NHS
South East London
Clinical Commissioning Group

South East London CCG Quality Report: Bromley Update

02 September 2021

Version: 1.0

Key highlights from the Quality and Safety Sub Committee 17 June 2021

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Waiting for Hospital Treatment

- Alice Godman (Healthwatch) presented a report of a study of patients' experience of waiting for treatment. The Healthwatch study found that patients waiting for treatment experienced four stages to their journeys:
  Uncertainty – lack of information and contradictory information
  Fighting – constantly fighting with the hospital for information – becoming a "Difficult Patient" – impact on mental health
  Crisis – mental health or identity – health deterioration – impact on relationships
  Resignation – "Pragmatic acceptance" as a coping mechanism – giving up
  Healthwatch made recommendations including giving more information to patients at set times; a clear contact person; expected timeframes; having a protocol for waiting patients. A summary was presented to Integrated Governance and Performance Committee and an action agreed to review how the system engages with patients waiting for hospital treatment.

Obstetrics and Gynaecology at LGT

- The Chief Nurse gave the sub committee a briefing on some issues affecting obstetrics and gynaecology which had come to light via anonymous letters from staff in Lewisham and Greenwich NHS Trust. Information sharing meetings have been held with the Trust and regulators and assurances have been received. An action plan has been agreed and this will be monitored at the CCG Quality and Safety Sub Committee.

The Management of Asthma Symptoms in Children and Young People

- The Sub Committee received a report from the Healthcare Safety Investigation Branch (HSIB) about the management of Children and Young People with Asthma. The HSIB investigation used a historical incident in Lambeth as a reference case and made recommendations that are being taken forward across the System by the South East London Asthma Network, with support from the Quality Team.

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Quality Alerts

- The January to March 2021 Quality Alerts report highlighted that 182 quality alerts were reported in the period. The top five category themes were: Referrals; Discharge; Communication; Results and Medication. The report highlights key learning from these.

Continuing Healthcare

- The Sub Committee noted the Continuing Healthcare Priorities for 2021 which are aimed at recovering performance after the pandemic:

Measure	Target
Proportion of CHC assessments completed within 28 days	>80%
Proportion of CHC Decision Support Tools completed in acute hospitals	<15%
Number of CHC assessments delayed by >12 weeks	0

Care Quality Commission

- It was noted that following a Care Quality Commission (CQC) inspection at Oxleas, ratings for Older Adult Wards had improved to “Good.”
- An inspection of acute services at South London and Maudsley (SLAM) and a Well Led Review was underway.
- An inspection had been completed at the Emergency Departments at the PRUH (since reported as improved to “Good”) at Denmark Hill and at GSTT (outcomes awaited).
- There will be a Well Led Review at Bromley Healthcare in September.

Infection Prevention and Control

Infection Prevention and Control

- A Champions Programme for care homes supported by the SEL CCG IPC forum has been agreed with local commissioners and stakeholders. The programme will have a broad remit and will include IPC and the reduction of gram-negative bacteraemia's, a key target for SEL CCG as well as focusing on CQC readiness and harm reduction.

- Covid outbreak reporting is currently being scoped by provider DIPCs due to national reporting arrangements being stood down. SEL CCG will collect this data as well as outbreaks occurring within care homes. This data and key learning will be reporting to the SEL CCG IPC forum and quality and safety subcommittee. A national process for Hospital acquired Covid infections resulting in death is expected imminently.

Learning from Quality Alerts

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- Quality Alerts are an informal way of notifying the CCG about concerns and issues in the system.
- Quality Alerts are raised by professionals, mostly but not only GPs, when they notice that systems and processes of care are not quite as they should be.
- The top reported themes in Quarter Four were:

  Referrals

  Discharge

  Communication

  Results

  Medication
- In the slides that follow some of the learning from Quality Alerts most relevant to the local borough and its main providers are presented. A full system wide Quality Alert Report has been shared widely across the CCG and is available on request.

Learning from Quality Alerts Q4 Report

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Clinical Imaging-PRUH: A patient in her 90s with suspected pancreatic cancer was referred under the 2 Week Wait pathway to the Upper Gastrointestinal Team. Her relative was contacted 7 weeks later to arrange a CT scan, the patient sadly passed away that morning. Despite the outcome being unavoidable, the GP expressed concerns about the lengthy delay. **Learning and outcomes:** The Trust acknowledged the lengthy delay and that a CT scan was ordered and cancelled due to the patient's poor renal function. The patient was due to attend hospital in the meantime due to renal function and poor hydration requiring an infusion. Several other complex factors impacted and there was difficulty in contacting the family - the hospital system had not been updated. **Key learning** identified the importance of maintaining up to date patient contact details and to maintain contact with the GP for delayed patients on the 2ww pathway.

Clinical Imaging - PRUH: A patient was discharged from hospital with a follow up X-ray required via GP referral. This referral was rejected by the Radiology Team which led to a delay in the patient's treatment. **Learning and outcomes:** The Trust acknowledged the error on their part and identified that the agreed protocol had not been followed. The alert details were shared with Junior Doctors to prevent this from reoccurring.

Learning from Quality Alerts Q4 Report

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Alerts were received from Kings College Hospital mostly for **general practices in Southwark, Lambeth and Bromley** in relation to 2ww referrals not being done properly. These highlighted that some GP practices referred their patients via the e-referral 2ww pathway but did not upload the required attachment at the same time as making the electronic referral at the point of booking. The attachment contains important information required by the Hospital in order to ensure the timeframes are met and the necessary clinical information is available in order to triage appropriately.

Learning and outcomes: Although no harm has resulted thus far, the practices have been sent the alerts and are reminded to ensure they follow the correct processes.

Quality Alerts by Borough Q4 Report

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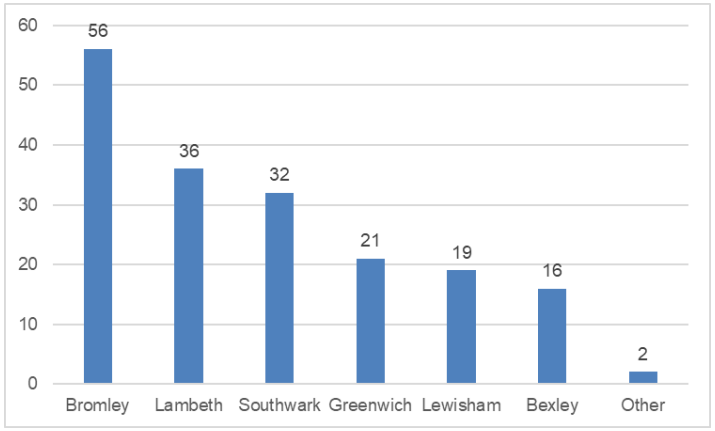
- Number of alerts by Borough Q4



- Quality Alerts by provider at Borough level