units with regular PEDIC surveys (90%) **(Quality Contract 13/14)** • Reporting of all action plans and lessons learnt resulting from PEDIC surveys **(Quality Contract 13/14)** • PEDIC satisfaction scores analysed by BME groups • Inpatient Service User Focus Group Findings at Q1 and evaluation of improvement at Q4. Implementation plans produced by SLaM at Q2. **(CQUIN 13/14)**	

ACCESS TO SERVICES

Dimension	**Priority areas**	**Possible Measures**	**Target**
Waiting Times / Transition to Adult Services/ Equality of Access	Wating times CAMHS priority	• Number of Teams compliant with national 18 week waiting time target (90%) • Services with waiting times?18 weeks to have action plans to reduce the wait (**National Target**)	
	Improving transistion to Adult services for CAMHS patients CAMHS priority	• Numerator: Percentage of notifications where appropriate sent to AMH SLaM staff for the above transition patients • Denominator: Number of complex and high cost patients within 6 months of their 18th birthday (**Quality Contract 13/14**)	
	Equality of Access	• Access to community mental health services by people from BME groups • Access to psychological services by people from BME groups **(The CCG Outcomes Indicator Set 13/14)**	

Guy's and St Thomas' NHS
NHS Foundation Trust

Southwark Council
Overview and Scrutiny Committee

25 March 2013

Quality Account Priorities 2013/14

Status: A Paper for *Information*

Elizabeth Palmer, Acting Director of Assurance

Guy's and St Thomas' NHS
NHS Foundation Trust

Overview and Scrutiny Committee

25 March 2013

A paper prepared and presented by Elizabeth Palmer

1.0 Purpose of the Paper

1.1 To present to the Committee the quality priorities for Guy's and St Thomas' NHS Foundation Trust for 2013/14.

1.2 In April 2010 the production of an annual 'quality account' by all NHS Trusts in England was laid in statue. Trusts are required to produce a set of quality accounts along with their financial accounts each year. The Trust's quality accounts are published in the annual report to Monitor, on the NHS Choices website, and sent directly to the Secretary of State for Health.

1.3 The Quality Account consists of a statement on quality from the Chief Executive, a look-back section on the previous year's performance against a number of quality indicators and a forward looking section which selects a small number of priorities or initiatives to focus on for the forthcoming year. These priorities are developed under the headings of patient safety, clinical effectiveness and patient experience. Guy's & St Thomas' accounts include the performance of the community services provided by the Trust.

1.4 The performance section for the previous year is set out in a specific format which is set out in the quality account regulations. This is intended to make it easy for the public to compare the performance of trusts across the NHS.

2.0 Consultation on priorities for 2013/14

2.1 As well as a staff consultation at the 'Safety Connections' Conference, two stakeholder events were held December 2012 and January 2013. These were led jointly by representatives from the Chief Nurse and Medical Directors' Offices. The events were very well attended by Trust Governors, Lead GP Commissioners, Lambeth & Southwark LINks, Local Overview & Scrutiny Committees, and KHP Partners.

2.2 At these events stakeholders were asked to review and comment on a final short-list of potential priorities for this forthcoming year. The resulting shortlist of priorities is set out in appendix 1.

3.0 Quality Account Assurance

3.1 Review and assurance of the quality account document by key stakeholder groups is prescribed by the quality account regulations.

3.2 The assurance process is carried out by providing local commissioners, the local Healthwatch and the local Overview and Scrutiny Committee with a draft of the accounts within the 30 days beginning with the 1st April following the end of the reporting period. At this point the performance information for the full year is available.

3.3 Local stakeholders have the opportunity to review the performance information and to comment on whether the information reflects their knowledge and experience of the Trust.

4.0 Recommendation:

The Overview and Scrutiny Committee is asked to:

- **Note the quality priorities for 2013/14**

Elizabeth Palmer **25 March 2013**

APPENDIX ONE

Extract from Quality Account:
Quality priorities for 2013-14

Patient safety

Our quality priorities and why we chose them	***What success will look like***
Keeping our patients safe and reducing the risk of harm: a continued focus on reducing the major harms in hospital; with a particular emphasis on pressure ulcers, falls and infection.	We will reduce pressure ulcers in line with our CQUIN targets, with zero attributable grade 4 pressure ulcers across our hospitals and community services. We will reduce moderate and severe harm events associated with falls by at least 10% by the end of quarter 4 in our hospitals and inpatient community services. We will achieve our 2013/14 C.difficile target of no more than 47 cases during the year.
Keeping you informed on how we are doing: transforming how we publish and present our outcome data to our patients and the public.	We will create a 'hub' of quality and patient experience information on our website, increasing the frequency, content and quality of data that we publish, including links to information about our services published by other organisations. Each hospital ward and community inpatient services will publish its Family and Friends Test results and provide regular updates on other performance and patient safety measures including the number of days since the last patient safety incident and what has been done to prevent it happening again.
Capturing how we are doing: implement the national safety thermometer across our hospital and community services.	In line with our acute and community CQUIN; we will embed the national patient safety thermometer in the hospital and roll this out to our community services.

Clinical effectiveness

Our quality priorities and why we chose them	***What success will look like***
From Board to Ward: focus on assuring the Board of our quality standards and reducing the administrative burden on our front-line clinical staff	Weekly 'Board to Ward' quality reviews will be carried out by the Trust's executive directors. Board to Ward quality improvement: Trust executive directors 'use & test' systems as if they were a ward sister or junior doctor. Report progress via the quarterly Quality and Patient Safety Report
Improve our out-patient department efficiency we have a brand new facility, but can do more to improve efficiency and the patient experience.	We will reduce the number of patients who 'do not attend' for their appointment. We will reduce how long patients have to wait for their first appointment. We will reduce out-patient clinic waiting times.
Improve communication between GPs and community nurses.	We will continue this improvement programme which was started last year.
Protect the future health of local children by improving childhood immunisation rates across Lambeth and Southwark.	We will continue this improvement programme and will increase the xxx immunisation rates by xxx.

Patient experience

Our quality priorities and why we chose them	What success will look like
Improving our complaints and PALs services	We will formally review both our complaints and PALs services and will recommend and consult on improvements to processes that will ensure rapid Trust-wide learning from the feedback we receive.
Improving the care of older people: a continued focus on patients with dementia and their carers.	In line with our CQUIN target we will focus on individualised care of dementia and on early assessment, identification and intervention and on 'caring for the carers' of patients with dementia. We will build on the work we have done using Barbara's Story to build a culture of understanding, knowledge and empathy amongst all staff and will develop the next phase of that project.
Extend user involvement in our 'quality health checks' (known as the ward accreditation assessment) which we carry out on each hospital ward and community inpatient service annually.	We continually assess the quality of our care, including through the annual health check assessment carried out by our staff and governors. We invite representatives from our local community (Overview and Scrutiny Committee, Commissioners, Healthwatch and others) to participate in the assessments and feedback sessions. Following our recent pilot, we will further develop our 'mystery shopper' programme and report our findings and actions to the Board.
Achieve our acute and community patient experience CQUINs in 2013-2014	We will roll out and embed the Family and Friends Test across our hospital wards and the emergency department. We will achieve our community patient experience CQUIN and roll-out of the 'Near Patient Experience' system.

South East London

A meeting of the SEL PCT Boards and Bexley Care Trust
29 November 2012

ENCLOSURE 6

ENCLOSURE 6

Serious Incident Summary Report

DIRECTOR RESPONSIBLE: Jane Fryer, Medical Director

AUTHOR: Michaelene Holder-March, Interim Clinical Governance Consultant

TO BE CONSIDERED BY: ALL

SUMMARY:
This report presents an overview of the serious incidents (SIs) and Never Events reported by all providers of health services within South East London between 1st July 2012 – 30th September 2012 (Q2).

The Integrated Governance Committees is asked to note the contents of the report.

KEY ISSUES:

The 2 highest reporting SI categorises reported for Q2 were:

- Pressure Ulcers: 120
- Care Delivery Concerns: 31

Never Events

There were a total of 5 Never Events identified in Q2. These are currently under investigation and were reported by:

- Guys and St Thomas' NHS Foundation Trust:
  - Wrong Site Surgery

- Kings: 3 SIs reported for:
  - Retained Foreign Object Post-Operation

- Lewisham Hospital NHS Trust:
  - Misplaced Naso- or Oro-Gastric Tubes

ACRONYMS:

- BHC: Bromley Healthcare Community Trust
- BSU: Business Support Unit
- CAPU: Community Acquired Pressure Ulcer
- CQRG: Clinical Quality Review Group
- GSTT: Guys and St Thomas' NHS Foundation Trust
- HAPU: Hospital Acquired Pressure Ulcer
- HPA: Health Protection Agency
- KCH: Kings College NHS Foundation Trust
- LHT: Lewisham Healthcare NHS Trust
- Q2: Quarter One
- RCA: Root Cause Analysis
- SI: Serious Incidents
- SLaM: South London and Maudsley NHS Foundation Trust
- SLHT: South London Healthcare NHS Foundation Trust

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Report Details:

This report presents an overview of the serious incidents (SIs) and Never Events reported by all providers of health services within South East London between 1st July 2012 – 30th September 2012 (Q2).

A total of 184 SIs were reported using either the STEIS system, or direct Commissioner Notification. This excludes any incidents of HCAI's which was reported by providers.

This is 101 less than was reported in Q1. An overview breakdown of numbers of SIs reported according to Provider organisation including Never Events follows:

- **Acute Providers and Community:**
  - Guys and St Thomas' NHS Foundation Trust: 32 SIs reported
  - Kings College NHS Foundation Trust: 24 SIs reported
  - Lewisham Healthcare NHS Trust: 50 SIs reported
  - South London Healthcare NHS Trust: 21 SIs reported
  - Bromley Healthcare Ltd: 30 SIs reported

Lewisham Healthcare NHS Trust has shown significant improvement in Q2 for reporting of serious incidents.

- **Mental Health Providers**
  - South London and Maudsley NHS Foundation Trust: 8 SIs reported
  - Oxleas NHS Foundation Trust: 19 SIs reported

Oxleas NHS Foundation has shown significant improvement in Q2 for reporting of serious incidents.

- **BSUs** SIs reported
  - Bromley: 1 SIs reported

Breakdown of the total number of Sis:

Figure 1a, b & c shows a breakdown of the total number of SIs according to the serious incident categories, excluding Never Events, according to provider:

Figure 1a: Acute & Community Trusts

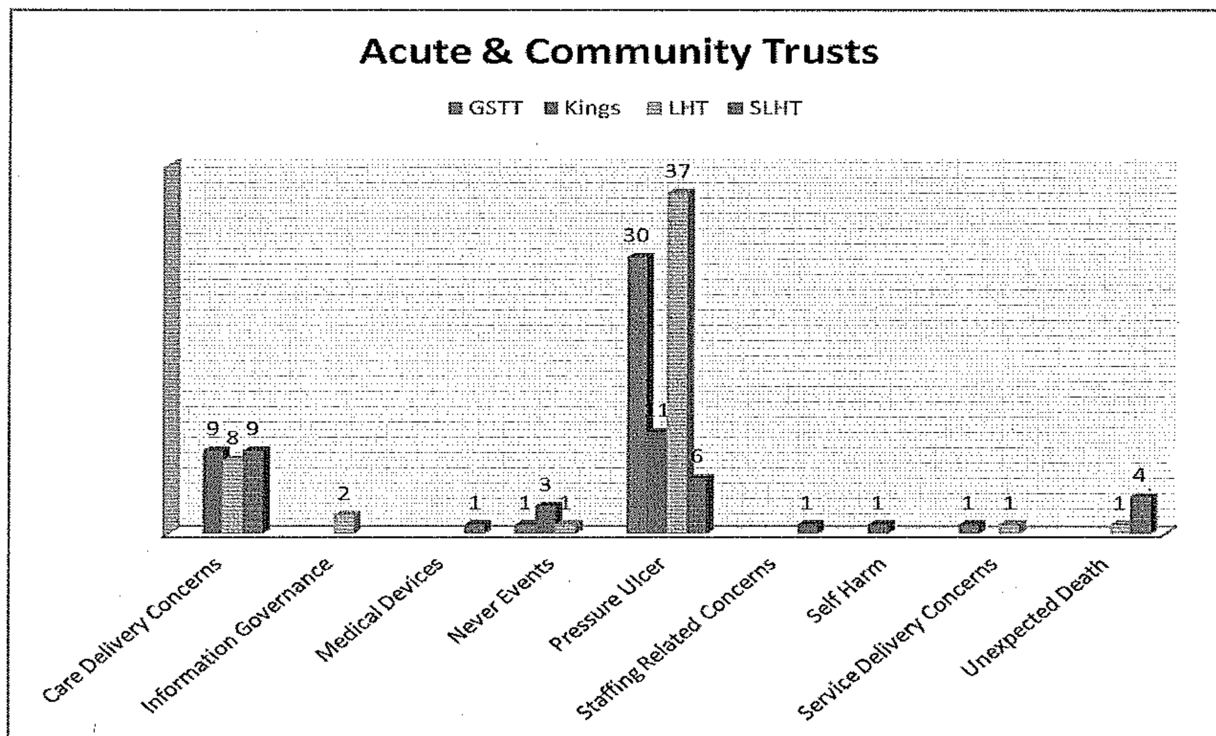
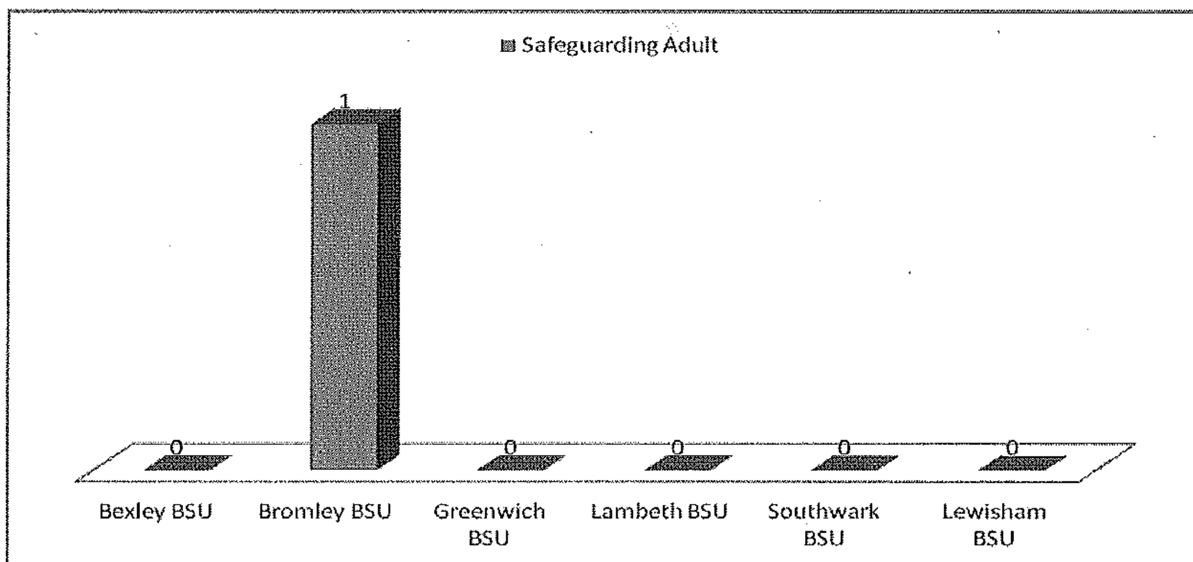
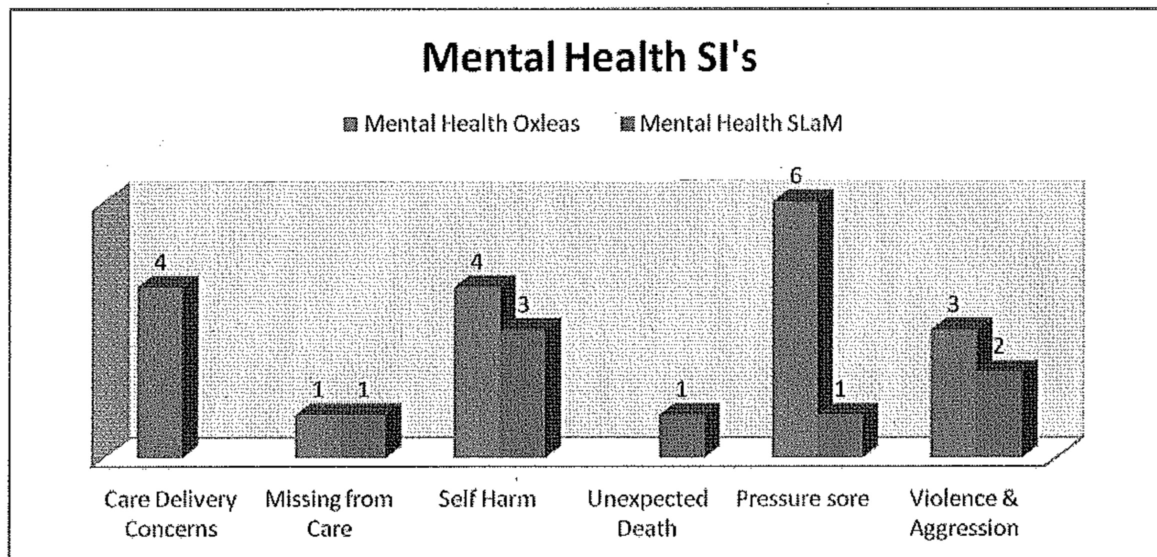


Figure 1b: BSU SIs



Previous reporting reflected HCAI's as Serious Incidents; this report excludes HCAI's.

Figure 1c: Mental Health SIs



Collectively, the 2 highest reporting SI categorises reported for Q2 were:

Pressure Ulcers: 120:

- Grade 3: 73
- Grade 4: 41
- Grade 3 or 4: 6

It should be noted that reporting of pressure ulcers (PU) includes patients admitted into hospital with pre-existing ulcers: A further breakdown of the 120 pressure ulcers reported shows:

- Community Acquired Pressure Ulcer: 92
- Hospital Acquired Pressure Ulcer: 27
- Unknown: 1

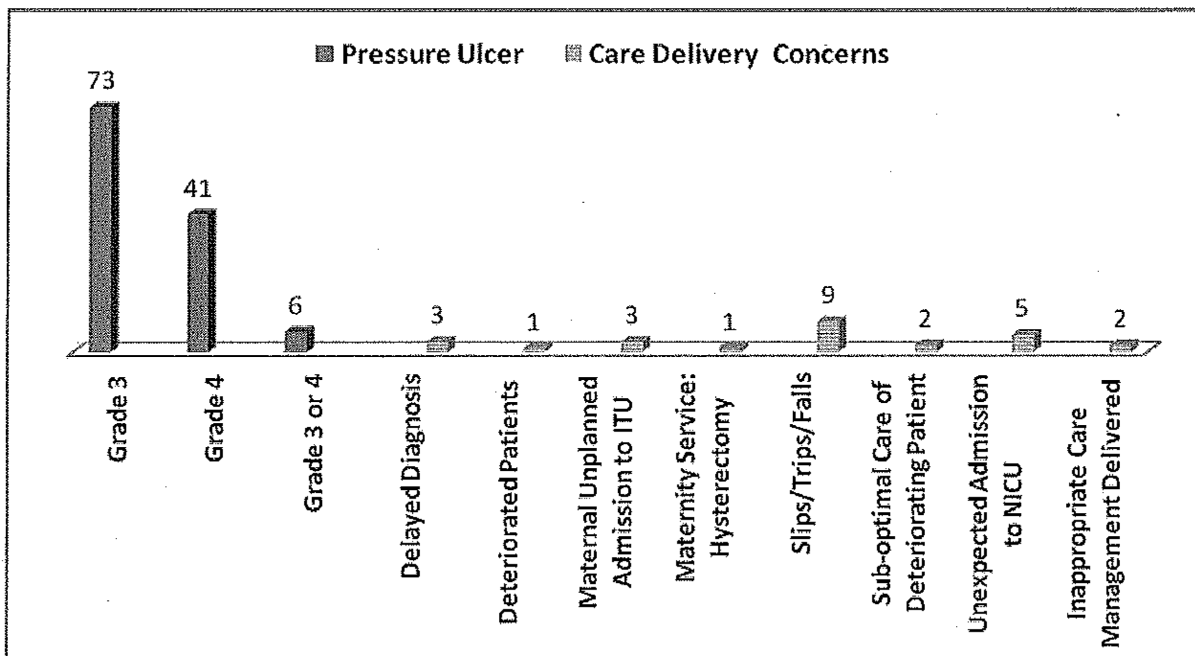
Care Delivery Concerns: 31:

- Ambulance Delay: 5
- Maternal Unplanned Admission to ITU: 3
- Maternity Service:1
- Slips/Trips/Falls: 9
- Delayed Diagnosis:3
- Deteriorated Patients:1
- Sub-optimal Care of the Deteriorating Patient: 2
- Unexpected Admission to NICU: 5
- Inappropriate Care Management Delivered: 2

Figure 2 below gives a breakdown of the 2 highest reporting SI categorises reported for Q2:

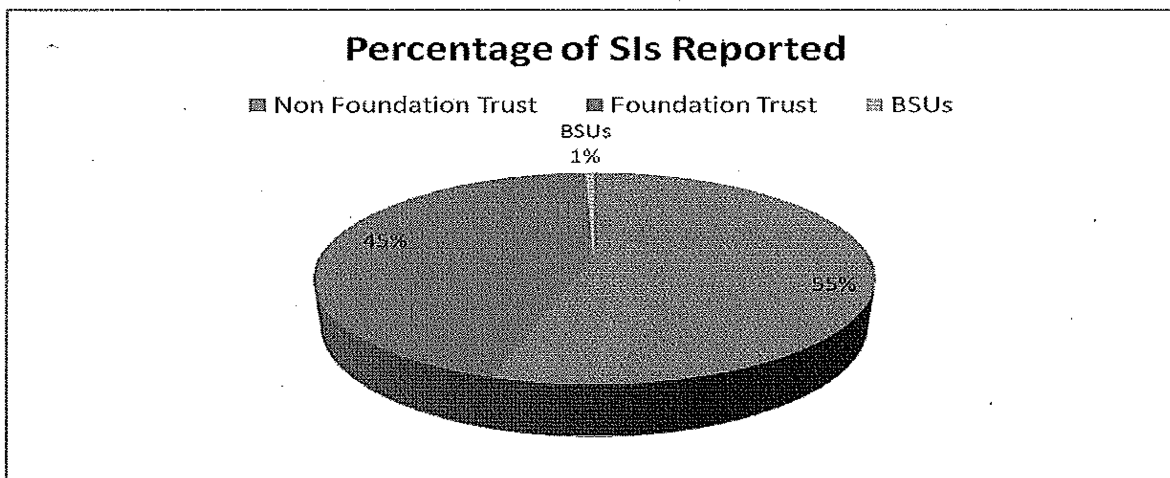
ENCLOSURE 6

Figure 2



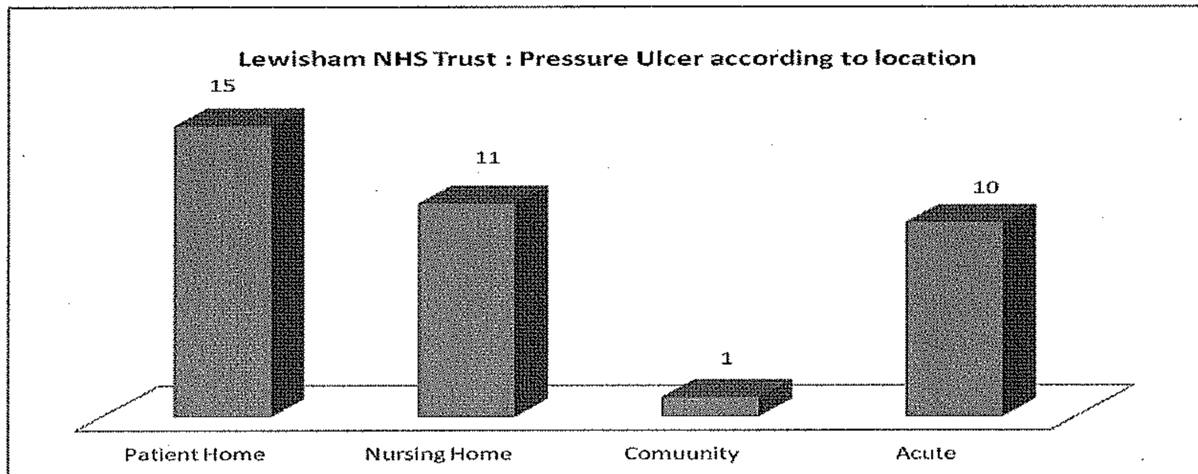
In Q2:

- Foundation Trusts accounted for 45% of the total number of SIs reported
- Non-Foundation Trusts (including Bromley Social Enterprise) accounted for 55% of the total number of SIs reported
- BSUs accounted for 1% of SIs reported excluding HCAIs



The 3 highest reporting *[1]organisations were:

- Lewisham Healthcare NHS Trust reported the highest total number of SIs: 50. This is attributed to:
  - Pressure ulcers:37 SIs reported
  - Care Delivery Concerns: 8 SIs reported
  - Information Governance: 2 SIs reported
  - Never Event:1 SIs reported
  - Service Delivery concerns: 1 SIs reported
  - Unexpected Death: 1 SIs reported



- Guys and St Thomas' NHS Foundation: 32 which is attributed to:
  - Pressure ulcers:30 SIs reported
  - Never Event:1 SIs reported
  - Service Delivery concerns: 2 SIs reported

- South London Healthcare NHS Trust: 21 SIs reported
  - Pressure ulcers:6 SIs reported
  - Care Delivery Concerns: 9 SIs reported
  - Medical Device: 1 SIs reported
  - Staffing Related Concerns 1 SIs reported
  - Unexpected Death: 4 SIs reported

Never Events

The occurrence of a 'Never Event' as a very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

[1] *It should be noted that when viewing Serious Incident data that evidence suggests that high reporting organisations are high performing organisations.(National Patient Safety Agency - noted that - 'Consistently high reporting levels tend to be a mark of high reliability organisations. Research shows that organisations with high and consistent levels of incident reports are more likely to demonstrate other features of a stronger safety culture such as high NHS Litigation Authority ratings' (Nov 2009).

ENCLOSURE 6

There were a total of 5 Never Events identified in Q2. These are currently under investigation and were reported by:

- Guys and St Thomas' NHS Foundation Trust:
    - Wrong Site Surgery

- Kings: 3 SIs reported for:
    - Retained Foreign Object Post-Operation

- Lewisham Hospital NHS Trust:
    - Misplaced Naso- or Oro-Gastric Tubes

NHS London Overview
NHS London provides oversight information for all SI reported on STEIS[2]:

- Commissioning Cases Outstanding
    - Bexley BSU: awaiting 1 RCA report
    - Greenwich BSU: 2 RCA report overdue
    - Lambeth BSU: 2 RCA reports overdue
    - Southwark BSU: 6 RCA reports overdue
    - Bromley BSU: 1 RCA reports overdue

- South London Healthcare NHS Trust: Cases Currently Overdue (20):

  The breakdown of overdue RCA's are:
    - Overdue by more than 6 months (2)
    - Overdue by more than 3 months (6)
    - Overdue by more than 1 month (9)
    - Overdue by less than a month (1)

[2] Please note – Reports submitted in the last 5 working days may be included in the list below.

Guy's and St Thomas' NHS
NHS Foundation Trust

Southwark Council
Overview and Scrutiny Committee

25 March 2013

Part 1: Response to SEL PCT Boards and Bexley Care Trust Paper – Serious Incident Summary Report

Part 2: Complaints and PALS report

Status: A Paper for *Information*

Debbie Parker, Deputy Chief Nurse and
Elizabeth Palmer, Acting Director of Assurance

Guy's and St Thomas' NHS
NHS Foundation Trust

Overview and Scrutiny Committee

25 March 2013

A paper prepared by Claire Acton, Tissue Viability Nurse Manager, Debbie Parker, Deputy Chief Nurse, Sally Brooks, Head of Complaints, Risk and Litigation and presented by Debbie Parker and Elizabeth Palmer

1.0 Purpose of the Paper:

1.1 This paper for the Southwark Council, Overview and Scrutiny Committee is presented in two parts. Part one provides information on pressure ulcers and serious incidents at Guy's and St Thomas' NHS Foundation Trust (GSTT) in response to the report to Lambeth PCT for quarter 2 2012/13.

1.2 Part two provides a summary of formal complaints and PALS contacts for quarter 4 2011/12 and quarters 1-3 2012/13 together with some examples of actions taken to improve the experience of our patients and their families.

Part 1: Response to SEL PCT Boards and Bexley Care Trust Paper regarding Pressure Ulcers

2.0 Quarter 2 2012/13 pressure ulcer data:

2.1 In Quarter 2 2012/13 the period from 01 July 2012 to 30 September 2012, GSTT reported thirty grade three and/or four pressure ulcers to Lambeth PCT, our lead commissioner.

2.2 Of the thirty reported, when reviewed nineteen pressure ulcers had developed prior to any contact with GSTT services. We are still required to report these, however we do not investigate or carry out root cause analysis as they were not acquired whilst receiving acute or community healthcare from GSTT and are closed as not attributable.

2.3 Of the remaining eleven reported in the period, one was downgraded (de-escalated) when early investigation found that the pressure ulcer had been acquired at Lewisham Hospital in April 2012. A further two notifications involved the same patient and the same pressure ulcer which was reported several days apart by two different wards as the patient was transferred between wards internally; therefore 1 investigation and root cause analysis was carried out in this instance.

2.4 Therefore, nine incidences of pressure ulcers at grade three and/or four required investigation by the Trust hospital and community teams.

2.5 Pressure ulcers at grade three and/or four reported to the commissioners for Q2

Table 1 shows a summary of the categories and numbers of pressure ulcers for Q2.

Category	Number
Not attributable	19
Downgraded	1
Investigated	9 (notification replicated due to 2nd datix report)
Total	**29 (30 see above)**

2.6 Patient and data monitoring verification

2.6.1 Within the hospital all grade two and above pressure ulcers are reviewed and verified by the acute tissue viability team. Within the community setting all grade three and four pressure ulcers are reviewed and verified by the community tissue viability team.

2.6.2 All audit data is collated on a centralised database within the hospital (ETRACE) and RIO within the community. All pressure ulcers that are grade two and above are also reported centrally on Datix for investigation and a mini single sheet root cause analysis (RCA) is also completed.

2.6.3 Pressure ulcers are categorised as avoidable or unavoidable. **Avoidable Pressure Ulcers** means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

2.6.4 **Unavoidable Pressure Ulcers** means that the person receiving care developed a pressure ulcer even though the provider of the care had evaluated the person's clinical condition and pressure ulcer risk factors; planned and implemented interventions that are consistent with the persons needs and goals; and recognised standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate; or the individual person refused to adhere to prevention strategies in spite of education of the consequences of non- adherence.

3.0 Outcome of investigations

Table 3 on the next page shows the outcome of the nine pressure ulcers that were investigated for Q2.

Acute/Community Acquisition	Stage & Location	Avoidable / Unavoidable	Actions/Outcomes
Acute and Community	Stage 4 - left heel	Unavoidable	Implementation of pressure relieving heel boots.
Community	Stage 4 - sacrum and buttock	Unavoidable	Patient choice declined care at home.
Acute	Stage 3 - ear	Unavoidable	This was related to oxygen equipment and was not required to be reported outside trust.
Acute – 2 notifications (one RCA - same patient)	Stage 3 - sacrum	Unavoidable	All prevention strategies in place; patient's condition deteriorated requiring ITU admission. During this period repositioning was unable to be undertaken.
Community	Stage 3 - left heel	Unavoidable	Patient had poor blood supply and was not known to community teams prior to hospital admission. There was a subsequent referral following discharge.
Community	Stage 3 - buttock & coccyx	Avoidable	Patient at home with district nurse input for insulin only. Pressure areas not checked regularly by carers. Following this prevention strategies were commenced.
Community	Stage 4 - left heel	Unavoidable	Patient had diabetes with poor blood supply. Patient was at home self caring.
Acute	Stage three - hip	Avoidable	Admitted with stage two pressure ulcer and deterioration due to inappropriate repositioning onto affected side.
Acute	Stage 3 - sacrum	Avoidable	Regular skin checks not undertaken as per policy. Following identification daily skin checks and prevention strategies implemented. Staff were given an educational update.

4.0 Management of Tissue Viability at GSTT

4.1 We take our responsibilities very seriously and continually strive to improve our care. We have one of the lowest pressure ulcer rates in the country. We employ a hospital and community tissue viability team who will shortly be integrated into one team.

4.2 There is a comprehensive Tissue Viability policy. We have a trust wide prevention and management policy to provide a robust process for clinical staff and patients to reduce avoidable pressure ulcers and skin breakdown.

5.0 Learning from our pressure ulcer incidents

5.1 We try to ensure accurate risk and skin assessment and prevention strategies are implemented for avoidable pressure ulcers, as per the trust pressure ulcer and prevention policy for the right patient, at the right time and right place. In addition we have: held a road show to promote 'World Stop Pressure Ulcers Day'; tailored the clinical and carer training including the patients and provided a 'know how' guide to the prevention of skin breakdown.

5.2 We encouraged timely intervention and seeking early specialist advice when necessary as outlined in the trust policy. The tissue viability team have raised their profile through a monthly trust wide tissue viability newsletter; feedback at the trust wide clinical 'Safe in our hands' weekly briefing and produced an e-learning package for education for all clinical staff. Early intervention from the tissue viability team is sought for all complex cases and there is training and education on pressure ulcer prevention and management for all health professionals involved in direct patient care.

5.3 Nursing staff also promote effective use of referral documentation on admission and discharge and discussing complex cases at multidisciplinary team meetings.

5.4 We have increased our education, training and support for families and carers and provide a point of contact for raising queries and issues pertaining to pressure ulcer prevention and management. We encourage clinical staff and carers to actively participate in health promotion and prevention of pressure ulcers.

6.0 Serious Incidents Never Event

6.1 GSTT had one reportable never event – wrong site surgery in the quarter. It involved a patient who consented to day surgery for right sided turbinoplasty, left sided turbinoplasty carried out.

6.1.1 Patients who suffer from persistent rhinitis usually present with nasal blockage, headache, postnasal drip and sneezing. This is caused by swelling of the lining of the nasal passage, mainly the inferior turbinates. Inferior turbinates are scroll like tissues on the wall of nasal passage, it is made of mucous membrane.

6.1.2 Turbinoplasty is a surgical procedure that reduces the overall size of the turbinates allowing for airflow which results in relief of the symptoms of nasal blockage and congestion.

6.1.3 In this case the patient had been seen by the surgeon in clinic previously, having complained of right nasal blockage, and then left nasal blockage at separate clinic visits. The patient was seen preoperatively on the day of surgery by a registrar who completed consent and specified the right side of the nose. The surgeon read the clinic notes before operating, and saw the correct side surgery form, which said 'turbinoplasty' but did not specify side. The patient's nose was unmarked, and the

box was not completed on the form.

6.1.4 On examination the left side of the nose only was blocked, so left sided turbinoplasty was undertaken - the right side was not enlarged so surgical intervention was not carried out.

6.1.5 The error was detected when the surgeon saw the registrar writing right turbinoplasty on the patient's discharge letter and realised the operation was not carried out on the side given on the consent form.

6.2 The investigation and analysis found the root causes of the incident were:

- The pre-operative marking verification checklist did not indicate the side to be operated on.
- The surgical site was not marked.
- The sign in was completed using the pre-operative marking verification checklist and not the consent form .
- The "time out" was not carried out.

6.3 Improvements in practice to mitigate risk and ensure safer surgery

6.3.1 In response to a number of never events where failure to use the surgical safety checklist was found to be a factor, the Surgical Safety Working Group has implemented a number of actions in order to ensure the checklist is used effectively and consistently across the entire organisation. These include:

6.3.2 **Network of surgical safety leads**
In order to improve communication with regard to the checklist and other aspects of surgical safety, a network of surgical safety leads has been established. Each relevant specialty was asked by the Medical Director to nominate a lead clinician to take on this role, and there are now 21 individuals in place across all but two areas. These individuals have been provided with a briefing pack and slide set and are cascading the relevant messages to their colleagues.

6.3.3 **Amendments to the checklist**
One of the issues raised by clinical staff using the checklist was that it was not clear who within the team is responsible for leading each section of the checklist. It had intentionally been left to clinical teams to decide who should lead each section, so as to empower all members of the team. However, in response to this feedback, the checklists in use in theatres have been updated to include designated responsibilities for each stage as follows:

Sign in: Anaesthetic staff
Time out: Surgeon
Sign out: Nursing staff.

6.3.4 **Amendments to the care plan: designated signatures**
To reflect the new responsibilities for each section, the appropriate staff member must sign the relevant section in the care plan to confirm that each stage of the checklist has been carried out. This means the anaesthetist must sign the box to confirm that sign in took place, the surgeon must sign for time out and a member of the nursing team must sign to confirm that the sign out was undertaken correctly.

6.3.5 **Telephone reporting line**
A telephone line has been set up to enable theatre staff to anonymously report any concerns they may have about use of the checklist. This will allow the implementation group and the clinical leads to focus their attention on those areas of

the Trust which most require assistance. The number for this line has been publicised widely amongst theatre staff.

6.3.6 These actions were widely publicised, and a relaunch event was held in November 2012. We are encouraged that there have been no further never events related to the checklist since then, and anecdotal evidence from theatre staff suggests its use has become more consistent. A reaudit of its use and a staff survey are currently underway, and a full report will be available in April 2013.

Part 2 Complaints and PALS report: January 2012 – December 2012 (Financial Q4 2011/12 – Q3 2012/13)

7.0 Introduction

7.1 A formal complaint as part of the Local Authority and National Health Service Complaints (England) Regulations 2009 is described as *"an expression of dissatisfaction with an NHS service".* Patients or another party with consent of the patient can make complaints. In the event a person has died a complaint can be made by anyone deemed to have "sufficient interest". Complaints are received in writing, by email and by telephone. Once a complaint is received it is acknowledged within 3 working days, graded for severity, checked whether consent is required, logged on the department's database and then passed on for investigation. Timescales for completing the investigation are given to the investigator/s. On conclusion of the investigation the investigator will provide a report or a draft letter which is reviewed by the complaints department to ensure it answers all concerns raised and that includes any remedial actions to be taken to minimise the risk of recurrence. The Trust secretary reviews all complaint response prior to signing by the Chief Executive.

7.2 Complaints received over 4 quarters from 2011/12 – 2012/13

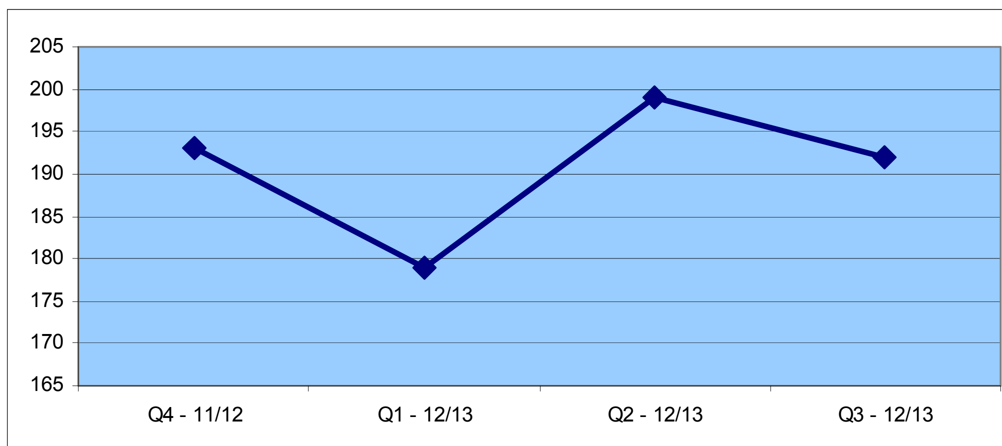


Table 1: Complaints received

7.3 Grading of complaints or severity

7.3.1 Complaints received are reviewed and graded in the complaints department using the Trust incident grading system, i.e. the AS/NZS 4360 categorisation protocol (risk matrix).

7.3.2 There were no serious or red-graded complaints across the Trust over the year however there were 131 (17%) moderate or orange graded complaints and 632 (83%) minor or green graded complaints.

7.4.1 Subjects raised in complaints

7.4.1 Clinical care is the most complained about issue at the Trust which is also reflected nationally. This covers a range of concerns which can be broken down as follows:

- Unhappy with clinical advice
- Concerns about clinical treatment
- Poor outcome
- Administration of treatment
- Inadequate discharge planning

The other subjects are fairly self explanatory apart from “waiting times/delays/cancellations” which are mainly about appointments and “hotel services/environment” which tend to be about accommodation and the physical environment of the hospital.

7.4.2 Figure 1 shows the subject of all complaints received by main subject over the four quarters (many complaints involve more than one subject). The four most complained about subjects of clinical care, communication/information, waiting times/delays/cancellations and attitude/behaviour of staff are reflective of national figures.

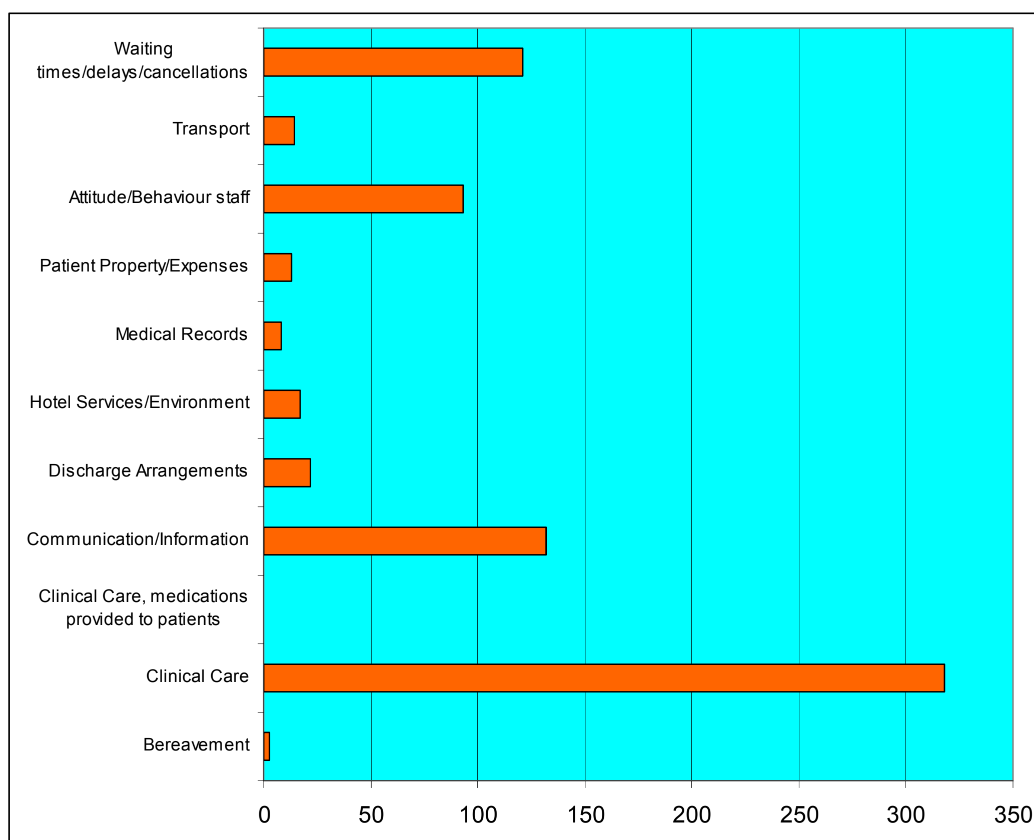


Figure 1: Complaints received by main subject of complaint

7.4.3 Figure 2 shows the number of the top four issues (main subject of complaint) received across the Trust over 2012.

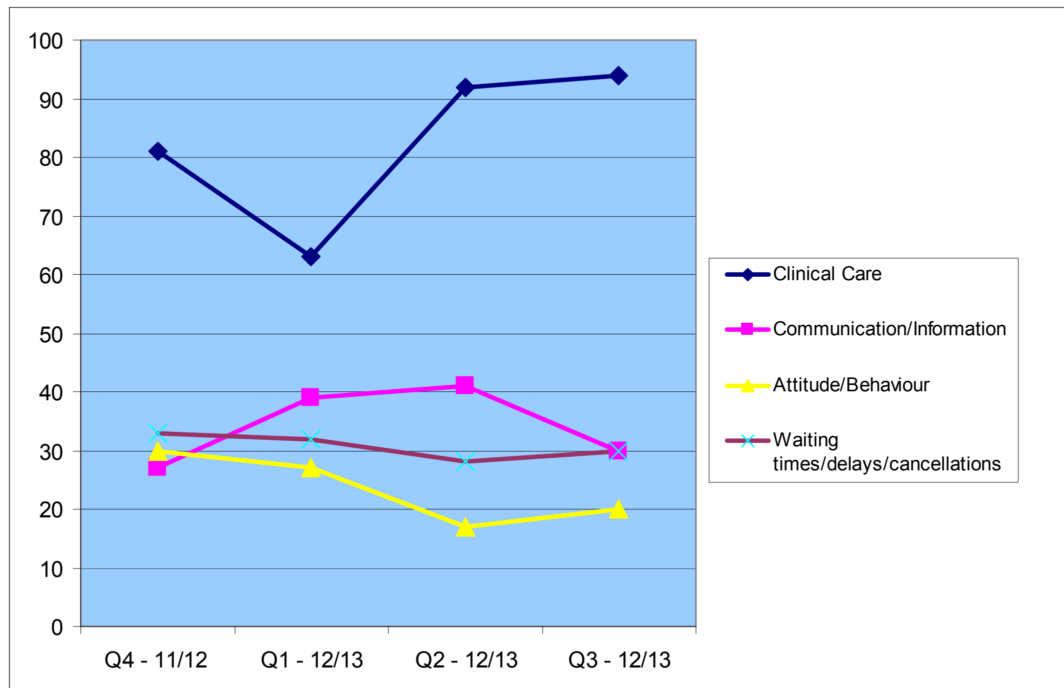


Figure 2: **Top 4 complaint subjects**

7.4.4 Complaint Example

The complainant brought their child to A&E twice and each time was told the child had a virus. On the third occasion the child was brought in by ambulance and they were then informed the child needed surgery for appendicitis.

Effect on patient
The child had been in a great deal of pain and the complainant was very upset their child had suffered and that it had taken so long to be diagnosed correctly.

Action
In this case many of the signs of appendicitis were not as clear as usual and the child was being treated for suspected gastroenteritis. The correct diagnosis was not made until the third visit.
The Children's Emergency team have reviewed several cases of appendicitis and have arranged, together with the paediatric surgical doctors, extra teaching and education sessions for the staff in the department so that they are extra vigilant to the complex and more unusual presentations of appendicitis.

8.0 Learning from complaints

8.1 Nearly all complaints have elements which are unique and personal to individual circumstances. Through investigation we are able to provide an in-depth and personal response to all the issues raised in any complaint. However there are opportunities to identify common themes and trends as a result of complaints both formal and informal, PALS enquiries and a wide variety of other feedback mechanism within the Trust. All directorates have a "complaints lead" and senior management involvement in the complaints process and therefore directorates are able to identify local trends and themes and take action to address these in local governance

meetings, through the "Big 4" and other locally identified ways. However it is also important to ensure a Trust wide approach to learning.

8.2 Access to medical records.
The department receives a variety of complaints some of which refer to requests to see their patient records but this is not the main reason for the complaint. From the complainant's perspective there does not appear to be a consistent message from members of staff about how to access records.

8.2.1 The Trust following feedback from all areas is currently refreshing a leaflet on information about health records. This leaflet has a section in it specifically on "Request to Access Health Records" and will be useful in reminding staff of the correct procedures to follow when dealing with such requests. It is planned to distribute this leaflet to all members of staff with their pay slips.

8.3 Failure to identify fractures in A&E and Urgent Care Centre.
There have been a number of complaints over time around the alleged failure to identify fractures following x-ray. There was also a recent serious incident investigation into a system failure which resulted in a backlog of abnormal x-rays not being reviewed by clinicians in A&E which led to the the potential for missed diagnosis. As a result a robust action plan has been implemented to prevent recurrence.

8.4 Clinical Care.
The outcome of investigation in 35% of these complaints highlighted issues related to the patient or their carers' understanding of their condition or treatment / care rather than a failing in diagnosis or service delivery. In these cases a detailed but appropriately simplified explanation is given in the complaint response which in general has resulted in satisfactory local resolution. More work is needed to support clinicians to convey, sometimes very complex clinical information in a way that can be understood by our rich and diverse population of service users.

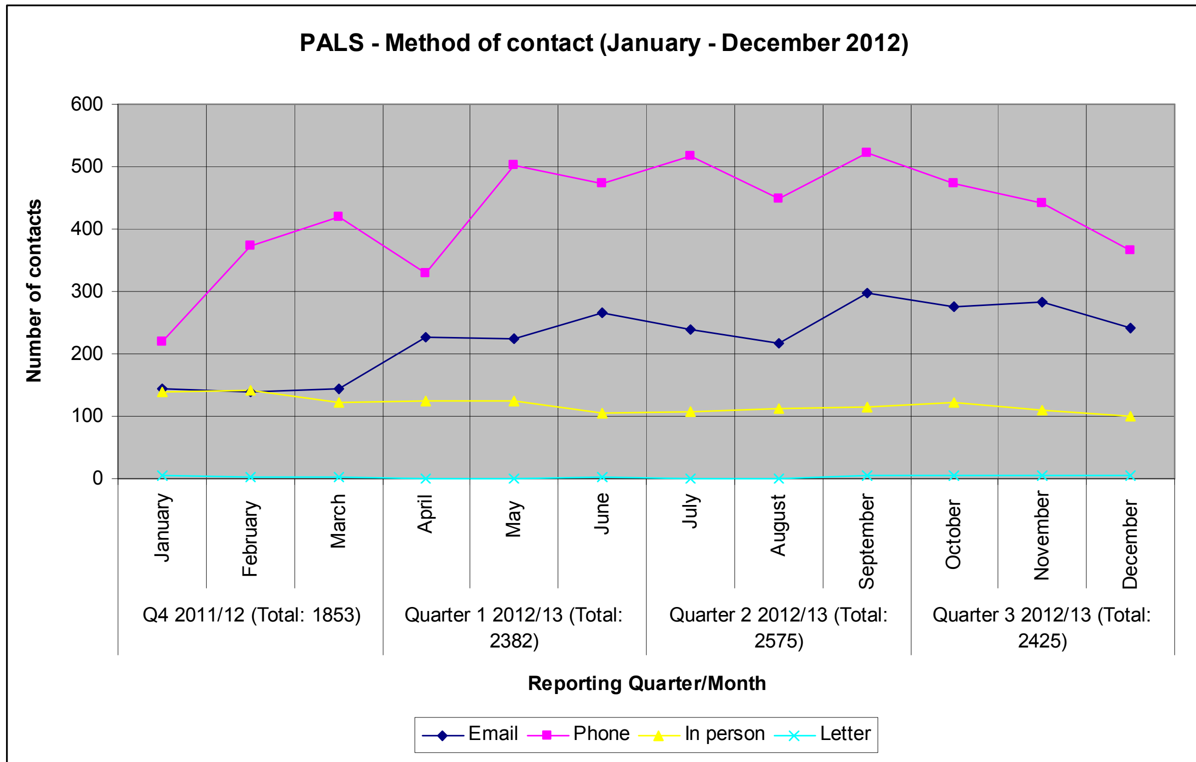
8.5 Staff attitude and behaviour
This subject of complaint is one of the Trust's top four issues of formal complaints. The Trust has a well established Values and Behaviours framework which is vital tool to addressing many of the issues raised in this subject of complaint, through appraisal, supervision and individual improvement plans. Women's services developed a local initiative entitled 'How can we help you'. This was introduced to tackle issues related to staff attitude and behaviour and to create a welcoming and supportive environment within the maternity unit for new mothers, their families and our visitors.

8.5.1 The Trust also introduced a Telephone Academy to train staff. This has been especially used to update the skills of appointment staff which develops their skills in answering telephone enquiries and responding to patients. It is also available to any service who deal with patients by telephone.

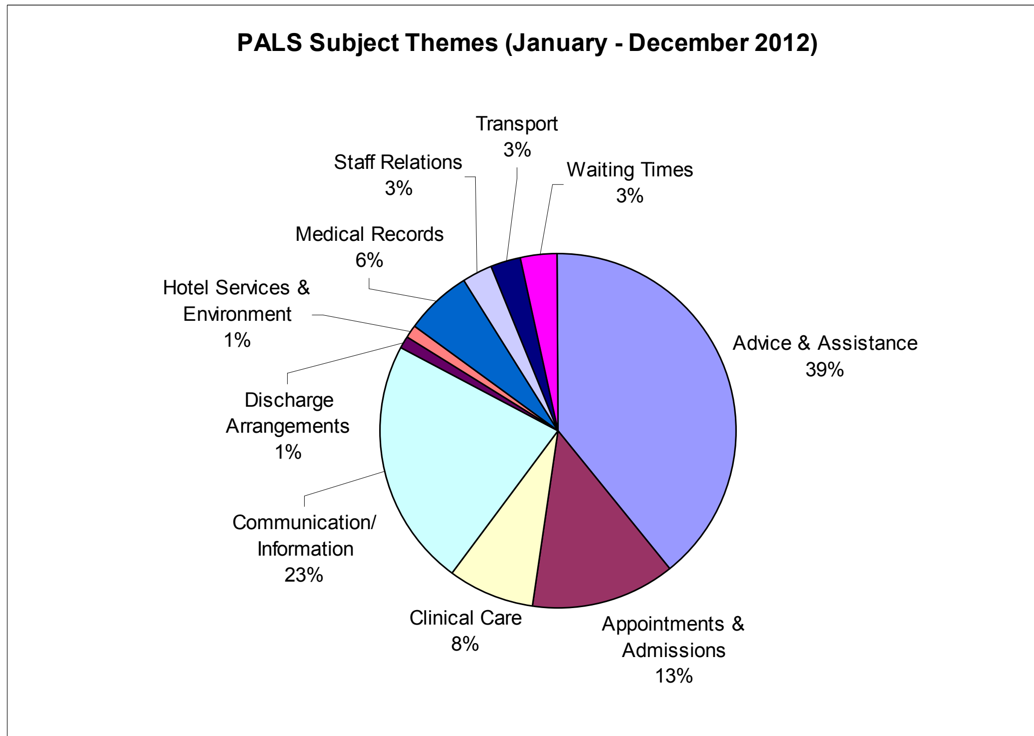
9.0 PALS Summary – January – December 2012

9.1 PALS ACTIVITY

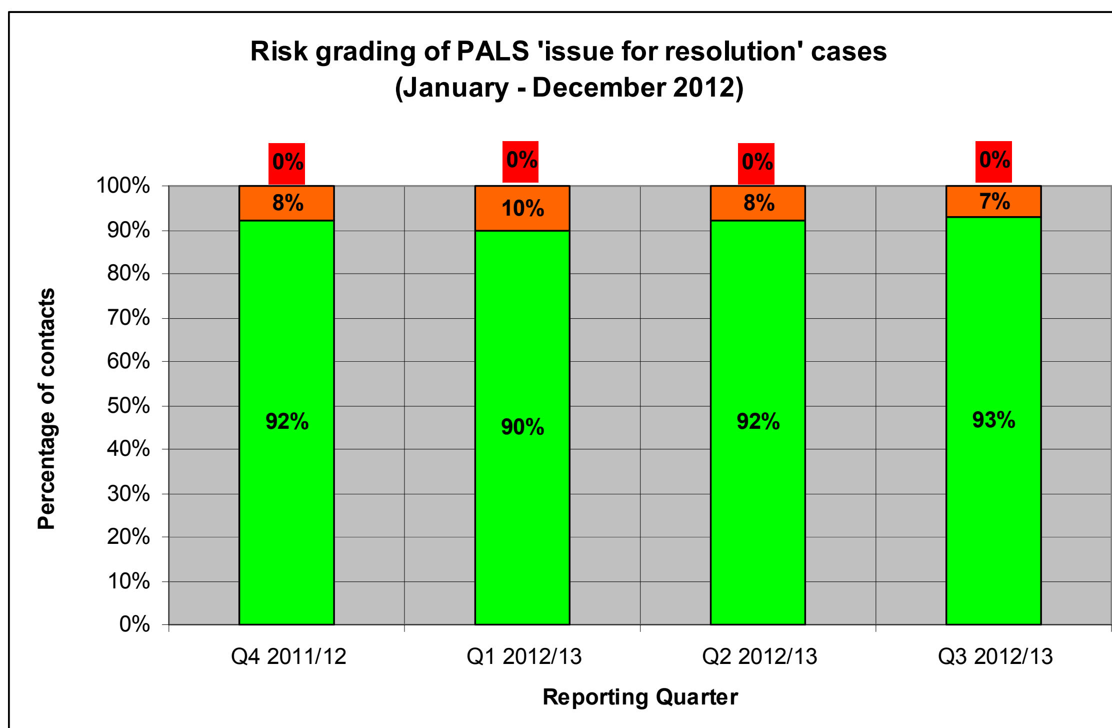
PALS received just over 9,000 contacts between January and December 2012 with the main methods of contact being via phone and email.



9.2 PALS Subject Themes



9.4 Grading of PALS 'Issue for Resolution' contacts



9.5 Examples of grading of PALS contacts

Grading - Green:

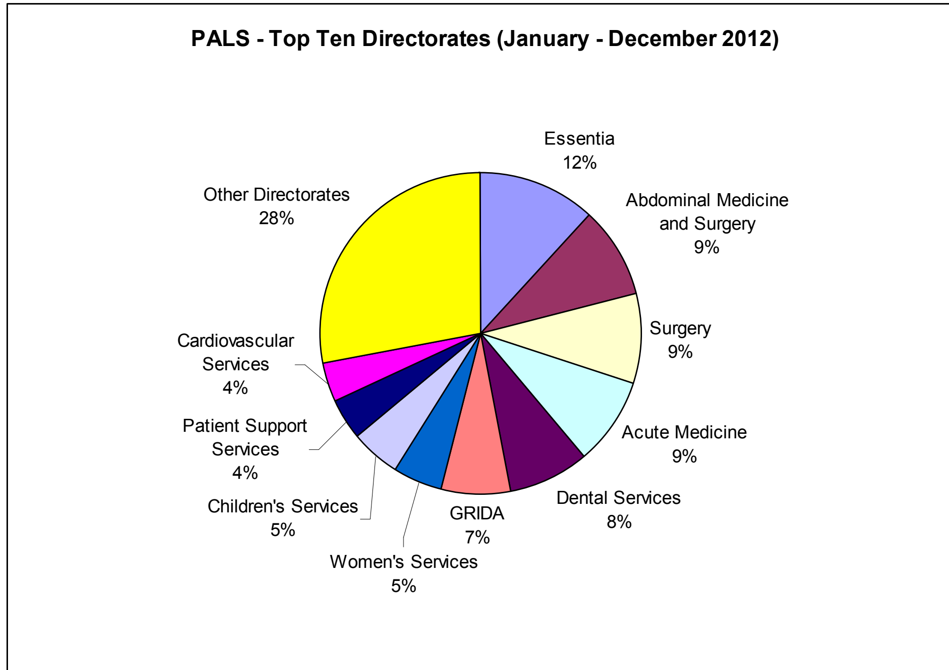
- Patient stated that they had one set of investigations but was told she would be called back for further tests and treatment. The patient said they have not received the appointments for the further investigations.
- Patient stated they were unhappy regarding staff attitude when contacting department in order to chase up missing referral.
- Patient explained that they had a pre-operative assessment, but was concerned they had not received a date for the admission.

9.6 Grading - Orange:

- Patient explained that when they attended for an ultrasound, her notes had been given to another patient by mistake. The patient was concerned about the possible repercussions.
- The patient's daughter explained they were very unhappy that the patient was discharged from hospital instead of being transferred to another ward as planned. The patient's daughter said they were also unhappy with lack of aftercare and 'failure' by hospital to communicate with district nurses regarding the patient's medication.

Note: 'red' grading – PALS use the Trust 'Incident grading matrix' as guidance for grading contacts. The 'red' grading indicates a catastrophic impact of an incident (such as an 'incident leading to death' and 'gross failure to meet national standards'). The PALS contacts received in the reporting period did not fall in to the red grading categories.

9.7 DIRECTORATES



9.8 Top five Directorates (January-December 2012)

Directorate	Number of contacts	Top three themes
Essentia	620	• Access to Medical Records • Transport Policy • Delay in providing transport
Abdominal Medicine and Surgery	446	• Health care/staff – information on Trust services/referral procedures • Concern re - Clinical treatment/care/service • Communication - lack of information (patients)
Surgery	446	• Health care/staff – information on Trust services/referral procedures • Concern re - Clinical treatment/care/service • Admission/Appointment letter not received
Acute Medicine	441	• Concern re - Clinical treatment/care/service • Compliments • Health care/staff – information on Trust services/referral procedures
Dental Services	421	• Health care/staff – information on Trust services/referral procedures • Admission/Appointment changed/cancelled/delayed by Trust Admission/Appointment letter not received

9.9 Escalation cases:

PALS cases that relate to dignity, safeguarding or other issues of particular concern are escalated to the Deputy Chief Nurse via the PIT Manager. The number of 'escalation' cases per month are provided below.

Month - 2012	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Number of cases	2	2	1	0	2	4	1	3	1	2	4	4

10 PALS Case Studies

Theme	Description of case	Outcome of case
Transport	• The patient explained that he and his wife were due to have hospital appointments on the same date; his wife's appointment was at Guy's Hospital at 11.30am and his own appointment was at St Thomas' Hospital at 12.10pm. • The patient requested assistance with Patient Transport to arrange for him and his wife to go to Guy's and then be transported to St Thomas' Hospital and then back home.	• PALS liaised with the department located at Guy's to arrange for the first appointment to be brought forward to earlier in the morning in order to facilitate the patients travelling between hospital sites to reach the second appointment in a timely manner. • The matter was then referred to the Patient Transport Department. They put the arrangements in place for collecting both patients, taking them to Guy's Hospital, then to St Thomas' Hospital and then back home. • On the day of the appointments; the Patient Transport Department confirmed the arrangements and ensured that both patients arrived at the appointments on time and were transported home afterwards.

Appointments/ Admissions	• The patient explained he attends follow-up appointments on a three monthly basis. • Patient said when he finishes his appointment; he always gives the receptionist the appointment slip to arrange the next appointment. He stated on one occasion he did not receive a letter and he had to contact the department to chase up the appointment. • The patient said at his last follow-up appointment, he had handed his follow-up appointment slip to the receptionist and again he was told the appointment would be sent to him. • The patient said it is important that he receives his follow-up appointment as requested by the doctor because if he is not seen every three months he can develop complications with his health.	• PALS liaised with the relevant department and the Access Team. The Access Team emailed the patient to thank him for raising the issue and to apologise for the inconvenience he had experienced. They confirmed that the patient should have appointments on a three monthly basis. • The Access Team provided the patient with information on the appointment booking system whereby patients who are to be followed up more than six weeks ahead are placed on a follow up waiting list. This is done in clinic by the receptionist. They explained they can ensure that the patient will receive notification 5-6 weeks before his next appointment. • The Access Team attached a leaflet to the email that explains the advantages of the six week booking system for the patient's information.

11.0 Recommendation:

The Overview and Scrutiny Committee is asked to:

- **Note the report for information / discussion**

Elizabeth Palmer & Debbie Parker

25 March 2013

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Pressure ulcers quarter 2

The table below highlights the admitted, acquired and unavoidable pressure ulcers for the quarter and the actions taken in response.

Pressure ulcers for quarter 2	Actions taken
Pressure ulcer incidence –second quarter Admitted • Grade 2 = 130 • Grade 3 = 12 • Grade 4 = 10 Acquired • Grade 2 = 32 • Grade 3 = 1 • Grade 4 = 0 Unavoidable • Grade 2 = 17 • Grade 3 = 2 • Grade 4 = 0	- Revised Waterlow assessment for all patients so that any patient with a score of 10 or above receives a dynamic mattress - Number of dynamic mattresses increased to 250 (no patients waiting) - Numbers of seating cushions increased for all those at risk (no patients waiting) -Staff advised to be vigilant regarding potential heel ulcers and to use heel protectors or Prevalon boots as required - Staffing levels increased in elderly care areas - Patients at risk highlight on white boards and handed over to the next shift of staff - Early detection of pressure ulcers identified by patient safety officer - Turning charts in place for all patients at risk -Commissioners to be informed of pressure ulcer incidence at each quality meeting -

Year to date

The charts below show the numbers of pressure ulcers and rate of pressure ulcers to date for 2012 and 2013.

Key points:

- There has been a sharp increase in numbers and rate of pressure ulcers since November 2012 when compared with the previous year.
- Since November, this is entirely due to an increase in grade 2 pressure ulcers
- Last year there were 7 grade 3 pressure ulcers, this year there have been 9, but none since October.

- We are unsure of the precise reasons why there has been an increase this year compared with last year, when all other inputs have been sustained and additional actions have been put in place. This could be due to better reporting of Grade 2 pressure ulcers, or due to the effects of an increase in patient acuity due to the increase in numbers of emergency patients. Between October and December 2012 there were 13,169 non elective admitted patients, in 2013 during the same period there were 13,720 (increase of 551 pts.)

- We are continuing to closely monitor the situation and are reassured by there being no significant in increase in more serious grade 3 and grade 4 ulcers.

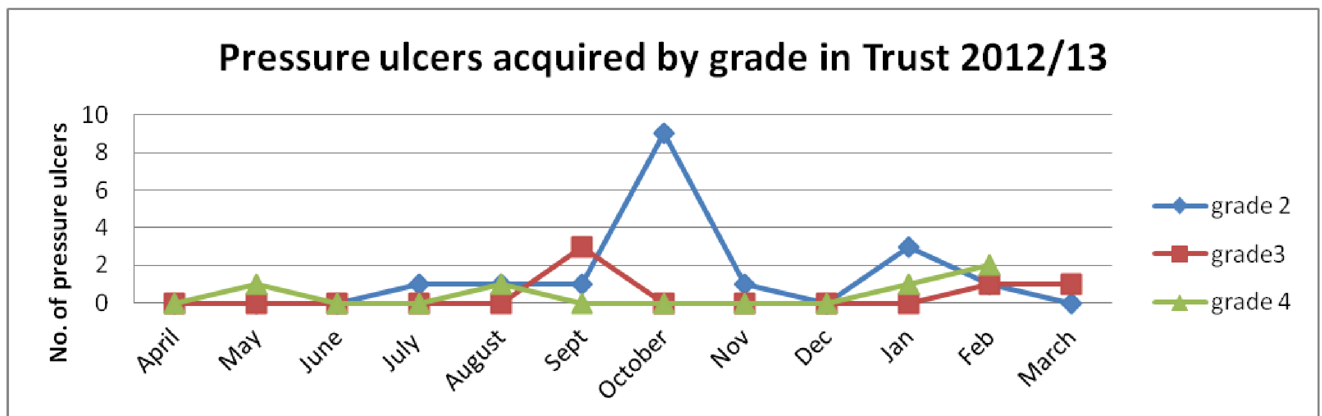
Pressure Ulcer Summary for SLaM 2012/13

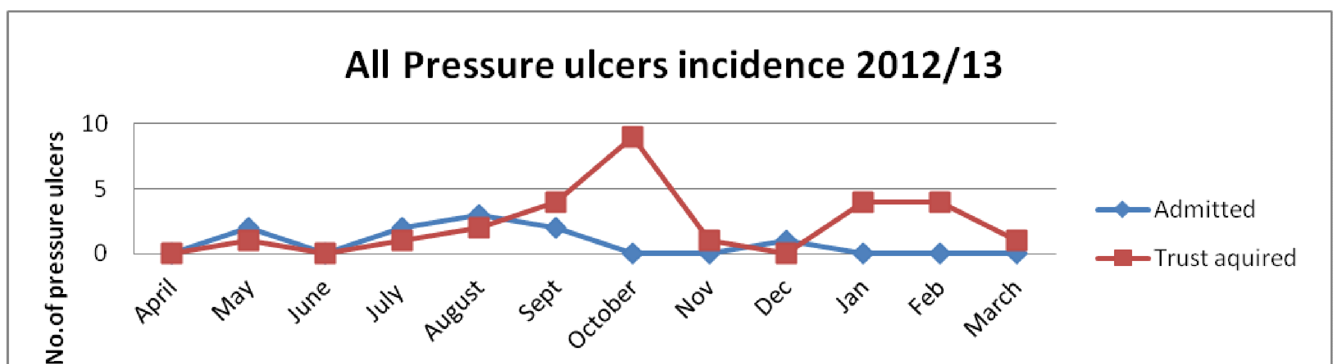
Pressure ulcer rates remain low within the Trust, however since the introduction of the NHS safety thermometer our incidence have increased, possibly due to an increase in reporting via another route other than the Datix system.

The incident team, the older adults' senior nursing team and Assistant Director of Nursing meet weekly to review all pressure ulcers and review each service user's treatment and care. All grade 3 and above pressure ulcers are automatically notified to the Local Authority Safeguarding Leads and all those grade 2 and under are considered for a safeguarding referral.

The current increase is located to one continuing care home within Lambeth in which three are Southwark residents. These are all under a structured investigation. To prevent and improve treatment and care the home is being additionally supported by both an additional matron and the older adults head of nursing.

The Trust is committed to reducing the incidence of acquired pressure ulcers within the organisation and a gap analysis has been commissioned across all the older adults services that will be completed by 31st March 2013, to inform the Trust's action plan in improving the care of our service users. The Trust will continuing with the 2013/14 NHS safety thermometer CQUIN to reduce pressure ulcers.





Natalie Warman- Assistant Director of Nursing 13.3.13

NHS
Southwark Clinical Commissioning Group

Briefing Note:

Health, Adult Social Care, Communities and Citizenship Overview and Scrutiny Sub-committee (HOSC)

Community Acquired Pressure Ulcers

1. Introduction

1.1. The following briefing note provides further details in response to the sub-committee Chair's request in relation to the 92 community acquired pressure ulcers across south east London (SEL) reported to the SEL Joint PCT Boards on the 29 November 2012 within the Serious Incident (SI) summary report.

1.2. The SI summary report to the PCT Boards related to quarter two, 2012/13 or the period July to September 2012. The report identified 120 Pressure Ulcers of which 92 occurred in community settings. The summary report provided details across the six boroughs that make up SEL[1]. Of the 92 community cases in the report there were three cases in that period relating to Southwark residents. More detailed reporting indicates that:

- One was acquired in a private home
- One was acquired in Guys and St Thomas' Hospitals NHS Foundation Trust (GSTT)
- One was acquired in a community setting (Source unknown)

1.3. It should be noted that in that same period 11 Pressure Ulcers were notified by Kings College Hospital NHS Foundation Trust (KCH) that had originated elsewhere (e.g. the patient had the Pressure Ulcer on admission) where the patient's borough of residence is unknown.

2. Pressure Ulcers in community settings

2.1. Pressure ulcers (PU) are caused by sustained pressure being placed on a particular part of the body. Blood contains oxygen and other nutrients that are needed to help keep tissue healthy. Without a constant blood supply, tissue is damaged and will eventually die[2].

2.2. When diagnosed, Pressure Ulcers are categorised as being of grade 1, 2, 3 or 4 in an ascending order of severity. Grade 1 are superficial with discolouration of the skin and may be itchy, Grade 2 show damage to the outer or deeper layer of the skin leading to skin loss and may look like a blister, Grade 3 result in entire skin loss to the area, there is no underlying damage to the bone or muscle, Grade 4 is the most severe type in which skin tissue begins to die and underlying bones and muscle may be damaged, this may result in the development of life threatening

[1] Bexley, Bromley, Greenwich, Lambeth, Southwark and Lewisham

[2] Further information on the causes of Pressure Ulcers and definitions can be found at: www.nhs.uk/Conditions/Pressure-ulcers/Pages/Causes.aspx, NHS Commissioning Board Patient Safety Action Team (PSAT) & NHSCB Serious Incident Framework

infections. The NHS regards PU grades 3 and 4 as being particularly severe and need to be recorded as a Serious Incident (SI). The 120 cases reported to the PCT Boards relate to grades 3 and 4.

2.3. The term "Community settings" refers to all environments apart from acute, mental health, or specialist hospitals. These settings include the following:

- Patients or relatives home
- Intermediate care setting
- Residential care homes
- NHS Funded continuing care placements

3. Commissioning actions

3.1. Until 1 April 2013 the PCT is accountable for the commissioning of local health services. After that date NHS Southwark Clinical Commissioning Group (CCG) will be accountable for that commissioning and has acted with delegated responsibility from the PCT Board for those areas since 1 April 2012.

3.2. Across London CCGs have worked together to ensure the safe and effective commissioning of acute, mental health and community based services. Given the geography of providers and the populations they serve CCGs, like PCTs before them, have developed 'Lead' commissioning responsibilities for particular providers.

3.3. In the local context NHS Southwark CCG has taken the lead commissioning role for KCH, partners in NHS Lambeth CCG have lead commissioning responsibility for GSTT (including acute and community services) and Southwark CCG works in partnership with three other CCGs (Lewisham, Croydon and Lambeth) to commission and contract South London and the Maudsley Mental Health Foundation Trust (SLAM). Each CCG takes the lead role for the commissioning of other services, such as continuing care, for their own borough.

3.4. Whilst lead commissioning responsibilities allow for effective management of providers, each CCG remains fully responsible (and in future accountable) for the care commissioned from all providers for its population and holds t contract with those providers. As such NHS Southwark CCG is directly involved in the management of SI across all relevant providers.

3.5. The on-going management of SIs is undertaken within the wider arrangements for clinical quality and contract management. An established system exists whereby CCG commissioners come together with individual providers at monthly Clinical Quality Review Groups (CQRGs) to address quality items. Contract monitoring meetings also occur monthly between Commissioners and providers; these are serviced by the Commissioning Support Unit and focus is upon the monitoring of performance in line with Key Performance Indicators (KPIs) within individual contracts.

3.6. During 2012/13 the Integrated Governance Committee of the South East London Joint PCT Boards invited providers across South East London to present to the committee their approaches to managing and minimising pressure ulcers.

3.7. Any SI needs to be reported by the provider to external parties, including commissioners, and a thorough investigation undertaken to ensure the possibility of

the same incident occurring again is removed as far as possible. Pressure Ulcers are also reported to the Safeguarding team of the resident's Local Authority (if a safeguarding issue).

3.8. In addition to the arrangements above an initiative to connect agencies involved in delivering care in Southwark (and Lambeth), to focus on PU present when patients are admitted to hospital, and further minimise their occurrence is being progressed. The Safeguarding Lead at Southwark Council is involved in this, alongside Southwark and Lambeth CCGs, KCH and GSTT (including their Tissue Viability leads).

4. Further action

4.1. NHS Southwark CCG monitors patient safety issues with its providers via regular quality meetings, where pressure ulcers are dealt with in detail.

4.2. The initiatives currently in progress will ensure that a specialist focus is maintained on pressure ulcers. This is being commenced through development of a reporting pathway owned jointly by the two main providers, KCH and GSTT (including Community services), and involvement from the Continuing Care and Safeguarding lead at Southwark CCG. Monthly Clinical Quality Review Groups take place with providers which monitor all aspects of quality including pressure ulcers.

4.3. Co-ordinated monitoring of pressure ulcers and other patient quality indicators forms part of each commissioning organisation's responsibility, seeking assurance that trend and analysis data are reviewed and acted upon. Commissioners have requested action plans from providers and have played an active role in monitoring their delivery.

South London and Maudsley NHS
NHS Foundation Trust

Complaints and PALS Report

Quarter 3

October – December 2012

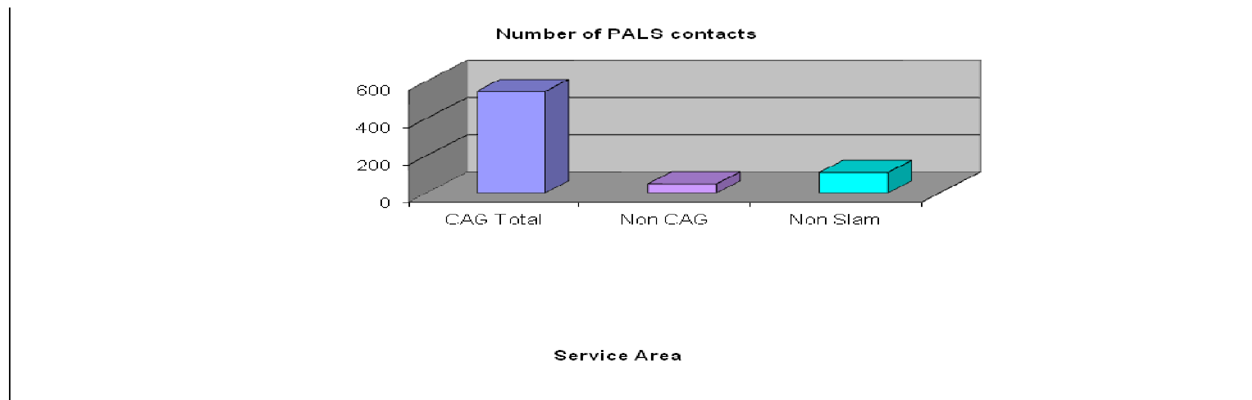
Prepared by : Mary O'Donovan, Head of Complaints and PALS
With input from Complaints and PALS Teams

Introduction

This report provides statistical information and a commentary of the Trust's performance on complaints and PALS' handling for the period October to December 2013. The Trust received a total of 149 complaints and 704 PALS contacts over this period.

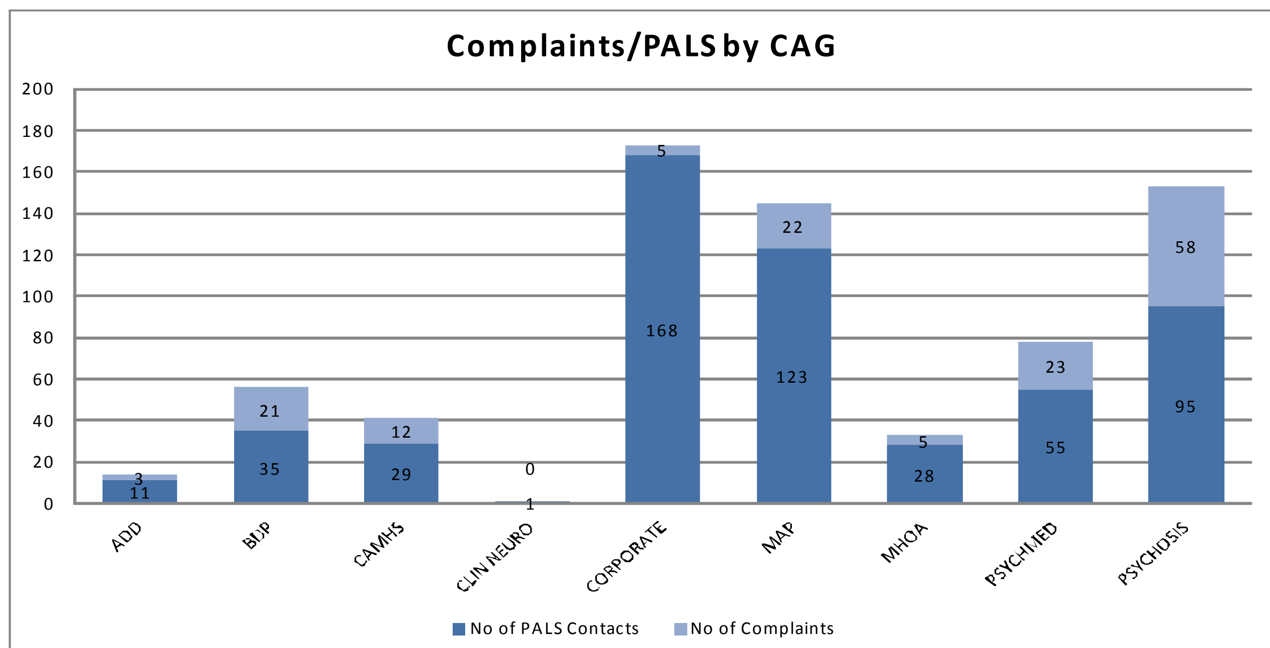
Activity

Thirty nine percent of all complaints received by the Trust this quarter came from the Psychosis CAG. Reviewing the complaints that have arisen from the Psychosis CAG over half the complaints (67%) have come from Inpatient and complex care areas highlighted later in this report. There was a significant increase (91%) in complaints coming from the CAG Psych Med from the previous quarter. Eight of the complaints arose from Triage Wards, Lambeth/Lewisham.



Graph one

Of the 704 contacts to PALS, 594 (84%) of them were attributed to SLaM services (see Graph One). From these 92% were linked to a specific CAG, with MAP CAG having the highest uptake (33%) of all known clinical CAG contacts, with Croydon East Assessment and Treatment Service receiving the most contacts which included contacts from GPs wanting contact and referral details.

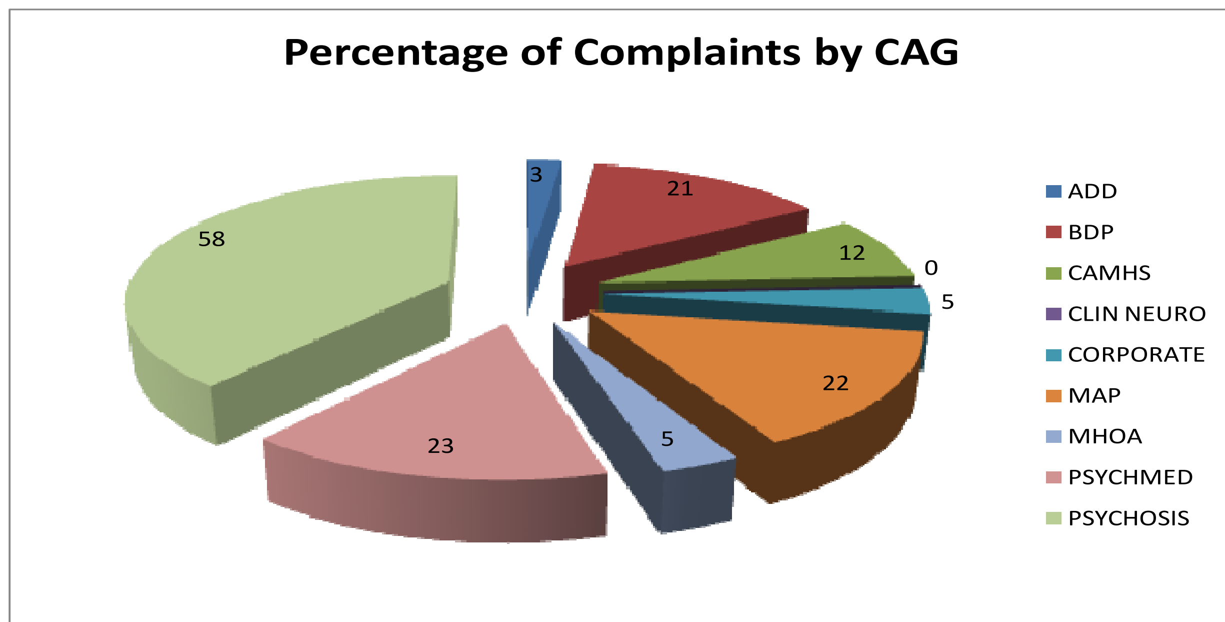


Graph Two

Areas within the CAG where there were combined high activity levels in both complaints and PALS in their respective areas were:

- Psychosis: JBU and Community Service (Lambeth West)
- Psych Med: Lambeth and Lewisham Triage Wards, KCH A&E
- MAP: IAPT service (Lambeth) Croydon East, Lambeth North and Southwark South Assessment Teams
  Purley R/C (Croydon West) and Psychological Therapy Service, MH
- B & D: Adult ADHD service, Behavioural genetics Unit and Denis Hill Unit
- Addictions: AAU

Complaints by CAG



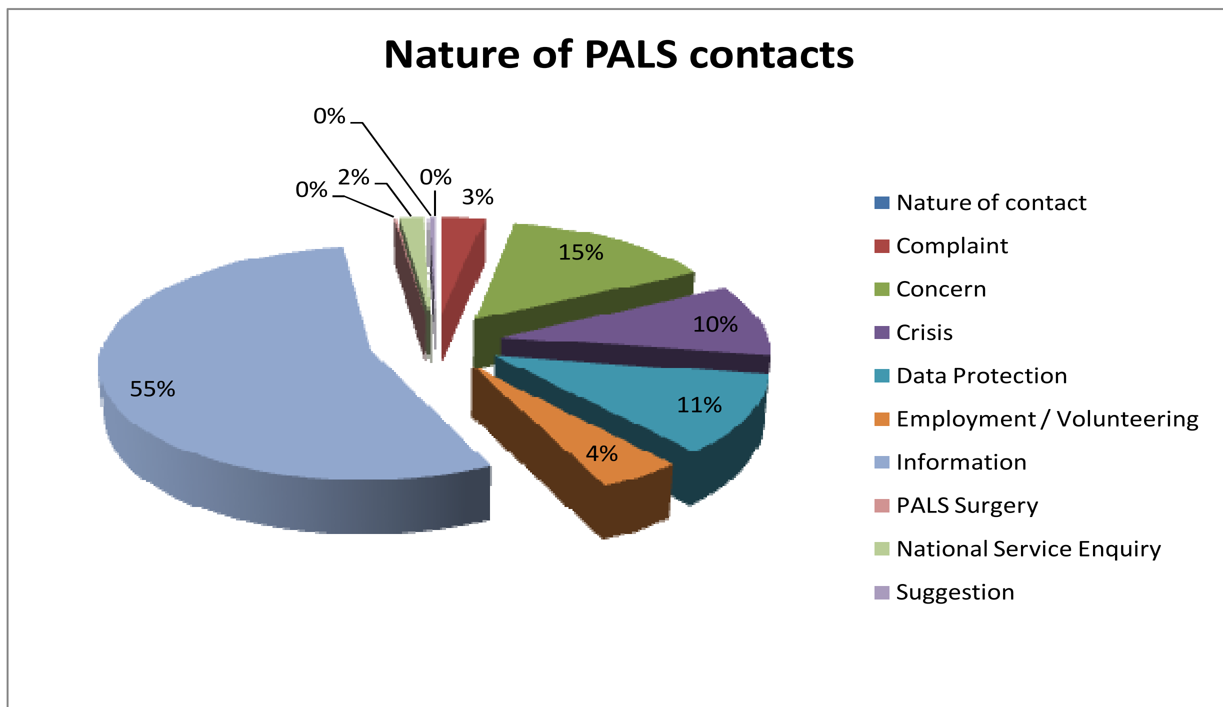
Graph Three

The highest concentration of complaints from a specific services areas, Neurodevopmental Disorders Service, Denis Hill Unit, Lambeth Triage Ward and Gresham 1 Ward.

The complaint subject matter concerned areas around:

- Family concerns regarding care.
- Funding arrangements.
- Patient on patient aggression.
- Diagnosis.
- Treatment and care/ medication
- Communication.

PALS contacts



Graph four

Looking through the cases PALS dealt with this quarter it is evident that the PALS team deal with a very wide spectrum of very different kinds of contacts. One noticeable theme is the calls and emails from people wanting help with welfare benefits issues particularly Work Capability Assessments. In may calls and contacts this whilst not the main reason for the call was in there background and adding to stresses of services users and their carers.

As well as the usual sort of themes: crisis calls (people in crisis themselves or alerting the Trust to those that are), calls and contacts from services users/carers/GPs wanting referral information; “switchboard” and Data Protection type calls, and companies and others wanting our infrastructure departments i.e. finance as well as obviously concerns and complaints. PALS has also dealt with:

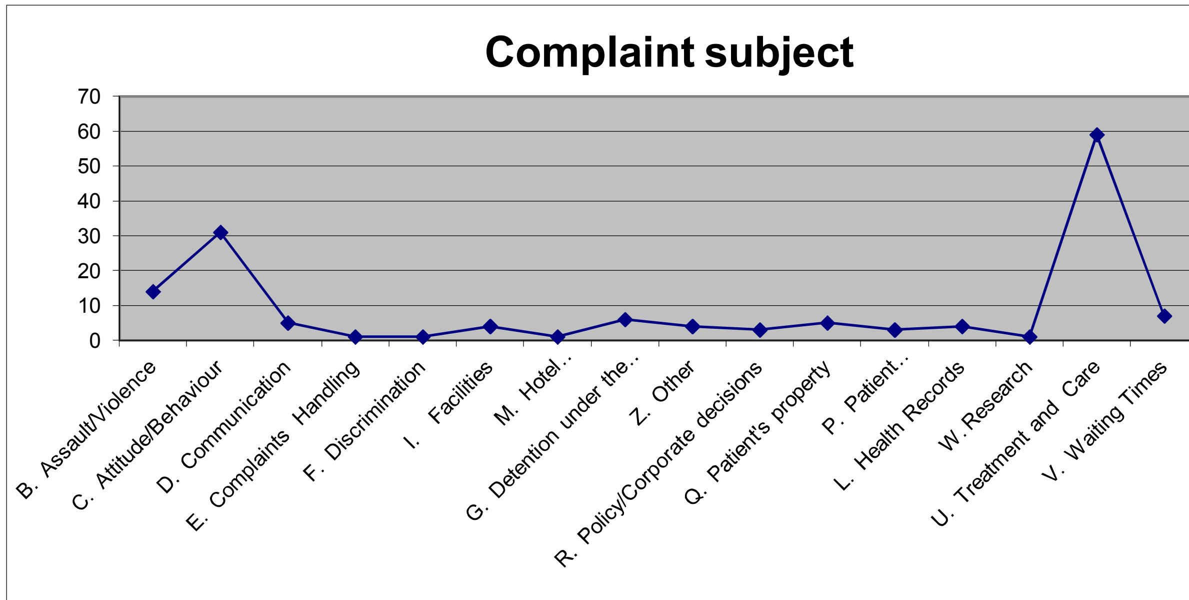
Information and advice on conditions of many types (ADHD; anxiety disorders and depression; eating disorders; schizophrenia and bipolar disorder; personality disorders, chronic fatigue, memory problems and dementias, and addictions problems. Whilst not clinically trained nor experts the team obviously have links with people who are.

Because of SLaM’s national and international reputation it received calls and contacts not just from London but further afield in the UK (for example from Somerset and Yorkshire). Sometimes this is of the flavour of ‘my local services aren’t good enough’ in ADHD or Eating disorders. In these circumstances we can give out our second opinion and treatment services but also general information and pointers to support in their local area including other PALS tams or equivalent.

PALS also has had some international contacts either wanting to come to SLaM services, or to get private treatment from us, or to ask specific questions from our world experts – these include not just people wanting services but other health services and researchers and the like. These contacts have come from Ireland Bulgaria, Romania, Turkmenistan, United State and Australia amongst others.

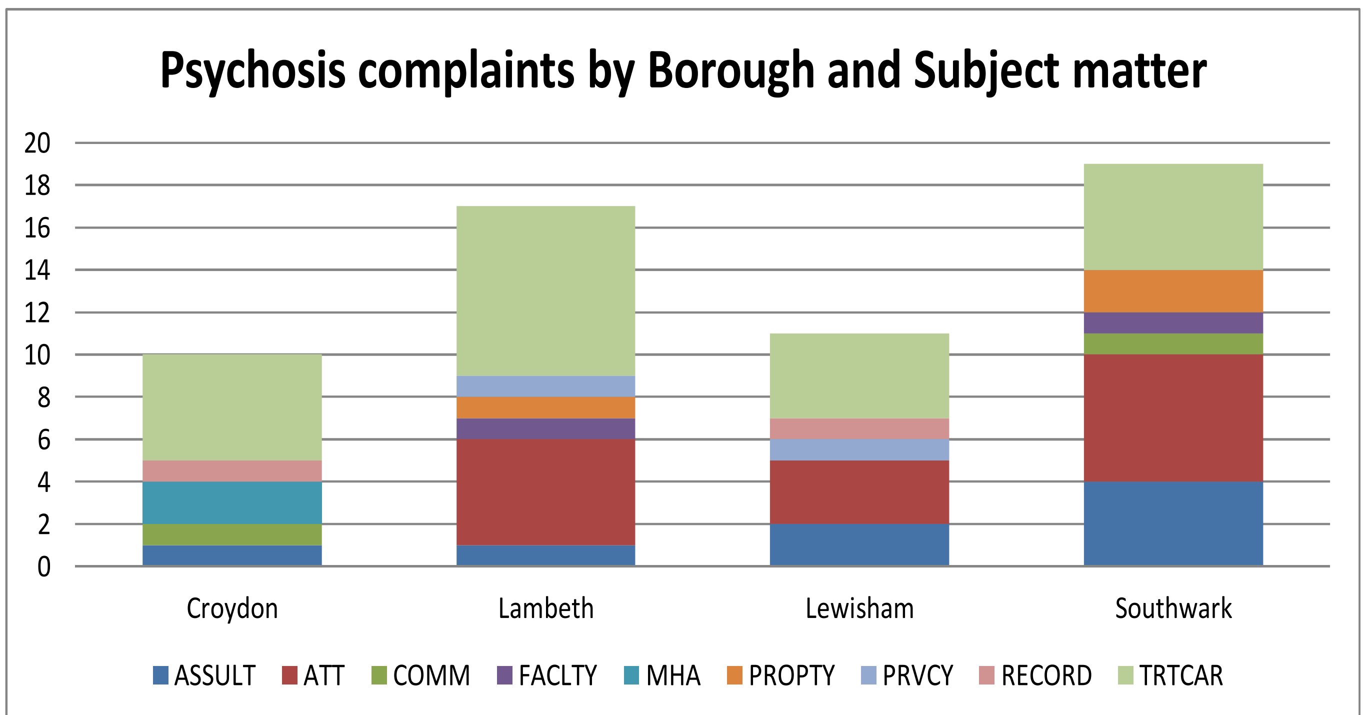
There are contacts that are extremely hard to categorise and is the sort of thing that only a PALS type service could do: Over Christmas people wanting to send Christmas card for their loved ones in hospital but not knowing where they were.

Complaints



Graph five

The number of complaints regarding treatment and care accounted for 37% of complaints received, lower than the previous quarter. The number of complaints for Psychosis by category and Directorate are outlined below. Southwark services saw an increase of complaints in this quarter in particular the month of November (8), however when analysing further there was no particular service which had more than one complaint and it was spread across all services. There has been a delay in responses from Inpatient areas during a transitional period in staff changes at management level. A meeting has been held with Psychosis Inpatient Leads in an attempt to mitigate further delays and manage future complaints.



Graph Six

Compliments

There were twenty five compliments formally recorded over quarter Two Some have been summarised below:

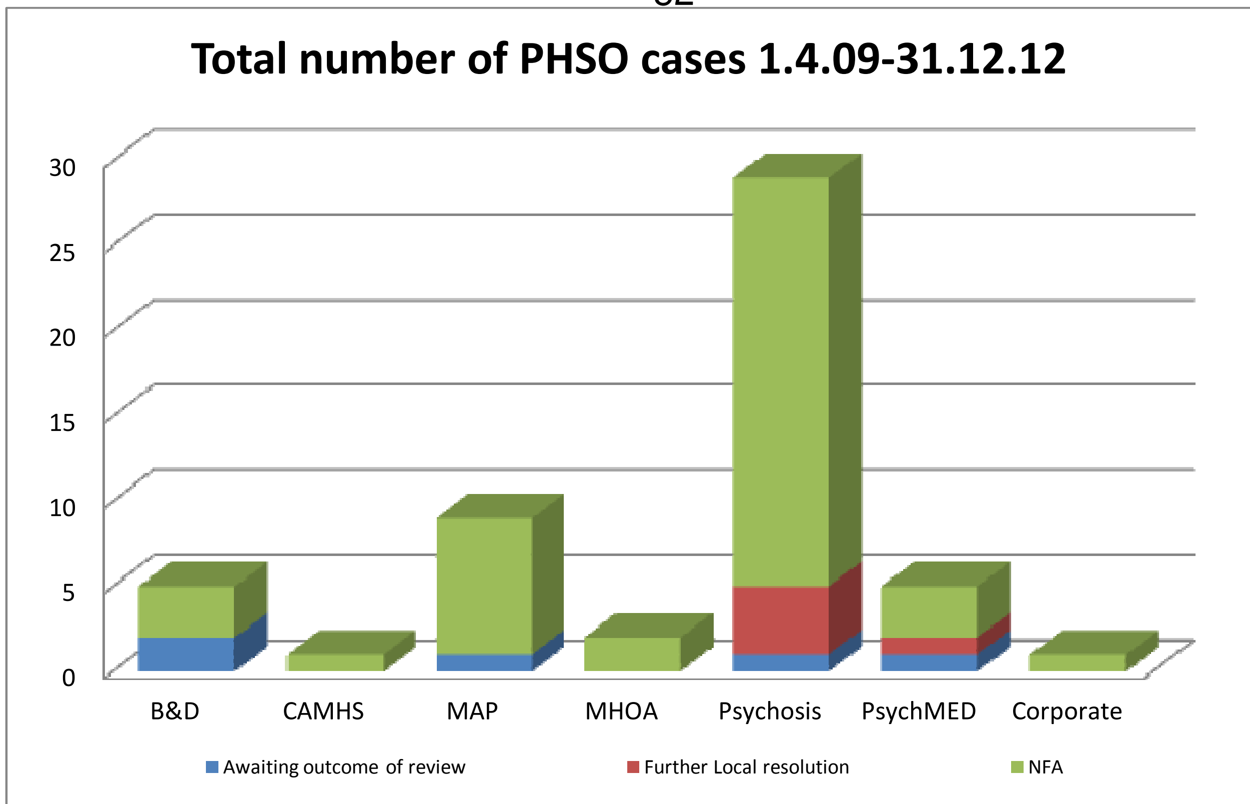
Table One:

Service Area	**Synopsis**
•Croydon Treatment & Recovery Partnership, Lantern Hall(Addictions)	• Email to staff reads: "Thank you. You helped to save my life! And I know u made an extra effort for me to get detoxed. so now I can function properly to do my job and help others. Can you please thank other staff for me too. The work you do may not get thanks sometimes but without you guys I think many people would be lost."
Acorn Lodge	• Thanks to Staff for their help and support to the daughter.
Chelsham House (MHOA)	• Email reads: "The care my son received from The Maudsley was exceptional and we were very grateful for the excellent high level of care he was given at Aubrey Lewis and at Chelsham House. Dr looked after my son's welfare throughout his stay at both hospitals and liaised with us at all times."
IAPT, Lewisham (MAP)	• Email reads: "I would like to express my thoughts and gratitude about your employee, who works as a psychologist. I cannot thank her enough for her support, time and patience with me when I was dealing with depression. She is literally a life saver! She has made me feel that my life is worth living and helped me gain back confidence in my own ability. She has helped me deal with some very stressful and difficult situations with great professionalism and kindness and as a result I am returning to work next week. An action I could not have done without her help and I will be eternally grateful. I hope she is appreciated and is given the praise and recognition she most definitely deserves."
Powell Ward Psychosis Unit	• E-mail to staff reads: "I'd just like to thank you for your patience and hard work whilst I was at the unit. Please pass on my thanks to the whole team for me, Especially 3 other members of staff. You guys totally rock!"
Eating Disorders In-patient, TW2 Psychmed	• Card to staff reads: "Thank you very much for all the help, support and guidance which you have given to patient over the past months.

Parliamentary Health Service Ombudsman (PHSO)

There were two requests for further review of their complaint by the PHSO in Quarter Three. They concerned areas; waiting times, assessment outcomes, inaccuracies of records and leave/discharge arrangements. These two cases are still under review and the Trust is awaiting the outcome.

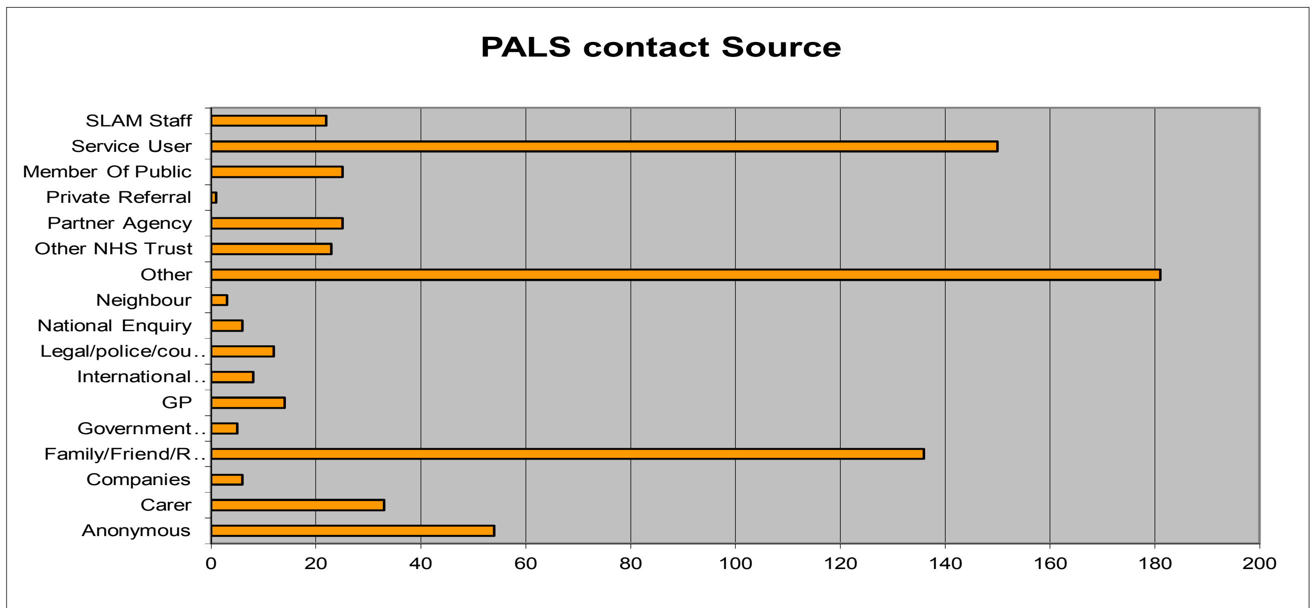
Graph seven outlines the cases reviewed or currently under review by the PHSO. There have been fifty two requests for the PHSO since April 2009 when they became responsible for the reviewing complaints at second stage of the NHS Complaints procedure. This accounts for under 3% of complaints received by the Trust over the same timeframe.



Graph Seven

Contact source

Many calls to the PALS service are anonymous. Therefore PALS staff are unable to obtain full information regarding person concerned. Where it was clear the information was logged and is shown in the graph below.



Graph Eight

Where the caller was clearly identifiable, Families, carers and friends accounted for 19% of the calls received by PALS.

Improvements to Services as a result of complaints

B& D CAG

BDP/Q3/04/12 - Chaffinch Ward

Apology given for distress caused. As a result of the complaint the MHA team are examining their processes carefully to ensure appropriate staff cover over Christmas period, so that similar occupancies are not repeated. They are also monitoring the timeliness of holding Hospital Managers reviews and reminding the MHA Co-ordination of the need to manage the process proactively.

BDP/Q3/03/12- ADHD Service, MH

Line manager to ensure relevant staff member undertake customer care training in the immediate future. Administration Team have been advised that in future all calls of a clinical nature should be passed to clinicians to address. In the clinician's absence the administrator will take a message and pass this on to the appropriate clinician. This will continue to be monitored to ensure that this standard of customer service is maintained.

CAMHS

CAMHS/Q3/02/12 - Assessment Liaison and Outreach Team (A LOT)

The A LOT team have also checked the database which contains all of their clients' details for those with recorded temporary addresses and now place an alert on the system to check the accuracy of any temporary address after one month. These addresses will then be checked on a monthly basis until such time when the alert is removed. In addition, the A LOT team will ensure that when any patient correspondence is being sent, there is a check made to confirm the address is the correct current address, by confirmation of the most recently given address recorded on the 'core information' notes, rather than relying on the address generated for the printed summary.

MAP

MAP/Q3/04/12 - North Lambeth A&T

The team have been briefed of the concerns raised and informed them of the importance of assisting the GP by explaining and communicating effectively of options available regarding crisis intervention; being assessed in the A&E department and if necessary SLaM staff would follow this up by contacting the A&E department whilst the client was being transported by LAS.

MAP/426/Q3/12 - Lewisham IAPT

In terms of effective communication regarding appointments, the Service manager has asked administration staff to use email addresses if they are unable to get through to patients over the phone. Email addresses are not provided to us by all our patients but the Service manager will be encouraging staff to use this method of contact where this information is available.

Psychosis

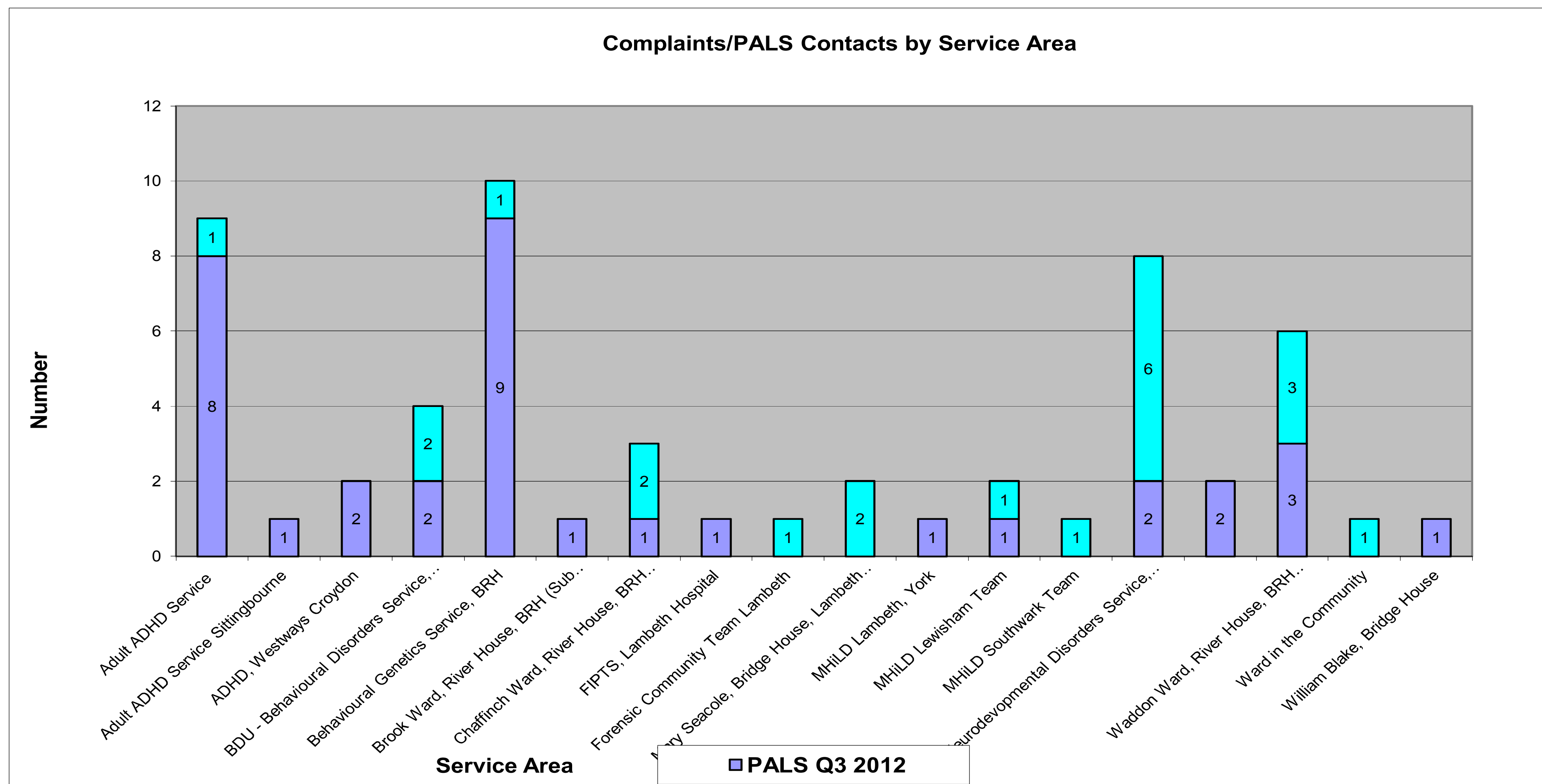
PSYCH/Q3/18/12 – Psychosis Community Service, South Southwark

As a direct result of the complaint, a review is being undertaken of the team's current referral system, particularly to the re-referral of people who have been known to the service in the past.

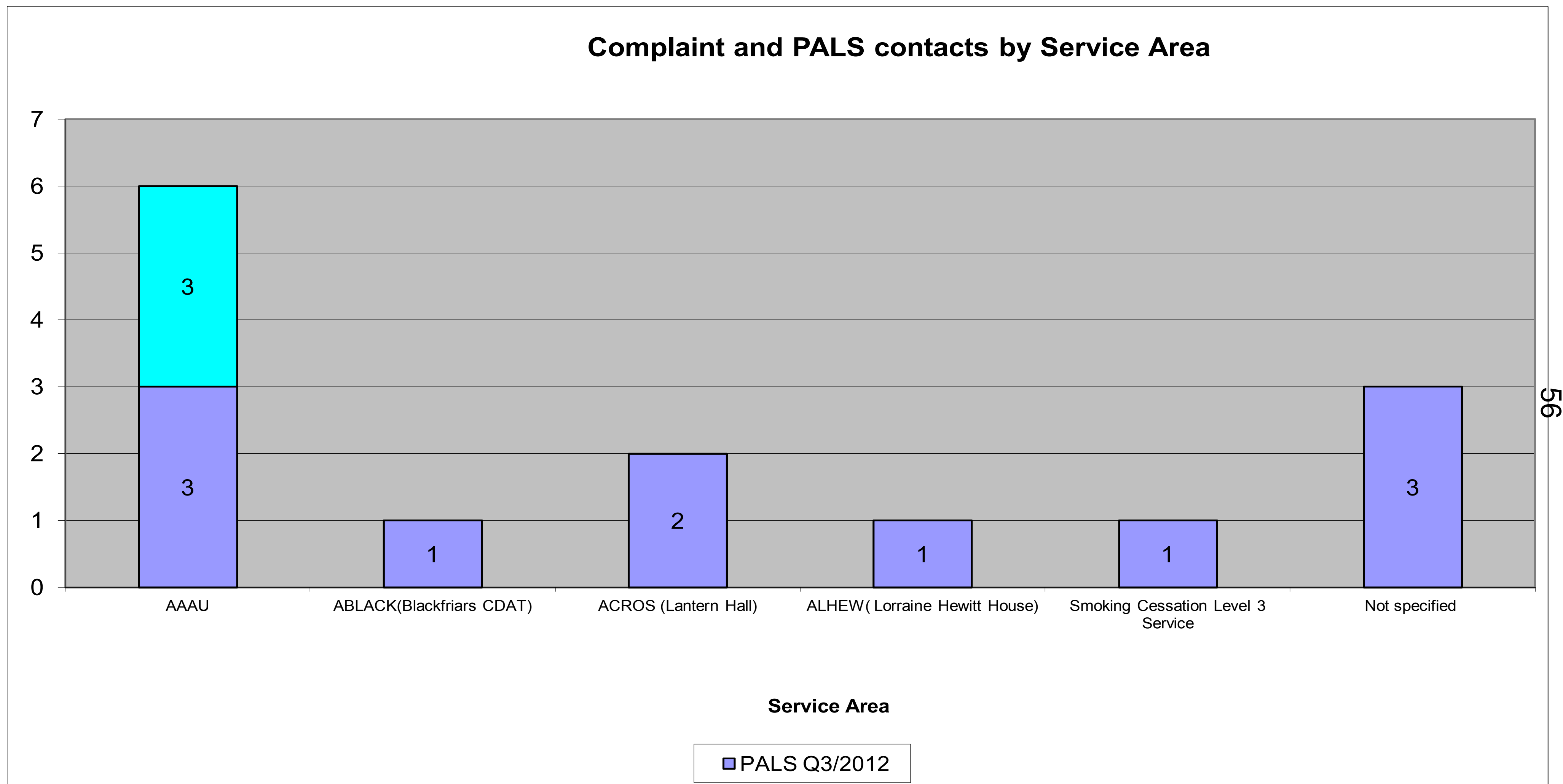
It has been agreed that the above improvements will be monitored and in some cases audited by the Clinical Governance Advisors. All the improvements and recommendations are also reported and monitored at the relevant Borough Complaints Monitoring Committees/Clinical Governance Committees

Appendix One

Behavioural and Developmental Psychiatry CAG Contacts Quarter 3 /2012



Appendix Two
Addictions CAG Contacts Quarter 2 /2012



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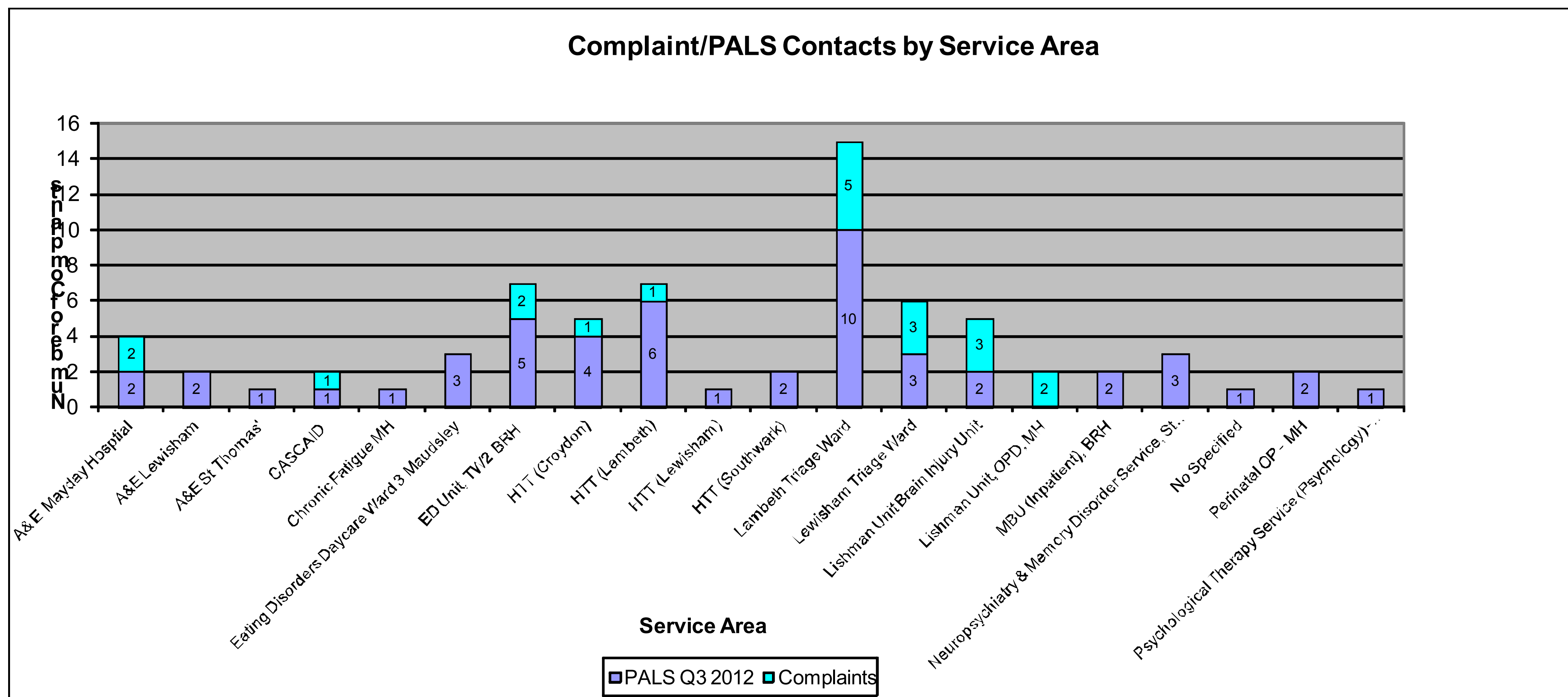
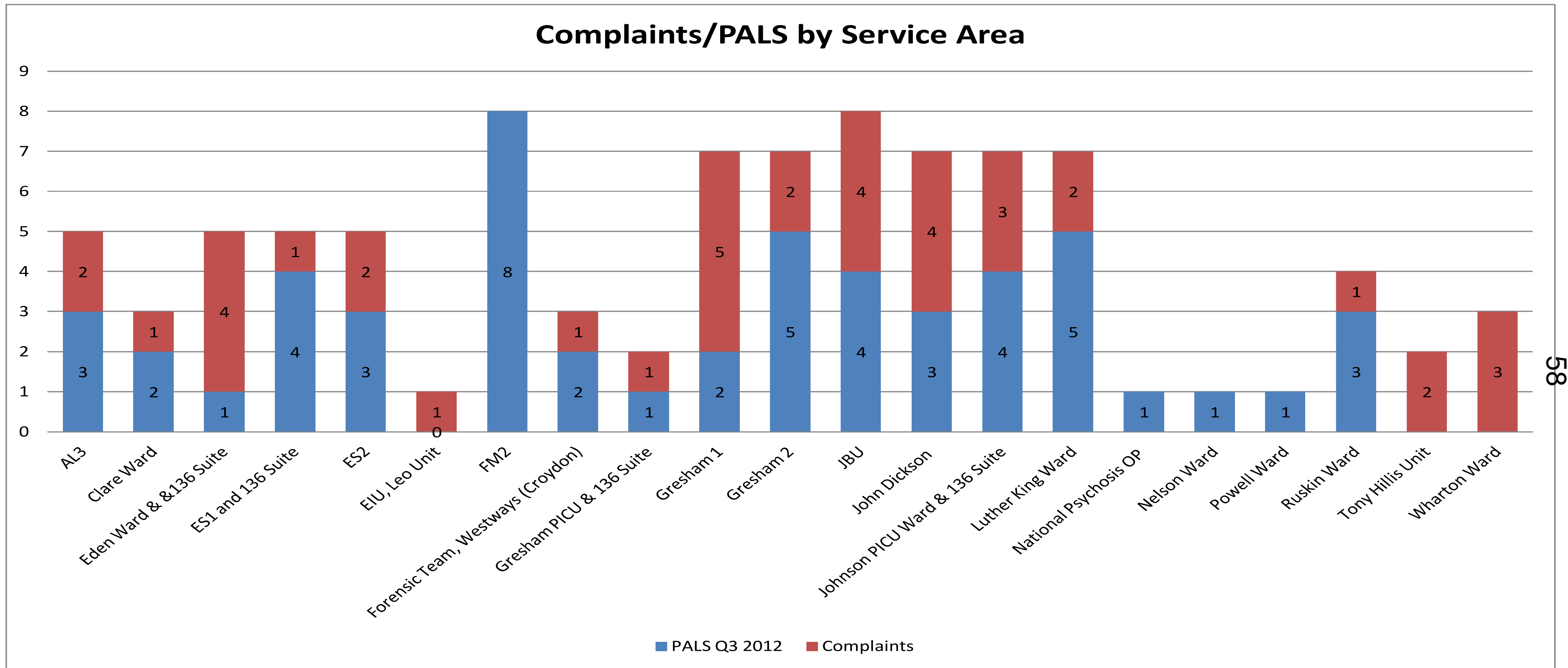
Appendix Three

Psychological Medicine CAG Contacts Quarter 2 /2012



Appendix Four

Psychosis CAG – Inpatient and Complex Care contacts Quarter 3 /2012



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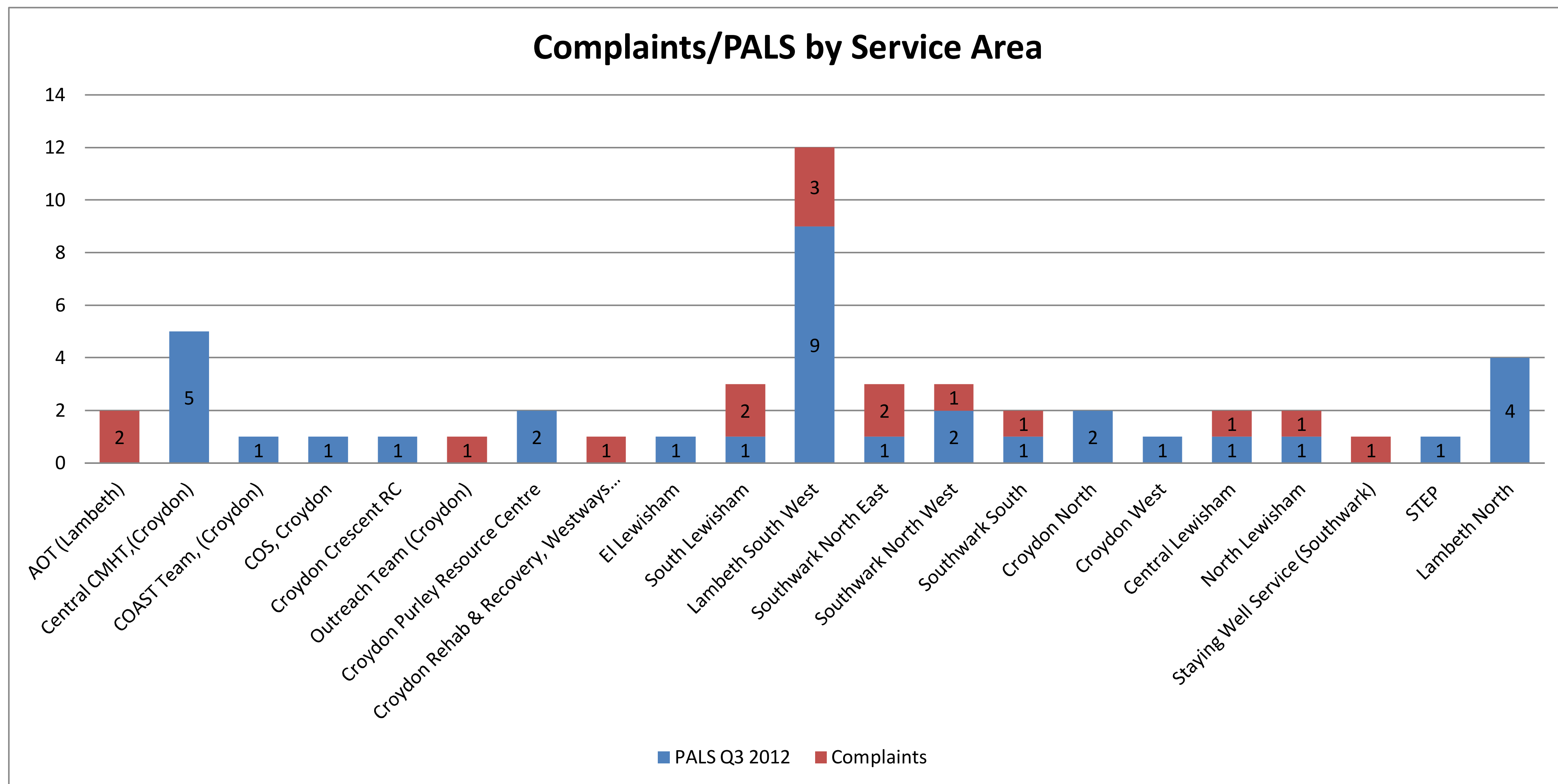
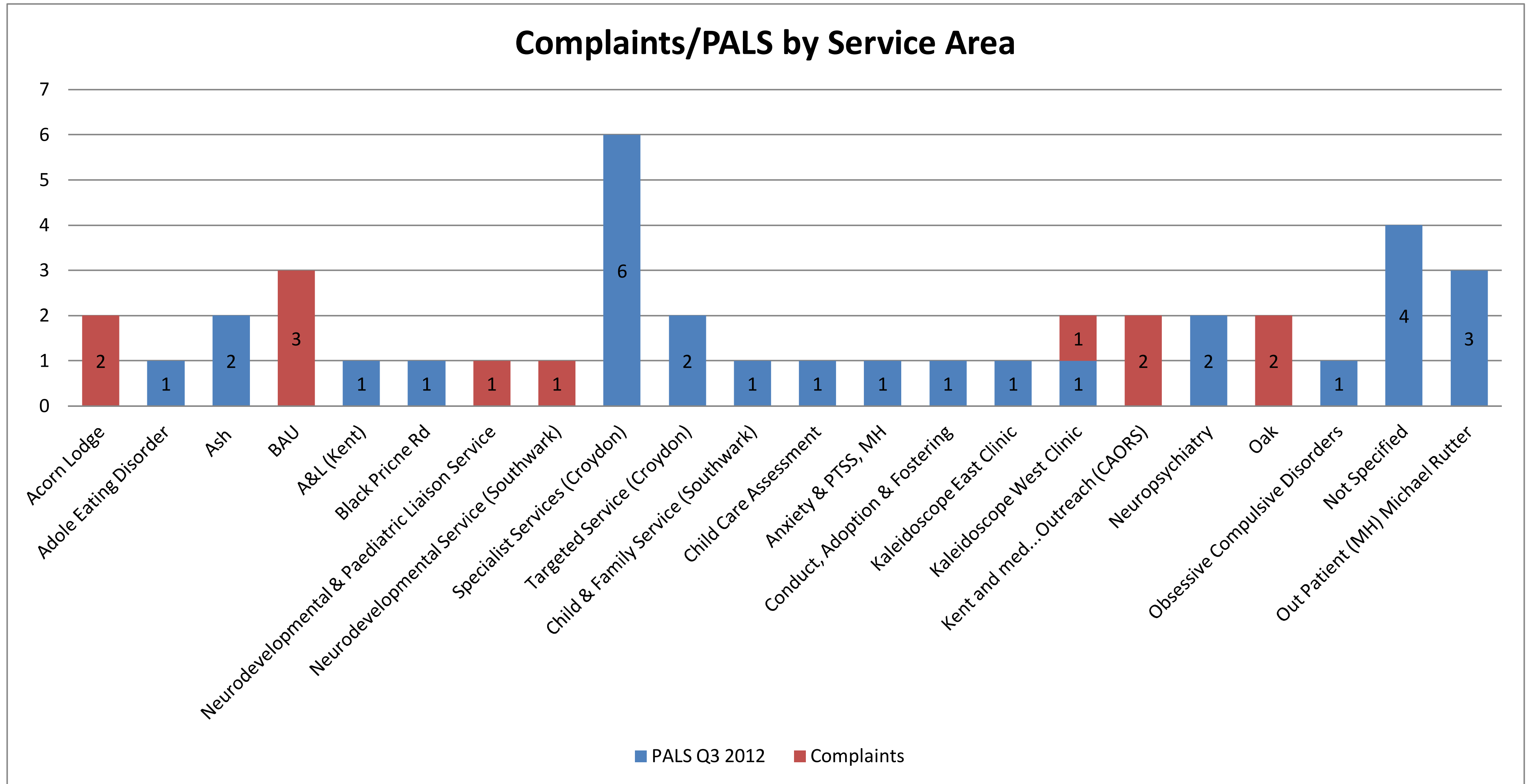
Appendix Five

Psychosis CAG – Community and Early Intervention contacts Quarter 3 /2012



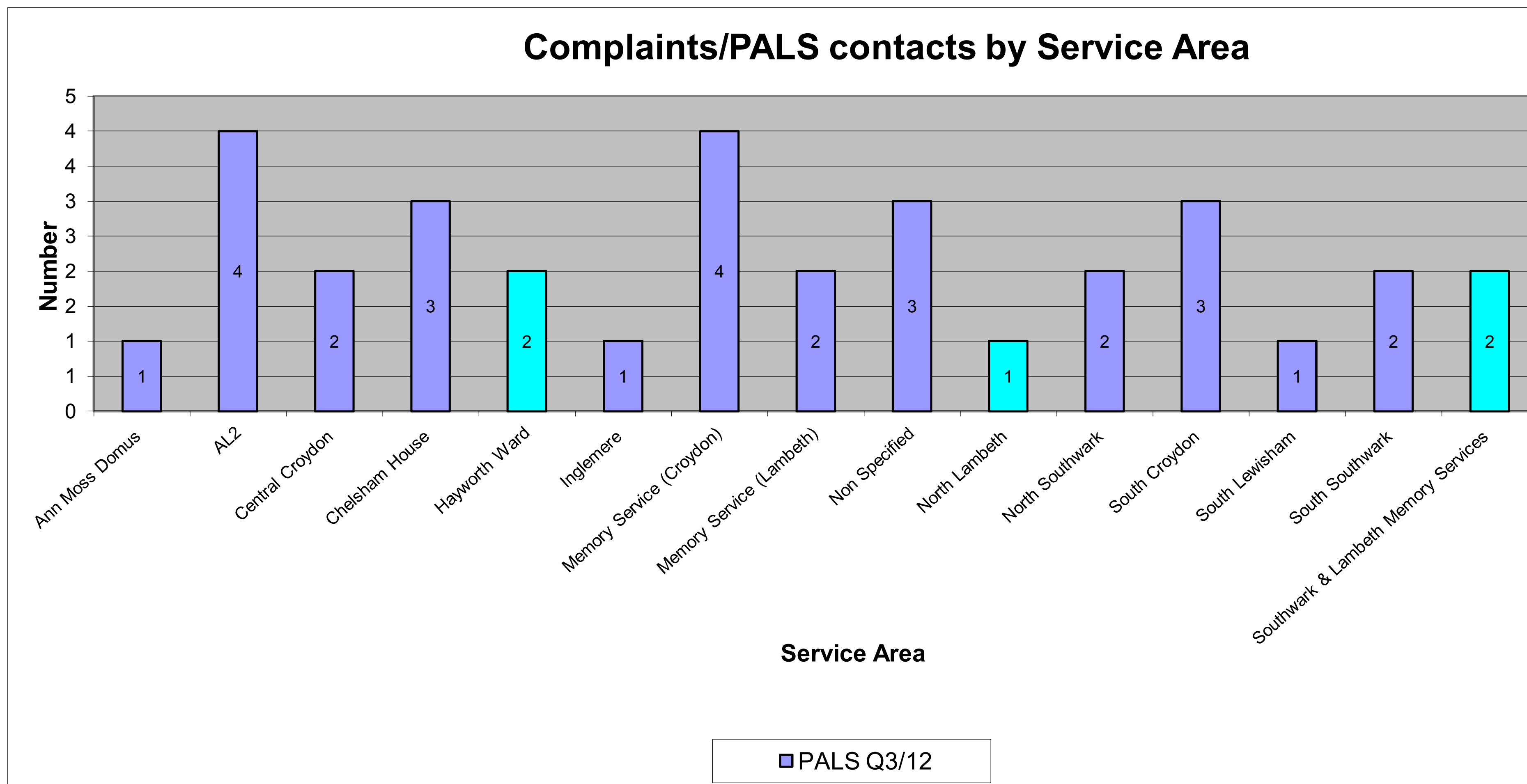
Appendix Six

CAMHS CAG Contacts Quarter 3 /2012



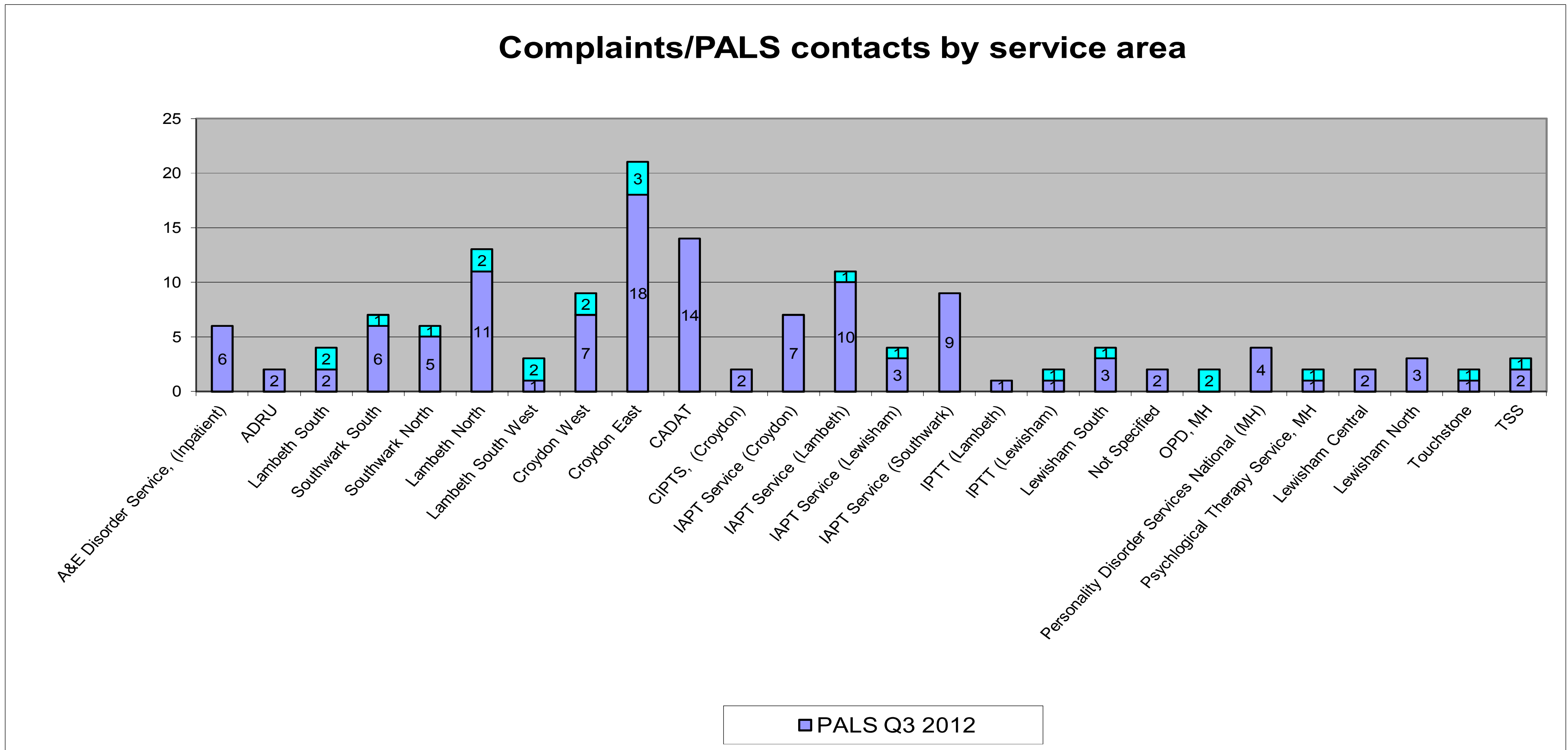
Appendix Seven

MHOA CAG Contacts Quarter 3 /2012



Appendix Eight

MAP CAG Contacts Quarter 3 /2012



King's College Hospital NHS
NHS Foundation Trust

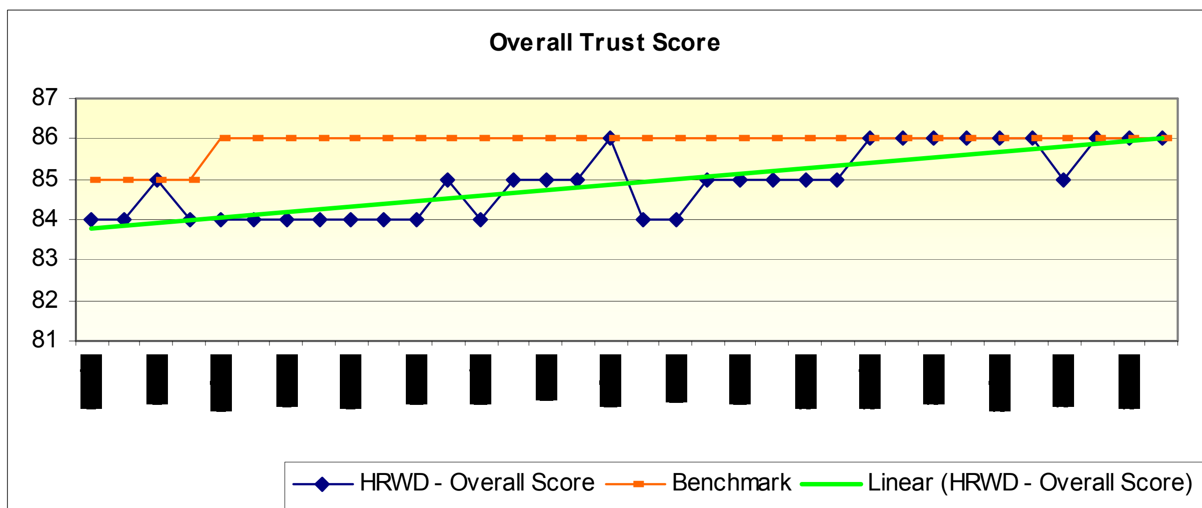
Complaints and PALS Report
Period April 2012 to February/March 2013.

1. Introduction

Delivering a quality service to our patients is one of the Trust's core strategic priorities - safe, kind and effective care.

King's has had a strong focus on improving patient experience over many years, and this continues to develop and evolve. There are well established mechanisms to capture the experience of patients, and drive ongoing improvement. These include the extensive 'How Are We Doing' patient feedback programme, use of information gathered through complaints and PALS, listening to patients through initiatives such as 'In Your Shoes' and patient stories and our growing volunteering programme. Over the course of a year, around 20,000 patients feed back to us on their experience of the Trust, both good and bad. All patient feedback is used to drive service improvement.

Over the last 2 years, patients' satisfaction with the experience of their care has improved steadily, as measured by the Trust's internal real time inpatient survey 'How Are We Doing' shown below.



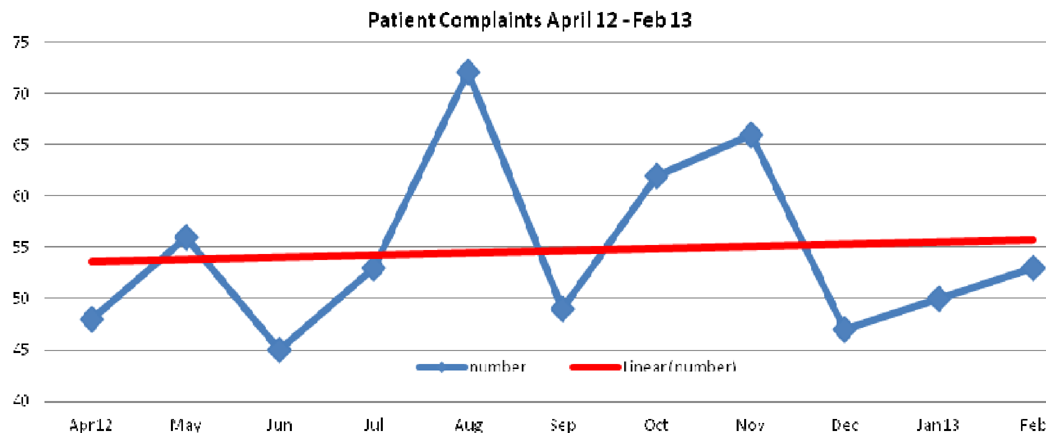
2. Reporting of and Handling of Complaints

Patient experience data, including complaints, is reported to the Board monthly, and more detailed trend information and analysis quarterly. There is a Trust monthly Patient Experience Report which integrates information about complaints with patient feedback from Patient Advice and Liaison (PALS), the How Are We Doing inpatient survey, and patient comments.

Complaints are received via a variety of different routes, from letter, email, telephone, to face to face contact. Complaints are acknowledged within 3 working days, graded for severity and passed on for investigation to the relevant Division. On conclusion of the investigation a draft letter is produced which is reviewed by the complaints department to ensure it answers all concerns raised and that it includes details of any action to be taken. All complaints are reviewed by the Chief Operating Officer and Chief Executive, and sent out under the cover of a personal letter signed by the Chief Executive. Both the Medical Director and Director of

Nursing review all complaints, which form part of the monthly performance management meetings for all Divisions, chaired by the Chief Operating Officer.

3. Complaints received April 2012 – February 2013



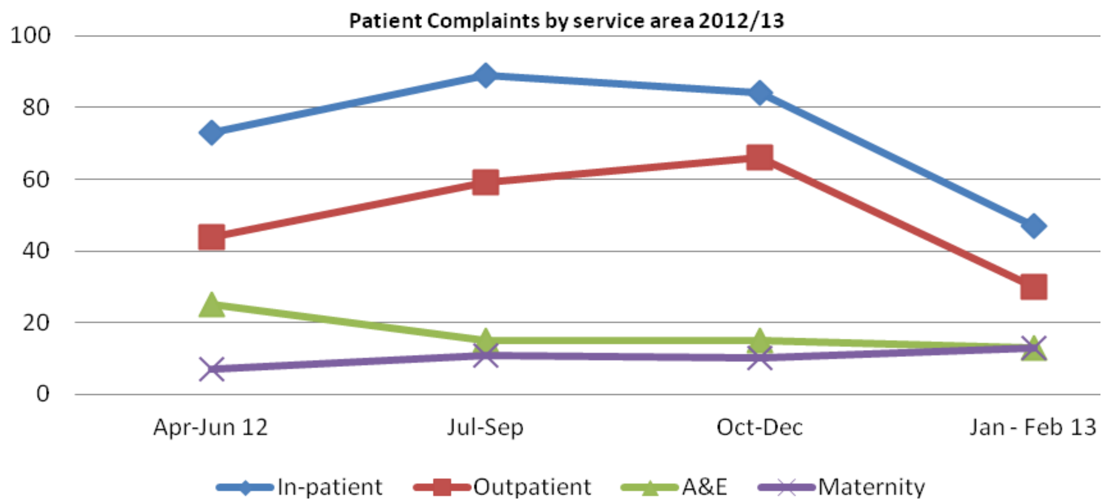
- 601 complaints received for the period April 12 – February 13 with a projected year end figure of 655. This compares with figures of 700, 560 and 590 in the preceding 3 financial years. This is against a background of significant increases in activity over the four year period.

- 52% of complaints received this year were responded to within the target of 25 working days. Performance is below the Trust's target of 70% with improvement noted since December 2012. The Trust's performance committee continues to monitor performance in responding to complaints.

- 3% of complaints were referred by complainants to the Parliamentary and Health Service Ombudsman. The PHSO investigated one case but did not uphold the complaint, and a further case is currently being investigated.

- 56% of complaints received YTD relate to an inpatient admission (including maternity) and 44% relate to outpatient services (including the Emergency Department).

- Maternity complaints for a consecutive year are at their lowest for many years, and ED complaints remain low relative to the significant and increasing activity within the department.



4. Causes of complaint:

As in previous years, complaints about clinical care and treatment are by far the highest cause of complaint (328), which is currently representing 55% of all complaints received. Other causes include:

- Staff attitude (58)
- Communication, written and oral (52)
- Admissions, discharge and transfers (39)
- Outpatient, delays and cancellation of appointment (35)

Main cause of complaint	2011-12	% of complaints	2012-13 (to month 11)	% of complaints
Admissions, discharge and transfer arrangements	34	6	39	6
Appointments, delay/cancellation (out-patient)	16	3	35	6
Appointments, delay/cancellation (in-patient)	37	6	26	4
Attitude of staff	56	9	58	10
All aspects of clinical treatment	335	57	328	55
Communication	41	7	52	9
Patients' privacy and dignity	13	2	16	3
Personal records (including medical and/or complaints)	8	1	10	2
Transport (ambulances and other)	17	3	13	2
Hotel services (including food)	4	1	3	0
Others	14	2	10	2

5. Grading of Complaints

All complaints are graded for severity by the Complaints team using the trust's Incident grading tool. All complaints that indicate an adverse incident may have occurred are flagged as a high priority for the investigating team and the Risk Management team are notified. This ensures senior review at the earliest opportunity to direct the required investigation and if necessary, Root Cause Analysis.

The table below illustrates the severity of complaints investigated since April 2012 which have now been closed. There were no very serious or red graded complaints. 16 (3%) were assessed as having significant issues, 132 (27%) with service or experience below reasonable expectations and majority (70%) with an unsatisfactory service or experience.

Grading of complaint	Total
Unsatisfactory service or experience	347
Service or experience below reasonable expectations	132
Significant Issues regarding standards, quality of care	16
Serious issues that may cause long-term damage	0
Totals:	**495**

6. Complaints Examples

Outlined below are some examples of complaints and how the Trust responded

Outline of Complaint	Outcome of investigation
Complaint – Example 1 Patient came to the Emergency Department (ED) with chest pain. He was assessed by several doctors and given a diagnosis of pericarditis (inflammation of the fibrous sac surrounding the heart) and discharged from the ED. He returned to ED 8 days later with similar chest pain but with increasing pain down the left side of his chest. He was further assessed and underwent some investigations and given a diagnosis of musculoskeletal pain. The patient was discharged with some medication and advised to visit GP. Patient felt he was not appropriately assessed and was given poor information about his condition.	The patients care was reviewed by an independent consultant. A review of the clinical notes and investigations confirmed that the patient had been appropriately assessed and on each occasion the attending doctor had obtained advice from senior doctors. Documentation confirmed that the doctors involved in the care had all given the patient appropriate explanations of his symptoms and did not make a diagnosis of pericarditis but one of musculoskeletal chest pain. A discharge notification letter to the GP was sent following the two attendances. The Trust apologised that the advice was confusing and that his care had been handed over from one doctor to another. It was explained that the review by more than one senior doctor was an important part of his care and safety in the ED.
Complaint – Example 2 Patient due to undergo an endoscopic retrograde cholangiopancreatography (ERCP). The patient developed a cold prior to the admission and was prescribed antibiotics by his GP. He was informed he would be assessed by the anaesthetists on the ward prior to proceeding with the ERCP. After an overnight stay it was recommended	The Trust apologised and agreed that the patient's experience was unsatisfactory. As a result of the complaint the patient was given assistance in rebooking the ERCP and liaised with the Consultant direct to minimise further inconvenience. In future, in the event a patient is in contact with the Trust prior to an

that the procedure should not go ahead. The patient complained that he should not have been advised to come to hospital which had caused inconvenience and worry.	admission, describing symptoms of a cold/flu, the advice of the anaesthetist will be sought. The patient replied saying "I did hope my observations and experiences would result in a proper investigation, and am pleased to note that not only have you looked into my complaint in some detail but as a result, have decided that improvements should be made".

7. Learning from Complaints

The Trust is committed to learning the lessons from complaints to drive service improvement both at a trust-wide and local level. Throughout the year complaints have fed into staff education and learning, reflective practice across multi-disciplinary teams and changes to local practice and procedures.

- **A patient complained after a portacath (medical device under the skin) had been fitted which was not correctly flushed and dressed and the patient developed complications.**

  The Trust apologised and has reviewed its policy for insertion of femoral lines. A protocol for administering portacaths has been written and distributed to staff with associated training.

- **Delay in informing patient that lump (from lip) which was biopsied was cancerous – delay in referral to oncology team at GST.**

  King's and GST have worked closely to establish a new care pathway for all patients with rubbery lumps in and around the mouth. It is designed to ensure that, until proven otherwise, they are considered salivary tumours and biopsied by fine needle aspiration prior to any treatment plans being put in place.

- **The incorrect interpretation of a limb x-ray led to a child being discharged home from the Emergency Department (ED). The x-ray was later reviewed by the consultant and a double fracture diagnosed. The parents were contacted and the child was brought back to ED.**

  There is a joint ED/radiology project underway to review the x-ray reporting process. All ED doctors have been reminded to seek specialist opinion from radiologists before patient leaves the ED if they are unsure about the findings.

8. Patient Advice and Liaison Service (PALS)

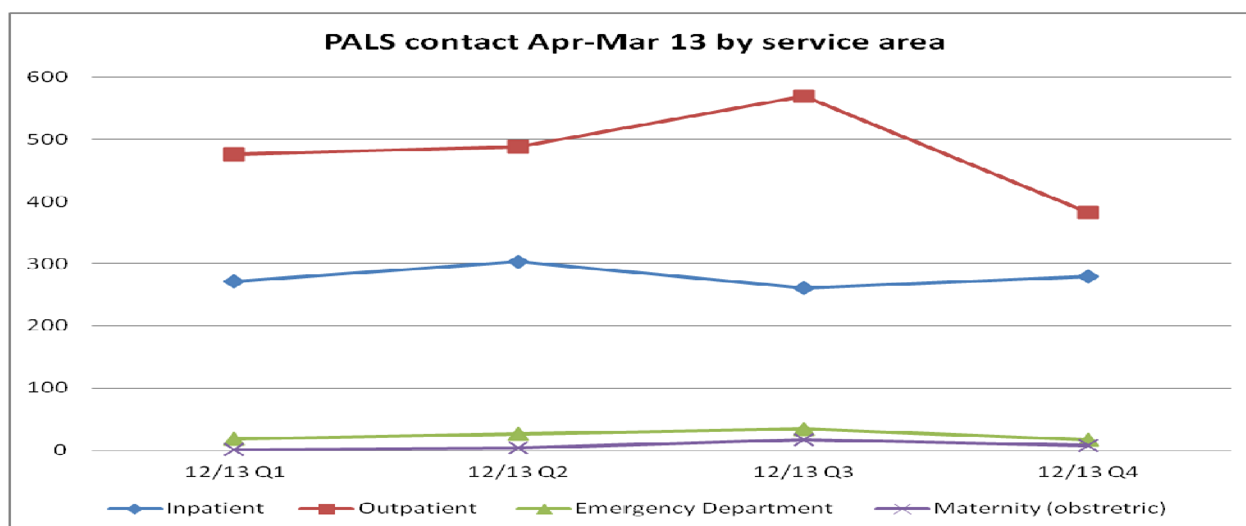
PALS provides a face to face, confidential service, accessible in the hospital main entrance. It often acts as the first point of contact for a patient or visitor to raise a concern. Contact can be made in person, by telephone, dedicated PALS email address and through a general enquiries email contact from the hospital website. The Hospital switchboard and other staff signpost patients and visitors to PALS. Contacts are also made through the "How are we doing" in-patient survey, Trust comment card feedback and external posting on websites such as NHS Choices and Patient Opinion.

The PALS service acknowledges contacts within 24 hours and aims to provide a response to “simple” concerns within 5 working days (these would include issues such as appointment or admission enquiries). More complex concerns which involve contact with a number of staff may require individual negotiation regarding a timescale for response.

The Head of PALS and the Head of Patient Complaints are co-located and work collaboratively. Where concerns discussed with PALS raise serious care concerns, complex issues which would require a significant amount of investigation, or allegations regarding staff behaviour, PALS will refer to Patient Complaints Procedure as the more appropriate method of investigating and responding to these concerns. In the rare event of a potentially serious adverse incident being reported to the PALS team, the issue will immediately be escalated to the Head of Patient Safety. There will also be occasions when the agreed PALS interventions or actions fail to achieve the desired outcome and the issue will be escalated to the Complaints team.

8.1 PALS Activity

A wide range of information and guidance is sought from PALS. The contacts documented for reporting purposes only represent contacts where significant support and assistance has been sought to resolve a problem or concern. In the period April 2012 to March 2013 there were 3161 PALS contacts.



During 2012/13, as in previous years, there were high numbers of contacts about outpatient appointment processes handled by the PALS team. Difficulties experienced include:

- contacting appropriate appointment staff
- identifying the progress of a GP referral
- seeking information about waiting times for appointments,
- concerns regarding cancellations and rescheduling.

One Division experienced particular delays in the processing of spinal surgery referrals affecting a large cohort of patients. The administration process for that referral pathway has been redesigned to minimise delays for future patients. The position is being closely monitored.

There were similarly enquiries about the inpatient admissions process for surgical patients. Enquiries can begin when patients are still in other Trusts awaiting transfer to a King's specialty bed. Elective surgical admission patients require information about length of waiting lists, delays, cancelling and rescheduling of admission dates. Winter bed capacity issues have exacerbated these issues.

In comparison to outpatient and inpatient activity, there are relatively few contacts relating to attendance in the Emergency Department or Obstetric wards. These are more likely to be registered as complaints when an episode of care has concluded as there is less opportunity for PALS to resolve a problem in an acute presentation.

8.2 Main causes of PALS contacts.

The profile of contacts in 2012-13 is broadly similar to that of the previous year.

Main cause of PALS contacts	2011-12	% of PALS contacts	2012-13 (to month 11)	% of PALS contacts
Discharge Arrangements (general)	166	6	133	4
Equipment, environment and facility	42	1	40	1
Waiting times - outpatient (general)	435	15	506	16
Waiting times - inpatient (general)	224	8	276	9
Staff Attitude	187	6	191	6
Dissatisfaction with clinical care	276	9	296	9
Communication	1303	44	1485	47
Privacy and Dignity	15	1	14	0
Patient property (lost or damaged)	54	2	48	2
Patient records	107	4	59	2
Transport	85	3	76	2
Hotel Services	21	1	5	0
Additional categories	36	1	17	1

Communication
In addition to requests for information about clinical care plans, appointments and hospital admission patients describe experiencing other communication difficulties. The quality of communication and documentation in some areas is criticised and poor experiences when trying to make telephone contact with hospital staff and departments are a common theme.

Communication themes	Number of PALS contacts
Information relating to care plan/ treatment	455
Information re: outpatient appointment	267
Information re: admission	152
Quality of communication / documentation	132
Unable to contact DDI or dept - no response	104
Information	94

Referral letter not written/ sent / received	56
Positive patient comments	56
Difficulty obtaining results	49
Outpatient appt / cancellation correspondence	38
Waiting time/cancellation for outpatient appointment	20
Waiting list delays for elective admission	18
Staff attitude	15
Telephone message not responded to / call not returned	15

8.3 Examples of PALS cases

Theme	Description of case	Outcome of case
Outpatient referral	Patient chasing the outcome of a referral from Consultant at another Trust for a diagnostic intervention	Identified that referral received as patient registered. Contacted department and told referral with Consultant. Contacted Consultant who confirmed delay and apologised. Details of appointment conveyed to patient. Consultant has written to confirm arrangement to referring Consultant (copied to patient)
Cancellation of admission for surgery	Patient very distressed as clinically prioritised as urgent. Concerned at lack of clarity regarding re-scheduled admission date. Required medical advice about drugs taken in preparation for her surgery which were causing side effects.	In view of situation PALS contacted Consultant directly. Admission re-scheduled for following week and advice given regarding medication.
Patient's father felt confusing information was given about his baby's condition	Father of baby unhappy with visit to Emergency Department where he feels conflicting/ unclear advice offered by medical teams.	With consent of father, PALS contacted Paediatric Specialist Registrar. Telephone discussion was arranged between Registrar and father to explain medical terminology and care plan on attendance. Intervention did not resolve father's concerns who also requested financial redress for a wasted journey. Escalated to a formal complaint.
Dissatisfaction with hand washing procedures and	Concerned that hand washing measures were not as robust on new ward. Issue with room	PALS outlined the patient's concerns to the Matron responsible for

ward environment when patient transferred between wards.	temperature not being adequately maintained and broken shower.	area. Meeting arranged between Matron and patient and his wife to discuss and resolve concerns. Facilities contacted and asked to review heating issue. Fed back that fault and broken shower had been repaired.
Patient arrived at outpatient consultation to be told that the doctor sick and appointment cancelled.	Patient unhappy that there had been no attempt to notify her of the unexpected sickness absence. The patient had travelled with partner at cost of £17. Will be difficult to re-attend because of joint work commitments.	PALS contacted Service Manager. It was acknowledged that there had been a delay in communicating the doctor's absence to patients and could have been handled more effectively. Agreed to reimburse travel costs. PALS contacted the doctor on returning from sick leave. Special arrangement made to see patient at end of clinic to minimise work inconvenience and seen within a week.

8. Recommendation:

The Overview and Scrutiny Committee is asked to note this report for information/discussion.

Jane Walters & Judith Seddon **25 March 2013**

NHS Southwark

PALS AND COMPLAINTS REPORT April 2011-March 2012

As of the 1 April 2011, Southwark Provider Services transferred to Guy's and St Thomas' Foundation trust (GSTT) therefore any PALS enquiries or Complaints received about the services they provide are redirected to the PALS or Complaints teams within GSTT. There were two outstanding cases at the time of transfer of the services, one involving children's services, which was resolved and one which was a combined complaint involving both a GP practice and the district nursing team. This complaint was signed off in July 2011.

There were significant changes in the complaints and PALS team. The two PALS and Complaints Managers posts were combined into one post, and one Complaints Officer's post was deleted. NHS Direct served notice on the contract to run the PALS helpline, so this service was brought back in-house. Both Complaints and PALS cover Adult Social Care, which is not reflected in other complaints departments elsewhere.

1 Patient Advice and Liaison Service Activity

The PALS helpline, on 0800 5877 170, has been provided within NHS Southwark since 1 April 2011, initially for two hours a day (10 am-12 noon), but the hours were extended from 1 July 2011 to five hours a day (9.30 am-12.30pm and 2pm-4pm). This is answered by a dedicated officer. Over the last year there have been 1,700 enquiries to the helpline.. Some of the enquiries involved straight forward signposting for the service user, and others involve more time spent on them and greater interaction with the enquirers eg assistance with GP registration, practice opening times, prescriptions and appointments.

PALS enquiries can also arrive via email or direct to the office (letter or in person). Of all the enquiries received by the various routes mentioned 444 were more involved. The table below provides a break down of the services. There were 183 GP enquiries that needed casework, 37 dental enquiries, three pharmacy enquiries and two regarding SELDOC.
The good local knowledge and experience of the staff providing this service has provided both contractors and service users with a valuable resource over the last year and on occasions has helped deflect enquiries from becoming complaints.

1.1 Casework

Service	Q1	Q2	Q3	Q4	Total
GPs	41	46	53	43	**183**
Dental	7	9	11	10	**37**
Commissioning	6	6	2	2	**16**
Patient Services	6	12	4	1	**23**
Mental Health	2	4	0	1	**7**
Pharmacy	1	1	0	1	**3**
Optometry	1	1	1	0	**3**
Total	**64**	**79**	**71**	**58**	**272**

1.2 PALS in King's College Hospital Emergency Department (ED)

PALS provides a service within King's College Adult ED , five days a week. PALS was present in ED for 225 days last year. The role of the PALS officer is to support the redirection to

NHS Southwark

General Practice of patients attending ED with a Primary Care need. The PALS officer works closely with the “Meet and Greet” triage team. This team is run by senior ED nurses with advanced assessment skills who identify service users who may not require attendance at ED but can be safely redirected to other services eg GP or walk-in-centre. When the “meet and greet” triage team system is running, the PALS officer works along side the triage nurse for part of the day. When the “meet and greet” team is not in place, reception will refer patients to PALS. On these occasions the number of patients referred to PALS will be dependent on the knowledge base and experience of the individual staff on reception.

During the last year 3, 225 patients were seen by the PALS officer in the ED, and 702 of those patients were redirected to services outside hospital.

The table below provides a break down of the figures

April 2011 to March 2012	Total Patients Seen	GP Information (1)	GP Details (2)	Return to ED (3)	Redirected to GP services	Referrals to other services
1st quarter	876	347	297	05	80	147
2nd	768	271	328	03	71	95
3rd	755	273	340	14	88	40
4th	826	343	292	10	127	54
Total	**3225**	**1234**	**1257**	**32**	**366**	**336**

(1) – Patients who were given information/assistance leading to GP registration.
(2) – PALS provided correct GP details for patients who were unsure of their GP details or status (registered or not)
(3) – Patients that could have been discharged but that PALS was unable to arrange same day appointments for and who were then seen in ED.

Total patients seen: 3,225

Total patients redirected to GPs and other services: 702

Total patients seen by PALS who were not booked in: 619 (39 patients came to ED for GP registration)

NHS Southwark

2. COMPLAINTS REPORT

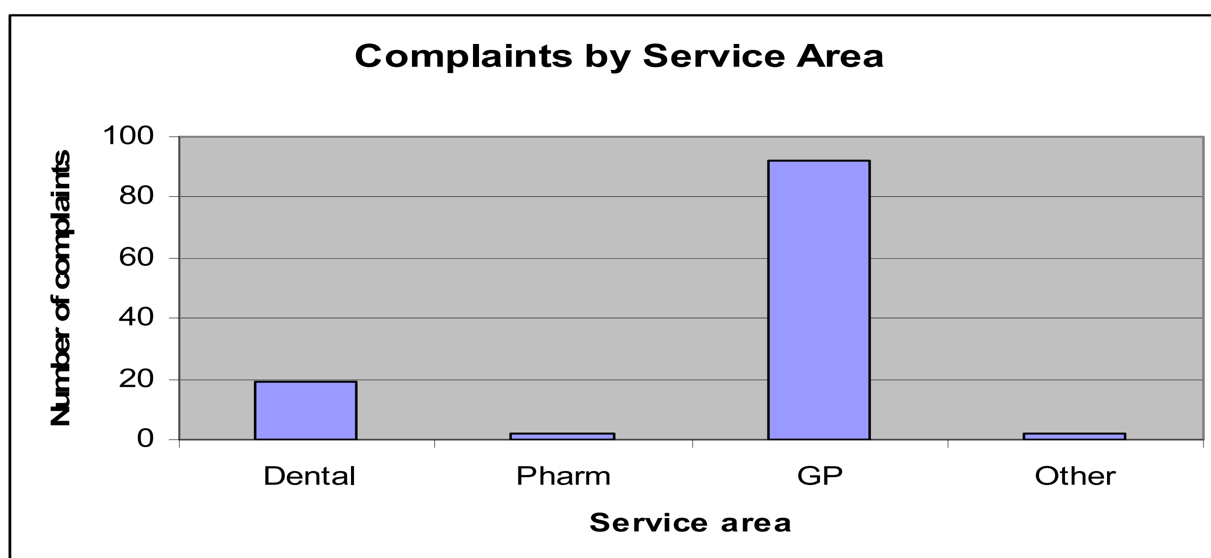
NHS Southwark received 117 (compared to 97 in the previous year) formal complaints from 1 April 2011 – 31 March 2012 relating to services within Southwark Of the complaints received 92 involved General Practices (GPs – 78 in the previous year)), 19 involved Dental Practices (12 in the previous year) and two about pharmacies (four in the pervious year). There were 4 other complaints: one about the Walk in Centre, one about SELDOC (two in the previous year) and two about community outpatients: Ear Nose and Throat (ENT) and one about dermatology. This is an increase on the 97 complaints received in the previous year. The majority of the complaints received were related to general practice.

2.1 Independent Contracted Services

The contracted complaints received for each quarter is in the table below:

Quarter	Q1	Q2	Q3	Q4
Number of Complaints	33	30	21 (incl 2 about community outpatients)	33

Table 1 Complaints by service providers



Of the General Practice complaints, there were several practices that received more than five complaints. A GP practice in the south received nine complaints, a GP practice in the North received eight complaints, another GP practice in the North received five complaints, another GO in the South received four complaints and three further all received three complaints

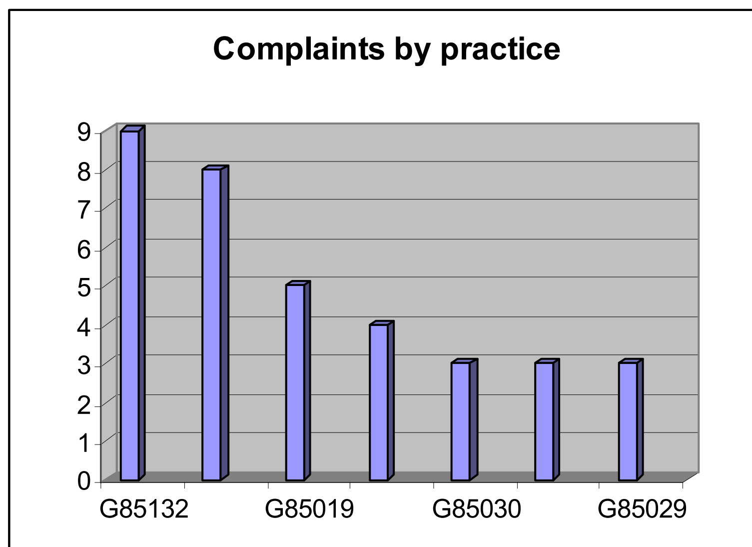
No Dental Practice received more than two complaints in the year

The Complaints team worked closely during the year with the members of the Issues of Concern team at NHS South East London . There continued to be concerns related to a GP

NHS Southwark

practice in the North regarding the failure to acknowledge or respond to complaints. This concern continues at the time of writing this report as the problem has not yet been suitably resolved.

Table 2: Complaints by practice



The above complaints are either where the complainant has chosen to copy us into the initial complaint directed to the practice, or have chosen to write direct to us with the complaint. If it is the latter, consent is required from the complainant to share the information with the practice. The complaints team do not actively become involved in managing complaints once they are forwarded to practices apart from to chase up responses, confirm that responses answer the complaint.

The complaints team can become more actively involved where more serious issues are identified and liaises with the primary care directorate at the NHS South East London where there is repeated failure to answer complaints and also liaises with the Medical Director for serious clinical concerns. In both of these latter cases the BSU / NHS South East London may choose to investigate the complaint directly rather then refer back to practice.

2.2 Subject of complaints

The most frequent causes of complaint were “clinical treatment” and communication/information to patients. Other notable categories were “appointment systems” and “Attitude of staff”.

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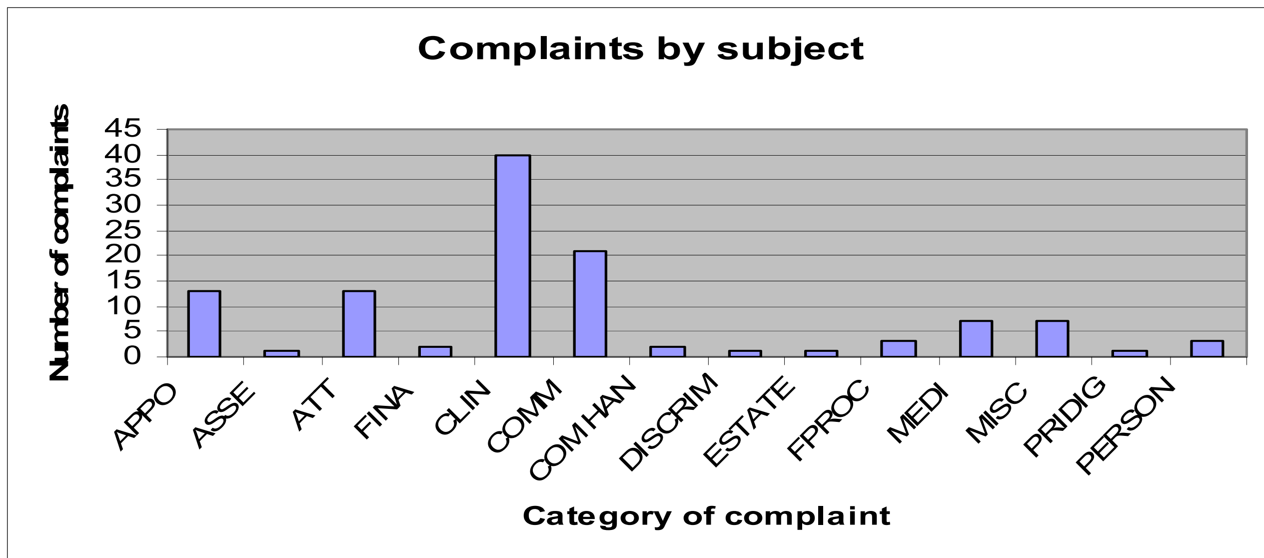
Table 3: Subject of Complaints



Key
APPO=Appointments; ASSE=Assessments ; ATT=Attitude; FINA = Financial Cost of treatment, CLIN=Clinical; COMM=Communication; COMPHA=Complaints Handling; DISCRIM = Discrimination, ESTATE=Premises; FPROC=Failure to follow procedures; MEDI = Medication, OTHER=Miscellaneous, PRIDIG = Privacy and Dignity, PERSON – Personal

2.3. Annual Complaints Return

GPs and Dentists are required to report to us annually on the numbers and areas of the total complaints they receive. These figures are submitted to the Department of Health as the KO41b return. The number of complaints submitted via KO41b for the dentists in 2011-2012 was 70 (down from 136 the previous year) and the number submitted by General Practice equalled 399 (a rise from 359 recorded for the previous year)

The tables below denote the figures for both groups of contractors.

KO41(b) Return	Comms /Attitude	Clinical	Other	Surgery management	Premises	Total
GP Practices 2010-11	131	118	44	63	3	**359**
GP Practices 2011-12	99	130	35	58	4	**399**

It should be noted that although the number of complaints referring to attitude or communication had reduced in GP practice , there was an increase In the number of clinical complaints reported.

KO41(b) Return	Comms /Attitude	Clinical	Other	Surgery management	Premises	Total
Dental Practices 2010-11	41	41	27	19	8	**136**

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Dental Practices 2011-12	15	24	12	9	1	**70**

It should be noted that there was a significant reduction in the amount of complaints reported about dental practices during this year.

2.4 Trends in Complaints Handling

It should be noted that we have previously reported on provider response times, so this is the first time we have reported on independent contractor handling of acknowledging complaints and response times. 100% of the complaints received by the BSU complaints team were acknowledged within three working days, which is a statutory requirement. All independent contractors are required to have their own complaints process in place and acknowledge complaints within three working days.

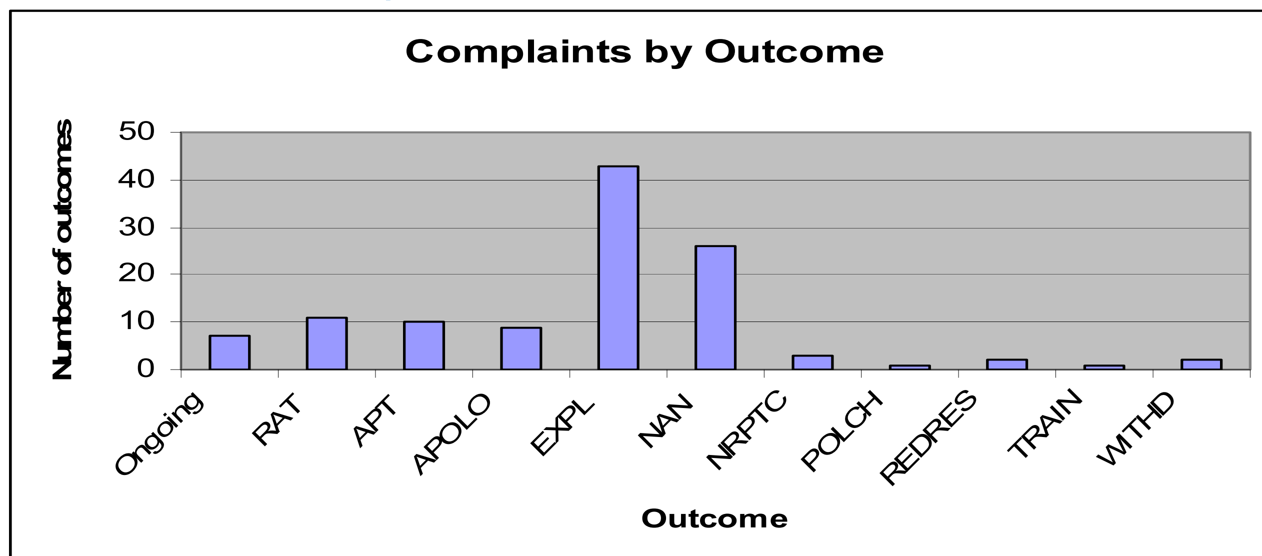
Although there are no statutory requirements in place for when a practice needs to respond to a complaint, other than the statutory six month timeframe, provided they keep the complainant informed, it is considered good practice to have a target date by which time the response should be sent.

Previously for the provider services there was a locally agreed time of 25 days, and we have set the same as a benchmark for complaints handling when we are aware of complaints that have arisen with independent contractors. In the past year 54% of the complaints have been responded to within 25 days.

2.5 Outcomes

The outcome of the complaints in many cases led to explanations (see table below). Although the number of apologies recorded is lower than explanations it would be expected that an apology is an integral part of the explanatory process, however this may not always be the case.

Table 4: Outcome of Complaints



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Key to table

ONGOING = Ongoing, RAT=Requested action taken; APT = Action Plan, APOLO=Apology; EXPLAN=Explanation; NAN=No action necessary; NRPTC = No Response from Practice to Complaint, POLCHN = Policy Changed, REDRES = Redress, TRAIN=Training; WITHD=Withdrawn

2.6 Complaints about commissioned services

There were very few complaints with regards to commissioned services over the year. There was one about the community ENT clinic, which also involved the referral pathway and one about a member of the clinical staff in one of the community Dermatology clinics.

2.7 Requests for an Independent Review from the Parliamentary and Health Service Ombudsman (PHSO)

There were three cases that progressed to PHSO, two concerning dentists, and one about deregistration of a patient from general practice. The two regarding the dental cases were both halted by the PHSO, one because there was a greater chance of local resolution as the dental practice had changed hands. In the other dental case the PHSO decided not to pursue the investigation, but did not provide a reason.

At the time of writing this report the one case concerning the deregistration is still under investigation by the PHSO.

One case that had been open at the end of the previous year was closed during this period. The complaint had involved a failure to diagnose and had involved both an acute provider, a GP practice and the PCT. The PHSO upheld the complaint on all accounts.

2.8. Future Developments

As from 1 April 2012, NHS Southwark Clinical Commissioning Group will have a statutory complaints function for the services it commissions. The CCG will purchase this function form the NHS South London Commissioning Support Unit. The NHS Commissioning Board will have a statutory function for the services it contracts such as GPs, pharmacy, dental and opticians.

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Southwark Clinical Commissioning Group

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PALS AND COMPLAINTS REPORT 1 October 2012- 31 December 2012

1 Patient Advice and Liaison Service Activity

The PALS Helpline is now provided in-house and is provided from 9.30 am – 12.30 pm and 2 pm – 4 pm.

The total number of enquiries the PALS Helpline dealt with in this quarter was 381, down from 436 in the previous quarter.

Of the 381 Helpline cases, 101 were straightforward signposting and 280 required more detailed information on a range of issues including GP registration, medication issues, dental charges and clinical treatment. Overall numbers of enquiries through the different PALS routes (helpline, email and direct to the office) amounted to 455.

1.1 Casework

110 of the PALS enquiries required case work. Of the 110 cases, 36 came from the Helpline, 71 via email and three directly to the office. Cases are enquiries where some investigation is required beyond information giving. A case may, for example, involve patients requesting immunisation records, individual funding requests or treatment abroad.

Below is a table of the cases logged for services:

	Oct	Nov	Dec	Total
GP*	30*	13*	12*	**55**
Dental	4	2	3	**9**
Pharmacy	2	2	0	**4**
Optometry	0	0	0	**0**
IFR	4	0	0	**4**
Treatment Access Policy	0	0	0	**0**
Commissioning	0	1	0	**1**
Patient Services	1	2	1	**4**
Community services	4	3	3	**10**
Miscellaneous	3	4	7	**14**
SELDOC	0	0	0	**0**
Acute	1	4	0	**5**
FOI	1	2	1	**4**
Total	**50**	**33**	**27**	**110**

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* GP breakdown	Oct	Nov	Dec	Total
Registration Issues	12	6	1	19
Access-appointments, phone	4	1	2	7
Clinical inc. medication	6	4	2	12
Other	8	2	7**	17
Total	30*	13*	12*	55

****3** of these were advice about making a complaint about the practice.
1 was positive feedback about their experience at the practice.

1.2 PALS in King's College Hospital Emergency Department (ED)

Until 30 September 2012 Southwark Business Support Unit had one PALS officer based in the adult Emergency Department at King's five days a week. The role of the PALS officer was to support the redirection to General Practice of patients attending ED with a primary care need. As from 1 October 2012, this ceased to be a NHS Southwark provision as the service TUPE'd over into Kings College Hospital.

2. COMPLAINTS REPORT

2.1 Independent Contracted Services

Southwark received 32 formal complaints from 1 September 2012 – 31 December 2012 as opposed to 29 during the previous quarter. Two complaints related to Commissioned services -one complaint related to SELDOC and the other related to care received at the Lister Walk in Centre (still awaiting consent to share).

Of the other two non-Primary Care Independent Contractor complaints received one related to an individual funding request (IFR). The other one was a highly complex complaint received which crossed organisational boundaries. It involved primary care, community, intermediate care and adult social care. Because of the complexity of the complaint it was agreed by all organisations that each of the responsible services should respond, but that the handling of the complaint would be co-ordinated by the NHS Southwark Complaints Manager. This was agreed by the complainant.

At the time of writing the report the complainant has received responses from Southwark Council and Primary Care. Community and Intermediate Care still have to respond. The complainant is regularly updated with the progress of the investigation by the NHS Southwark Complaints Manager.

Of the 28 remaining complaints, 25 related to GP practices, two related to Pharmacies and one related to a Dental Practice.

Six complaints out of the 32 complaints received in the quarter were not investigated-four regarding GP practices, the Dental practice and one of the pharmacies did not proceed as we never received consent to share the complaints.

Southwark Clinical Commissioning Group

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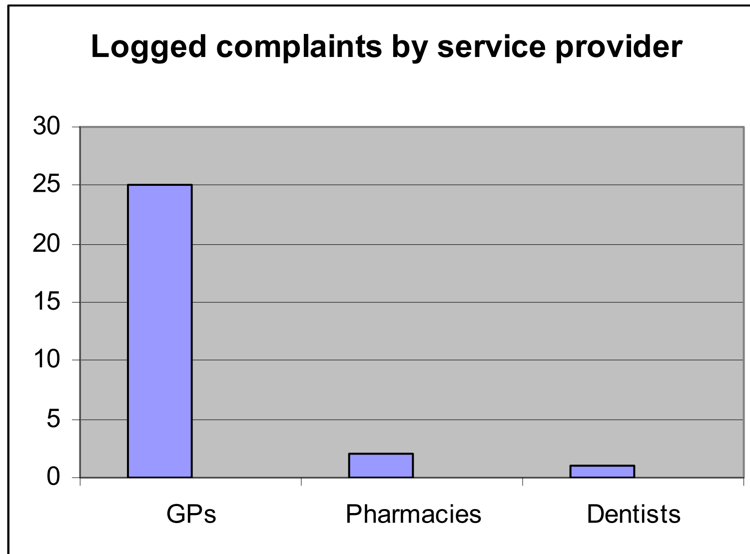
Six complaints (five investigated) were concerning one particular practice, specifically relating to problems accessing appointments and the attitude of staff. One other practice received five complaints (four investigated) which mainly related to staff attitude, clinical care and appointments. Over the last few quarters we have had increasing problems receiving acknowledgements and responses from the latter of these two practices.

Table 1 Logged complaints by service providers



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The complaints team can become more actively involved where more serious issues are identified and liaises with the primary care directorate at the NHS South East London where there is repeated failure to answer complaints and also liaises with the Medical Director for serious clinical concerns. In both of these latter cases the Southwark/ NHS South East London may choose to investigate the complaint directly rather then refer back to practice. The complaints team may co-ordinate complaint responses when they are about more than one service or a GP and another service.

GPs and Dentists are required to report to us annually on the numbers and areas of the total complaints they receive. These figures are submitted to the Department of Health as the KO41 return in April of each year

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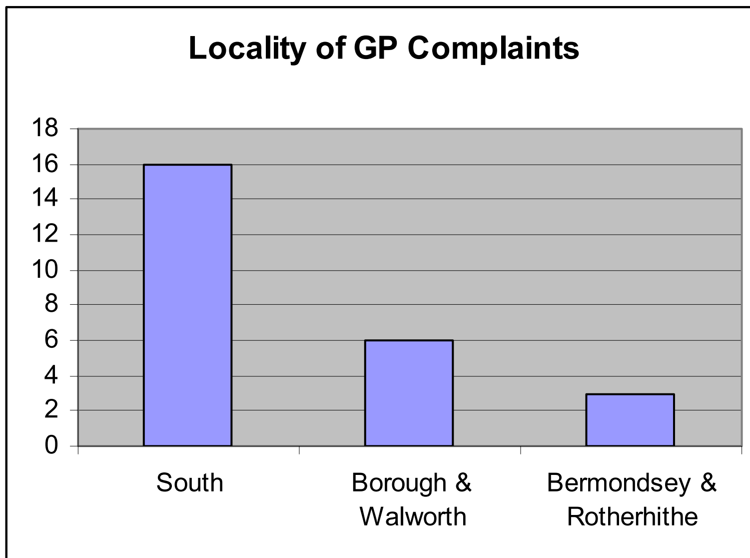
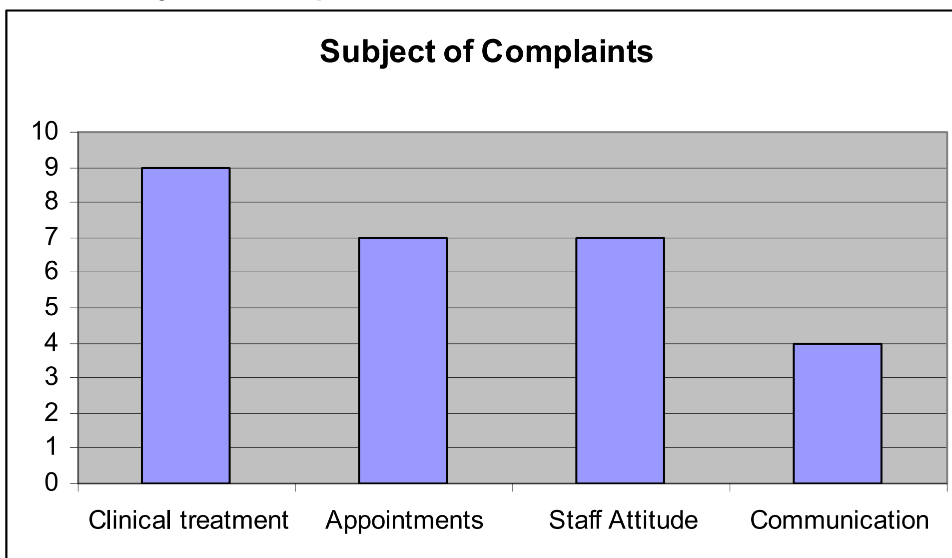
Table 2: Locality of GP complaints



2.2 Subject of complaints

The most frequent causes of complaint were "clinical treatment" (9) followed by seven each concerning appointments and staff attitude, and four concerning communication.

Table 3 Subject of complaints



2.3 Trends in Complaints Handling

100% of the complaints received by the Southwark complaints team were acknowledged within three working days, which is a statutory requirement. All independent contractors are required to have their own complaints process in place and acknowledge complaints within three working days.

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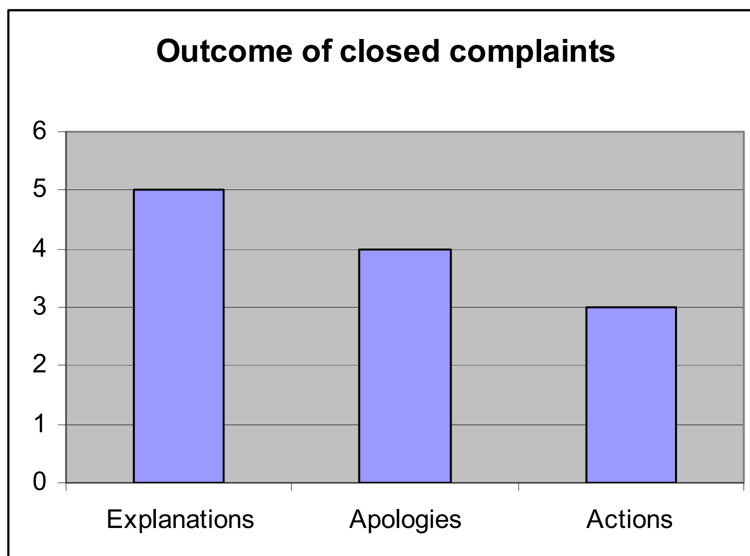
Although there are no statutory requirements in place for when a practice needs to respond to a complaint, other than the statutory six month timeframe, provided they keep the complainant informed, it is considered good practice to have a target date by which time the response should be sent.

8 (30%) of the complaints investigated between October and December were opened and closed within 25 days. Five (19%) were closed between 26 days. 13 (50%) of the cases remain ongoing at the time of writing the report.

2.4 Outcomes of Complaints

The outcome of the complaints in most cases led to explanations, apologies or requested actions being taken (see table below). Of the cases closed in this quarter there were five explanations, four apologies and three actions.

Table 4: Outcome of Complaints



2.5 Complaints about commissioned services

There was one complaint about the GP led walk in centre, and one complaint concerning SELDOC (this latter complaint also related to the ED services provided by the foundation Trust)

2.6 Requests for an Independent Review from the Parliamentary and Health Service Ombudsman (PHSO)

Currently there is one complaint with the Parliamentary and Health Service Ombudsman (PHSO). It relates to the removal of the patient from a GP practice list and also to do with clinical treatment provided. Removal from practice lists was an area highlighted in the Ombudsman's 2010-2012 Annual Report as an area of concern as she noted that 21% of the complaints about GPs that the Ombudsman investigated nationally were about being removed from GP lists. This has remained a common theme in 2011-2012 report,

Listening and Learning, which has shown an increase on the number of complaints received by their service over the past year in relation to de-registration of patients.

Towards the end of the last quarter we received notification from a Dental practice that they had been contacted by the PHSO requesting details of a complaint they had answered. At the time of writing this report we have been contacted by the PHSO requesting information concerning this complaint. At this stage they are considering whether they will investigate further. This may be something that is not resolved by 31 March 2013.

2.7 Issues of concern involvement with complaints

Towards the end of the previous quarter we received a complaint regarding a serious clinical matter. The allegation was that the practice had failed to make a cancer diagnosis which subsequently led to the death of the patient. The complaint was flagged up with the Head of Issues of Concern and the Medical Directorate. The complaint remains ongoing at the time of this report.

One practice that had a number of outstanding complaints in the previous quarter continued to fail to respond to complaints. The Head of GP Contracting and Performance NHS South East London and the Complaints Manager of NHS Southwark have both worked with the GP to resolve this. This work remains ongoing. Ongoing intransigent problems in this area subsequently led to a further Breach of Contract notice being issued in December 2012

2.7 Future Developments

On 1 October 2012 NHS Southwark ceased to manage Adult Social Care complaints. This function has returned to Southwark Council.

Complaints handling for Commissioned Services will move into the South London Commissioning Support Unit.

It has been identified that the future handling of complaints concerning independent contractors will rest in the National Commissioning Board. There is still, however, no clarity about how this will be provided. In the meantime, NHS Southwark remains responsible for the management of complaints until its dissolution on 31 March 2013.

Southwark Clinical Commissioning Group

NHS Southwark CCG authorisation:

Updated actions in response to the Recommendations of the Southwark HASC in November 2011:

In November 2011 the then HASC agreed a series of recommendations for the development of governance arrangements for the emerging Clinical Commissioning Group (CCG) in Southwark. In January 2012 the Southwark Clinical Commissioning Committee (leadership of the Shadow CCG) reported on its progress in responding to those recommendations.

Since that time NHS Southwark CCG has been established by the NHS National Commissioning Board (NCB) and will become a statutory body for local commissioning from 1 April 2013. In order to gain establishment the CCG has successfully completed a national authorisation process and has published a series of establishment documents, including its Constitution.

Ahead of the 1 April 2013 the CCG now welcomes the opportunity to update the Committee on its progress against the original recommendations. The table below outlines the original recommendations and the CCG's latest update (accepting that some of the recommendations related to other bodies).

No.	November 2011 HASC Recommendation	NHS Southark CCG Update
1	The committee recommends that the practice of co-opting members onto the SCCC's board continues in the future to broaden the range of experiences available when making commissioning decisions. *[SCCC, NHS SE London]*	Complete
2	Given the importance of SCCC's work and of the vital need for transparency to build public confidence in the new arrangements the committee recommends the following:	

2a	All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.	Complete
2b	Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted where by any 'closed items' can be discussed in private, but minutes of the non-public part of the meeting should be published.	Complete
2c	Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.	Minutes of the meetings are published in an easy to find location. At present the CCG (in Shadow form) has not met this two week time standard but has arrangements in place to achieve this from the point of authorisation (1April 2013)
2d	Declarations of Interest are recorded at the beginning of meetings and recorded in sufficient detail in the minutes.	Complete
2e	The register of interests should be made public by being published online, in an easy to find location. To avoid confusion the SCCC should use consistent terminology when referring to *declarations* of interest and *the register* of interests.	Complete (Please note the CCG is in the process of annual review of these arrangements which may lead to further enhancements post April 2013)
2f	Southwark's HASC committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark LINk/HealthWatch, SCCC Chair and the local press.	Outstanding – The CCG awaits confirmation from the HASC regarding the process it would wish to follow. The CCG makes its register publicly available and as such it is accessible by the Press. The Health & Wellbeing Board and healthwatch are not yet formally established.

2g	If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.	Complete
2h	Under the SHC’s existing conflicts of interest policy under ‘Related Parties’ a new category be added of ‘close friend’.	Complete
2i	The SCCC ensures there is a non-executive non-GP ‘Conflict of Interest Lead/Tsar’ on its board and amends it’s constitution accordingly.	Complete
2j	In line with best practice a new clause be added to the SHC/SCCC’s conflict of interest policy to emphasise: “That a member in possession of material none public information that could affect the value of an investment must not act or cause others to act upon that information”.	Complete
2k	The SCCC should develop a comprehensive policy for handling and discussing confidential information.	Complete
2l	In the interests of transparency, the SCCC should publish the results of election ballots for the 8 lead GPs, in addition they should publish full details of the ballot process and who conducts the ballot.	Complete
3	The committee recommends that the SCCC’s tendering process for any service includes standard clauses in the contract to ensure collaborative working and integration continue to take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority. *[SCCC, NHS SE London and Southwark Council]*	Subject to national contract requirements the CCG will seek to comply with this recommendation
4	That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers. *[SCCC, NHS SE London and Southwark Council]*	Agreed

5	That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC Committee for scrutiny, including outsourcing	The SCCC welcomes this recommendation in principle but would wish to work with the HASC committee to define the terms referred to and to ensure they can be applied adequately.
6	The committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'. *[DH, via HASC Ctte]*	The SCCC would welcome feedback from the Committee as and when detailed responses are received.
7	The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision. *[HWB and Monitor through HASC Ctte].*	The SCCC would welcome feedback from the Committee as and when detailed responses are received.
8	As a contractual obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are. *[SCCC, NHS SE London, Southwark OSC].*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**
9	Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health. *[HASC Ctte].*	The SCCC would welcome this action and is happy to participate in any work as appropriate.
10	The committee recommends SCCC and it's BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing). *[SCCC, NHS SE London, Southwark Council].*	The SCCC welcomes this recommendation in full.

11	The committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational capabilities. The details of this arrangement should be for the SCCC to decide, but contract management must not be an afterthought in any potential tendering process but at the centre. *[SCCC, NHS SE London and Southwark Council].*	The SCCC welcomes this recommendation in full.
12	That the Health and Wellbeing Board has as a central aim of stimulating integration and collaboration between local health care providers to improve patient outcomes. *[HWB].*	N/A
13	Patient views and perceptions of the level of care they receive are vitally important to improve services. It is therefore recommended that the Acute Trusts continue to conduct patient surveys, and the SCCC drives patient surveys at GP practices across the borough to capture patients' views and perceptions of their care to help understand what can be improved. *[Acute Trusts x 3 and SCCC]*	The SCCC welcomes this recommendation in full.
14	It is recommended that the SCCC introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis. *[SCCC, NHS SE London]*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures.**
15	It is recommended that robust monitoring of satisfaction amongst patients placed with all providers takes place as a matter of course.	The SCCC welcomes this recommendation in full.
16	In addition to clinical standards, set out by government, it is recommended that minimum levels of patient satisfaction are included in any contracts signed by the SCCC with financial penalties if these are not met, the exact levels, and how they are measured, should be a matter for the SCCC. *[SCCC, NHS SE London]*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures.**
17	Guidance on managing conflict of interest for GP commissioners should be set out nationally. It is recommended that the HASC writes to the Dept of Health requesting this to take place. *[HASC]*	The SCCC welcomes this recommendation in full.

18	It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that governance training continue for GP commissioners and a programme of ‘refresher’ training, sharing experiences and best practice from other public bodies and clinical commissioning groups takes place. *[NHS SE London, HASC]*	Complete
19	It is recommended that the SCCC consider their capacity for developing contracts and build this into their development plan, in particular where they will access expertise in drawing contracts up and monitoring them when signed.	Complete
20	It is recommended that the SCCC works closely with and pays close regard to the priorities of the local authority and health and wellbeing board to foster cooperation and meet the mutual goal of improving health outcomes of Southwark’s residents.	The SCCC welcomes this recommendation in full.
21	It is recommended that that the SCCC monitors clinical outcomes, including measures such as mortality rates, and that these are related to contracts signed with all providers, with financial penalties attached.	The SCCC welcomes this recommendations and will endeavor to comply with it provided actions do not fall outside of national contract requirements.
22	It is recommended that the SCCC appoints external auditors	Complete

Agenda Item 9

Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee 2012/13

Work Programme

25 March 2013
Health Services in Dulwich
Trust Special Administrator (TSA) recommendations for South London Healthcare NHS Trust and the wider South East London healthcare system.
Hospital Quality Accounts : of Guy's and St Thomas', Kings Collage Hospital, and SLaM - supported by a commentary on the Serious Incident Summary Report (with a focus on pressure ulcers) and complaints received by hospitals / PALs /Community settings / GPs
Southwark Clinical Commissioning Group transition to full delegation and implementation of the committees recommendations (update).
1 May 2013
Review : King's Health Partner merger
Review : Public Health BME mental health : prevalence and access to services. Evidence requested from : SLaM , Public Health, CCG and LINk / Healthwatch

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HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE

MUNICIPAL YEAR 2012-13

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Dated: February 2013