QUALITY, PATIENT SAFETY & RISK COMMITTEE MEETING

Tuesday 29th September 2015, 11.30 am – 2.00 pm

St Paul's Church, Hammersmith

Governing Body members:		
Vanessa Andreae	H&F Clinical Commissioning Group – Practice Nurse (Chair)	VA
Trish Longdon	Lay member	TL
James Cavanagh	H&F Clinical Commissioning Group – GP	JC
Michele Davison	H&F Clinical Commissioning Group – GP	MD
Peter Fermie	H&F Clinical Commissioning Group – GP	PFe
Paul Ferguson	H&F Clinical Commissioning Group – Practice Manager	PF
Jane Wilmot	Lay member	JAW

Officers in attendance:		
Mark Jarvis	Head of Governance and Engagement, HFCCG	MJ
Michael Roach	Quality Improvement and Clinical Assurance Manager, CWHHE	MR
Julie Dalphinis	Lead Nurse for Safeguarding Adults & MCA, HFCCG	JD
Samira Ben Omar	Associate Director of Patient Experience & Equalities	SBO
Julie Fuller	Complaints Manager	JF
Jane Beckford	Lead Nurse for Infection Prevention, CWHHE	JB
Toby Hyde	Head of Strategy, HFCCG	TH
Margaret Kelly	Business Support Manager, H&FCCG (minutes)	MK

Item	Agenda Item /Discussion	Action Owner
1.	**Welcome & Apologies**	
1.1	Introductions were provided. Apologies were received from Susan McGoldrick, Kathleen Sadler and Jason Tong.	
2.	**Conflicts of Interest**	
2.1	The general conflict of GPs as commissioners and providers was noted.	
3.	**Minutes of the last meeting**	
3.1	The minutes of the last meeting were approved as an accurate record of the meeting and include the comments made by Jane Wilmot.	
4.	**Matters Arising/Action Log**	
4.1	See the action table for updates.	
5.	**Integrated Patient Safety, Quality and Performance Report month 4**	
5.1	MR introduced the month 4 Integrated Patient Safety, Quality and Performance Report 2015/16. The following key messages were reported: • **Patient Safety Reports:** There has been continued improvement by some of our providers in submitting overdue reports following escalation by the Assistant Directors for Quality Improvement. • Correspondence from the Director of Nursing, Quality and Patient Safety addressing CCG concerns about low reporting numbers has been sent to providers along with information about Patient Safety Improvement and the revised Operating Policy for Patient Safety. A lot of work has taken place focusing on trends and lessons learnt. • **Serious Incidents and Pressure Ulcers (PUs):** Further work with providers is proposed to assure the organisation-wide pressure ulcer action plans proposed in the Serious Incident Policy, which would allow organisations to reduce the number of pressure ulcer serious incidents investigated, but not the numbers reported. MR noted that the PU Working Group has been re-established and Nicola Clarke will be reviewing our trusts PU action plans. VA asked which clinical leads sit on the PU Working Group and stated that she is keen to be on this group. • Analysis of data from the past six months show that trusts are taking an average of between 9 and 19 days to identify an incident as a Serious Incident, with one trust taking an average of 28 days. This issue has been raised with NHSE to understand the scope of the problem and to consider and agree proportionate responses. **Imperial** • **ENT subcontract arrangement:** Ealing CCG met with the LNWH trust team on 11th August regarding ENT services at	

	Ealing hospital, a further meeting with Imperial is now being arranged to discuss clinic relocation and service provision. • **Staff training and complaints:** It was noted that the CCG should see an improvement in staff training in the next quarter. The number of complaints being reported following agreement of the centralised approach to complaints by the Imperial trust board should also improve together with the response trajectory. The committee raised the following questions: • TL commented that paediatrics and ITU were excluded from the tube trust audit as Imperial has its own policy and questioned whether the policy was effective. MR agreed to raise this at the next CQG meeting. • TL highlighted that the workforce paper presented by Keith Loveridge stated that recruitment process timelines have now reduced and Imperial trust was working with partners to provide a large advertising campaign specifically for nurses. She asked whether the workforce issues have been addressed and stated that the information provided in the cover sheet did not tell us whether there is assurance around their workforce. JC commented that the trust has been challenged on their maternity recruitment and any general queries around staffing could be raised prior to the CQG meeting or at the meeting. MR agreed to take this back and ensure it gets raised through the correct channels. • TL commented that section 2 of the integrated quality and performance report includes a number of red areas and queried why no narrative is included in the report and said that the CCG requires assurance that appropriate actions are being taken to address all red areas. • TL stated that no information is included in the report for out of hospital services, the CIS scheme and in-health diagnostics and asked whether there are any quality issues with these services. VA informed the committee that the out of hospital services have been running for approximately one month and information should start to come to this committee in due course and be included in the integrated quality and performance report. TH noted that a CIS contract meeting was held on Monday where detailed information on referral numbers and patient experience was discussed and could be shared with this committee if required. • MJ commented that plans are in place to trial a new integrated quality and performance report with clearer narrative and assurance and would discuss this further with James Eaton, Associate Director for Performance and Delivery. • MR agreed to arrange a meeting between VA, TL, Liam Edwards and Mary Mullix to discuss the best way to present the integrated report and front page in order to provide the committee with the required level of assurance. VA commented that the cover sheet would need to be clearly set out for all services by exception. • VA asked for the LPOG report for Whole Systems to come to this committee. TH agreed to provide the LPOG report at future committee meetings as part of his Whole System update. **Actions:** • **To clarify which clinical leads sit on the Pressure Ulcer Working Group** • **To raise at the next Imperial CQG whether the paediatrics and ITU policy is effective** • **To ascertain whether the workforce issues at Imperial have been addressed** • **To discuss the trialling of a new integrated quality and performance report with James Eaton** • **To arrange a meeting between VA, TL, Liam Edwards and Mary Mullix to discuss the integrated quality and performance report and front page and how best to present this at future Quality meetings to provide the committee with the required level of assurance, to include a plan and trajectory for the action plans. To decide following this meeting whether the Imperial concerns the committee has need to be escalated to the November Governing Body** • **To ensure the LPOG report for Whole Systems is presented at future committee meetings as part of the Whole System update** The Committee noted and discussed the month 4 Integrated Patient Safety, Quality and Performance Report and requested further assurance and narrative on a number of areas in the report rated as red	**MR** **MR** **MR** **MJ** **MR** **TH**
6.	**Briefing on the CQC visit to WLMHT**	
6.1	MR presented the briefing for the Chief Officer following the CQC visit to WLMHT. He noted that a number of areas have been identified that require improvement and appendix A provides a snapshot of the areas inspected, the ratings for each area and the overall rating. He reported that at yesterday's CQG meeting the Trust were asked to revise their detailed plan to include salient posts and be monitored at the CQG with a report to come back to this committee. MJ queried why the document was marked as confi**d**ential. MR clarified that the document is confidential as the information has yet to be published. MJ asked committee members to be mindful that the data is confidential and to ensure the document is disposed of appropriately. VA queried what notice 4 meant, in particular patients having their books signed to say they have completed activities before their leave was agreed. MR clarified that what should happen is that activities are signed off and work is completed prior to leave being granted. The Committee **noted** the briefing on the CQC visit to WLMHT.	
7.	**Improving Hydration in Older People in Nursing Homes to reduce morbidity and prevent hospital admissions**	

7.1	JD introduced her paper on improving hydration in older people in 2 Nursing Homes, one in Ealing and one in Chiswick, to reduce morbidity and prevent hospital admissions. She informed the committee that patients have been recruited from the homes to take part in the research over the 18-month period to focus on improving their care, and noted that many of the patients in the homes suffer from dementia. JAW commented that it focuses on two nursing homes and asked if this research is successful will the guidelines be shared with other homes. JD explained that a toolkit will be developed that is sustainable to be rolled out in other nursing homes. VA clarified that any learning from this research would be rolled out to the other nursing homes. The Committee **noted** the report on improving Hydration in Older People in Nursing Homes to reduce morbidity and prevent hospital admissions.	
8.	**Whole Systems Integrated Care (WSIC) update**	
8.1	TH presented the Whole Systems Integrated Care update. He explained that the focus of whole systems is around the development of more effective models of care for the elderly. In H&F whole systems has been developed with the focus on CIS, which has shown reasonable success to date. In H&F, the focus is now on primary care, concentrating on those patients that should refer into CIS and how we can manage them more effectively in primary care. The main work over the next 6 months will centre on co-design with practices and how we can work with them to build on existing provision, working closely with the CIS operational team in the design of expanded models but recognising the wider constraints around workforce availability. Further details of the co-design approach and outputs will be brought back to this committee through the monthly updates. Other elements of the whole systems work will focus on social prescribing at Parkview and North End, which has shown that it improves the quality of patient lives and the lives of those GPs referring into this service and that evidence from other areas of the country shows tangible benefits. Currently we are looking to improve the set-up of how the Parkview hub is managed focusing on community engagement and ownership. A lot of work is taking place between the CIS and GP practices to ensure appropriate referrals and the latest data shows that referrals are increasing but we require tangible work and one to one conversations in order to engage better with GP practices. The key discussions were as follows: • PF asked if the CIS resources are being fully utilised and whether the service is overworked. TH explained that the activity levels are less than the contractual requirements. He reported issues in recruiting staff but noted that no patients have been refused into the service based on capacity. He noted that consultation is underway in the Local Authority to transfer the workforce and that the service has recruited two additional GPs. • PFe queried whether all practices use the CIS service equally or whether it depends on the level of engagement. TH explained that there is a huge variation per GP practice and that work will be underway in the coming months to look at the correlation between the levels of referrals into CIS and numbers of non-elective admissions in the over 65 cohort of patients. • PFe queried those GP practices that do not refer into CIS and asked how these patients are being managed and whether they are on the District Nurses (DNs) caseloads. TH agreed to review the DN referral levels for those practices with low referral into the CIS service. TH said that there is two-way dialogue with all GP practices to ensure we are working effectively across the patch. • PFe commented that there is a pharmacist based at his practice that goes through the discharge summaries and sorts out the medicine reviews which has made a big difference to the practice GP workload. • TL asked if whole systems would assist with the Parkview issue. She said that a fall in quality of care homes will be a strategic issue of whole systems and as we are now doing co-commissioning whether whole systems will engage with this piece of work. TH explained that he is already working with Jenny Platt, Strategic Lead for Integrated Care and Joint Commissioning on our nursing home programme of work and is cited on the different elements of care and that whole systems is key to this piece of work. • JAW questioned how the committee could be assured that the whole systems work is of good quality. TH clarified that there are three elements to whole systems, which will show the impact of this work. The three areas are 1) the CIS scheme 2) the two social prescribing pilots and 3) the work that whole systems are planning to do in primary care. He noted that regular updates on the three work streams to be brought to this committee, with details of the design process and plans and clinical elements prior to any funding being approved. It was suggested that once we obtain the whole systems reports that performance information is included at the back of the integrated quality and performance report and is included in the front cover sheet by exception. **Actions:** • **To compare the DN referral levels for those practices with low referral levels into CIS** • **To include whole systems performance data at the back of the integrated quality and performance report and on the front cover sheet by exception** The Committee **noted and discussed** the Whole Systems Integrated Care update.	**TH** **TH/MJ**

9.	**Healthcare Associated Infection Q1 Report – 2015/16**	
9.1	JB introduced the Q1 Healthcare Associated Infection Report for 2015/16. She reported the following key messages: • **MRSA Bloodstream Infections (Zero Tolerance)** - There were seven infections reported in Q1 with three attributed to Imperial, compared with five for Q1 last year and twenty-three in total for the whole of 14/15. Several of the cases were complex with work taking place across a number of Trusts and with GPs to ensure integrated care and appropriate discharge planning is in place for patients. She noted that for three of these cases there were lapses in wound management, and that these are being addressed with our community healthcare providers. • **Cdiff –** JB reported that quarterly meetings take place between the CCG Lead Nurse and the acute Trust Infection Prevention Leads and that the Q2 visits will take place in October to determine whether trusts have implemented the national guidance and are handling cases correspondingly. She noted that all 23 cases reported at Imperial were sporadic with no concerns about their process and that an in-depth analysis is carried out on each case to check whether they have the same strain. Nine of the 23 cases at Imperial were examined in more detail as there was evidence that a patient had been on the same ward as another patient with Cdiff, but it does not mean there was a lapse in infection control practice but that a lapse may have occurred. She noted the four key actions that Imperial trust must address to prevent C Diff infections. The actions include a review of their antimicrobial policy to ensure optimum prescribing practice to reduce the risk of C Diff and a review of the isolation audit and trust plans to address the lack of isolation Facilities at the St Mary's site in particular. • **Serious Incidents and Outbreaks:** JB reported that the most significant event in Q1 has been an on-going outbreak of Carbapenem-resistant Enterobacteriaceae (CRE) across renal and vascular wards at Imperial. At the trust, 40 cases have been identified although a significant number have been colonisation rather than infection and identified by enhanced screening. The trust is developing contingency plans to include a designated ward on each main site. JB participates in weekly control meetings and Public Health England is fully involved. The trust's action plans are reported to the CQC, and a meeting has taken place with the Trust Development Agency (TDA) and NHSE to reflect on what has happened since the outbreak. She noted that Imperial has not fully implemented the C Diff guidance and this is being monitored through their route cause analysis (RCA) with the trust looking at the lessons learnt. JB said that she will be reviewing the Imperial action plans and would be carrying out a follow-up visit to the trust. The following points emerged in discussion: • JC commented that of the 23 C Diff cases at Imperial that 2 related to lapses in care and asked how the trust were able to determine that 90% of the cases were not trust attributed and due to lapses in care. JB explained that the risk factors are looked at to determine whether the case occurred due to a lapse in care and page 8 of the report provides the detail for each of these cases and the outcome. • TL commented on the seven C Diff cases where patients were not isolated within two hours of developing symptoms and asked whether this was a risk of infection to other patients coming through the doors during this two-hour period. JB clarified that the guidance specifies that if isolation facilities are not available it can take up to 2/3 hours before these patient need to go into isolation and that C Diff is not air borne therefore are not a risk to other patients. The Committee **noted and discussed** the Healthcare Associated Infection Q1 Report for 2015/16 and **raised concerns** about the outbreak of Carbapenem-resistant Enterobacteriaceae (CRE) across renal and vascular wards at Imperial	
10.	**IFR Annual Report 2014/15**	
10.1	The committee **noted** the IFR Annual Report 2014/15.	
11.	**Joint Complaints and Patient Experience Annual Report - 2014/15**	
11.1	SBO and JF presented the joint Complaints and Patient Experience Annual Report for 2014/15. SBO explained that this is the first time that a joint Complaints and Patient Experience Annual Report was produced and said that it does not include data from the engagement leads events but does include the nationally mandated data and information from Healthwatch. Furthermore, it includes data on recurring themes and trends from CLCH, Imperial and WLMHT. Although we do not commission GP services, we have also analysed patient experience themes from the 2014 GP survey data across CWHHE. SBO reported the following key messages: • **Patient Professional Interaction:** The level of doctor/nurse interaction came out as negative. In particular patient involvement in care planning, the discharge process and shared decision making • **The quality of information and advice provided:** The level of information provided through leaflets was considered insufficient in particular relating to post-operative care, post-discharge care and condition-specific information and about how to share their views, especially the complaints procedures • **Waiting times**: This came out as an issue at Imperial and was linked to long queues on appointment lines, long waits during outpatient appointments and delays in discharge • **Quality of Food**: Although the choice of food scored high, the quality of food was low across NW London.	

JF reported that the complaints report provided an overview of the four quarterly complaints reports and informed the committee of the following:

- In 2014/15 there were 65 complaints attributed to Hammersmith and Fulham (H&F) CCG for the year but 23 of these related to GP practices that were sent to NHSE to follow-up, with eight complaints relating to acute trusts.
- Continuing Healthcare was the biggest area for complaints but was not a huge issue.
- Six of the complaints related to commissioners and there were eight complaint delays but no issues regarding how the complaints were managed.

The following points emerged in discussion:

- PF asked what the CCG specific issues were. JF clarified that there were nine issues relating to continuing healthcare but did not have the detail relating to each case and said that this level of information would have been presented to the committee in the quarterly reports.
- TL queried whether our providers have the relevant information around what they need to do for patient experience. SBO explained that this is included in their contract but this piece of work has not been undertaken. In the care quality schedule, we have asked trusts for a quarterly themed report and narrative to include the actions addressed over the past 12 months. For this year, we have produced a template to assist trusts and have talked through the different elements with each provider. She noted that she has received the Q1 patient experience reports and that they vary in terms of quality and data but need to be reviewed and a form of response provided to trusts to address any key issues and would be requesting an action plan and forward view document.
- JAW asked when the Q2 report is due. SBO clarified that the Q2 report is due in November/December and will be discussed at the CQG meetings to determine whether the actions have been addressed.
- JC queried the performance management of patient experience and asked if her team require support to undertake this piece of work. SBO explained that she is the lead across CWHHE, works 4 days a week and works closely with Lizzie Walman and Liam Edwards the quality leads to build relationships with our providers. She said that the support is available but the issue is around capacity to review the information in detail and triangulate the data. She noted that this issue was discussed at the Collaborative Quality Committee and a report on how this work should be undertaken has been shared with the Managing Directors for their comments.
- JC commented that we would need to determine whether there are any trends and changes in the behaviour of our providers. SBO commented that when we ask Imperial for information they inform us that the quality of the data is not good and implement a new system but do not evidence the outcomes as the system being implemented is at infrastructure stage.
- VA commented on the negative trends and in particular, how nursing scored poorly across H&F and asked for the detail and narrative from the results as she would like to raise this at the next Practice Nurse Forum. SBO clarified that there were five questions with regard to practice nursing and that 40% of patients said they could not access a practice nurse when they wanted to and the shared decision-making around their care and treatment scored quite low.
- MJ commented on the request for additional resources to develop future reports as outlined on the cover sheet and asked where this had been discussed. SBO said a paper was sent to the Managing Directors two weeks ago, but was still awaiting their feedback.
- MJ said on page 9 of the report it refers to the published actions and asked where this information would be published. SBO clarified that the actions would be published in the trust reports and on the CCG websites and could be discussed at the PRG groups and shared with Healthwatch. She noted that the trusts must include the responses to the feedback on their websites.
- MJ stated that if this report is to go to the November Governing Bodies it should be discussed with Ben Westmancott in the first instance. SBO clarified that a copy of the report has been shared with Ben.
- JAW commented that in the report it talks about lack of understanding around how to contact the out of hours GP service and the need for improved explanation and communication of the service and how to access it and whether this flags an action for the CCG to make sense of the changes and what this means for patients. SBO stated that this was mentioned across North West London and in particular, with regard to Hammersmith Hospital and the percentage of people who knew what services were provided in the UCC was higher than out of hours.
- VA asked in regards to patient experience data how do we know that it includes all GP practices. SBO said it includes each GP practice and their services and the information can be broken down by CCG. She said that the information is on the NHSE website and agreed to send VA the link to access the data. VA commented that we would need to share the link with GP practices and direct them where to go if they wish to discuss the results further.
- MJ said that the CCG would need to feedback what it is planning to do to address the negative trends highlighted in the annual report.
- JAW asked how the information in this report could be shared wider. SBO explained that once the report has been to Governing Bodies and is approved it could be made public and uploaded to the CCG website and shared with Healthwatch.
- JAW asked if this joint report could be produced quarterly. SBO explained that the Q1 data was received in August/September but would not be able to produce a report in time using that data due to capacity issues but could produce a report using published data and noted that for some services the data is only published annually therefore

	would need to be excluded. • SBO said that as this is a CCG report it would need to specify what level of information is required for future reports. **Actions:** • **To share the patient experience slide and narrative with VA to include the responses to the five question raised around practice nursing** • **To develop comms around how to contact the out of hours GP service for GP practices to share with their patients and include on their website** • **To send VA the link to the NHSE website to access the GP practice patient experience data and share with GP practices. To also provide details of who to contact if practices wish to discuss their results further** • **To feedback what the CCG are planning to do to address the negative trends in the patient experience and complaints annual report** • **To let SBO and JF what level of information is required for the quarterly combined patient experience and complaints reports** The Committee **reviewed and noted** the Joint Complaints and Patient Experience Annual Report for 2014/15.	**SBO** **MJ** **SBO** **MJ** **MJ**
12.	**Clinical Quality Group (CQG) minutes of meetings**	
12.1	The Committee **noted** the CQG minutes.	
13.	**Exception Reporting – CWHHE Quality and Safety Committee**	
13.1	No exceptions were reported.	
14.	**Any Other Business**	
14.1	<u>Joint Quality and Finance and Performance Committee</u> JAW asked if any progress has been made in rescheduling the timing of future Quality and F&P Committees to discuss the integrated Quality and Performance report. MJ explained that he will be talking through the logistics is looking to hold the first meeting in November but also needs to look at the scheduling of the PMCF and whether this can be moved to a different day and would need to have a discussion with Sophie Ruiz. He agreed to circulate his ideas on how to move this forward in due course. **Action: To circulate details of the proposed timing of future Quality and F&P Committee meetings from November onwards**	**MJ**
	TL commented that there were no representatives from Healthwatch at the meeting. JAW explained that Jason Tong had to attend another meeting, which was scheduled for the same time, and that his colleague Marie Connolly was unable to attend. MK informed the committee that Jason would be attending the next meeting and that Healthwatch were planning to produce a report for this meeting.	
Date of next meeting: Tuesday 27th October, 11.30 am – 2.00 pm, St Paul's Church, Hammersmith		