QUALITY, PATIENT SAFETY AND RISK COMMITTEE MEETING

Tuesday 19th September 2017

North End Medical Centre, 160 North End Road, London, W14 9PR

Governing Body Members Present:		
Trish Longdon	Lay member, H&F Clinical Commissioning Group (Chair)	TL
Jane Wilmot	Lay member, H&F Clinical Commissioning Group	JaW
Amy Wilson	GP member, H&F Clinical Commissioning Group	AW
Sena Shah	Practice Manager member, H&F Clinical Commissioning Group	SS

Officers in attendance:		
Liam Edwards	Assistant Director for Quality Improvement and Clinical Assurance, H&F Clinical Commissioning Group	LE
Susan Roostan	Deputy Managing Director, H&F Clinical Commissioning Group	SRo
Molly Larkin	Safeguarding Lead, H&F Clinical Commissioning Group	ML
Margaret Kelly	Business Support Manager, H&F Clinical Commissioning Group (minutes)	MK

Apologies:	
Vanessa Andreae	Vice Chair, H&F Clinical Commissioning Group
Mark Jarvis	Head of Governance and Engagement
Beverley Mukandi	Safeguarding Children Lead, H&F Clinical Commissioning Group
Andy Petros	Secondary Care Consultant, H&F Clinical Commissioning Group
Pritpal Ruprai	GP member, H&F Clinical Commissioning Group

Item	Agenda Item /Discussion	Action Owner
1.	**Welcome & Apologies**	
1.1	TL welcomed everyone to the meeting.	
2.	**Conflicts of Interest**	
2.1	The general conflict of GPs as commissioners and providers were noted. No additional conflicts other than those published were declared.	
3.	**Minutes of the last meeting**	
	The committee approved the minutes of the last meeting.	

4.	Matters Arising	
4.1	TL asked LE to provide a brief summation of the findings from the LAS demand management reports, to include an update on next steps and level of assurance provided. LE reported that the most pertinent points were that Hammersmith & Fulham (H&F) CCG have shown the biggest increase across NWL CCGs in ambulance contacts with an increase of 15.8%. He added that the CCG had a target to reduce the number of contacts by over 4,000 contacts by the end of 2017/18. SRo asked if they were 999 contacts or contacts via 111. LE responded that the contacts were through 999 but the aim was to try to get people to call 111 and for 111 to transfer the calls accordingly. AW asked if GP referrals for ambulances were included and noted the relatively small numbers. LE responded that GP referrals were included. LE said to reduce the contacts, the work was focusing on three particular areas, which included growth, the drivers and trajectory to reduce the numbers. LE said eight specific interventions were being looked at but were unable to alter two areas in particular, the frequent callers, which was an issue in H&F with one person calling 45 times every month. TL said there were few alternative places available for these people, in addition to A&E, with little or no provision in social care in a large number of cases. LE noted the huge social factors and overall reduction in mental health spending also impacting provision. LE informed members of the links with the CQUIN work (CQUIN 4) around mental health avoidance, but highlighted the difficulties in having to work within an existing envelope with limited effects. LE said the Metropolitan Police reported an increase in the number of calls of 22%. He added that the 111 service had shown an increase of 26.6% and 999 category Cs should an increase of 34.5%. LE said the next steps are to establish leads for each of the eight interventions. LE reported that Business Intelligence (BI) were creating packs for each CCG to allow them to drill down into the best interventions to be taken forward and said that Matthew Chisambi was the H&F lead for this work. LE said he was the CWHHE link for the quality element but the work was being considered from multiple angles. SRo said this work formed part of the non-elective (NEL) programme and was one of the areas where the CCG could attempt to manage demand. LE stated that it was more applicable to GP surgeries, and some of the work undertaken showed that GP surgeries were calling ambulances to convey people to hospital, because it was quicker and easier to do so. AW asked whether the increase in volume was across the board or specifically related to high caller patients. LE responded that it was across the board and a NWL issue. TL requested further clarity around timescales and dates for the actions in train, given that this was an in year target. LE noted the continued anticipated growth. LE clarified that Matthew Chisambi was making contact with those places showing the highest number of calls, to determine a way of reducing the numbers, and was also engaging with those GP practices that showed the highest number of calls.	**LE/ SRo**

	LE noted that some of the places that showed high calls were attached to Urgent Care Centres (UCC's) therefore showed a slightly imbalanced picture. LE explained that stand-alone UCC's might call an ambulance to transfer a patient to hospital, for example, Charing Cross might do an ECG and transfer the patient to Hammersmith Hospital. AW said as a CCG, it would need to prioritise the actions and feed this information back to GP practices through whole systems and into the care dashboard with an intervention to be put in place for each patient. She suggested using the network plan and whole system dashboard and to ask GP practices to review those patients with high call rates and to consider having this as an objective for each GP practice. SS suggested the BI team should establish links with the primary care team and visit each GP practice, and focus on those GP practices that use the service frequently and are high users of unscheduled care. He suggested running a report to be discussed at multi-disciplinary team (MDT) meetings and to establish the right social care contacts and links with the GP Federation. ML suggested establishing links with Malcolm Rose, Head of Complex Care at the Local Authority and agreed to share his details with Liam to make contact and to hold a wider MDT discussion. SRo commented on the difficult types of patients and challenges faced in altering their behaviour and said capacity around GP time would need to be considered. AW asked SRo to follow this up and hold a discussion with Sophie Ruiz. JaW commented that all GP practices would need to be engaged. AW responded that GP practices are already receiving payment for some of this work. SRo talked about non-conveyances and informed the committee of the pathway work currently happening around LAS, with patients that fall being treated where the fall occurs, rather than transferring the patient elsewhere such as a hospital. She added that further work was happening around care homes and residential homes but the numbers are small. SRo said as the CCG are already doing quality work in care homes that this work should be included to deliver greater patient outcomes in care homes and residential homes. JaW questioned what was preventing the number of calls from reducing. AW said it was multifactorial and it was hard to understand the drivers and said due to winter approaching the benefits would be masked making it more difficult to measure and assess, and would need to take into account resource issues. SRo reiterated that given a component of the work was included in the NEL programme, suggested holding a discussion at a clinical or governing body seminar, in the context of QIPP, the CCGs biggest opportunity utilising the work that Matthew Chisambi had undertaken to date. She suggested the CCG should focus on the real, tangible things it can do with the case studies useful in terms of learning. SRo agreed to circulate the NEL plan, which includes timescale and actions to the committee. LE reiterated the importance of establishing greater links between the difference organisations such as BI, LAS and the Metropolitan Police and to focus on the quick wins. LE noted that the care home element was small but patient experience was huge. LE said that the CCGs focus should be on contacts as the CCG gets charged for them. TL mentioned the detailed work at GP face-to-face meetings, the importance of reviewing the data and the use of social care. SS said access to PID data would be required and to focus on what could be done differently. TL commented on the lack of a clear-targeted plan with dates, timescales and milestones, to provide the CCG with a level of assurance of the work currently underway and asked for the clinicians to build some case studies simultaneously. The committee **noted the verbal update and discussion** on the LAS demand management reports	**ML** **SRo** **SRo** **SRo**

5.	**Action Log**	
5.1	The outstanding actions were reviewed and discussed; please refer to action log for updates.	
6.	**Corporate Risk Register – Quality Risks**	
6.1	TL introduced the Corporate Risk Register, Quality Risks, which the committee were asked to note and asked SRo for an update following the Ops Group discussion. SRo informed members that Mark Jarvis mentioned it was an iterative process but gaps remain and himself and MK would be holding conversations with individual teams to review their risks and local process and had tasked managers to speak to teams to ensure they were receiving the right level of support. AW said that the Corporate Risk Register (CRR) was predominantly Imperial focused with lots of the risks being reported also pertinent for Chelsea and Westminster (C&W); one of the CCGs main providers, therefore should be reflected in the document. LE stated that there should be a read across between the Quality Report and CRR. MK agreed to share a copy of the CRR with AW for review and to draw to the committee's attention any risks identified at the next C&W CQG meeting and to ensure these are captured in the CRR. ML noted the number of risks on the H&F CRR; the importance of establishing plans that are regularly monitored and the use of smart objectives to reduce the risk scores. LE explained the CRR process; he stated that it includes initial risks and mitigations also an element of uncontrolled risk and additional mitigations required to achieve the risk appetite, the level of risk that the CCG are willing to accept. LE said that only risks scored 8 and above are escalated to the CCGs CRR, with all other risks to remain on local team risk registers until such time that they close. SRo clarified the three tiers of risk management, the local risk registers (team owned risks), the CCGs CRR (includes all CCG owned risks scored 8 and above) and the Strategic Board Assurance Framework (BAF) across CWHHE, which includes a local CCG component. AW said that one of the actions from last week's Governing Body was to go back to the C&W CQG to request an update on caesarean section rates. She added that an e-mail was sent to the Trust but given people's obvious concerns would decide following CQG feedback whether this should be included as a risk on the CCGs CRR. TL noted that the cover sheet would alter for the next month's report to include narrative around the risks and exclude the numbers. TL commented on risk HF115 concerning mandatory training and lack of access to the OLM system since April 2017 due to a technical issue with the system. TL commented that this was an additional risk and sought assurance around what was happening to address this risk. SRo responded that this was an HR function and there were technical hitches with the software. SRo noted that HR owned this risk and Maggie Gibbs should be the risk owner. TL suggested escalating this reputational risk to the governing body to include an update on progress in resolving the technical issues from Maggie Gibbs. SRo informed members that Mark Jarvis attends the monthly OD Working Group and HR Committee meetings and raises this issue on a monthly basis. The committee discussed how best to take this issue forward and whether to email the Chief Officer and HR. SRo suggested having a discussion with Mark Jarvis and Janet Cree about raising it formally as an email up to Clare Parker, Chief Officer and Maggie Gibbs, Director of HR. JaW suggested an e-mail be sent to those staff whose training was due to expire. LE explained that people whose training had automatically sent an e-mail and are provided with special access to the OLM system to complete their refresher training modules.	**MK/ AW** **MK/ SRo**

	TL commented on risk HF76 *(Core quality indicator data available at varying levels of consistency for Out of Hospitals Services for CWHHE CCGs, could lead to a lack of assurance and possible variability of patient safety)* and asked if there was a timescale to address this risk and reduce the risk score. TL also sought further clarity on the risk owner and outcome. LE explained that Ola Aroyehun, Senior Contracts Manager in the Central Contracts Team and the CCG are ultimately responsible, but need to hold the GP Federation to account, and require contractual levers for those GP practices failing to provide the data. AW stated that the Out of Hospital Services (OOHS) review was still on-going and therefore would be difficult to include a completion date currently. SRo said it would be helpful to include the name of the reviewer and for this risk that would be Ola Aroyehun. She added that ultimately, the risk would include a lead director or head of service (senior manager) as the risk owner, but would also include the reviewer and people within the team to mitigate the risk through their operational work. LE suggested including an action to explore the contracting route with the GP Federation and agreed to obtain an update from Ola Aroyehun. TL commented on risk HF94 *(WLMHT continue to experience significant delays in relation to closure of Serious Incidents due to non-submission)*, which was on the CRR since March 2017. She asked for the risk to include a timescale and escalation process if not addressed. LE was unclear of the escalation process as the CCG was not the risk owner. SRo clarified that as part of the mitigation process that this West London Mental Health Trust (WLMHT) risk was deliberated regularly at CQG meetings, with Ealing CCG as lead commissioner. SRo added that it formed part of a range of other issues such as quality improvements and leadership arrangements, but it was unclear what levers could be enforced to bring about the changes. TL mentioned the risk to patient care. ML said the risk should have reduced due to a decrease in the backlog. LE noted that the serious incident (SI) backlog had reduced however; the number of serious incidents being reported continues to grow with approximately 10 declarations each month with the Trust still an outlier. TL asked if the committee was assured that WLMHT were taking appropriate action to reduce the numbers and respond sooner to the SI's, but suggested that additional assurance be provided. LE explained the process, with the Trust utilising the risk-profiling tool with greater focus on SI's but noted significant delays with the response rates with some SI's two years old. SRo noted that the patient safety report includes some additional narrative. TL suggested the committee focuses on one of the top risks, share local intelligence and suggested focusing on the WLMHT risk (HF94) at November's meeting, to determine whether the CCG was adequately assured by the additional mitigations, the timelines and outcomes provided. She added that if the CCG was not assured with progress, it would need to consider the next step of action and route to be taken with Ealing CCG. LE suggested inviting Gordon Turner, Assistant Director of Quality Improvement and Clinical Assurance for Ealing CCG to the meeting as he holds greater insight into this area. TL asked for this risk to be escalated to the governing body. To inform members of the governing body of the mitigating actions, timelines and outcomes and plans in place by the committee to review the risk in detail at November's meeting to obtain greater assurance and to inform the governing body of any mitigating concerns. SRo explained that if the CCG has issues around CAMHS and children's services, provided by WLMHT, that the issue would be raised by the children's commissioners on behalf of the CCG. LE added that Ealing CCG are not assured over the Termination of Pregnancy (TOP) service with Marie Stopes International (MSI) but need to be specific around what they want H&F CCG to escalate on their behalf.	**LE** **LE** **LE** **MK/LE**

7.	**Patient Safety Q1 Report – 2017/18**	
7.1	LE presented the report. He informed the committee that each quarter the collaborative Patient Safety Team undertakes a thematic analysis. For this quarter the biggest theme that came out of this work was surgical/invasive procedure incidents and highlighted that exploring barriers to effective communication was also a recurrent theme. LE said eliminating variants in policies and clinical practices and processes was a further theme that came through each quarter, in relation to any kind of CWHHE wide thematic analysis, and in terms of H&F, that Imperial was the largest reporter of SI's. LE noted an increase in the number of SI's sent back by Imperial for additional questions and explanations due to a change in process, with more of a panel approach within CWHHE. LE noted that the good learning, in particular in relation to Imperial, had been disseminated. LE reported that C&W's reporting had significantly decreased over the past nine months; however, the Trust was starting to show an increase in the numbers being reported. LE noted that WLMHT were now using the risk-profiling tool. LE informed the committee that the report includes the results of the 2016 staff survey into patient outcomes. He noted that Imperial come out in the middle for declaring instances of SI's; however, when you combine this figure with the Trust's SI reporting it provides a separate figure. He added that concerning the safety of the organisation that the Trust came out in the top third, which it considered good. AW mentioned the CWHHE rigorous assurance process to ensure the learning and resulting action plans were fully implemented and embedded but wanted to understand how easy it was for the patient safety team to undertake this type of assurance, and asked if Trusts welcomed this kind of scrutiny and if they were fully engaged in the process. LE informed the committee of the new CWHHE system and new panel arrangements for closing off SI's which means that all SI's are presented for closure, with the exception of falls and pressure ulcers. He added that the panel would decide whether to close the SI or if additional questions would need to go back to the Trust for response. LE said he was the only external person representing the CCG, who attends the weekly provider panel meetings at Imperial to review their action plan. LE said that one of the difficulties with the process was that the more people involved in an SI could result in more questions being asked of the Trust; which was good from a robust and rigorous process, however, an increase in returns going back to the Trust could prevent the provider from declaring more SIs. LE emphasised the importance of being clear about the appropriateness of questions going back to the Trust. LE highlighted the importance of organisational memory to challenge the plan and to decide which SI's are suitable for CCG submission. However, he highlighted the difficulty faced by the patient safety team in retaining organisational memory given the number of SI's coming through the system. LE added that during the panel meetings it would collectively agree with the Trust any learning to be taken forward. LE said with any large scale organisation the Trust are focusing on system-wide learning but are further ahead compared with a lot of other organisations with the Quality Improvement Team at Imperial driving through a lot of these improvements.	

	TL commented on the review; which highlighted six issues in the patient safety report, with communication the most common failing and noted that Imperial had not made any recommendation about addressing this issue, which fails to assure the committee that the right learning and actions are being taken forward to prevent reassurance. TL added that it does not show the committee that the Trust has learnt from the actions following these incidents. LE responded that the committee should focus on the number of incidents reported and degree of harm. He added that Imperial reported a large number of incidents with low numbers of harm and were the lowest out of all the acute providers. LE said that C&W reports half the number of incidents compared with Imperial but the level of harm was generally higher at C&W.. TL said that the focus of this committee was to determine how the learning was embedded and to be assured that the Trust was taking forward the learning and disseminating it throughout the organisation. LE agreed to make it clear on the front of future cover sheet what the main points are and how Trusts were embedding the learning. LE explained that the Patient Safety Team signs off the root cause and applied methodology and that the action plan covers off the root cause but does not monitor it. He added that at the next meeting it would challenge any SI with a similar theme or action plan and reference it back to the previous SI. LE explained that Imperial presents a partial thematic analysis at the CQG but not to the same level as the CWHHE Patient Safety Team. TL asked if Imperial were managing the risk of pressure ulcers better. LE said that the numbers reported at Imperial's CQG were small with the majority of pressure ulcers reported by community colleagues. LE reported that an Education Strategy across North West London was devised to focus on the core educational requirements for professionals such as nurses and doctors, also practice managers and admin staff, predominantly all staff involved in the management of pressure ulcers or in the monitoring of equipment. TL asked that the committee receive a report on the impact of the training on the occurrence of pressure ulcers and the outcome of activity, and what the committee should be concerned about. TL added that the providers' ability in managing pressure ulcers was a real indication of the quality of care in any organisation.	**LE** **LE**
8.	**Month 4 Quality Report – 2017-18**	
8.1	LE introduced the month 4 Quality Report. The key quality themes that emerged were as follows: <u>Review/Audit of Services</u> LE reported that as part of the RTT review process into long waiters, the Intensive Support Team had produced a list of actions for Imperial to work through. LE said the Trust had worked through the bigger actions in the highest speciality areas and are now focusing on the smaller actions in the lower risk specialities. He stated that as part of the process the Trust uncovering additional 52-week breaches not previously declared. LE noted that the data clean up exercise was on going with formal numbers expected in due course. LE explained that the trajectory was to reduce the numbers to 127; however, the numbers had increased to approximately 240, with an additional 80 or 90 breaches reported. LE said it anticipates an increase in numbers as the Trust works through the lower risk specialities. TL asked LE if he was informed by the Trust that a full review was not carried out. LE responded that the CCG were given assurances by the Trust it had a robust system in place. He added that the Trust mentioned at the Associates that the system was not as robust as hoped and members of the Associates expressed their	

	disappointment that the numbers would increase. LE mentioned that the long waiters and 52-week breaches were raised at very high level with an in-depth discussion had between Clare Parker, Chief Officer and Ian Dalton, CEO at Imperial Trust. TL suggested reporting to the governing body that despite repeated assurance about the number of long waiters coming down that the committee were concerned about the increase in numbers being reported at Imperial. JaW said that the Trust had poor admin systems and were not managing the data. LE acknowledged that the Trust were very open and transparent with the CCG. LE stated that it was difficult to determine if people's appointments were cancelled, as the triangulation of DNAs and cancellation had not yet been complete. LE reported that the first step was to obtain a proper picture of the 52-week waits. TL said even if patients are not physically harmed it was worrying and distressing for patients having to wait for over a year for their treatment. <u>St Mary's Birthing Unit</u> LE mentioned the significant structural issues at the St Mary's Birthing Unit with all women booked being offered alternative facilities over the next three months or longer whilst the birthing unit was closed to allow work to be carried out. He noted that alternative facilities were provided at Queen Charlottes and Chelsea Hospital or the labour unit at St Mary's Hospital. AW asked what sort of impact this had on the birthing units in other areas. LE clarified that it had no impact, as the birthing unit was vast and able to absorb all of the women. He added that the number of deliveries was small with one or two births at Chelsea and Westminster (C&W) and three women deciding to give birth from home. LE said that the number of births and workforce, which had moved across, would need to be monitored and diplomatically managed. SRo said this would need to be discussed with David Hill and Janet Cree, as part of the commissioning discussions for 2018-19. TL suggested escalating to the governing body that women were being accommodated elsewhere at alternative birthing units and that their wishes were adhered to with Imperial using alternative sources of communication to ascertain if women were happy to move their care to alternative areas or providers. AW said it would be worth monitoring the numbers over the coming months to determine whether the position was likely to alter. TL asked LE to report to the committee at future meetings on the top three areas not mitigated that he was concerns about. The committee **noted and discussed** the 2017-18 month 4 Quality Report	**LE/MK** **LE** **LE/MK**
9.	**I-Hydrate Project**	
9.1	ML presented the I-Hydrate Project. She informed the committee that it came to the committee as one of the nursing homes that H&F has commissioned places from was used in the study. ML said the University of West London who carried out the study went to the NHSE Safeguarding Pan-London Network to present the findings. ML discussed the key actions, which included replacing the type of crockery/equipment and colours used in a care home setting. ML said a further headline was about how difficult it was to sustain the workforce and change the culture and over reliance on low-paid individuals, such as Healthcare Assistants, who were unwilling to lead the change. ML noted the use of strategic forums to discuss what could be done at care homes to reward recognition.	

	ML mentioned thirdly, the choice of drink being offered to patients, and said following the study recognised that by offering a greater choice of drinks would result in an increase in residents overall satisfaction rates. TL commented on the lack of correlation identified in relation to greater fluid intake and the clinical outcomes it was trying to address, but agreed it was worth doing to ensure patients/residents were offered a greater variety of drinks and received a drink whenever they wanted one. TL added that she was intrigued it made no difference to instances of UTI's and antibiotic usage. ML responded that mid-study the university did not expect to encounter an issue with workforce; or by altering the cups or choice of drinks would have had such an impact. AW said she was sceptical of the findings and lack of difference clinically, and said it could be due to what was happening on the ground and how the charts were being filled compared with what was actually happening. The committee **noted** the findings from the I-Hydrate Project	
10.	**LCW update on NHS 111/LCW Incident**	
10.1	TL asked LE to provide a brief summation of the NHS 111/LCW incident. LE stated that the internal review has not substantiated any of the concerns made especially as the journalist has taken photos, produced videos and recorded information. LE noted that an independent investigation was planned but was unclear who was leading the investigation. TL asked if the CCG could obtain further information and challenge the review findings. LE said the review was being challenged by West London CCG. SS asked how H&F could influence the independent investigation. LE responded that he had asked to be formally involved in the key lines of enquiry. TL asked about patient experience, checking with patients and patient interviews. SS said their definition of harm would also need to be looked at. TL said the committee were not assured of the internal review findings, as it did not substantiate any of the concerns made and welcomed a report following the conclusion of the external review. The committee **noted** the LCW update on NHS 111/LCW Incident and welcomed a report following the conclusion of the external review.	**LE**
11.	**Any Other Business**	
11.1	No other business was discussed.	
Date of next meeting: Tuesday 24th October, 12.30 - 3.00 pm, St Paul's Church, Hammersmith		