



# 2018-21 Quality Strategy

## Our overarching aim

We are committed to ensuring that the Vale of York community can experience services that are safe, of a high quality and deliver patient centred outcomes within the resources that are available.

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## Foreword

The CCG, as a statutory organisation, is required to commission the best possible services and positive outcomes for patients, within the financial resources available to it.

Ensuring people are safe and cared for when they require services is of paramount importance and the delivery of high quality care rests with each provider organisation. Under its statutory duty to secure continuous improvement within the services it commissions, and work to pursue assurance of safety and quality, the CCG's Quality Assurance Strategy builds upon the recommendations of reports by Francis, Keogh, Berwick and others, defining the CCG's vision for 'quality' and how the CCG will assure itself, and its stakeholders, that people within the local community will receive high quality care.

This strategy outlines the actions required to identify and measure the quality of services the CCG commissions in line with the values of the CCG and the NHS Constitution. It also sets out the governance arrangements within the CCG that ensure the Governing Body is informed on the quality of commissioned services, the assurance methods used, and the processes for escalation and additional support for quality and safety concerns.

The CCG is committed to openness and transparency when developing or assuring services and seeks to hear the voice of the local population and the impact of its decisions on people.

Quality is everyone's business and the CCG is committed to working with partners across the system to ensure the best possible outcomes and experience for patients and their carers and families.



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**“All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support” (Berwick 2013).**

## **Introduction**

This Quality Assurance Strategy and accompanying framework sets NHS Vale of York Clinical Commissioning Group’s (the CCG) objectives, responsibilities, and governance arrangements for the monitoring and assurance of quality in the services it commissions. Clinical Commissioning Groups have clearly identified responsibilities in relation to commissioning for quality, informed by the NHS constitution (2011):

- To ensure that services commissioned are safe, effective, provide good patient experience and ensure continuous improvement
- To secure health services that are provided in an integrated way, working in partnership with the Local Authority
- To actively seek patient feedback on health services and engage with all sections of the population with the intention of improving services
- As a membership organisation, working with NHS England, support primary medical and pharmacy services to deliver high quality primary care.

The Health and Social Care Act (2012), states ‘each clinical commissioning group must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness’.

This strategy describes how the CCG will work with partners, identifying quality standards, measuring and monitoring quality and what actions it will take if there are concerns about the quality of services commissioned. This includes services commissioned by NHS Vale of York CCG and those it may not commission directly but which provide services to the population within the Vale of York. The CCG will review its quality priorities constantly to ensure quality remains the key focus and the Quality Assurance Framework will identify key objectives and methods of monitoring compliance against them.

## Strategic objectives for quality assurance

### Core strategic objectives

- The CCG will discharge its statutory functions with regards to quality
- The CCG will contract for quality and effectiveness, within resources, to ensure standards can be monitored, maintained and improved

### Additional strategic objectives

- To seek and hear the patient voice, ensuring it is incorporated into the CCG commissioning plans and quality assurance processes
- To be transparent- openness and candour are key values for the CCG. Candour and honesty are integral to healthcare and quality assurance as well as service improvement
- To support the development of a strong safety culture
- To learn and support learning for improvement in the providers of services we commission, to act and share learning from safety incidents and patient experience
- To ensure awareness of and inclusion of national documents, reports and directives to influence and update the Quality Assurance Framework.

## Background

### Roles and responsibilities

The Health and Social Care Act 2012 makes it clear that all Clinical Commissioning Groups have the responsibility to ensure continual improvement in the quality of local NHS services for everyone, now and for the future. Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between the CCG, provider organisations, other commissioners, system and professional regulators, local authorities and other national bodies.

This Quality Assurance Strategy sets out a number of measurable actions and related outcomes which will help ensure the CCG is commissioning safe, effective services that meet patient need. The strategy also describes the various mechanisms that are in place to assure quality. Defining quality is complex, this strategy will describe what the CCG means by the term quality and how it will assure itself that people within the populations it serves are receiving high quality care.

The core operating principles for Quality set out in the NHS constitution identifies the following behaviours the CCG seeks to apply:

- Patients and the public come first – not the needs of any organisation;
- Quality is everybody's business – from the ward to the board; from supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers;
- If we (health and care professionals, staff as well as patients and the wider public) have concerns we speak out and raise questions without hesitation;
- We listen in a systematic way to what our patients and staff tell us about the quality of care; and
- If concerns are raised, we listen and investigate and determine appropriate action.

## Key drivers for quality

### **NHS Constitution (2014)**

Sets out the standards of care and the rights that all patients have and should expect

### **Patient and Public Involvement (PPI)**

The CCG is committed to working with patients, carers, community and voluntary groups and other partners to involve, engage and listen in order to identify commissioning priorities and inform service redesign.

### **The NHS Outcomes Framework (2015)**

A national framework to drive local improvements in quality and outcomes for patients. Covers five domains.

### **Quality schedules in contracts**

Contracts with providers contain both national and locally set quality indicators which allow CCGs to monitor and measure performance. Contractual levers can be applied if quality is not achieved.

### **The Next Stage Review: High Quality Care for All (2008)**

The review placed emphasis on being more patient centred, clinically driven, valuing people and promoting lifelong learning and improving quality of commissioned services.

### **Quality Accounts (2010)**

Every NHS provider organisation has been required by law to report its performance on the quality of care; incorporates views of stakeholders and published annually.

### **The CCG Outcomes Indicator Set**

The aim of the set is to support and enable CCGs and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of commissioned services.

### **NHS Operating Framework (2016-17)**

The framework sets out national priorities and performance targets to drive continuous quality improvement. It places quality as the organising principle through contracting and payment systems.

**Care Quality Commission standards**

All providers of health care are required by law to register their services with the CQC who are the regulator of health and adult social care in England. Registration is subject to compliance with a regulatory framework based on a series of 'fundamental standards' of quality and safety.

**Statutory Duty of Candour**

Since 2015, every healthcare professional are required by law to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. Professionals are also required to be open and honest with colleagues and employers in order to promote a culture of patient safety improvement.

**National Quality Board (NQB)**

The National Quality Board (NQB) was established in 2009. It has no statutory responsibility. It is the only forum where all the national bodies with some responsibility for quality of care come together to provide strategic oversight and leadership on quality across the system.

**Equality, diversity and human rights**

Promoting equality, valuing diversity and upholding human rights is integral to the pursuit of quality and addressing gaps in health inequalities. The NHS Equality Delivery System (EDS) was launched in 2011 which the CCG self-assesses on performance of the nine 'protected characteristics' in the Equality Act 2010 to inform and drive quality improvement.

**NICE Quality Standards**

Are a set of prioritised statements designed to drive measurable quality improvements in a particular area of healthcare. Guidance is derived from high quality independent input from a wide variety of health and social care professionals who consider patient experience, safety, equality and cost effectiveness in the development.

### **NHS England Accountability and Assurance Safeguarding Framework**

The purpose of the framework is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care to protect people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place and hold them to account through contracting arrangements. CCGs are also responsible for securing the expertise of Designated Professionals on behalf of the local health system.

### **Learning from patient feedback**

'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' was published post Francis Report highlighting changes required to ensure providers listened to patients and carers, looked for trends, disseminated lessons learnt and made changes to ensure care improved. The report also recommended that Healthwatch, as the patient and public champion for health services, should be as strong and effective as possible so that it can speak up for patients and provide independent support on complaints.

### **Learning from failure**

National enquiries and reports often follow failures in care and come with recommendations to prevent recurrence such as that which followed the investigation into Winterbourne View and Jimmy Savile. The CCG scrutinises all such reports and incorporates into its accountable functions including holding providers to account for delivery of changes where required.

### **Facing the Facts, Shaping the Future**

A draft health and care workforce strategy for England to 2027

This document outlines why a workforce strategy is needed and describes three key elements; education and training; retaining current workforce and recruitment to workforce. It also describes actions to grow capacity and capability across the public sector workforce.

Working with Health Education England the CCG has a responsibility to commission service that have robust workforce models to maintain quality and safety standards.

## What is quality assurance?

Quality assurance is the systematic and transparent process of determining whether a product or service being developed is meeting specified requirements through a variety of measures.

The mechanisms for monitoring and escalation are further illustrated in [appendix 1](#). These include:

- Clear expectations of quality defined through detailed service specifications and contracts
- Monitoring of provider performance through contract management board and associated quality meetings or groups
- Scheduled clinically led site quality visits to providers to follow the patient journey and assess care provision
- Assessment and monitoring of provider quality accounts which are published each year
- A Quality Surveillance Process discussed at regular Quality Surveillance Groups, led by NHSE, to have oversight of quality across the system
- Non-scheduled quality visits

As statutory bodies accountable to the public this strategy will be overseen by the Governing Body and the strategy describes how this will take place.

## Context

Following a number of high profile reports and enquiries, particularly the Public Enquiry into the care at Mid-Staffordshire NHS Foundation Trust (2013) carried out by Sir Robert Francis, it was reiterated by the Department of Health (2014) that CCGs had key roles and responsibilities for continual improvement of quality in healthcare. During the last few years there has been a number of investigations of hospitals and care homes that have highlighted the tragic consequences of poor care and treatment, neglect and abuse. This has resulted in decisive action from the Department of Health (DH) including further in-depth inspections of poorly performing Hospitals/Care homes, a national review of patient safety, complaints and support worker training. The two notable reviews are Winterbourne View (2012), a Hospital for people with Learning Disabilities, and the Francis public inquiry into Mid Staffordshire Hospital (2013). As a result of lessons learned, policy changes and guidance have been introduced.

The recommendations accepted in the Francis report provide the framework for this document alongside recommendations in reports which followed, namely:

- The Munro Review into Child Protection: Final Report, (2011)
- Winterbourne and follow up Winterbourne View Concordat (2012)
- A promise to learn— a commitment to act. Improving the Safety of Patients in England, Berwick Report (2013)
- Safeguarding children and young people: roles and competencies for health

- care staff – Intercollegiate Document (2014)
- Compassion in Practice. Nursing, Midwifery and Care Staff Our Vision and Strategy. (2012)
- Leading Change, Adding Value, a Framework for Nursing, Midwifery and Care Staff. (2016)
- Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015, (2015).

The main key quality recommendations from the Francis Enquiry and Winterbourne View can be found in [appendix 2](#).

## **Strategic vision and plan**

This Quality Assurance Strategy sets out the fundamental approach of the CCG to quality in the commissioning and monitoring of services. Building on the recommendations of the Francis, Keogh, Berwick and other reports the strategy defines the CCG's vision for 'quality' and how the CCG will assure itself and others that people within the populations it serves receive high quality care whilst outlining CCG responsibilities. It also sets out the governance arrangements within the CCG to ensure Governing Body is informed on the quality of services commissioned and the assurance methods used, as well as the process for immediate escalation of quality concerns.

Our strategy outlines the actions required to identify and measure the quality of services the CCG commissions in line with the values of the CCG and the NHS Constitution.

## **Our approach**

### **Working proactively**

The CCG will share gather and share information and intelligence as appropriate with relevant stakeholders about the quality of care so that it can identify potential problems early, prevent harmful impact and manage risk.

### **Reacting and responding (working reactively)**

In the event of a potential or actual serious quality concern becoming apparent, the CCG will make and support informed judgments about quality and ensure that appropriate, timely responsive actions are implemented. It will also include other stakeholders as necessary placing patient safety at the centre of any decisions and subsequent actions.

## **Local context and CCG commissioned services**

The CCG has 26 member practices covering a population of approximately 300,500 people. In total there are eight CCGs across North Yorkshire and the Humber, whose patients may also access Vale of York providers. The CCG has a responsibility to act on behalf of other CCGs in the monitoring of standards of quality provided by all providers, and provide assurance to them that care is of the highest quality possible.

The CCGs commission activity from providers that are registered with the regulatory body the Care Quality Commission (CQC), and, as part of contracting arrangements the CCG works closely with them to monitor standards and deliver continuous improvement.

## Consultation and key stakeholders

To develop this strategy we have consulted with our partners and other stakeholders.

## What is Quality?

Quality is difficult to define and incorporates many aspects of data, information of feedback from a wide variety of sources. Measuring quality and gaining assurance is complex. The Care Quality Commissions' definition includes organisational culture and leadership and responsiveness which are incorporated into the CCG's dimensions of quality. The key drivers for quality have been taken into account and are included within this strategy.

**'Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning'.**

**Berwick Report 2013.**

# NHS Vale of York CCG - Definition of quality



## Commissioning for quality

Commissioning is not one action but many, ranging from assessing the health-needs for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with simultaneous continuous quality assessment occurring. The role of commissioning, as a key driver of quality, efficiency and outcomes for patients, has become increasingly important to the health system in England.

### **How the CCG establish expectation of quality in its commissioned services**

Commissioning involves a series of stages usually conducted in a systematic cyclical process over the course of a year which assist the CCG in deciding what services are needed and whether existing services require review. Quality assurance is inherent and integral to that process.

### **Contracting process**

Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust framework through which a commissioner can set clear standards for a provider and subsequently hold it to account for the quality of care it (and any sub-contractors) delivers against those standards. The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care and any agree local quality requirements (NHS Standard Contract 2015). The contract is managed by Contract Management Boards and relevant sub contract groups (e.g. Quality and Performance Sub CMB). These forums address under performance against all quality requirements and either agree action plans for improvement and/or provide a process for escalation of quality or performance concerns which are impacting on quality.

Each commissioned provider is required, contractually, to submit information on recognised indicators of the safety, quality and effectiveness of services. This includes:

- Patient experience information from internal and external surveys, Family and Friends, complaints and PALS information
- Incident and Serious Incident reporting data, compliance with national and local reporting timeframes. Quality of reporting, analysis, including medication errors, never events and completed investigation reports
- Infection prevention and control measures, including clinical practice, environmental audit data and numbers of healthcare –associated infections and outbreaks of infections identified.

This information is reviewed and considered along with the context of other available data and intelligence, external agency reports and benchmarking against comparable organisations where appropriate. Where NHS Vale of York CCG is not the lead contract holder, for example with Yorkshire Ambulance Service, the lead CCG contact will provide Quality feedback, which will include feedback from NHS Vale of York CCG.

The CCG's Quality and Performance Committee (Q&P) receives monthly reports on provider performance against their respective quality and performance schedules including CQUINS and quarterly data packs describing performance over time. Current issues impacting on performance and plans to resolve compliance issues are also monitored.

The Quality and Patient Experience Group (QPEC) meets bi-monthly and produces a detailed quality report reviewing all aspects of quality for all providers. Reports and issues requiring escalation are then shared with the CCG's Governing Body at each meeting held in public. Reports on both adult and children's safeguarding are reported to QPEC each quarter and presented by the Designated Professionals working on behalf of the CCG.

A Primary Care Co-Commissioning (PCCC) meeting occurs bi-monthly and has a pivotal role in receiving information to provide assurance on the quality and safety of primary care services. It receives reports and updates providing information on compliance with Quality Outcome Framework (QOF), and meeting standards against CQC and patient satisfaction domains. The committee will produce a Primary Care Assurance report which will incorporate both local and national data including identification and correction of any gaps in available information. The committee will request and obtain data to continue to provide insight into quality and safety challenges and support resulting quality improvement programmes. QPEC will be kept informed of any issues as required as well as support any quality improvement projects.

### **Quality schedules**

The NHS contract includes clauses which serve to focus the provider and commissioner on the achievement of quality improvement and places emphasis on avoiding harm. In addition to the terms within the main body of the contract there are also specific schedules which both parties work on collaboratively prior to sign off which are directly related to quality.

### **Key Performance Indicators (KPIs)**

Key performance indicators assist the CCG to define and measure progress on a range of issues. 'In year' targets and trajectories are set to demonstrate ambition towards continuous improvement, in conjunction with existing and emerging national and local priorities. These will also consider areas where the CCG considers priority of need to improve where quality and performance issues have been identified during the year.

## **Commissioning for quality and innovation (CQUIN)**

The National NHS Contract includes the CQUIN payment framework which allows commissioners to reward innovative solutions and/or quality improvements beyond the standard. There are two sets of CQUINS. One is nationally prescribed, the other is locally determined and can include as few or as many as are agreed. The financial reward equates to 2.5% of the contract value, with 0.5% attributed to the national schemes and Commissioners can determine the split of financial reward across the schemes weighting payments across the year as the objectives are met. The provider reports against CQUINS on a monthly or quarterly basis through the contract management route.

## **Quality, Innovation, Productivity and Prevention (QIPP)**

**“We need to fashion a vibrant, creative NHS that really fizzes with ideas of how to improve quality and how to reduce costs..... So, instead of relying on ever more funds flowing from the Treasury, we must look to ourselves to make savings.**

**This practical imperative is what QIPP is all about.....**

**We have the resources, we have the knowledge and we have the ability to give the people of this country a truly first class NHS and to deliver it within our means.”**

**Earl Howe, Minister for QIPP**

In the development of the CCG's QIPP schemes, the Quality and Nursing Team undertake Quality Impact Assessments (QIAs) to determine the risk to quality by any scheme and initiative. Finance and performance Committee review the CCG QIPP programme to make sure that the impact from a quality perspective has been considered alongside ensuring the delivering of schemes.

## Patient safety

A fundamental priority for commissioners is to commission high quality care which is safe, prevents avoidable harm and risk to patient safety. This includes systems to not only protect patients but robust processes to investigate and learn from incidents.

Quality Measures the CCG will routinely monitor include:

- Serious Incident Management
- Safeguarding
- Adverse outcomes such as pressure ulcers and falls
- Care of the Deteriorating Patient
- Medicines Management
- Summary Hospital –Level Mortality Indicators (SHMI)
- HCAI rates

## Serious incident reporting

All Serious Incidents (SIs) are reported through the Department of Health's central Strategic Executive Information System (StEIS). Incidents are reported and investigated in line with providers and CCGs policy, which both reflect the National Framework (NHS England 2015). The expectation is that learning from incidents is shared across the whole of the provider organisation and if appropriate shared more widely.

Providers Serious Incident Investigation reports are reviewed at the combined CCG SI Panel to ensure comprehensive investigations with appropriate action plans demonstrating organisational learning have been completed.

QPEC Governing Body will receive regular reports summarising the Serious Incidents and incidents and any relevant themes, trends and learning.

### **Assurance of Learning from Serious Incidents**

The CCG has a responsibility to obtain assurance following declaration and investigation of a Serious Incident. This includes robust quality scrutiny of the completed SI report to ensure all pertinent issues have been identified and considered within the report, and that relevant actions are included in an action plan which identifies SMART actions.

If the CCG is assured the Serious Incident report contains a robust action plan to reduce the risk of a similar incident from happening again the incident will be closed on StEIS. However the CCG must be assured of completion of actions and embedding of learning identified in the action plan the following assurance framework schedule, agreed with providers will take place.

Assurance Method	Frequency	Data	Lead
Monitoring of recurrent incidents and appropriate action as required on situational basis	Ongoing	STeIs reports SI reports Other intelligence	SI team CCG Quality team- Head of Quality Assurance and Maternity
Robust quality review of completed investigations and action plans	Monthly	SI reports	SI team Clinical reviewers Head of Quality Assurance and Maternity
Scheduled planned Quality Site visits	As per agreed schedule	SI data from area Actions from SI action plans for area Patient relations intelligence Recurrent applicable themes	Head of Quality Assurance and Maternity
CCG attendance at Trust SI panels	As invited	SI report Analysis of recurring trends and themes	Head of Quality Assurance and Maternity
Assurance visits to Trust	Quarterly	Random number of SI's selected and audit of evidence of completion progress provided, e.g. ward visits, guideline updates, safety briefs	Head of Quality Assurance and Maternity
CCG attendance at Falls and Pressure Ulcer panels	Monthly	Collation of themes and trends	Head of Quality Assurance and Maternity

## Duty of Candour

A duty of candour is included in the standard NHS contract (NHS England, 2015). Its function is to ensure patients and their families are told about patient safety incidents which affect them, receive an apology, are informed of the investigation plus its outcomes and provided with support.

Compliance with Duty of Candour is required to be included on all investigation reports. Submission of evidence of overall organisational compliance against all the aspect of the requirement occurs via quality schedule contracting processes.

## Quality accounts

All NHS Foundation Trusts are required to produce reports on the quality of care (as part of their annual reports). Quality reports help Trusts to improve public accountability for the quality of care they provide (Monitor 2015). The CCG is responsible for providing scrutiny and a supporting statement which will be included in the account which is publicly available.

## Cost Improvement Plans (CIPs)

CIPs are integral to all trusts' financial planning and require efficient, sustained performance in order to be achieved. CIP success varies among Trusts and no single approach works for all organisations. However, several factors are common in organisations performing well in CIP planning, delivery and sustainability. A successful CIP is not simply a scheme that saves money. The most successful organisations have developed long-term plans to transform clinical and non-clinical services that not only result in permanent cost savings, but also improve patient care, satisfaction and safety. The CCG has a duty to examine the Cost Improvement Plans of its main service providers and the process by which these are agreed and ratified. This is done as part of the contractual arrangements by the Contract and Quality and Performance Teams.

## Quality in Care Homes and the domiciliary care sector

Ensuring quality in care homes and the domiciliary care home sector is challenging and complex. The CCG recognises it has an important role in supporting providers to deliver high quality services and improvement plans, in order to contribute to the sustainability of out of hospital care. These services provide care to frail, vulnerable people and often care is joint or wholly funded by the CCG under NHS responsibilities for continuing healthcare, a joint package of care, or through a contribution to the registered nursing care that a person who is a resident in a care home with nursing will receive.

The Refreshing NHS Plans for 2018 delivering the Five Year Forward View explains ways to progress towards system integration and achieving the deliverables identified in 'Next Steps on the NHS Five Year Forward View' published in March 2017 and the CCG will ensure quality remains inherent to all parts of that process in special measures and the CCG contributes to this support to care homes.

The CCG will work on a multi-agency basis to collaboratively deliver improvements in the quality of care in care homes and provided by domiciliary care, including medicines management, intermediate care and rehabilitation and through the CCG's 'Partners in Care' Forum. This Forum is a CCG led group which meets regularly with care home representatives to share best practice, implement initiatives and support continuous quality improvement.

The CCG will work with Local Authority colleagues on assurance visits to care homes, when visits are required for action/ improvement plans or where concerns are raised. This aims to provide supportive to the care homes and facilitates joint working between health and social care.

## **Care Home Closure**

NHSE together with partners have published good practice guidance for Local Authorities, CCGs, NHSE, CQC, Providers and Partners. It helps partners to co-ordinate action, avoid duplication and prevent confusion from providers of health and care staff in the home closing or that receive residents from homes that close. Managing Care Home Closure aims to ensure that when closure arises, there is a joined-up and effective response from all partners to minimise as much as possible the impact on people using services, their families, carers and advocates.

The guidance can be found here:

[http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/1577\\_QuickGuide-CareHomes\\_9.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/1577_QuickGuide-CareHomes_9.pdf)

A Joint Working Protocol has been developed by NHS England (North) and partners to give guidance to organisations when a hospital, service or facility closes unavoidably at short notice. The memorandum gives clear guidance and direction to any organisation involved in a short notice closure to take appropriate and timely action in supporting patients and making sure they get the care and treatment they deserve.

The protocol is now available online at:

<https://www.england.nhs.uk/publication/joint-working-protocol-when-a-hospital-services-or-facility-closes-at-short-notice/>

## **Safeguarding**

Robust safeguarding processes are integral to all aspects of patient care and patient safety. The CCG Executive Lead for Safeguarding Children and Adults is the Chief Nurse. The Chief Nurse is supported in this role by the Designated Professionals for Adults and Children's Safeguarding. The CCG acknowledges its statutory function and responsibility as both a commissioner of services and as an employer and has clear governance processes in place for safeguarding children and vulnerable adults.

Related policies are:

- Safeguarding Adults Policy
- Safeguarding Children Policy
- Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- Allegations Against Staff Policy

The CCG provides training for its staff and supports member practices by investing in capacity and has invested in providing nurse consultant and named doctor for safeguarding in primary care. The CCG works in partnership with local authorities to discharge its statutory functions and sits on relevant Safeguarding Boards. The CCG recognises the importance of 'parity of esteem' for those with mental health and learning disability needs. This applies to the monitoring and assurance of all commissioned services.

The CCG ensures that safeguarding requirements are integral to any contracts with providers and holds them to account for the delivery of those standards. through the receipt of compliance with staff Safeguarding training uptake, review of Safeguarding reports and participation in clinical site visits. Designated Leads for Safeguarding attend provider Quality meetings, sub Contract Management Boards, and Quality and Patient Experience Committee where reports and updates are received. Governing Body are informed of any safeguarding issues via the QPEC reports and directly for serious or urgent issues by the Chief Nurse.

### **How the CCG measures quality and prevention of harm**

- Regular, routine measuring and monitoring of quality indicators and data within the contract, escalating and taking action where required as outlined in appendix 1
- Clinical visits / walk rounds/Scheduled and unscheduled Quality Assurance visits
- Hearing the voice of the person, their carers and families through complaints / compliments / surveys and development of key relationships with Healthwatch and other service user groups
- Scrutiny of Risk Registers- providers will be asked to share their Red rated risks through sub CMB which relate to or could have an impact on quality and safety of services
- Further development to allow the collection and scrutiny of soft intelligence from primary care through the CCG and by proactive partnership working across the STP
- Dialogue with Quality Leads across Yorkshire and Humber and participation in key pieces of regional work across the STP
- Contribution to inspections and monitoring of action plans from CQC and others
- Sharing of information and intelligence across the system and appropriate escalation via Quality Surveillance Groups (NHSE)
- Safeguarding processes

## **Primary care quality**

The CCG recognises it has an important role in supporting primary care to deliver high quality services whilst acknowledging that assuring quality in primary care creates complex challenges. The CCG is establishing processes to receive reliable data on incidents, serious incidents, significant event audits and any patient experience feedback. This will include review and receipt of the Primary Care Assurance Report and Quality and Outcomes Framework figures by The Primary Care Commissioning Committee, QPEC will receive a summary of this.

The Quality Lead for Primary Care will develop a framework to support the offer of a schedule of quality visits, incorporating a range of quality assurance measures and including sharing any learning from incidents and from local primary care CQC assessments.

The CCG will develop a Safety Bulletin to share learning from events, incidents and Serious Incidents in Primary Care.

## **Infection prevention**

Management of healthcare acquired (HCAI) and organisational approaches to infection prevention are not only crucial to maintaining patient and population safety, but ensure a continued focus on the management and reduction of all HCAI.

The CCG receives information and assurance on Infection Prevention and Control measures through a variety of means. It receives provider reports on HCAI reduction plans and provider DIPC reports which include antimicrobial prescribing and adherence, surveillance data and audits including hand hygiene. The Head of Quality Assurance participates in post infection reviews of cases of C-diff, MRSA as well as contributing to any outbreak responses. Themes and trends from PIR's are incorporated into the report received at QPEC including the number of declared HCAI cases against trajectory. Antimicrobial prescribing is monitored by Medicines Management team.

Combined CCG and Provider action plans are in place against emerging HCAs which are reviewed through the shared CCG IPC Locality meeting.

Assurance on IPC in primary care will form part of the quality visit schedule. The shared community IPC resource will support this as well as education and IPC support in care homes.

## **Clinically led site visits**

A schedule of planned clinically led visits will be devised on an annual basis in agreement with providers. This will involve a multidisciplinary team visiting a service or

ward and gaining more information to provide insight into both the patient experience and staff perspective.

Prior to the visit information will be collated regarding Serious incident themes, complaints, PALS and any performance issues which will inform some of the focus of the visit. A feedback letter will be sent which summarises the visit and an action plan devised for any resultant actions. This will be monitored at both the TEWV Performance and Quality sub CMB, YTH sub CMB and included in the QPEC report. Site visits which require a more formal approach will utilise the guidance the STP have issued.

## How the CCG will work with partners to quality assure services

**‘Quality...is not the responsibility of any one part of the system alone, but a collective endeavour requiring collaboration at every level of the system.’**

**National Quality Board 2014**

In addition to the CCG’s work regarding quality, other local and national bodies and agencies are required to provide oversight, leadership and additional assurance into patient services. Local partners also have a responsibility to ensure people are protected from harm and failures in quality including neglect and abuse.

## Roles and responsibilities of partners in the system

### Providers

Providers have a responsibility to understand and identify what high quality care looks like and must strive to deliver this. They are required to have robust governance arrangements in place to monitor, manage and drive improvements and must publish an annual Quality Account (excluding primary care).

All providers are governed by legislation and regulated by various national agencies.

The CCG took over fully delegated commissioning responsibility from NHSE in April 2014. As such primary care is subject to the same monitoring of agreed quality indicators and potential action taken if quality is at risk.

## **Regulators**

The Care Quality Commission (CQC) is the agency responsible for monitoring, inspecting and regulating services. The CQC ensures services meet fundamental standards of quality and safety and publish their findings, including performance ratings to help people choose care. The Quality and Nursing team offer support to Primary Care prior to inspections and promotes the sharing of good practices across the locality. The CCG scrutinises CQC inspection reports and monitors action plans for improvement. The CCG also supports the CQC when quality concerns are identified about a provider and is involved in supporting improvement work and monitoring patient safety. The CCG and CQC discuss providers to share information promoting a cohesive approach to both the regulatory and CCG function.

National Health Service Improvement (NHSI) acts as the main regulator of Foundation Trusts and NHS Trusts ensuring they are well-led, and have regard to whether their services are effective, efficient and of good quality. NHSI has been set up to support providers to deliver, helping the NHS meet its short-term challenges and secure its future.

Ofsted is the Office for Standards in Education, Children's Services and Skills. They inspect and regulate services that care for children and young people, and services providing education and skills for learners of all ages and publish their results. The CCG will participate in inspections and be part of developing and implementing any actions for children.

Professional regulators such as the Nursing and Midwifery Council (NMC), General Medical Council (GMC) and Health and Care Professional Council (HCPC) set standards, hold a register, quality assure education and investigate complaints. The CCG has the responsibility to ensure compliance with regulatory standards of the professionals they employ and report concerns of practitioners.

## **Planning and Advisory Bodies**

Healthwatch is the national body that champions people who use health and social care and has a key focus on the design of integrated care. Each local authority has a local Healthwatch Group which feed into the national network. A Healthwatch representative attends the CCG Governing Body and meets with key members of the CCG to share patient feedback.

Health and Wellbeing Boards (HWB) were established as part of the Health and Social Care Act 2012 where leaders from the health and social care system come together to improve the health and wellbeing of their local population. Its main concern is to reduce health inequalities.

They have a statutory duty to involve local people in the development of the Joint Strategic Needs Assessment (JSNA) and the development of joint health and wellbeing strategies. The CCG attend and contribute to the HWB ongoing agenda.

Overview and Scrutiny Committees (OSC) were established under the Local Government Act 2000. They are made up of locally elected councillors who are independent of executive or cabinet parts of the council. They can investigate any area of concern in the local area and they have powers to require officers, including the CCG to attend meetings and answer questions and must comply with requests for information. They hold decision makers to account.

Local Safeguarding Boards - Section 13 of the Children Act 2004 requires each Local Authority to establish a Local Safeguarding Children's Board (LSCB). The Care Act 2014 requires Local Authorities to establish Safeguarding Adults Boards (SABs). The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The CCG is a statutory partner on the Boards.

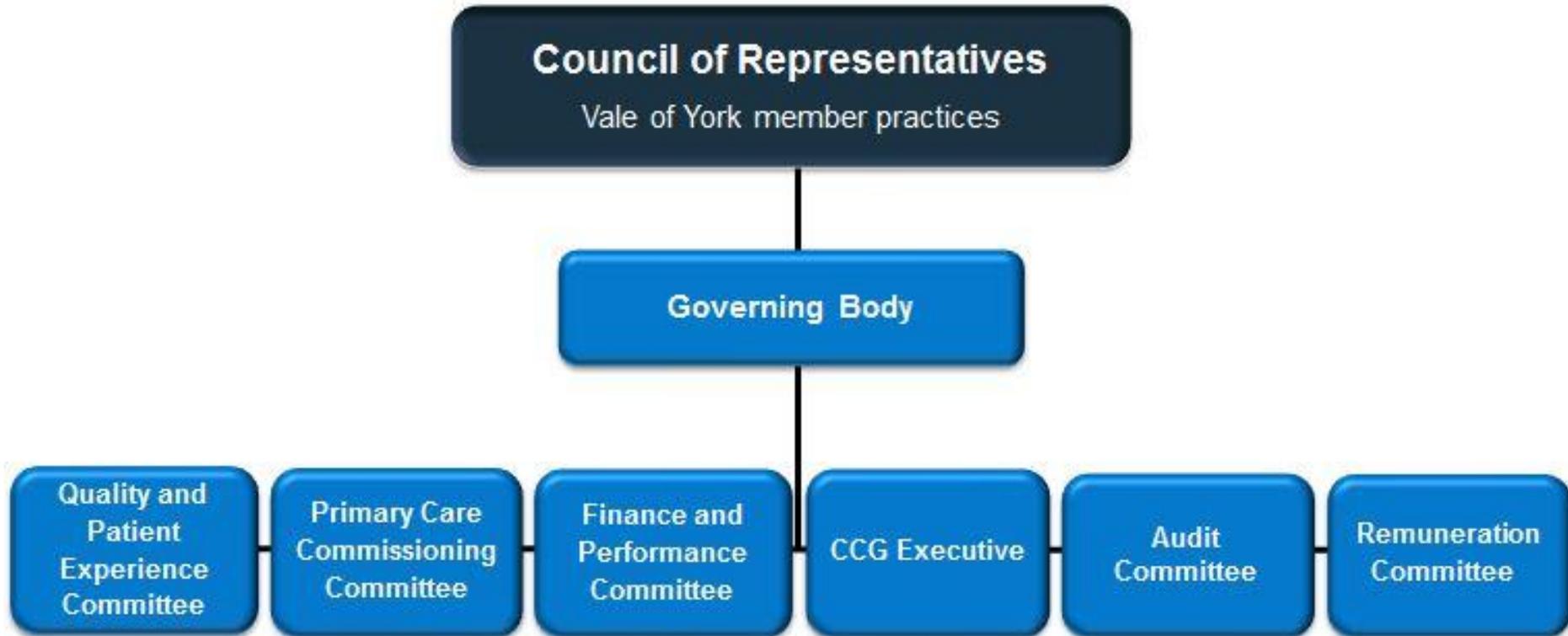
The Public Health function sits in Local authorities who tailor local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities. The Director of Public Health supports local political leadership in improving health. They champion health across the whole of the authority's business, promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed. The CCG works closely with Public Health and the Director of Public Health is a key member of the CCG Governing Body.

## **NHS England**

NHS England commissions specialised services, primary care (when CCGs do not have delegated authority), offender healthcare and some services for the armed forces. It has four regional teams but is one single organisation operating to a common model with one management board. The CCG works with NHSE to share quality surveillance information and to work together across the system to monitor and improve quality. Quality Surveillance Groups (QSGs) were established in advance of the new health and care system going live on 1 April 2013. They were introduced following the publication of the National Quality Board's (NQB's) report Quality in the New Health System: Maintaining and Improving Quality from April 2013. The NQB brings together the leaders of national statutory organisations across the health system, alongside expert and lay members. Members of QSGs, including the CCG should work together, as part of a culture of open and honest cooperation, to identify potential or actual serious quality failures and take corrective action in the interests of protecting patients.

The CCG also collaborates with education bodies such as the Health Education England, Academic Health Science Networks and local Universities.

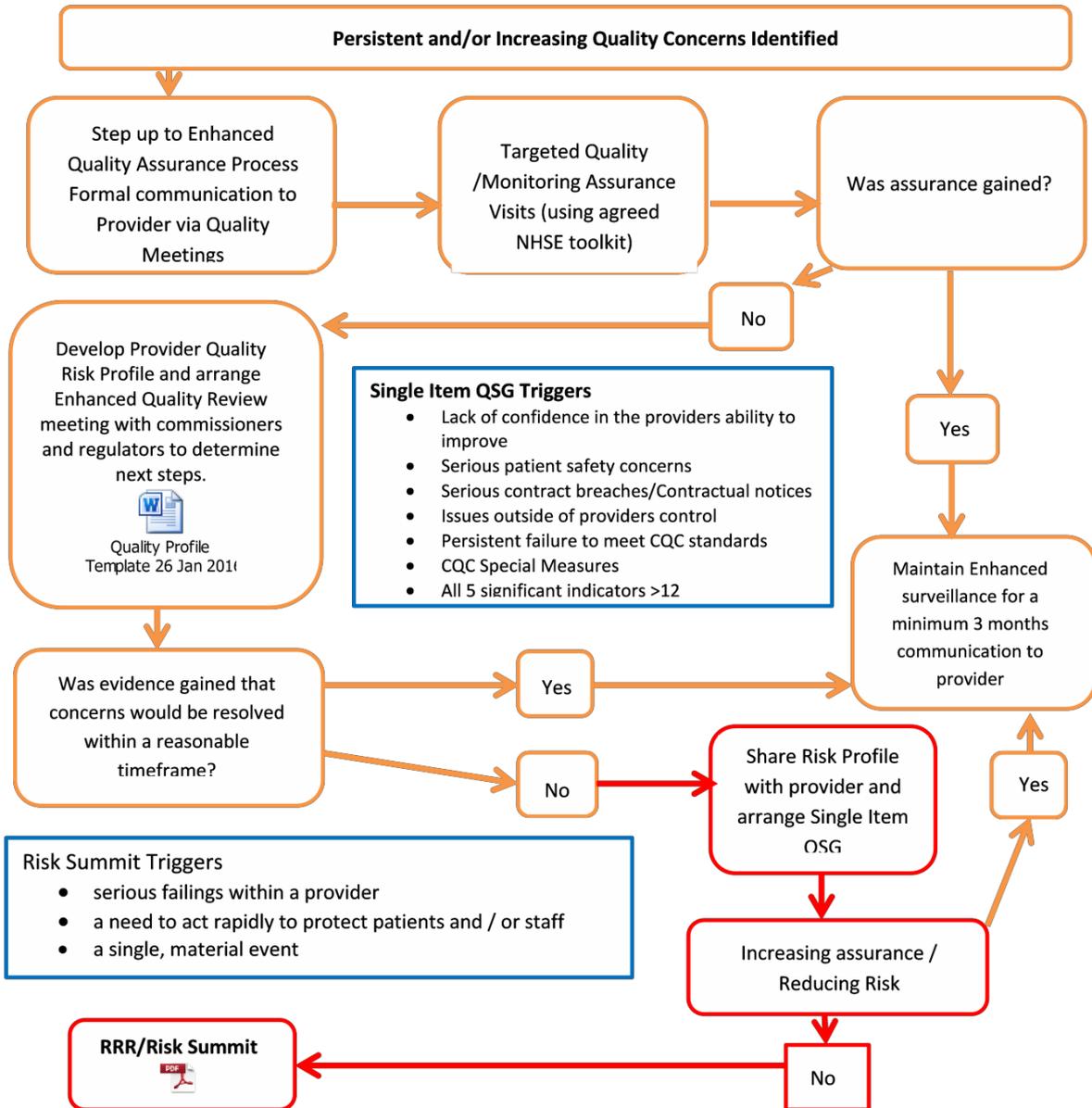
# The CCG's Governance Structure



# Appendix 1: Quality Monitoring and Escalation Process

## Commissioners Quality Monitoring and Escalation Process for Providers – Appendix 1

- Routine Quality Monitoring examples include:**
- CQC minimum standards
  - NHS Constitution/Mandate
  - Complaints/Friends and Family test
  - MHPS
  - Safeguarding
  - GP Outcomes Framework
  - Partnership working arrangements
  - Risk Registers
  - Serious incidents/Never events
  - Leadership/workforce numbers
  - Governance arrangements
  - Delivery against contract specification
  - Emergency admissions data and referral rates
  - Contract Review Meetings
  - CQUIN
  - Clinical visits



The escalation to a rapid response review or risk summit could be instigated at any point in the process if patient safety concerns require urgent action.

## Appendix 2: Key Quality Recommendations from the Francis Enquiry and Winterbourne View

### Francis Enquiry key quality recommendations:

- GPs need to undertake a monitoring role on behalf of their patients who receive acute Hospital or other specialist services.
- The Commissioner is entitled to and should, apply a fundamental safety and quality standard in respect to each item of service it is commissioning, and agree method of measurement and redress for non-compliance.
- Local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers services.
- In selecting indicators, the principle focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained.
- Commissioners – not providers – should decide what they want provided.
- Commissioners need to identify and make available alternative sources of provision.
- Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period. They must also have the capacity to undertake their own audits, inspections and investigations.
- Commissioners should be entitled to intervene in the management of an individual complaint on behalf of a patient where it appears to them, it is not being dealt with satisfactorily.
- Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.
- Commissioners should have contingency plans to ensure that patients are protected from harm, if they are risk from substandard or unsafe services.

### Winterbourne key quality recommendations:

- **One shared vision**, driven forward by active senior leadership, based on the presumption that hospitals are not homes, and that people should be supported to live in the community.
- **One pooled budget**, allowing maximum flexibility for commissioners to fund what individuals truly need, and aligning the financial incentives on all commissioners to invest in community-based provision.
- **One robust plan** for commissioning on a whole life-course basis, supporting early intervention and support (from early childhood onwards), expanding the provision of community-based support and care, and reducing the number of inpatients and inpatient provision.



# Commissioner site visit policy and procedure for Humber Coast and Vale Clinical Commissioning Groups

## Policy and Procedure

Version number	Date changed
1.5	29.09.17
1.6	06/10/17
1.7	14/11/17
1.8	08/12/17

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## **1. Purpose**

The purpose of this document is to clearly define the commissioner site visit policy and procedure. To outline conduct and commissioner responsibility when organising, attending, contributing to and reporting a site visit. The document aims to align the commissioner approach to site visits across the Humber Coast and Vale Partnership and to enable cross-organisation effective collaborative working.

## **2. Scope**

This procedure relates to all announced and unannounced site visits undertaken to the CCG's (commissioned) providers, this includes Acute Trusts, Primary Care, Providers who hold a contract or AQP (Any Qualified Provider Agreement) with the CCG, and Care Homes (Nursing and residential homes) including Continuing Healthcare placements.

## **3. Policy**

Site visits are a tool to be utilised within the commissioning cycle and at every level of quality surveillance. The frequency, focus, key lines of enquiry and type of the visit will be determined by the level of quality surveillance and concern (as indicated by the intelligence we receive, which may include but is not limited to Customer Care, Public Engagement, Safeguarding and Incident intelligence, or by a drop or trend in performance or quality indicators).

It is helpful to frame and clarify the types and purpose of site visits are described below in 3.1, from a commissioner information gathering site visit, to a commissioner inspection site visit. It is recognised that a review of a service user journey on a commissioned pathway may be indicated.

This policy and process also applies to a site visit based on a patient/service users journey through the health and social care system, therefore this process can be applied across a range of service providers. The nature of these visits can be complex due to the involvement of more than one organisation; therefore, they are usually conducted as an information gathering or routine site visit, within an announced framework, as defined in table 3.1 overleaf, to easily facilitate the review of a service user's journey.

Providers, regulators or other stakeholders, such as the local authority, NHS Improvement, CQC or Healthwatch, may seek supportive site visits, either led by themselves or at their request by the Commissioner. Where Services or other organisations choose to lead a site visit and invite Commissioner representatives section 4.3 of the procedure is applicable and should be adhered to by the Commissioner. Where the organisation asks the Commissioner to lead the site visit

the full procedure applies but in addition to this the type of visit and section 4.2 of the procedure should be completed in collaboration with the Provider's designated lead (this must include sharing the briefing and the site visit reporting template)

**4. Table to define the types of site visits**

Type of visit:	Why undertake the visit?	Key visit principles:
<b>1. Information Gathering</b>	To gain information and learn more about how services are being provided and to give providers an opportunity to share any challenges or best practice.	<p>Announced visit.</p> <p>This could include a commissioned pathway review (patient journey).</p> <p>The provider is normally under routine quality surveillance.</p>
<b>2. Routine</b>	In response to an area of concern which requires further information/assurance on the services position.	<p>Announced visit, however, there may be rare exceptions where an unannounced visit is indicated.</p> <p>This could include a commissioned pathway review (patient journey).</p> <p>The provider is normally under routine quality surveillance.</p>
<b>3. Inspection</b>	This is in response to a serious concern or a significant service user safety risk.	<p>Unannounced visit, however, there may be rare exceptions where the visit needs to be announced to the provider in order to safely facilitate the visit.</p> <p>The provider is normally under enhanced or summit quality surveillance.</p> <p>However, the provider could be on routine surveillance where significant concerns need investigating.</p>

## **4. Procedure**

### **4.1 Visit Indications**

The types of visits are defined in the table above and the indications of a visit are outlined within. The key visit principles articulate the level of quality surveillance the provider is usually under with the Lead Commissioner.

For all visits the Commissioner must formally record the rationale for the visit.

### **4.2 Preparing for the visit**

The first stage of preparing for a visit requires the Commissioner to confirm why the site visit is required, which type of visit, either 1, 2 or 3 is needed. This helps the commissioner to determine whether the visit is announced or unannounced. Unannounced visits should be rare and by exception limited to the undertaking of a visit where there are serious concerns about service user safety.

The Key Lines of Enquiry (KLoE) must be determined prior to the visit and recorded in the site visit template, for example under the Safe Domain Safeguarding Procedures may be a KLoE. The site visit template must be populated with the key lines of enquiry to ensure the visit meets its desired purpose. It is recognised that focused visits, and following a service user's journey through a commissioned pathway, requires the use of a template which is flexible to adaptation to meet the purposes of the visit. In addition, type one visits require a simple template to record information gathered on a non-complex visit. Therefore, the template found in appendix one of this document has been designed as a basic template to build key lines of enquiry within the CQC five domains for quality and safety.

The size of the site visit team needs to be determined. The size of the team needs to be appropriate for the scale of the visit and proportionate to the size of the Provider being inspected. The key lines of enquiry for the visit need to be clearly articulated and the skills/experience/specialism of the site visit team need to be appropriate for the purpose of the visit, for example where a KLoE is specific to safeguarding it would be appropriate to ensure a member of the site visit team is an experienced safeguarding practitioner. The organiser needs to be able to rationalise the involvement of each member of the site visit team. It is desirable and considered a gold standard to seek lay representatives on Inspection and Routine visits.

Announced site visits must be organised with the Provider, with a minimum of six weeks' notice, and a date and time for the visit must be mutually agreed upon. When organising the date of the announced site visit the reason for the visit, size of the team, and the lead commissioning contact must be shared with the provider. It is recognised that on a planned announced visit the Provider may choose not to inform

their staff that a Commissioner-Led visit is being conducted. It is key that the site visit team are made aware of this prior to the visit; therefore, it is essential that the Commissioner establishes the Providers position regarding this prior to the undertaking of the visit.

Prior to all Routine and Inspection site visits the Commissioning Lead must prepare a briefing to be shared, along with the Site Visit reporting template, with the site visit team and held as a record in the Commissioning Provider file which includes as a minimum; the rationale for the visit; any supporting intelligence (such as, but not limited to, audit results or performance/quality indicator data); the key lines of enquiry; roles of each individual (including identifying a Site Visit Team lead); reporting mechanism for urgent concerns and plans to report on the visit.

### **4.3 Conducting the visit**

All members of the site visit team must be bare below the elbow, short nails (varnish free), hair off the collar, no open toe sandals, smart and presentable and be wearing identification (no lanyards). It is recognised that the site visit team will not have clinical contact with service users; however, the principles of good infection prevention and control practice and professionalism must be embodied by the team.

On all three types of site visit the Commissioning Lead must announce their presence; the purpose of the visit; determine visit boundaries (for example, when visiting an acute provider there maybe restrictions in access due to a patient on an imminent end of life journey); confirm the mechanism for escalating immediate concerns and agree a process for enabling a verbal feedback to the provider on the day at the end of the visit.

All members of the site visit team must act in accordance with their employers and where applicable, professional bodies, code of professional conduct. The team must be respectful to the organisation they are visiting, and the staff and service users accessing the setting. The site visit team will at all times; act professionally; respectfully; confidentially; sensitively and supportively. The team will be courteous at all times and be mindful of the privacy and dignity of patients; relatives and staff during the visit.

### **4.4 Reporting on the visit**

#### **4.4.1 Sharing visit findings on the day**

Areas which pose a safety risk to any staff or service users must be escalated at the time of the site visit. All members of the team must escalate any safety risks to the Site Visit Team Lead; it is the Leads responsibility to address these with the appropriate senior representative from the Provider. It is anticipated that there will be extremely rare occurrences where a member of the inspection team identifies a significant immediate risk and has to escalate outside of this defined process to the

Provider, this must always be followed up by informing the Site Visit Lead of the risk and the immediate action taken to address it.

At the end of the site visit, on the day, the designated site visit lead will provide high level summary feedback to the Senior Provider representative. The summary feedback must include; any risks to service user safety; any significant positive and negative findings.

#### **4.4.2 Sharing a formal site visit report**

A formal documented report must be completed and agreed by the site visit team and shared with the provider within 10 working days of the site visit. The report must be tabled through the contract meeting process and a formal response from the provider must be sought via the contract process. Please note formal responses may range from; acknowledgement of the site visits findings; challenge to the findings or an action plan to address the findings. Each formal response must be considered in isolation to the findings, through the contract management process.

#### **4.5 Seeking assurance from findings**

Assurance from the findings may range from, but is not limited to; requesting particular intelligence or evidence (for example, audit results, an action plan or a particular policy); completing a follow-up visit or seeking (and monitoring) a providers action plan to address any areas which require improvement.

#### **4.6 Informing level of quality surveillance**

Site visit findings, triangulated with all other commissioner mechanisms for determining the quality of a services delivery, should be utilised to facilitate an informed decision of the level of quality surveillance the provider is subject to.

Appendix 2 on page 9 outlines the full process map from the initial planning to reporting and follow-up.

### **5. Glossary**

#### **5.1 Visit types**

Information Gathering – Announced visit to gain information and learn more about how services are being provided and to give providers an opportunity to share any challenges or best practice.

Routine – A visit conducted in response to an area of concern which requires further information/assurance on the services position. This is usually an announced visit but may be unannounced.

Inspection - This type of visit is in response to a serious concern or a significant service user safety risk. The visit is usually unannounced but may be announced.

## **5.2 Announced and unannounced**

Announced – The Provider has prior knowledge of the arranged site visit, in line with the standards outlined in this policy and procedure.

Unannounced – The Provider does not have prior knowledge of the arranged site visit, in line with the standards outlined in this policy and procedure.

## **5.3 Provider led site visit**

A site visit is led, organised and facilitated by the Provider. The visit is subject to the Provider's governance arrangements for visits.

## **5.4 Commissioner led site visit**

A site visit is led, organised and facilitated by the Commissioner. The visit is subject to this policy and procedure standards.

## **5.5 Service user journey**

The visit focuses on reviewing a particular Service User pathway. This type of visit often intersects a number of services; therefore, it is usually conducted as an announced visit partly due to the planning implications to enable a full pathway review.

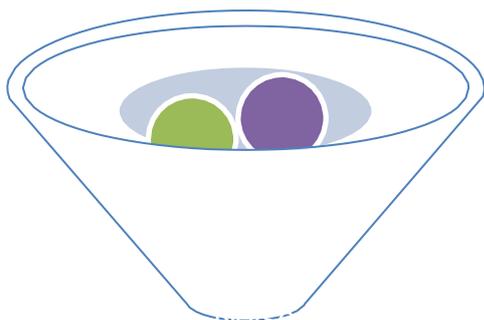
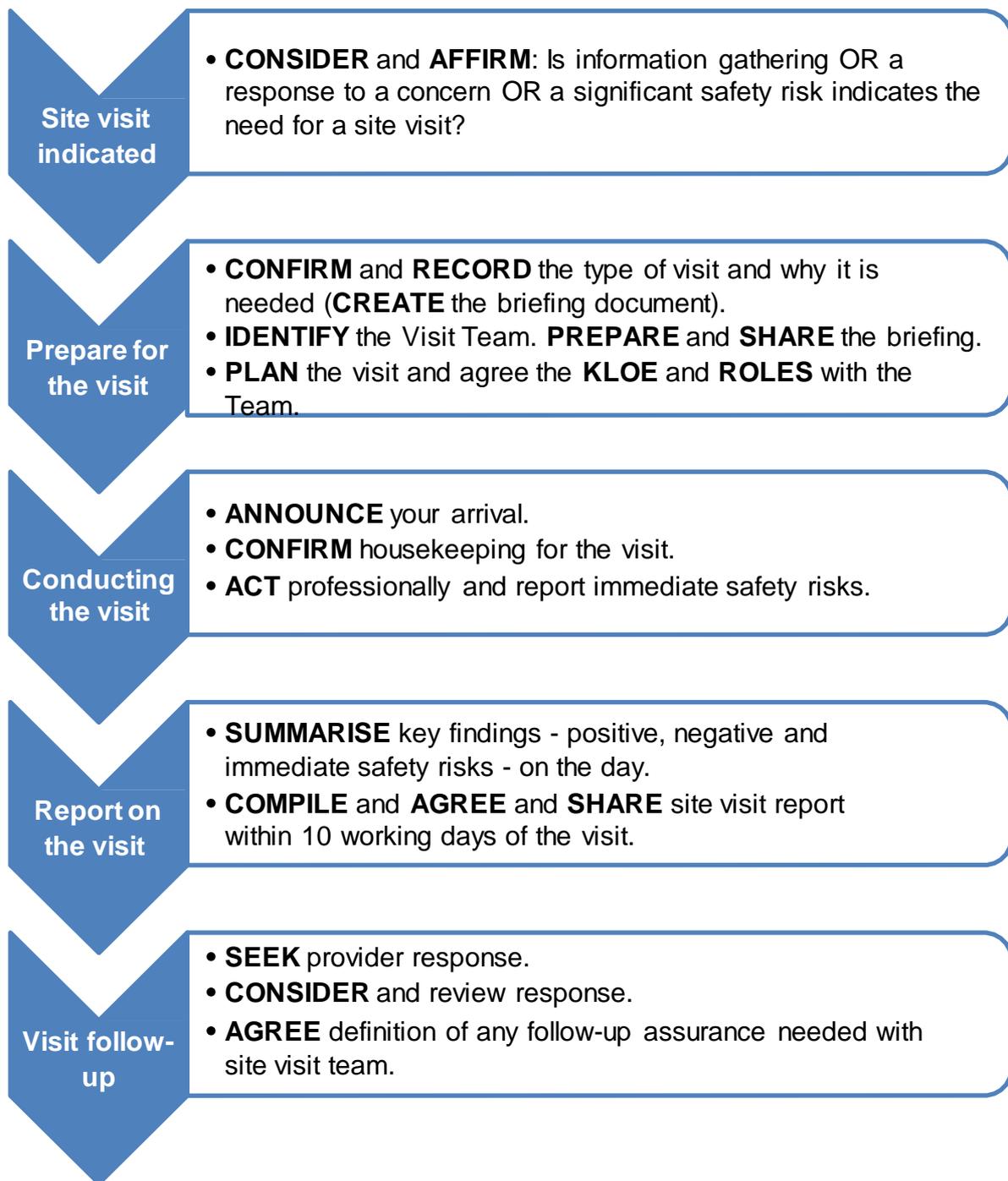
## **5.6 KLOE**

Key Line of Enquiry also referred to as a KLOE. A specific area to focus attention on within the five domains; safe; effective; caring; responsive and well-led.

**6. Appendix one – Blank site visit reporting template**

<b>15 step audit (five senses on first 15 steps into the site visit area)</b>	
<b>Domain</b>	<b>Key Lines of Enquiry and findings</b>
<b>Safe</b>	
<b>Effective</b>	
<b>Caring</b>	
<b>Responsive</b>	
<b>Well led</b>	
<b>Summary of the highlights from the visit</b>	
<b>Positive exceptions</b>	
<b>Negative exceptions</b>	
<b>Risks requiring immediate attention</b>	

## 7. Appendix two – Site visit process map



**Level of  
Quality  
Surveillance**

**8. Appendix Three – Example of a site visit reporting template populated with the Key Lines of Enquiry**

<b>15 step audit (five senses on first 15 steps into the site visit area)</b>	
<b>Domain</b>	<b>Key Lines of Enquiry and findings</b>
<b>Safe</b>	Infection Prevention and Control - Cleanliness of the environment with appropriate access to hand hygiene facilities  Health and Safety – equipment Escalating Concerns
<b>Effective</b>	Policy and Guidelines – Is there a pregnancy testing in children policy? Can staff access it? Do staff know the policy?
<b>Caring</b>	Attitude of staff
<b>Responsive</b>	Providers response to feedback
<b>Well led</b>	Is clinical leadership visible on the shift?
<b>Summary of the highlights from the visit</b>	
<b>Positive exceptions</b>	
<b>Negative exceptions</b>	
<b>Risks requiring immediate attention</b>	

## 9. Appendix four - Example of a completed site visit report

15 step audit (five senses on first 15 steps into the site visit area):	
<p>The Visiting Team found the appearance of the environment to be very pleasing. Carpets appeared clean; there was good signposting throughout the building to direct visitors to the reception area. Staff were welcoming. There were health promotional resources on display in the waiting areas and magazines available in for visitors to occupy their time whilst they waited. The environment was quiet and calm, and was welcoming to visitors.</p>	
Domain:	Key Lines of Enquiry and Findings:
<b>Safe</b>	<p><b>Infection Prevention and Control - Cleanliness of the environment with appropriate access to hand hygiene facilities</b></p> <p>Overall the environment appeared clean. The reception area would benefit from access to hand hygiene materials, such as an alcohol-gel dispenser, at the reception desk for staff and visitors. The visitor toilets for the building appeared clean but needed maintenance in the men's facility. Sharps bins were secured with appropriate content.</p> <p><b>Health and Safety</b></p> <p>The working environment was free of clutter and the paths to escape from the building were clear and accessible. Waste management appeared to be compliant with National Standards. The equipment we inspected was safety tested and appropriately labelled.</p> <p><b>Escalating/De-escalating Concerns</b></p> <p>Staff were able to articulate what to do if they had concerns. There was a documented process for managing safeguarding concerns which was readily available to staff. Staff informed us that they have a whistleblowing policy in place. We saw evidence of a formal mechanism for de-escalation – through staff meetings. Staff also told us that informally de-escalation occurred through meetings with their manager</p>
<b>Effective</b>	<p><b>Policy and Guidelines – Is there a pregnancy testing in children policy? Can staff access it? Do staff know the policy?</b></p> <p>A policy was in place, we asked three members of staff and they were able to locate and access the appropriate policy. Staff demonstrated knowledge of the policy contents and the application of it in practice.</p>

<b>Caring</b>	<p><b>Attitude of staff</b></p> <p>We found that staff were caring and considerate of each other and their patients. Staff told us they really enjoyed working here and that they were very proud to work for the organisation.</p>
<b>Responsive</b>	<p><b>Providers response to feedback</b></p> <p>The provider had a process in place for receiving patient feedback and learning from complaints. We did find that the provider needs to improve on the recording on informal concerns raised and the action they have taken in response to these. Staff were able to give us examples of where they have learnt from patient feedback and what they have done in response to the feedback given. Staff also informed us that they receive a significant amount of positive feedback from patients in the form of thank you's, cards and small gifts. FFT data was clearly displayed in patient and staff areas, including the response of the organisation. We followed two of the articulated responses and were satisfied that they had been completed.</p>
<b>Well led</b>	<p><b>Is clinical leadership visible on shift?</b></p> <p>Clinical Leadership was visible to both staff and patients. The Shift Lead was noted on a Board accessible to both patients and staff. Staff we spoke to felt supported and able to readily access supervision and support on a shift by shift basis.</p>
<b>Summary of the highlights from the visit</b>	
<b>Positive exceptions</b>	
The visit to the service was extremely positive. We were welcomed by staff and patients. Staff were open and candid with the inspection team and were extremely confident when responding to enquiries raised by the Visiting Team.	
<b>Negative exceptions</b>	
The recording of informal concerns raised and the action taken in response to these needs to be improved to clearly evidence the feedback received and the action taken by the organisation.	
<b>Risks requiring immediate attention</b>	
None identified.	

**- End of document -**

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