Report of the Quality and Patient Safety Committee which met on 20th January 2012

1.0 Introduction

2.0 Quality and Safety Priorities

3.0 NHSLA Update Report

4.0 Patient Safety Walkabouts

5.0 Infection Control Committee Quarter (3) Report

6.0 Quality and Safety Dashboard - Divisional Reports

7.0 Revision of Committee Terms of Reference

8.0 Reflections on the working of the committee.

9.0 Policies and Guidelines approved for information

1.0 Introduction

1.1 The Quality and Patient Safety Committee met for the fourth time on Friday 16th December 2011. This report provides a summary of key items discussed and decisions made

2.0 Quality and Patient Safety Committee Work areas

2.1 The Quality and Patient Safety Committee covers three main domains, Safety, Clinical Effectiveness and Patient Experience. Each of these quality dimensions will be explored in depth through a cycle of reporting and bi-annual in depth quality meetings with each Division.

2.2 The Committee has identified the following hotspot areas as areas where there is concern about quality, patient safety and patient experience – derived from reports to the committee since its inaugural meeting in September 2011: These include:

2.2.1 Maternity Services: in particular the consequences of a sub-optimal care environment

2.2.2 District Nursing: reflected particularly in the incidence of Grade 3 and 4 pressure ulcers in Haringey and pointing to concerns around management arrangements and care management processes for this service

2.2.3 HMP Pentonville Healthcare: inherent in the high risk population served

2.2.4 Emergency Department: reflected in poor performance against targets, low staff morale following a review of staffing levels, trends of poor performance in nursing audits and a high number of complaints

2.2.5 Children's Services, to include Health Visiting, School Nursing and Child Protection: recent high turnover of medical staff in Haringey and a number of Islington cases are being heard in the High Court in October, November and December.

2.2.6 Achievement of NHSLA Level 1 where progress is encouraging but the risks of failure to achieve are significant

2.2.7 Falls

2.2.8 Mandatory training – raised more than once in this forum and being monitored by Audit Committee and managed by Executive Committee.

2.3 The January 2012 meeting identified the following issues which have been highlighted across a number of service areas from audit reports, score cards and dashboards

2.3.1 The lack of measurement of community indicators on the Patient Safety and Quality Dashboard

The following reports were presented to the Committee at its meeting on 20th January 2012:

3.0 NHSLA Update report

Report spoken to by David Williams, Assistant Director of Governance. David highlighted the status of the project, bringing attention to the number of policies that had progressed. The project was on an improved trajectory, and David highlighted the fact that some of the policies were risk rated as Red, however these would be compliant by the submission

deadline as work was in place to rectify deficiencies. David also highlighted that to complete this project a number of core staff had worked evenings and weekends to ensure the project remained on track in addition to their normal core working requirements. A query was raised by Helena Kania regarding maintenance of the position - David explained that once feedback has been received following the assessment an action plan would be developed to implement the policies and gather evidence to demonstrate implementation.

Thanks were recorded for the work that has been done by Claire Topping and the wider project team recognising the additional work the team had completed.

4.0 Patient Safety Walkabouts (Appendix 1)

Report spoken to by David Williams, who drew attention to committee members that the proposal put before them had been agreed by the Executive Committee previously. It aimed to establish a program for the whole Integrated Care Organisation and work has been carried out with Divisional leads to gauge how best to implement this.

Anita Charlesworth identified the need to track agreed actions especially in relation to safety issues, David Williams added that when issues arose related to complaints and serious incident it was important there was an effective method of ensuring they were fed back to senior managers, the Patient Safety Walkabouts going forward will also be cross referenced to the risk registers to ensure there is not duplication of activity.

There was a discussion about walkabouts being completed outside of normal working hours to ensure this captured staff working weekends, evenings and nights.

It was confirmed that a new system and rota would be in place by March 2012 and non executive involvement would be recorded, in addition a progress update from the 2011/2012 program would be submitted highlighting those actions that are completed and areas where progress has not been achieved.

5.0 Infection Control Committee Report Quarter (3) Oct-Dec 2011 (Appendix 2)

Report spoken to by Dr Julie Andrews

5.1 There had been no incidents for MRSA that quarter – the last recorded case had been c.200 days ago, so the Trust was under trajectory in this area. There had been two c difficile related deaths, both of which had been investigated and the Trust's care had been found to be exemplary with good documentation in both cases. The issues identified had been found to lie with primary care prescribing which was being followed up via the commissioners. Both cases would be reviewed by the Executive SI Panel in due course.

5.2 Most Trusts situated within North Central London area had experienced outbreaks of norovirus, however despite a few cases being diagnosed within patients and staff, Whittington Health had not suffered an outbreak. It was noted that the Trust has assisted other organisations in the area when there have been shortages of beds by assisting with diverts of patients.

5.3 Considerable effort has been made to improve hand hygiene throughout the Trust, with particular emphasis on junior doctors. Hand hygiene was being monitored on a daily basis, to include monitoring by Dr Andrews, in addition a letter from the Nursing Director, Medical Director and Chief Operating Officer has been designed to send to staff who were non compliant with practice in this area. Training for hand hygiene is

taking place on a fortnightly basis. There was a discussion concerning the standards set for hand hygiene and it was clarified by Celia Ingham Clark, Medical Director that the standards were set at an appropriate level.

5.4 The terms of reference of the newly formed Infection Prevention and Control committee were received with the committee reporting to the Quality and Patient Safety were received, it is intended to appoint a GP to the committee.

5.5 Sue Rubenstein congratulated Julie and her colleagues on both their performance and the report, mentioning in particular the helpful summary set out on the front sheet.

6.0 Quality and Safety Dashboard (Appendix 3)

Introducing this item Sue Rubenstein identified the intention to meet with relevant senior staff from Bronagh Scott, Fiona Smith and Maria Da Silva's Divisions/Directorates to ensure all available community data is included within future reports.

6.1 Discussions were held about the content of the report. It was noted that divisional narrative has improved, however some disappointment was identified in terms of the delays in getting completed reports. Questions were raised in relation to falls data, emergency re admission and the correlation of these issues in relation to the seniority/experience of the clinicians.

Discussions were also held concerning the move to 12 hours consultant coverage 7 days a week. It is expected that when more coverage is available for related services where this is currently not available this will lessen readmission rates. It was noted however that under the national contract we cannot insist on weekend working arrangements for this purpose and so the organisation is working to develop a hybrid solution.

6.2 There was a request made to ensure that the dashboards are communicated to Consultants in future, in addition a report from the East Midlands Quality Observatory has been shared with Performance and Planning Information colleagues to assess its application to Whittington Health.

6.3 There is a need to develop the annual audit program further to include community services, which is being addressed by the Audit and Clinical Effectiveness Committee.

7.0 Revision to the Committee Terms of Reference

The revised terms of reference following NHSLA review were submitted and approved by the committee. As part of the committee cycle these will be reviewed again in January 2013 or prior to this if changes occur to the workings of the committee or organisational form.

8.0 Reflections on the workings of the committee

The Committee started this discussion very mindful of the multiple pressures on Senior leaders and staff across the Trust over this first year of the ICO – a merger, new Board (with new relationships and mutual expectations to establish) restructure, new strategy, the FT process, very demanding CIP programme, significant improvement interventions in key parts of the Trust (e.g. ED) etc, It is also important to keep in mind that the Committee has only been established for one full 'quarter'.

8.1 What's going well?

- Overall, the culture of openness and the absence of 'defensiveness'. There appears to be a genuine wish to expose all aspects of the care that we offer to patients to appropriate scrutiny as part of a drive for continuous improvement. The Committee has established the climate of trust and candour that is critical to its on-going effectiveness. This should not be under-estimated as a strength and the Committee wished to express its appreciation to all staff.
- The basic 'architecture' for the Committee is broadly in place – reflected in an annual work programme that should enable us cover the 'quality' territory.
- We have made a reasonably good start on bi-annual 'visits' from the Divisions aimed at enabling the Committee to explore in more depth both the current position of each Division and to understand the Division's quality aspirations
- Likewise we have managed to create an outline of a quality dashboard and a good start on the quarterly patient safety report (bringing together incidents, complaints, legal claims)
- The Committee has received 2 helpful and comprehensive quarterly Infection Prevention and Control reports

What needs further strengthening?

- Although the Committee has identified key quality 'risks' – there should be a more explicit and consistent thread between the quality risks on the Trust risk register and the risks identified in the committee and forming a focus for its work – the Committee should review the Risk Register regularly to ensure this consistency
- Overall the information provided to the Committee could still be considerably tighter and more focused.
- The quality dashboard, as it stands, is still incomplete. The Committee is particularly concerned about the lack of consistently provided information from community services – this is true of both the dashboard and other reports where only some reports include community. We are informed that the Divisions are looking at quality data across the piece. It is not clear therefore what the obstacle is to capturing this information for the Committee. Other gaps persist too.
- The quality dashboard has been helpfully strengthened by the 'narrative' on reds and ambers provided by the Divisions. However there is scope to support the Divisions to provide this background narrative in a more concise and consistent way. Likewise we need to build on the good start that has been made in relation to Divisional 'visits' and offer further support to Divisions in the preparation of the background papers to ensure a consistent, focused approach.
- The quality dashboard would be strengthened by the addition of a visual symbol that would tell the reader about the 'trajectory' – is this getting better or worse and when is it reasonable to expect that interventions to improve the position might take effect
- The quality dashboard provided to the Committee is 2 months in arrears (e.g. November dashboard at the January meeting). It would be helpful to understand why this is the case – and what it would take to give the committee access to more current information
- The Committee has consistently expressed a wish to see more comparative information where appropriate and available. We need to be helped to 'contextualise' the ICO position.
- The committee is keen to see the development a more sophisticated set of 'patient experience' metrics. Even with those currently in use on the dashboard there remain gaps.

- The ESR continues to be a source of considerable concern. Its accuracy and reliability is consistently referred to in explanations of poor performance in relation to sickness absence and training. Staff absence is a critical 'early warning' metric in relation to quality and it is critical that we are able to place reliance on the information.
- papers and presentations are valuable, as is the advice received from the experts.
- it is difficult for the non-experts to know what the priorities are, non-experts are heavily reliant on the divisions to keep us informed
- There is a need to look out for best practice and keep this under review.

8.2 Sue Rubenstein thanked everyone for their work throughout the year. She pointed out that significant progress had been made during a year in which the organisation had been through a major integration, major internal restructuring, and had a new Board which should be recognised.

9.0 Policies and Guidelines approved for information

9.1 The committee noted the list of policies and guidelines that had been agreed by the policy approval group as follows:

- Clinical Audit
- Incident Reporting
- Best Practice - NICE
- Best Practice - National Confidential Enquiries/Inquiries
- Hand Hygiene
- Patient information & Consent.