Trust Board Meeting

ITEM: 09
Doc: 05

DATE:	23 May 2012

TITLE:	Quality Committee Report April 2012

SPONSOR: Sue Rubenstein Non Executive Director	**REPORT FROM:** Bronagh Scott Director of Nursing and Patient Experience

PURPOSE OF REPORT: To Receive the Report

EXECUTIVE SUMMARY: This report gives an account of the issues discussed at the Quality Committee held on Friday 20th April 2012.

The April 2012 committee received the following reports

- **Quality and Patient Safety Dashboard** - which identified a need to triangulate quality and safety key Performance Indicators with Performance and Access Indicators and Finance. This is being taken forward by the Chief Operating Officer (COO) who will report on progress at the Quality Committee in future months. Other issues identified include the need to highlight where targets are not being met and outline a trajectory showing interventions that will lead to improved performance. Issues in relation to the narrative matching the data in dashboards and SPC charts were discussed and the COO was charged with reviewing this.

- **Infection Prevention and Control Report (Quarter 4)** – The Trust's Director for Infection Prevention and Control (DIPC) presented the Quarter 4 report. The strong performance in relation to 2011/12 targets was recognised and congratulated. However caution was noted in relation to the ever growing challenging HCAI targets and the need for continued strong performance in this area which is dependent on staff being aware of and adhering to Trust IPC policies and procedures. The particularly strong performance in the recent European Prevalence Study was noted. A recent case of MRSA bacteraemia in a patient was reported.

- **Integrated Care and Acute Medicine Quality and Safety Report –** The report was presented by the Division's Director of Operations and Head of Nursing. Areas of concern related to quality and safety were identified as
  (i) High incidence of falls
  (ii) Grade ¾ pressure ulceration rate in community settings
  (iii) Pentonville Prison
  Benefits of being an Integrated Care Organisation (ICO) were expected to be demonstrated in coming months in the following areas
  (i) Ambulatory Care
  (ii) Emergency Department Performance
  (iii) Pentonville
  (iv) Patient Experience in ED and Out-Patients.

- **CQC – IRMER Inspection – Draft Action Plan -** The draft action plan in response to the recent IRMER inspection by CQC was presented and highlighted issues related to policy and process for assuring the Trust and others that patients are not being harmfully exposed to radiation. The action plan will be approved by the IRMER board, the SC&D division and Trust Operational Board and then appropriately monitored through this network. Further updates against actions will be reported to Quality committee.

- **Safe Guarding Adults Quarterly Report –** An update report on the work of the Safeguarding Adults Board was presented. The following points were noted
  (i) There is no legislation governing safeguarding adults
  (ii) The Councils of Haringey and Islington have different approaches to Safeguarding Adults
  (iii) Lack of clarification regarding definitions of abuse
  The Trust has senior representation on the Safeguarding Adults Boards in both councils and is working in partnership with both councils to address the issues outlined above

- **Committee Terms of Reference -** The committee approved a number of Terms of Reference for feeder committees.

- **Policies for Approval –** There were no policies for approval

PROPOSED ACTION: For Noting

APPENDICES:

Appendix 1 - Quality Committee Work Programme
Appendix 2 - Quality and Safety Dash Board
Appendix 3 – Infection Prevention and Control Quarter 4 Report and Action Plan
Appendix 4 – ICAM Quality and Safety Report

DECLARATION

In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:

This report relates to the Following Trust Strategic Objectives –

- Deliver effective services that improve outcomes
- Improve the health of the local people
- Change the way we work by building a culture of innovation and continuous improvement

It complies with the Trusts requirement for CQC registration in relation to assuring the Board of the Trust's ability to provide safe and effective care and to question and challenge where there are concerns. As the committee that approves all clinical related policies it provides evidence and assurance as required by NHSLA.

Report of the Quality Committee which met on 20th April 2012

1.0 Introduction

2.0 Quality Committee Priorities

3.0 Quality and Patient Safety Dashboard

4.0 Infection Prevention and Control Report

5.0 ICAM Quality and Safety Report

6.0 IRMER – CQC Report and Action Plan

7.0 Quality Review Profile - CQC

8.0 Safe Guarding Adults – Quarterly Report

9.0 Terms of Reference of Feeder Committees

10.0 Policies Approved

1.0 Introduction

1.1 The Quality and Patient Safety Committee met on Friday 20th April 2012. This report provides a summary of key items discussed and decisions made

2.0 Quality Committee Priorities

2.1 The Quality and Patient Safety Committee covers three main domains, Safety, Clinical Effectiveness and Patient Experience. The Committee's programme of work is appended at (**Appendix 1)**. 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 2 in financial year 2013/14
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.
2.2.9 Training for Child Protection – Reliability of information

2.3 The April 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 currency and reliability of performance data
2.3.2 HCAI – In light of the MRSA bacteraemia identified on 20th April 2012 which means that any additional cases throughout the year breaches the Trust's target.

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

3.0 The Quality and Safety Dash Board (Appendix 2)

Anita Garrick Senior Information Officer presented the Quality and Patient Safety Dash Board and the performance dash board on behalf of the divisions. The main issues raised were the need to triangulate the quality and safety indicators with Finance and performance.

There was discussion about the currency of the information presented on the dashboards and it was recognized that this is currently being discussed with in the Executive Committee with a view to identifying a specific resource to focus on information timeliness and analysis.
It was also noted that the commentary from Divisions related to the dashboard data should direct the committee to areas where targets are not being met, the reasons for this, actions being taken to rectify the situation and the identification of a trajectory to address the area of concern within targeted timescales. It was specifically emphasized by the committee's non executive directors that where a target is red there should be a trajectory for improvement, if that same target remains red for two months running then there should be a detailed action plan for improvement and if it remains red for three months or more it should be on the Corporate Risk Register. Concern was particularly raised in relation to health visiting performance against new born visits. The committee was reminded that there had been a specific report on this issue at Trust Board in February 2012 and that this issue is on the Women Children and Families Divisional Risk Register and the Corporate Risk Register.

There was discussion about lack of consistency and congruency across the dashboards with Out-Patients flagging green despite the Trust recognizing the need for significant improvement in this area. It was agreed that this would be better reflected with an amber flag. Carol Gillen advised that the Divisions are currently devising a pan Trust Out-patient improvement plan which is being led by Matthew Boazman Director of Operations in the Surgery, Cancer and Diagnostics Division (SC&D). Bronagh Scott added that there is a specific action plan based on the learning from the recent Out-Patients satisfaction survey which will be presented to Trust Board in May 2012.
This also related to Discharges before 11am being flagged as green when all would agree that this is unlikely and the Length of Stay indicator where the noted improvement in the narrative is not supported by the SPC chart.

There was discussion about the Ward Quality Dashboards and how these are being benchmarked with other Trusts. BS advised that a number of the indicators are benchmarked across London through NHSL and the Energising for Excellence programme – (A London wide Quality and performance Indicator benchmarking programme). She added that in some areas e.g. HCAI this is quite sophisticated and reliable however in other areas such as pressure ulceration and catheter related sepsis the bench marking data is not so reliable. Specifically he Quality Committee members sought assurance on the rate of falls within wards. BS reminded the committee that a specific Project Board to review practice in relation to reducing the incidence of Falls had been established and would be reporting on progress to the committee in June/July 2012. Debbie Clatworthy Head of Nursing in SC&D Division added that improvements are already being seen and monitoring will continue to ensure this improvement is sustained.

In relation to sickness levels committee members were particularly concerned about high levels of nurse sickness in Victoria Ward and Thorogood ward and the apparent high use of agency particularly in Victoria Ward. DC advised that there are a number of genuine long term sickness issues in Victoria Ward which is being addressed and that in Thorogood ward the low staff baseline means that any sickness level will translate into high percentages. In relation to agency usage, DC explained that this related mainly to the extra beds that are open in Victoria Ward to deal with winter pressures.

In terms of mandatory training the committee recognized the significant progress made towards the target but emphasized the continuing need for robust action plans to sustain and further improve performance towards the Trust's self imposed target of 90% of all staff meeting their mandatory training requirements by the end of December 2012.

There was also discussion about the recent media attention on night time discharges and it was agreed that this should be added to the dashboard as a quality indicator. Celia Ingham Clarke informed the committee that the Trust's policy is clear that patients should not be discharged between 10pm and 7am. However the definition of discharges needs to be revised as it currently includes those patients who have died, those who have left the hospital contrary to medical advice and those patients who leave ED following a period of observation.

4.0 Infection Prevention and Control Report – Quarter 4 (Appendix 3 i and ii)

Dr Julie Andrews the Trust's Director of Infection Prevention and Control (DIPC) presented the Quarter 3 report.

The main points of interest were highlighted as

- The strong performance against HCAI targets in 2011/12
- There had been one C Diff related death which had been investigated through RCA
- 68% of staff had completed the E-Learning module on IPC
- The European prevalence study which had been completed in December 2011 and in which the Trust had demonstrated a 5.3% of patients acquiring HCAI compared to the previous study in 2009 in which 11% of patients acquired HCAI.
- A Trust wide IPC action plan has been developed in partnership with divisions through the HONs
- An improved performance in Surgical Site related Infection (SSIs) – there has been zero incidence in the past two quarters which has resulted in a reduced length of stay for patients with a fractured neck of femur
- IPC Dashboards now include community indicators and are the result of 217 audits conducted by the IPC team and others
- The Infection Control Committee at its meeting in April 2012 considered the findings and recommendations of an interim review into an outbreak of pseudomonas in hospitals in Northern Ireland in January 2012 which had resulted in the deaths of 3 neonates.

At the end of the report Dr Andrews advised the committee that unfortunately the Trust has already met the 2012/13 MRSA Bacteraemia target with a patient who previously had an MRSA bacteraemia in February 2012 re testing for MRSA bacteraemia .

While recognizing that this was disappointing the committee noted the otherwise strong performance of the IPCT and congratulated Dr Andrews and her team on the strong performance and leadership provided across the Trust.

5.0 ICAM Quality and Safety Report (Appendix 4)

The Integrated Care and Acute Medicine Division Senior Management team was represented by Carol Gillen Director of Operations and Kara Blackwell Head of Nursing who presented the half yearly report to the Committee.

The following issues of concern related to Quality and Safety were identified:

(i) Falls
(ii) Pressure Ulcers- particularly in community
(iii) Pentonville

Concern was noted regarding the ward dashboard that indicated a high incidence of pressure ulceration in Chestnut Ward. KB advised that this is currently being reviewed as this is the first time Chestnut ward has been included in the dash board and there are issues related to data quality and cleansing. She further advised the committee that there have been no grade 3 or 4 pressure ulcers in Chestnut Ward.

AC asked the Division how they would demonstrate the benefits of being an ICO in terms of Patient experience, quality and safety. Discussion ensued which highlighted some of the transformational pathway work which is currently ongoing - Examples were given including

- Ambulatory Care pathway which was demonstrating a reduced length of stay for older people.
- Emergency Department – Sustained improvement against the 4 hour target – due to review of staffing numbers and skill mix, greater clarification of roles and responsibilities
- Pentonville – Reduced admissions to hospital through greater use of tele care,
- Improved patient experience in ED, OPD

BS specifically referred to a number of wards where sustained improvements are being experienced. In particular she highlighted Cloudsley Ward which in 2010 was an area of real concern with high incidence of patient complaints and staff dissatisfaction and high incidence of HCAI. She pointed out that a focused piece of work around responsibilities and roles had been carried out with all staff and a new ward manager had commenced in February 2011 – she added that there have been no ward related c-diff cases since February 2011, complaints have reduced, ward based audits are consistently good and staff are more satisfied. She also highlighted Mercers ward which has a long history of staff issues, issues related to poor patient experience all of which have been addressed in the past year. Since a rapid review of care in Mercers Ward conducted in August 2011 there has only been one complaint about care in the ward, improvements in staff morale have been noted and improvements in patient care and experience have been evidenced.

Maggie Pratt Practice Development Nurse also advised the committee of work she is leading in the Division around patient safety and productivity. She invited committee members to join her in structured observations of care that she will be conducting across the older peoples wards.

KB also informed the committee of a project 'We Care' that she is leading across the division in which she will seeking the views of patients regarding their care and again she invited committee members to contact her with any suggestions or recommendations.

6.0 IRMER Inspection by CQC – Draft Report and Action Plan

Mary Jamal Assistant Director for SCD Division presented the CQC report on the recent IRMER inspection. She informed the committee that the inspection related to the legal requirements of ionizing radiation in terms of patient safety and health and safety of staff.
The report while not identifying any breach of regulations had highlighted a number of issues to the Trust in terms of its systems and processes and robustness of policies. The Trust has developed an action plan to address the issues raised by the CQC and is required to provide the CQC with an update on progress in June 2012. The action plan will be monitored by the recently established IRMER Board and will report to the SC&D Divisional Board and the Trust Operational Board and will provide progress reports to Quality committee.

7.0 CQC - Quality Review Profile (QRP)

The recent QRP received in February 2012 was presented to the committee. It was noted that the QRP covers some 570 items and highlights where indicators have deteriorated, improved or remained the same since last reported. However some of the indicators are only measured annually or bi-annually and therefore in some places the results in the QRP refer to old data. Areas of concern that have been highlighted in the QRP include Surgical Site Infection where the Trust in the Quarter preceding the QRP was an outlier. However this situation has improved following a number of interventions and this will be identified in a future QRP. In terms of overall response rates and outcomes in patient satisfaction surveys the Trust is also an area of concern which is being addressed. Committee members in particular discussed Outpatient satisfaction and expressed concern at outcomes. The committee requested that the Trust conduct a deep dive into Out-Patient performance at a future Trust Board seminar to allow further scrutiny of the issues and actions being taken.

8.0 Safe Guarding Adults – Quality Report (Appendix 5)

The Safeguarding Adults quarterly report was presented by Martin Grant Safeguarding Adults Officer. The main issues discussed were

- Lack of legislation governing safeguarding adults
- Different approaches and focus in Haringey and Islington Councils
- Lack of clarity regarding definitions of abuse – difficulty for staff in determining when to report or raise a safeguarding alert

The following decisions were agreed by the Committee

- The Trust should enter discussion with both Haringey and Islington boroughs to encourage consistency of approach to the safeguarding Adults Agenda
- The Trust should develop a score card which measures performance against a number of key indicators including, staff training, the number of safeguarding alerts raised by the Trust

9.0 Terms of Reference of Committees

The Terms of Reference (TORs) of feeder committees were approved. It was agreed that they should be reviewed again 6 months.

10.0 Policies for Approval

There were no policies for approval.

Trust Board Meeting 23 May 2012 - Report of April Quality Committee - Appendix 1

	FREQUENCY	20-Jan	17-Feb	16-Mar	20-Apr	18-May	15-Jun	20-Jul	21-Sep	19-Oct	16-Nov	21-Dec	January	February	March	April	May
Safety Domain Quarterly																	
Quality and Risk Profiles	Quarterly																
CQC Registration / Reviews/ Visits	Quarterly																
NHS Litigation Authority	Monthly																
Patient Safety Committee	Bimonthly																
Patient Safety Walkabouts	Quarterly																
Aggregated Report (Incidents, Complaints, Claims and PALS).	Quarterly			Q3 2011/12			Q4 2011/12	Q1 2012/13		Q2 2012/13			Q3 2012/13			Q4 2012/13	
Serious Incidents (SIs SUIs)	Quarterly																
Workforce & Development																	
Equality and Diversity																	
Workforce Report																	
Patient Experience Domain																	
Patient Experience / Satisfaction	Quarterly																
Clinical Effectiveness Domain																	
Patient Environment Action Team “PEAT” Scores	Annual																
Audit and Effectiveness (Effective Care)	Biannual																
Research & Innovation	Annual																
Drugs & Therapeutics	Biannual																
Clinical Ethics Annual Report	Annual																
Integrated Care and Acute Medicine	Biannual																
Women Children and Families	Biannual																
Surgery, Cancer and Diagnostics	Biannual																
Terms of Reference Review	Annual																
Infection Control Report	Quarterly																
Child Protection Report	Quarterly																
Safeguarding Adults Report	Quarterly																

QUALITY & SAFETY DASHBOARD

FEBRUARY 2012

Whittington Health NHS

Domain	TRUST Summary	IC & Acute Medicine	Surgery, Cancer & Diagnostics	Women, Children & Families

Quality & Safety Outcomes

Domain	TRUST Summary	IC & Acute Medicine	Surgery, Cancer & Diagnostics	Women, Children & Families
MRSA bacteraemia				
C difficile				
E. coli	71			
MSSA	26			
Number of Serious Incidents	5	4	0	1
Never Events	2	1		1
Hospital SMR				
Summary Hospital Level Mortality Indicator				
Deaths in low risk conditions				
Deaths after surgery				
Post operative sepsis				
Grade 2/3/4 Pressure ulcers				
Falls in hospital	30	17	7	2
VTE screening				
Hospital acquired VTE rate				
Appropriate prophylaxis for VTE				
Community Dentistry: Compliance with Infection Control Standard				

Clinical Effectiveness

Domain	TRUST Summary	IC & Acute Medicine	Surgery, Cancer & Diagnostics	Women, Children & Families
Safety Alerts compliance				
Emergency Readmission rate				
Helping older people recover their independence after injury or illness				
Emergency admission rate for LTC				
Emergency admission rate for Paediatric conditions (asthma, epilepsy, diabetes)				
Emergency admission rate for VTE				
Safeguarding				
Incident reporting rate/1000 adms/contacts				
Community Matrons Outcome - % patients reporting confidence to manage their condition				
Community Heart Failure/Cardiology - % of patients on optimum Ace therapy				
Community Heart Failure/Cardiology - % of patients on optimum Beta Blocker therapy				
Greentrees - patient dependency levels				
CAMHS - % of cases where target mental health problem has been resolved or improved				
CAMHS - % of cases where the severity of mental health at end of treatment is normal/mild				
Simmons House - Discharge Outcomes				
Children's Community Nursing Outcomes				
Community Paediatrics - Individual management plans agreed				
Sexual Health - Clinical Outcomes				

Above standard | at risk/near miss | Below standard | "as expected" [Dr Foster] | under development | not applicable

Patient Experience

Net promoter score - Wards				low data
Net promoter score - OP				
Net promoter score - ED	low data	low data		
Net promoter score - Community	low data	low data	low data	low data
Single Sex Accommodation				
Cleanliness				
Complaints per 10,000 activity				
Complaints Responded in time				
Community Dentristry: Patient Involvement				
Community Dentristry: Patient Experience (Overall Rating)				
Greentrees - Patient Satisfaction				

Early Warnings

Staff Sickness				
Vacancy rates		wait for HR data	wait for HR data	wait for HR data
Turnover		wait for HR data	wait for HR data	wait for HR data
Mandatory training				

Above standard — at risk/near miss — Below standard — "as expected" [Dr Foster] — under development — not applicable

Monthly Ward Quality Indicators

Whittington Health NHS

Integrated Care & Acute Medicine Directorate Summary: FEB 2012

FEB 2012		Target	Cavell	Chestnut	Cloudesley	Isis	Mary Seacole North	Mary Seacole South	Mercers	Meyrick	Montuschi	Nightingale
Infection Prevention and Control	Number of MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	1	0	0
	Number of MSSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0	0
	Number of C Diff Cases	0	0	0	0	0	0	1	0	0	1	0
	Number of E Coli Cases	0	0	0	1	0	0	0	0	0	1	0
	Hand Hygiene Audit Score*	95%	-	100%	100%	80%	-	100%	-	95%	100%	-
	Ward Cleanliness Audit Score	95%	100%	-	100%	100%	-	-	-	96%	-	99%
	Number of Indwelling Urinary Catheters	num	1	-	3	0	1	0	5	6	2	2
Patient Experience	Number of Complaints	0	1	0	0	0	1	1	0	0	0	0
	Number of Patient Survey Responses	num	-	-	-	-	34	-	26	14	25	-
	Net Promoter Score	+ve %	-	-	-	-	56%	-	23%	79%	56%	-
	Activity Follow Score	%	-	-	-	-	-	-	-	-	-	-
	Number of Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	Number of High Risk/Serious Incidents	0	0	0	1	0	1	2	0	0	0	0
	Number of Grade 2/3/4 Pressure Ulcers	0	3	12	2	0	0	1	0	0	4	1
	Number of Falls	num	7	2	3	0	3	1	5	4	4	1
	Number of Discharge Alerts	0	0	-	1	1	0	0	1	2	0	0
	Number of Incidents Reported	num	9	7	9	1	15	8	10	12	11	1
Quality of Care	Nutrition screen on admission (48hrs)	95%	94%	88%	100%	-	100%	100%	100%	100%	100%	100%
	Number of Nurse-Lead Discharges	num	-	-	-	2	4	4	1	-	-	-
	Patients Discharged before 11am	num	39%	35%	32%	-	25%	32%	14%	44%	28%	10%
Staffing	WTE Vacant (% of Establishment)	%	19%	58%	7%	-	4%	9%	11%	26%	16%	11%
	Sickness Absence Percentage	3%	6.0 %	-	10.1 %	-	11.7 %	-	2.9 %	2.3 %	2.4 %	4.3 %
	Bank Hours (% of Vacant WTE)	%	94%	72%	87%	-	210%	125%	2%	67%	149%	137%
	Agency Hours (% of Vacant WTE)	%	26%	0%	106%	-	145%	48%	59%	14%	14%	21%

*** Note that Chestnut ward Hand Hygiene data is non comparable as different audit tool used**

Monthly Ward Quality Indicators

Whittington Health NHS

Surgery, Cancer & Diagnostics Directorate Summary: FEB 2012

FEB 2012		Target	Coyle	ITU	Thorogood	Victoria
Infection Prevention and Control	Number of MRSA Bacteraemia Cases	0	0	0	0	0
	Number of MSSA Bacteraemia Cases	0	0	0	0	0
	Number of C Diff Cases	0	0	0	0	1
	Number of E Coli Cases	0	0	0	0	0
	Hand Hygiene Audit Score	95%	97%	96%	95%	100%
	Ward Cleanliness Audit Score	95%	97%	97%	98%	93%
	Number of Indwelling Urinary Catheters	num	1	10	1	7
Patient Experience	Number of Complaints	0	0	0	0	0
	Number of Patient Survey Responses	num	57	-	30	20
	Net Promoter Score	+ve %	44%	-	55%	55%
	Activity Follow Score	%	-	-	-	-
	Number of Mixed Sex Breaches	0	0	0	0	0
Patient Safety	Number of High Risk/Serious Incidents	0	0	0	0	0
	Number of Grade 2/3/4 Pressure Ulcers	0	0	5	0	3
	Number of Falls	num	3	0	1	3
	Number of Discharge Alerts	0	2	-	0	1
	Number of Incidents Reported	num	12	11	1	24
Quality of Care	Nutrition screen on admission (48hrs)	95%	100%	100%	-	93%
	Number of Nurse-Lead Discharges	num	1	-	-	-
	Patients Discharged before 11am	num	24%	20%	28%	38%
Staffing	WTE Vacant (% of Establishment)	%	38%	25%	16%	3%
	Sickness Absence Percentage	3%	5.1 %	2.8 %	8.3 %	6.3 %
	Bank Hours (% of Vacant WTE)	%	56%	31%	77%	307%
	Agency Hours (% of Vacant WTE)	0	8%	9%	7%	370%

Monthly Ward Quality Indicators

Whittington Health NHS

Women, Children & Families Summary: FEB 2012

FEB 2012		Target	Betty Mansell	Birth Centre	Cearns (Me3)	Cellier Mothers	Ifor	Labour	Murray	NICU	SCBU
Infection Prevention and Control	Number of MRSA Bacteraemia Cases	0	0	0	0	0	0	0	0	0	0
	Number of MSSA Bacteraemia Cases	0	0	0	0	0	0	0	0	3	0
	Number of C Diff Cases	0	0	0	0	1	0	0	0	0	0
	Number of E Coli Cases	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene Audit Score	95%	100%	-	-	100%	100%	66%	100%	100%	-
	Ward Cleanliness Audit Score	95%	100%	-	97%	100%	-	100%	100%	-	-
	Number of Indwelling Urinary Catheters	num	0	-	-	-	0	-	-	-	-
Patient Experience	Number of Complaints	0	0	0	0	1	0	1	1	0	0
	Number of Patient Survey Responses	num	-	-	-	-	-	-	-	-	-
	Net Promoter Score	+ve %	-	-	-	-	-	-	-	-	-
	Activity Follow Score	%	-	-	-	-	-	-	-	-	-
	Number of Mixed Sex Breaches	0	-	-	-	-	-	-	-	-	-
Patient Safety	Number of High Risk/Serious Incidents	0	1	0	0	0	0	0	0	0	0
	Number of Grade 2/3/4 Pressure Ulcers	0	0	0	0	0	0	0	0	-	-
	Number of Falls	num	2	0	0	0	0	0	0	-	-
	Number of Discharge Alerts	0	1	-	-	-	-	-	-	-	-
	Number of Incidents Reported	num	15	3	3	6	5	11	1	-	-
Quality of Care	Nutrition screen on admission (48hrs)	95%	86%	-	-	-	-	-	-	-	-
	Number of Nurse-Lead Discharges	num	-	-	-	-	-	-	-	-	-
	Patients Discharged before 11am	num	34%	-	-	-	-	-	-	-	-
Staffing	WTE Vacant (% of Establishment) *	%	12%	-	-	-	-	-	-	-	-
	Sickness Absence Percentage	3%	0.9 %	-	-	-	2.8 %	-	-	1.7 %	-
	Bank Hours (% of Vacant WTE) *	%	172%	-	-	-	-	-	-	-	-
	Agency Hours (% of Vacant WTE) *	%	59%	-	-	-	-	-	-	-	-

* WC&F Staffing figures are currently not separated at ward level on ESR (with the exception of Betty Mansell and Ifor)

Infection prevention and control report

Quality and patient safety subcommittee of Trust Board 20th April 2012

Covering Quarter 4 2011/12 from 1st January 2012 - 31st March 2012

Prepared by Dr Julie Andrews, Consultant Microbiologist and DIPC, Whittington Health
15th April 2012

1. MRSA related issues

There were **2** Trust attributable MRSA bacteraemia episodes in 2011/12 against an agreed objective of **3**. These were diagnosed in a surgical patient on Coyle ward in July 2011 and a medical patient on Meyrick ward in February 2012. The latest MRSA bacteraemia was fully investigated and the source was related to a peripheral line. Critical issues relating to the care of peripheral lines and administration of MRSA suppression protocol were widely shared.

The agreed objective for 2012/13 is **1** trust attributable MRSA bacteraemia.

MRSA screening audits demonstrated **91%** compliance in February 2011 (down from 94% in November 2011) for our emergency patients. ED staff and IPC staff are meeting regularly to aim to improve these compliance figures. Rapid MRSA screening using Polymerase Chain reaction (PCR) technology has been introduced for augmented care patients (Critical care and neonatal unit) and emergency surgical patients.

MRSA screening audits demonstrated **84%** compliance in February 2011 (down from 88% in November 2011) with elective patients. These results have been feedback to relevant outpatient staff.

There were no MRSA bacteraemia episodes diagnosed in patients covered by the Community Infection control services in Islington and Haringey.

2. *Clostridium difficile* diarrhoea issues

Trust attributable (post 48 hour) *C.difficile* cases at end of March 2012 were below trajectory with **18** cases against the trust attributable objective for 2011/12 of **34**. All post 48-hour cases were followed up with a focused questionnaire and staff feedback. Antimicrobial prescribing in

these patients was fully compliant with trust policy. Only 66% of patients were immediately isolated when their symptoms commenced. This information has been discussed with all ward managers.

There were no cases of *C.difficile* diarrhoea diagnosed in patients covered by our community Infection control services in Quarter 4 2011/12.

A medical patient admitted with diarrhoea had *C.difficile* associated diarrhoea recorded on part 1b of her death certificate in February 2012 and a STEIS report has been completed. Widespread communication and collaboration between primary care staff, ward staff, IPCT and patients relatives was clearly documented. The patient had complex antimicrobial prescribing issues but these had discussed widely between the teams involved in her care.

A new 2 stage laboratory method of diagnosing *C. difficile* infection, as recommended by DoH guidelines, has been recently introduced.

The *C. difficile* objective for 2012/13 has been confirmed as **21**.

3. MSSA/*E.coli* bacteraemia episodes

There were 16 Trust attributable MSSA bacteraemia episodes and 18 Trust attributable *E.coli* bacteraemia episodes in 2011/12. There are no set objectives for these organisms.

4. Other relevant Healthcare associated Infection (HCAI) issues

Whittington Health (acute inpatient beds only) recently took part in a European point prevalence study focusing on HCAI and antimicrobial prescribing. Our HCAI prevalence rate was calculated at **5.3%**. In 2006 when we participated in a similar HCAI prevalence study our rate was **11.9%.** The local sector and national results will be published on 20th April 2012.

There have been sporadic Influenza and norovirus cases but no outbreaks.

There has been a focus on invasive *Pseudomonas aeruginosa* infection related to the investigation into the deaths of three neonates in Northern Ireland in January 2012. We have reviewed our practice at Whittington Health compared to Best practice guidance issued recently by the DoH. The actions plans that have ensued from this review are being monitored through the IPCC and the decontamination committee. A water committee has been set up and will report directly to the decontamination committee.

5. Audit

The dashboard has been refreshed to present audit results by divisions with a section covering some of the higher risk community areas. The dashboard is included as **appendix A**. A total of 187 out of possible 207 (90%) were completed. Overall **79%** of IPC audits completed were fully compliant, down from 85% in Q3.

Audits showing concerning results included:
12 clinical areas were non-compliant in recent hand hygiene audit. These areas have to complete follow up audits and feedback of results. A new corporate hand hygiene strategy is soon to be relaunched including disciplinary actions for non-compliant staff.
13 community services were non-compliant in latest environment audits. Action plans are being drawn up for each service with focus of the lowest scoring areas such as CDC services at St Ann's.
8 wards non-compliant with MRSA suppression protocol starting and completing. Further guidance on the correct prescribing of MRSA suppression therapy has been given by IPCT.

The dashboard results have been shared with clinic/ward managers, matrons, facilities staff and divisional leads.

The Whittington Health IPC dashboard will continue in 2012/13 but more emphasis will be placed on ward staff (monitored through Heads of nursing) completing IP and C based audits rather than the Visible leadership team. IPCT will continue to collate and disseminate information supported by clinical governance administration support.

6. IP and C training

Infection prevention control mandatory clinical and non-clinical training is now provided predominately via E-learning. 68% of Whittington Health staff have received recent (within the last 2 years) IPC training, up to 31st March 2012.

Bespoke clinical and non-clinical face to face IPC training is delivered at least weekly at various sites throughout the ICO by our IPC nursing staff.

7. Antimicrobial prescribing

Antimicrobial targets of <10% unjustified IV antimicrobial prescribing longer than 72 hours, <10% restricted antimicrobials used but not discussed and <10% antimicrobials continuing for more than 7 days (unjustified) were all achieved in Q4 2011/12. Documentation of duration and indication of antimicrobials has improved to 75% but not reached the agreed target of over 90%. Antimicrobial sessions have been delivered to FY1/2, CMT, orthopaedic staff and Anaesthetic trainees in 2011/2.

Weekly ward based antimicrobial audits performed by Dr Andrews and Ai-nee Lim will continue in 2012/3. It is predicted that £44,500 savings (7.6% fall) will be achieved on expenditure on antimicrobials in 2011/12.

Antimicrobial steering group at Whittington Health has been expanded to include junior medical representatives and community based staff. All three divisions have Consultant representatives.

8. Surgical site surveillance

Orthopaedic surgical site infection surveillance data in Q3 2011/12 have shown infection rates in hip implants of **0%** (national benchmark 1.6%), knee implants of **4.9%** (2 out of 41 operations, national benchmark 1.1%) and repair of fractured neck of femur NOF **0%** (national benchmark 1.9%) respectively. Early data suggests no surgical site infection have occurred in the NOF patients during Q4.

A fractured NOF workstream has been set up with representation from IPCT. The focus of these groups is to reduce length of stay and increase compliance with pre, intra and post-operative factors known to reduce the risk of complications. Early results show that average LOS has reduced from 21 to 16 days.

Presentation of audit data of patients undergoing NOF surgery to anaesthetic and orthopaedic staff demonstrated previous non-compliance issues around antimicrobial prophylaxis and documented operation times. A recent re-audit of operation times from Q3 demonstrated that only 1 out of 37 procedures breached the recommended T-time of 90 minutes.

9. Integration of acute and community teams

Sue Tokley is leading work on the integration of the community and acute side Infection prevention and control teams and a consultation document will be ready by the end of May 2012. The teams are currently working very closely together and covering leave, combining policies and teaching etc;

Work to combine the acute and community IPC annual plans has been completed and is presented as appendix B. Work has started on the annual DIPC report which will be completed by June 2012.

By the end of June 2012, 2 out of the 5 nursing posts will be unfilled. The band 7 post is back out to advert and another senior role will be back out to advert following the consultation document.

10. Decontamination issues

Dr Micheal Kelsey and both IPC lead nurses attend the decontamination committee. There are ongoing issues with endoscopy rinse water test results, validation of bedpan washers and surgical equipment failing decontamination procedures but these problems have active and timely action plans that are monitored through the decontamination committee.

A full review of dental services is nearing completion and the IPCT have participated in review and relocation of 2 dental service delivery areas that did not meet national guidance. The dental review is being monitored through the IPCC.

11. New Whittington Health Infection prevention and control Annual strategic plan

See appendix B for the Whittington Health IPC strategic action plan for 2012/13. This action plan was reviewed by the April IPCC and has been disseminated to relevant staff.

It combines the previous community and acute side action plans. The plan has been put together in collaboration with the entire Whittington Health IPCT, the learning and development team and the 3 divisional Heads of Nursing/Midwifery.

The action plan is split into 4 sections covering:

- Saving lives interventions
- Care Quality Commission regulations
- Governance
- Education, training and communications.

Whittington Health NHS

Infection Prevention and Control Strategic Action Plan 2012 - 2013

The Whittington Health (WH) strategic action plan for infection prevention and control (IPC) has been divided into key sections and aims to set out the work required in 2012/13 across the integrated care organisation (ICO) to meet the standards and targets placed upon the ICO as outlined in NHS Operating framework 2012-2013, The Health and Social Care Act 2009, and the Care Quality Commissions (CQC) Outcome 8, of regulation 12 in order to fully meet the judgement framework for inspections, allowing WH ICO to continue registration without restrictions with the CQC.

The key infection prevention and control objectives for 2012/13 are:

1. To have no avoidable cases of MRSA bacteraemia acquired by patients while in our care.
2. To have less than 20 cases of *Clostridium difficile* associated diarrhoea acquired within the ICO.
3. To achieve a compliance rate of 95% or above for all environment audits.
4. To achieve a compliance rate of 95% or above for all hand hygiene audits.
5. To achieve compliance of over 90% in all antimicrobial prescribing targets.
6. To ensure more than 90% of Whittington Health staff receive infection prevention and control training by end of 2012-2013.

Service objectives and operational details are contained within the annual report, service operating policy, and service workplan. This action plan should be read in conjunction with these three documents.

This action plan provides a comprehensive tool against which progress may be assessed and reported at the Infection Prevention and Control Committee and forms part of the self-assurance framework of the trust for CQC self declarations. It is intended that this is a live document and therefore progress against this will be reported to divisions at quarterly reports but also reported to the IPCC as a standing item.

All infection prevention and control policies referred to are available on the ICO's intranet.

The Executive Director with overall accountability for the delivery of the plan is the Bronagh Scott, Director of Nursing and Patient Experience. The Director of Infection Prevention and Control (DIPC) is Dr Julie Andrews.

Actions to meet Saving Lives High Impact Interventions (HII's)

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
1. Every adult patient admitted either as an emergency or electively will be screened in the Emergency Department, Pre-operative assessment clinic or on admission to a clinical area as detailed in the ICO's MRSA screening policy.	All elective and emergency admissions are screened for MRSA.	All adult patients admitted via ED to be screened in ED. Receiving ward staff to check screen has been undertaken as part of admission procedure, and if not, take it.	Monthly	HON SCD Delegated to relevant Ward Managers HON WFC Delegated to relevant Ward Managers HON ICAMS Delegated to relevant Ward Managers	LNIPC	Monthly compliance audits Weekly IPCT ward checks and visits
		Bed Management Team to allocate a bed post screen.				
		All adult elective patients to be screened in the pre-operative assessment or outpatient clinic.				
		Ensure all relevant staff are aware of which patients are to be screened when and how.				
		Monthly compliance audits are undertaken by IPCT and added to dashboard for IPCC.				
2. Every MRSA positive patient will have suppression therapy prescribed and given for required number of days and be commenced on a MRSA positive patient care plan.	All MRSA positive patients receive full suppression therapy at the correct time for the correct duration.	When result is positive, suppression therapy to be prescribed via the pre-printed prescription/or drop down menu (electronic prescribing), by relevant doctors/nurses/midwives.	Monthly	Ward Managers	LNIPC	Monthly compliance audits undertaken by IPCT IPC dashboard presented at IPCC
		Suppression therapy to be given for correct length of time as soon as possible.				
		Failure to administer full course to be treated as a drug error.				
3. Every surgical patient will receive optimal peri-operative care as set out in Saving Lives HII4.	Surgical site infection rates in patients undergoing surgical intervention will be reduced.	All recommendations to prevent surgical site infection to be implemented as per Saving Lives guidance and monitored via patient safety check list.	Every other month	Dr Ahmed Chekairi	Dr Julie Andrews	ORMIS to be used as audit tool when set up
		Input and audit SSI data via ORMIS.		Mr H Charalambides		Orthopaedic SSI data reviewed at each IPCC
		Input and audit orthopaedic SSI rates.		Graham Booth		
4. Clinical staff all comply with best practice in urinary catheter care as	The number of catheters placed will reduce.	Continence/ bladder and bowel team to deliver refresher training on urinary catheterisation to relevant staff.	Monthly	HON ICAMS HON WCF	LNIPC Nurse	Competency assessment records

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
set out in the Saving Lives HII6.	The number of catheter associated infections will reduce. The duration of use of catheter will be reduced. The use of catheter will be appropriate and relevance reviewed regularly.	Practice Development teams/clinical leads to assess non-medical staff every 3 years to ensure they maintain their competency. Junior doctors to receive training and competency assessment via the post graduate medical centre. Compliance with the care bundle in in-patients assessed by Energising for Excellence audit monthly. All in-patients with catheter to have daily Catheter checklist completed. Data gathering exercise for all patients with *E.coli* bloodstream infections to commence to determine possible interventions in future.		HON SDC Head of Clinical Development Lead for Safety and Productivity Maxine Hammond Liz Bonner Fernando Garcia Director of Postgraduate Medical Education	Consultant IPC	available for all relevant staff ESR updated locally Quarterly audits presented as part of IPC dashboard *E.coli* blood-stream infection rates monitored through IPCC
5. Clinical staff comply with best practice in the taking of blood cultures as set out in the Saving Lives guidance.	Reduced false positive blood culture results.	Training programmes to be delivered for new, untrained staff including medical staff. Training should include the use of blood culture stickers and documentation.	Monthly	Head of Clinical Development	Dr Julie Andrews Nurse Consultant IPC	Audit number of blood culture contaminants Competency assessment record available for all relevant staff
6. Clinical staff comply with best practice in peripheral cannula care as set out in the Saving Lives HII2 Care Bundle.	No peripheral cannulae insertion, care of or management issues identified by MRSA RCA investigations.	Provide cannulation training to all relevant clinical staff to deliver the actions in the care bundle. Provide updates to current staff to support them in maintaining their competency. Ward Managers to carry out quarterly audits using the Saving Lives.	Every other month	Clinical Education Team Clinical Area Managers supported by Link Practitioners	Nurse Consultant IPC LNIPC	Audits as part of IPC dashboard

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
7. The ICO complies with best practice with regard to isolation of patients, as set out in the Saving Lives guidance.	Patients who are subject to transmission precautions are ideally isolated in side rooms or cared for in cohort bays with patient with similar conditions in order to reduce transmission of alert organisms or conditions.	Ensure all site managers understand and use the LIPS, allocate known and potentially infected patients to single rooms, or cohort nursing accordingly. Ensure that transmission precautions are in place and followed at all times. Ensure that transfer and movement of patients is kept to a minimum. Ensure that correct decontamination of equipment and the environment is carried out where patients are seen. Quarterly monitoring of time to isolation, (aim to isolate within two hours). Introduce *Clostridium difficile* management care plan.	Every other month	Bed Management Team Assistant Director of Facilities HON ICAMS delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	LNIPC	Quarterly Isolation compliance audits based on the ICO Policy carried out by IPC Team Weekly IPC Team ward visits Quarterly monitoring of time to isolation times for patients with diarrhoea
8. Clinical staff in augmented care areas all compliy with best practice in temporary central venous catheter care as set out in the Saving Lives HII1 Care Bundle.	No CVC related *Staphylococcus aureus* bacteraemia cases.	Ensure all new staff are trained to deliver the actions in the care bundle. Ensure current staff receive updates and maintain their competency. Continue CVC insertion care bundle documentation in Critical Care areas. Carry out regular audits using the Saving Lives Audit tool.	Every other month	Dr Tim Blackburn Dr Andrew Badasconyi Dr Sarah Gillis Critical Care Lead Nurse Dr Juliet Penrice Lead Nurse for Neonatal Unit	Dr Julie Andrews	Annual audit of insertion and maintenance of CVCs

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
9. Critical care staff comply with best practice in caring for ventilated patients as set out in the Saving Lives High Impact Intervention 5 Care Bundle.	Reduce the prevalence of ventilator-associated pneumonia.	Ensure all new critical care staff are trained to deliver the actions in the Ventilator Associated Pneumonia care bundle. Ensure current staff receive updates and maintain their competency. Carry out annual audit using the Saving Lives Audit tool. Measure prevalence of Ventilator Associated Pneumonia regularly.	Every other month	Dr Sarah Gillis Dr Andrew Badasconyi	LNIPC	Annual audit of compliance with guidance
10. The ICO's medical and relevant pharmacy staff all comply with best practice with regard to antimicrobial prescribing, as set out in the Saving Lives guidance and ICO's Antimicrobial Policy and HII7.	Every patient receives antimicrobials in accordance with principles of prudent antimicrobial prescribing. Reducing the incidence of *Clostridium difficile* associated Diarrhoea HII7.	Ensure all relevant medical and pharmacy staff understand and follow the antimicrobial prescribing guidance. Carry out a rolling programme of monthly audits at ward level to ensure compliance.	Every other month	Clinical Leads for 3 Divisions	Dr Julie Andrews Ai-Nee Lim	Audits of compliance with the Antimicrobial Policy HII7 audits undertaken on every case of post-48 hour *Clostridium difficile* Diarrhoea Detailed review of audits at each Antimicrobial Steering Group meeting
11. The ICO monitors environmental cleanliness and decontamination of equipment as outlined in HII8.	The clinical environment looks and is visibly clean at all times	Deep cleans undertaken as per identified programme held by Estates & Facilities, and Infection Prevention & Control Team. Monthly environmental audits of higher risk clinical areas by clinical leads. Quarterly meetings with NCL sector facilities managers for both boroughs, discuss cleaning audits, issues and SLI's.	Monthly	Assistant Director of Facilities Heads of Nursing Clinical Area	LNIPC Nurse Consultant IPC	Audit of compliance with HII8 monitored through audits on IPC dashboard

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
		Meetings with Pentonville and deliver training on how to clean to BICS and inmates to standardise cleaning practices in the prison and healthcare wing.		Managers NCL Sector facilities managers Dynamic supervisor Regent supervisor Head of Facilities NCL		
12. The ICO complies with best practice with regard to reducing risk of infection in chronic wounds as set out in HII9.	Reduce the risk and incidence of chronic wound infections and chronic would related blood stream infections.	Embed wound care and patient management care bundles into care of all patients with chronic wounds. TTA's to include wound packs and dressings. Community teams to use dressing packs and knowledge of when to use then and how to facilitate ANTT in patients home. Integrated wound care formulary.	Every other month	Jane Preece Claire Davies HON ICAM HON WCF HON SCD	LNIPC	Annual audit of compliance with HII9

Actions to meet Health & Social Care Act; Care Quality Commission Regulations

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
Criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their	The ICO is compliant with Regulation 12 of Health & Social Care Act 2008 and outcome 8 of CQC guidance and thus able to maintain registration with the CQC.	Capture all relevant IPC work and audits findings to demonstrate compliance.	6 monthly	Director of Nursing and Patient Experience HON ICAMS HON WCF	DIPC Nurse Consultant IPC	Quarterly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
environment and other users may pose to them.				HON SCD		
Criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	The clinical environment looks and is visibly clean at all times.	See Saving Lives item 11 above.	6 monthly	Assistant Director of Facilities	LNIPC	Quarterly report presented by DIPC to Quality Committee
Criterion 3 Provide suitable accurate information on infections to service users and their visitors.	To provide assurance to service users and their visitors.	Clinical areas to display key IPC quality indicators.	6 monthly	HON ICAMS delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers Dr Julie Andrews	LNIPC	Quarterly report presented by DIPC to Quality Committee
Criterion 4 Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	To provide timely accurate IPC advice to front line clinical staff.	ICO has an accessible reactive timely Infection Prevention & Control Team.	6 monthly	Dr Julie Andrews	LNIPC	Quarterly report presented by DIPC to Quality
Criterion 5 Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to	To ensure that IPC advice delivered to front line staff is acted upon in a timely manner.	Integrated IPC and Microbiology team review of relevant patients in a timely manner.	6 monthly	Dr Julie Andrews	LNIPC	Quarterly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
reduce the risk of passing on the infection to other people.						
Criterion 6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	To ensure that patients receive clean safe care at all times.	To maintain and review the delivery of training and implementation on all IPC related matters.	6 monthly	HON ICAMS delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	Nurse Consultant IPC	Quarterly report presented by DIPC to Quality Committee
Criterion 7 Provide or secure adequate isolation facilities.	Patients who are subject to transmission precautions are ideally isolated in side rooms or cared for in cohort bays with patient with similar conditions in order to reduce transmission of alert organisms or conditions.	See Saving Lives item 7 above.	6 monthly	Director of Facilities HON ICAMS delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	Nurse Consultant IPC	Quarterly report presented by DIPC to Quality Committee
Criterion 8 Secure adequate access to laboratory support as appropriate.	To provide accurate diagnostic information for patients and service users.	Maintain Clinical Pathology Accreditation (CPA).	6 monthly	Dr Michael Kelsey	DIPC	Quarterly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
Criterion 9 Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Staff and patients have access to relevant information/education material for education and governance purposes.	Co-ordinated review of all IPC and Microbiology policies. Review of all patient information leaflets.	6 monthly	Director of Nursing and Patient Experience	DIPC Nurse Consultant IPC	Quarterly report presented by DIPC to Quality Committee
Criterion 10 Ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	Healthcare workers are protected from exposure to infections	All clinical and non-clinical staff undertake relevant IPC e-learning modules.	6 monthly	Director of Nursing and Patient Experience Medical Director	LNIPC	Quarterly report presented by DIPC to Quality Committee

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Governance

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT responsible lead	Evaluation/ Assurance
1. A full RCA is carried out for every case of MRSA bacteraemia and outbreaks or death from post 48 hours cases of *Clostridium difficile.*	The ICO has a robust RCA policy and processes, owned by the relevant operational clinical staff that facilitates identification of the root causes of infections, and identifies and implements corresponding actions to	HCAI action plan by IPCT and reviewed regularly. Relevant staff to attend RCA training.	Every other month	Nurse Consultant IPC	Nurse Consultant IPC	Every RCA identifies the likely root causes and actions needed to improve practice. Action plan

	reduce reoccurrence. The ICO has adopted a zero tolerance approach to all avoidable healthcare associated infections.					reviewed every other month and presented at IPCC
2. The ICO uses relevant clinical indicators to monitor IPC performance.	The ICO has a dashboard of IPC indicators to monitor performance and share with relevant internal and external staff groups and committee members.	Use dashboard to monitor performance over time at local and corporate levels. Use information to identify where prompt remedial action is needed.	Quarterly	HON ICAMS delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	Nurse Consultant IPC	Dashboard is standing agenda item at IPCC. Shared at local level with clinical area managers and consultants
3. The ICO record all Infection prevention and control risks on service specific and corporate risk registers.	IPC risks are reviewed on a regular basis.	ICO corporate IPC risks added to the HCAI action plan and reviewed regularly. Divisional IPC risks added to divisional board quarterly reports.	Quarterly	Nurse Consultant IPC	Nurse Consultant IPC	Open risks discussed at each IPCC
4. The ICO Infection Prevention and Control action plan is regularly reviewed.	The Infection Prevention and Control Committee agenda and action plan reflect progress made, and identify work still required.	Progress with plan reviewed prior to each IPCC by small implementation group	Every other month	Nurse Consultant IPC Heads of Nursing all divisions	Dr Julie Andrews	Monitoring every two months of delivery of actions as per IPC Plan by implementation group presented at IPCC.
5. An annual IPC report is written and widely distributed to relevant committees and made publically available	Staff, ICO board, and public have access to information and assurance of infection prevention and infection control measures implemented by IPCT, and performance against HCAI targets	DIPC to write annual report	Annual	Dr Julie Andrews	Dr Julie Andrews	Report to be presented at IPCC June 2012

6. IPCT member present at all relevant ICO committees.	Committees have up to date IPC advice as required.	IPC membership of all committees is reviewed.	Every other month	Nurse Consultant IPC	Nurse Consultant IPC	Attendance at committees is monitored
7. IPCT provides input at all stages of commissioning services/ re-builds/refurbishments and relocations.	Infection Prevention & Control at forefront of services.	IPCT provide timely input as required.	Ongoing	Nurse Consultant IPC	Nurse Consultant IPC	Problems reviewed at IPCC
8. IPCT provides comprehensive IPC service to Pentonville Prison.	Clean safe care delivered to all offenders by staff with up to date knowledge and skills.	IPCT provide timely input as required.	Ongoing	Head of Prison Healthcare	Nurse Consultant IPC	Problems reviewed at IPCC

Education, Training & Communication

1. Programme of training delivered as per IPC action plan. This includes induction, mandatory training and on request/as required/bespoke training.	All staff know how to access the IPCT and resources available to them.	Continue rollout of ICO-wide practical competency training programme (BCs, ANTT, and urinary catherisation). Review and update content of E-learning IPC modules.	April 2013	IPCT Learning Development Team	Nurse Consultant IPC	Attendance monitored and reported by ESR Compliance with training is reported via the individual directorates monthly
2. Training is tailored to the needs of the individual and the environment they work in.	Staff feel supported with and are competent with their IPC knowledge and skills.	Programme of training as per Training Needs Analysis - Induction training and mandatory training via E-learning.	April 2013	IPCT Learning development team	Nurse Consultant IPC	Attendance monitored and reported by ESR
3. Regular updates to Link Staff via e-mail	Link staff are kept up to date and aware of current trends in IPC	Circulate IPC dashboard and other relevant information on IPC to link staff	Annual	Nurse Consultant IPC	Nurse Consultant IPC	At master class events link staff report usefulness of communications
4. Planning and deliver National Infection Control Week	Raised awareness in both staff and patients / public around IPC	Organise promotional stand, campaign, and attend key events to raise awareness of IPC annually to coincide with national event	Annual	Nurse Consultant IPC	Nurse Consultant IPC	Raised awareness within workforce of IPC

5. Making public information available on IPC for staff and patients	Regular information on a display or newsletter on IPC, continued raised profile and high awareness amongst workforce around IPC	Provision of ward boards to display IC information to staff, patients and the public. Provision of regular updates / posters on IPC	Annual	Nurse Consultant IPC	Nurse Consultant IPC	Feedback from staff and patient surveys demonstrates material is effective
6. IPC Team are contactable for advice 24 hours per day 7 days per week	All staff knows how to access the IPC for advice/support. Timely and relevant advice given and advise logged for records	Microbiology/Infection Prevention and Control Team contact details are easily available.	Ongoing	Dr Julie Andrews	DIPC LNIPC Health Protection Agency	Refresh communications to all staff annually or sooner if significant changes

Clinical Leads

Name	Title
Julie Teahan	Matron for Acute Services
Dr Andrew Badasconyi	Consultant Anaesthetist
Dr Tim Blackburn	Consultant Anaesthetist
Graham Booth	General Manager Theatres
Kara Blackwell	Head of Nursing for Medicine
Mr H Charalambides	Orthopaedic Consultant
Dr Ahmed Chekairi	Consultant Anaesthetist
Debbie Clatworthy	Head of Nursing for Surgery
Jennie Cleary	Head of Nursing for Midwifery
Fernando Garcia	Urology Nurse Specialist
Mr Omar Haddo	Orthopaedic Consultant
Philip Ient	Director of Facilities
Tina Jegede	Matron for Medicine
Maggie Pratt	Practice Development Nurse Medicine
Steven Packer	Assistant Director of Facilities
Lisa Smith	Head of Clinical Development
Bronagh Scott	Director of Nursing & Patient Experience
Nickola Amin	Matron for Emergency Department
Dr Sarah Gillis	Consultant Anaesthetist
Sue Tokley	Deputy Director of Nursing and Patient Experience
Jane Preece	Tissue Viability Specialist Nurse
Claire Davies	Lead Nurse Tissue Viability
Maxine Hammond	Lead Nurse Continence Islington
Liz Bonner	Lead Nurse Continence Haringey
Celia Ingham-Clark	Medical Director

Infection Control Team

Name	Title
Dr Julie Andrews	Director Infection Prevention & Control (DIPC)
Patricia Folan	Infection Control Matron & Deputy DIPC
Dr Michael Kelsey	Consultant Microbiologist, Head of Laboratory
Gretta O'Toole	Infection Prevention and Control Nurse Specialist
Tracey Groarke	Infection Prevention and Control Nurse Specialist
Jennifer Marlow	Surveillance Co-ordinator
Ai-Nee Lim	Antimicrobial Pharmacist
Yvonne McCarthy	PA to Infection Prevention and Control Team
Kris Khambhaita	Lead Nurse Infection Prevention and Control
Stephanie Bimpong	Infection Control Service Co-ordinator

Abbreviations

LNIPC = lead nurse infection prevention and control
IPCT = Infection Prevention and Control Team
HON = Head of Nursing
ICAMS = integrated care and acute medicine
IPCC = Infection prevention &control committee meeting
SDC = surgery diagnostics and cancer division
WCF = women's children and families division

QUALITY IMPROVEMENT UPDATE REPORT
DIVISION OF INTEGRATED CARE & ACUTE MEDICINE.

1. Background

1.1 The purpose of this report is to provide an update to the Quality Committee on the main approaches being used in terms of quality improvement across the Division of Integrated Care and Acute Medicine; this report will give context as well as the impact of the improvement activities being undertaken.

1.2 This report will also enable links to be made between aspects of quality improvement which are often regarded as separate; with specific focus on improvement from clinical and divisional perspectives so that we are able to get a blend of information of both achievements and areas for concern at a team and directorate level.

1.3 This report will also provide a structured update to the core Quality improvement initiatives as identified by the divisional business objectives for the financial period 2011/2012. The emphasis is to use this report for an active dialogue surrounding areas of concern, innovation and quality improvement.

2. Divisional Management Structure

2.2 Within the division there are a range of Directorate Board meetings that occur chaired by the relevant Clinical Director as illustrated. At each of these boards there are standing agenda items covering issues of quality (using divisional performance and quality dashboard), complaints and incidents and patient experience. These feed into the Divisional ICAM Board. There are also a number of service level meetings which take place at operational level, and these feed into Divisional Management Team (held weekly) via the appropriate Head of Service.

- Urgent Care Board chaired by Dr William Zermansky
- Emergency Department Board chaired by ED Clinical Lead
- Acute Medicine Board chaired by Dr Richard Jennings
- HASS chaired by Director of Social Services
- Divisional Management Team chaired by the Divisional Operational Director

2.3 All these boards report into the monthly Integrated Care and Acute Medicine Divisional Board, which is chaired by the Divisional Clinical Director, Dr Richard Jennings. The Divisional Board has the performance report as a standing agenda item along with service presentations, Workforce report, CIPs report and finance report. Alongside these reports all new high risk incidents and STEIS reports are presented and formally approved by the board and there is a quarterly report on overall trends in terms of patient experience, complaints and associated action plans.

2.4 The Division last presented to the Quality Committee in October 2011. Three services were presented which were identified as high risk from a quality and/or patient safety perspective. These were:

- Healthcare services at HMP Pentonville
- Community District Nursing
- Emergency Department.

This report follows on from these presentations and outlines the current work being undertaken by the Division, key priorities, areas of good practice and challenges in relation to patient quality and safety agenda for the services which sit within the Division of Integrated Care and Acute Medicine.

3. Quality Improvement Work Areas:

3.1 The quality improvement work covers 3 main domains: Safety, Quality (Clinical Effectiveness), and Patient Experience, within these domains they are broken down into discreet areas of activity which are detailed below (note some of the themes are cross cutting and this will be detailed within the report).

3.2 **Domain (1) Safety:**

- NHS Litigation Authority (NHSLA)
- Environmental
- Complaints/Incidents/Claims
- Infection Control
- Serious Incidents (Sis, SUIs)
- Patient Safety (CAS Alerts, Medication Errors, Slips Trips and Falls, Pressure Ulcers and Wound Management, Nutritional Screening, Essence of Care etc).
- Safeguarding Vulnerable Adults and Children.

3.3 **Domain (2) Quality:**

- Care Quality Commission registration and ongoing monitoring of compliance/ internal service reviews of evidence both at local and divisional level/visits planned & responsive by the CQC/visits planned and responsive by the organisation
- NHS Litigation Authority (NHSLA)
- Environmental (Patient Environment Action Team “PEAT” Scores)
- CQUIN/Quality Frameworks
- Quality Innovation Productivity and Prevention
- Productive Series (NHS Institute for Innovation and Improvement)
- National Institute for Clinical Excellence (NICE)
- Equality and Diversity
- Audit Programme.

3.4 **Domain (3) Patient Experience:**

- Environmental (Patient Feedback) (Complaints/PALS/Claims)
- Compliments/Complaints/PALS/Incidents/Claims
- Patient and Public Involvement (PPI)
- Patient Experience and Patient Satisfaction.

4. Overall Summary - Areas of Good Practice and Quality Improvement

4.1 This section provides a very brief overview on some of the notable areas of good practice of which the division would like to make the Quality Committee aware. This list is by no means exhaustive but simply aims to pick out some of the key elements and examples from across the division and its specialties.

4.2 Hospital Mortality Rate /Patient Safety

The Whittington is in the select group of hospitals with a low standardised mortality on both the Hospital Standardised Mortality Ratio (top 10) and Standardised Hospital Mortality Index (number 1 nationally).
The Trust's SHMI for 2010-2011 was 67.
The table below outlines the SHMI for the 10 diagnosis groups with the highest number of deaths within the Trust, a majority of patients with this diagnosis would be cared for by the medical physicians.

Condition	Observed deaths	Expected deaths	Spells	SHMI	Lower Confidence Interval	Upper Confidence Interval
Pneumonia	111	164	786	68	55.8	81.5
Congestive Heart Failure	35	45	262	78	54.4	108
Cancer of the Bronchus	26	28	71	94	61.7	137.3
Acute and unspecified renal failure	25	32	156	77	50.4	114.0
Septicaemia (except in Labour)	25	32	110	79	51.6	116.6
Urinary Tract Infection	17	33	528	51	30.5	82.3
Acute Cerebrovascular disease	17	24	118	72	42.4	114.7
Chronic Pulmonary disease and bronchiectasis	16	33	473	48	28.1	78.4
Acute Myocardial Infarction	15	12	121	121	69.0	199.5
Aspiration pneumonitis	12	22	46	55	29.0	95.4

4.3 Trauma Assessment.

The Whittington is a designated 'Trauma Unit' within the pan-London trauma network launched in April 2010. In December 2011 the organisation was assessed against the 'Trauma Unit Designation Criteria' by the London Trauma Office (LTO). The Whittington had to provide a detailed report into the many aspect of trauma care from admission to discharge with key personnel attending the assessment day from across the organisation. The Whittington received a very positive report in March of this year. In particular the LTO reported: "The assessment process revealed both commitment across the patient pathway and throughout the organisation from operational to Trust level employees. The Whittington Hospital demonstrates a good understanding of the trauma caseload received, available skills and expertise, commitment to education and effective internal and governance processes supporting care."

4.4 Ambulatory Care Pathways

To avoid unnecessary admission and to ensure that older people get the appropriate treatment they need without delays that lead to longer admissions, both senior clinical decision making and multi-disciplinary assessment and planning are required as close to attendance at the hospital as possible, along with co-ordination of ongoing care with community services in order to ensure safe return home and avoidance of re-attendances. The new ambulatory care clinic which is consultant led commenced in February 2012. This was funded through 30 day re-admission money and it is anticipated that this will result in a reduction of over 2000 bed days in 2012-2013.

4.5 Pressure Ulcers

Although the Trust did not achieve the 80% reduction target set in the Safety Express work stream for acute Trusts there has been a 55% reduction in the acquisition of grade 3/4 pressure ulcers in the Trust. This is a significant reduction and demonstrates a clear improvement in the quality of patient care delivered within the hospital.

4.6 Discharge Planning and 7 day working by therapists

Seven day working by therapists within the Emergency Department and Medical Assessment Unit has been in place since January 2012 and complements the in-reach service from Islington Re-ablement Service. Although in its infancy this has led to good outcomes to date in relation to increasing weekend discharges from these areas, and in admission avoidance or reducing length of stay if patients are admitted by having done the therapy assessment and contribution to the Estimated Discharge Date (EDD) based on criteria to be achieved for safe discharge.

Weekend Discharges - from weekly pre 11 am reports (i.e. only patients with at least one night stay)

	W/e 1.1.12	w/e 8.1.12	w/e 15.1.12	w/e 22.1.12	w/e 29.1.12	w/e 5.2.12	w/e 12.2.12	w/e 19.2.12
AMUs	9	8	9	10	14	10	10	13
Medical total	20	13	15	16	22	16	19	24
Surgical total	12	11	8	10	15	11	20	15
Total	41	32	32	36	51	37	49	52

Therapies weekend working in place.

4.7 HMP Pentonville

Currently HMP Pentonville is outperforming all London Prisons in relation to the following areas:-

- Fast tracked mental health assessments
- Meeting 28 day transfer target to admission under the MHA
- Access to clinical assessment and access to nurse led services

Primary Care Improvements 2011/12

- Retinal screening rates increased in 2011/12
- Epilepsy register cleaned to provide accurate information 2011/12
- Diabetes and patient education improved through using recognised literature
- Health Promotion Strategy work stream commenced January 2012
- Targeted Health Promotion Months to commence May 2012: Oral Health
- Levels of clinical care improved by targeted nurse training: Minor Ailments Clinics introduced in 2011: All nurses trained & competent to run these clinics.

Substance Misuse Service Improvement

- Continued high performance in activity numbers: 25% prison under care of SMU team at all times of year.
- 98.5% of service users received confirmed medication in 24 hours

4.8 Hanley Road Primary Care

The practice has submitted their QoF data onto the QMAS system and the Qof Achievement for 11/12 is 97.14% (contract target 95%). This is before the additional indicators (for patient experience) are added before the results are released in May.

4.9 Pharmacy Services

In this years peer reviews of the adult and paediatric chemotherapy service pharmacy have met all the standards and received excellent feedback for medicines management from the last Care Quality Commission and the General Pharmaceutical Council inspections.

In January 2012, working closely with the Information Technology (IT) department the pharmacy department led a successful roll out of electronic discharge prescriptions in conjunction with the IT roll out of electronic discharge letter ensuring the organisation met all the commissioners requirements.

In November 2012 pharmacy won a grant from the Design Council to improve the patient experience in the out-patient pharmacy, develop it as a site for health promotion and as a retail space. This project is underway.

Working with the enablement team and social services (SHINE) pharmacists are visiting older patients in their homes once discharged to support the patients with their medicines and any medication related issues and providing a service to vulnerable adults reviewing and advising on their medicines.

In long-term conditions pharmacists are now working both in the hospital and community in the musculoskeletal services and diabetes clinics reviewing patients' medication, optimising their use and advising on changes and counselling.

In the community a pilot is underway using a pharmacy technician instead of a district nurse to evaluate their impact on patient care and medicine costs through medicines optimisation.

All these projects are being evaluated and present opportunities for research in service development within such a new organisation as the ICO.

Medicines Safety day - May 2011, held in the atrium highlighting medicines safety issues for patients and staff.

Every 2 months the pharmacy produces a bulletin "Medicines Matters" which covers medicine safety issues and new information on medicines.

Medicines safety information now signposted on the intranet – the committee has designed the medicines safety icon which when clicked takes the user directly to medicine safety information.

5. Quality – Areas to address and Key Priorities

5.1 This section provides a brief level summary of some of the key areas of quality that the division is currently focused on and seeking to address and improve. They will be detailed further in this paper along with the associated action plans in place and progress.

5.2 *Infection Control* - This remains an area of considerable focus within the division. Local action plans have been developed and implemented to address key areas of concern (see Infection Control Section).

5.3 *Patient Experience* - Patient experience across the Division remains a priority particularly in ED and Outpatients (see Patient Experience Section).

5.4 *PPI* - whilst the division has PPI involvement in some service areas this is recognised as an area where both the division and the organisation as a whole need to increase the level of engagement and embed PPI within its services in order to maximise the benefits associated with greater PPI.

5.6 *Consultant presence* - the division does have daily consultant input but does not currently meet the requirements which will be set out by NHS London requiring us to have 12/7 coverage in acute services. This is one of the major quality initiatives within the division in order to enhance the service provided throughout the week. This will now be achieved in 2012 as a result of the recently agreed business case for additional consultant capacity to meet commissioning and performance standards in emergency care.

5.7 *ED Quality Indicators* - the time to treatment quality indictor remains a challenge and the department has been trialling a consultant led “pit-stop” providing early access to senior decision making. The pilot has shown that during the hours of operation of the pit-stop the initiative is successful and during that time we are meeting the target. However, longer waits in the evening, when this system is not in place remain high and so achieving this quality indicator remains a significant challenge. The ED Board has recommended that medical staffing rotas are reviewed to increase clinical capacity in the evening.

6. Other Programmes supported by this Work

6.1 This document, the proposed work areas and action detailed link in with a number of Trust-wide plans and initiatives across a broad range of service areas.

6.2 *QIPP Board* - within the ICAM Division there are 4 programmes of transformation work focusing on the improving the pathway and patient experience:

- Transformation of Care of the Older Person
- End of Life Care,
- Transformation of the long term conditions pathways for Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD) and Diabetes
- Prevention of 30 day readmissions/ambulatory care.
- MSK Chronic pain
- Health Promotion strategy

6.3 *CIP Board*- a number of the projects and areas detailed within this report support the CIP programmes for 2011/12 and 2012/13. These are reported through on a weekly basis to the CIP Board in terms of progress against supporting CIP target delivery. One CIP programme achieved at the end of March 2012 was the closure of Cavell ward, this has a full year saving of £1.1 million.

The Division also has several staff consultations which have either been completed or are currently in process. These are aimed at reducing costs across these services but also aim to ensure greater integration and continuity of services across the patient pathway.

There was agreement that the CIPS savings identified for Community District Nurses services could be re-invested into the District Nursing service, and this has been used to provide a Twilight District Nursing service in Haringey 7 days a week which will runs until midnight. This will enhance the safety and quality of nursing care services received by Haringey residents.

Domain 1 Safety:

A.NHS Litigation Authority (NHSLA)

The Division of Integrated Care and Acute Medicine led on NHSLA documentation as part of the NHSLA assessment which recently took place in the Trust across the areas listed below. This required the production of a single trust wide policy for Whittington Health for the relevant areas that were approved and ratified for use.

- Safe Transfer of Patients and Bed Management
- Slips, Trips and Falls
- Blood Transfusion
- Discharge Policy
- Medicine Policy

B. Environmental

Acute Wards
A few environmental concerns were flagged with regard to some of the acute ward areas earlier in the year. Environmental audits are carried out every 4-6 weeks by the ward manager &/or matron with the domestic supervisor for that area. However, since December all acute wards have been RAG rated as Green for environmental cleanliness. This is covered further in the Infection Control section of this report.

Emergency Department
In October 2011 an environmental audit of the Emergency Department raised several concerns around the cleanliness of the department (see Infection Control Section) and identified some of the facilities within the Emergency Department as not being fit for purpose. This resulted in a capital bid being approved for £100K for the following work in the Emergency Department which will be carried out in 2012:

- Redesign/refurbishment of the Drug Room and possible relocation of the Sluice Room
- Refurbishment of the majors.

HMP Pentonville.
The environmental issues at Pentonville are complex due to the Prison being the principal managers of the environment. However there are joint management arrangements for the healthcare areas and we include these areas in the wider organisational NHS structures.

Cleanliness checks and audits are carried out during the business year and reports are taken on progress at the local clinical governance board. This is now a regular report and demonstrates the commitment to improve the clinical environment and maintaining quality and standards to a higher level than was the case prior to Whittington Health becoming the health contractor.

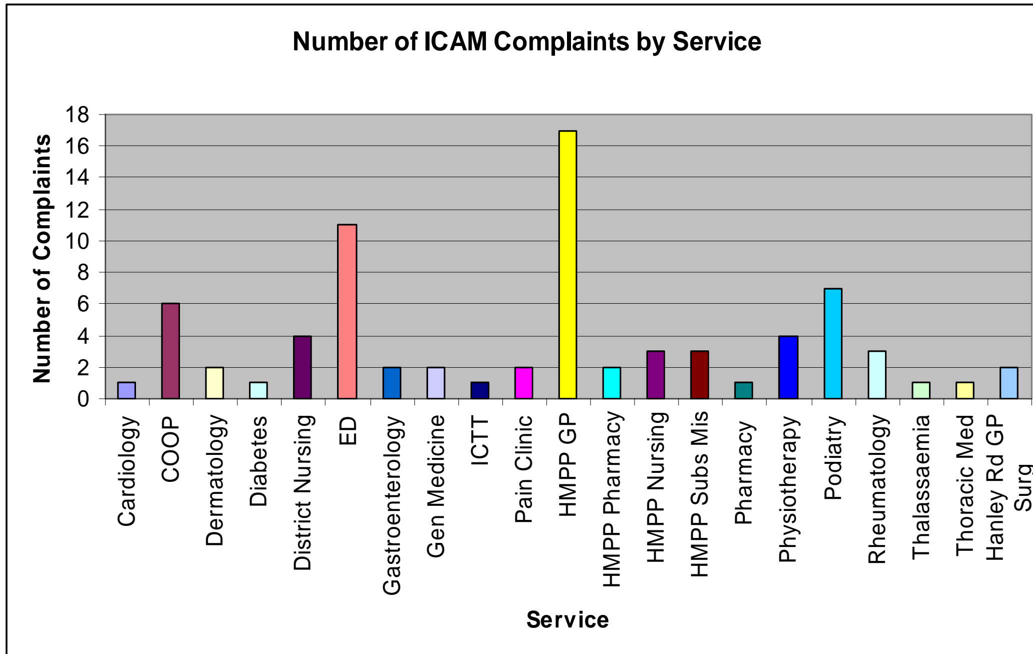
C. Complaints & Incidents

1. Complaints

In terms of overall numbers the division has the highest number of complaints accounting for 62% (76) of the overall complaints across the three divisions in quarter 3. This was an increase from the previous quarter and largely related to an increase in complaints regarding care at HMP Pentonville. None of these complaints were

identified as high risk, 11% were moderate risk and 89% low risk.

The chart below shows the number of complaints by service within this division. GPs in HMP Pentonville Healthcare received the highest number of complaints this quarter with 17. This is a significant increase on six in the previous quarter, however many of these were not upheld. The Emergency Department saw a slight decrease in the number of complaints from 14 to 11. Podiatry received seven complaints which is an increase from two complaints in the previous quarter. The Care of the Elderly Wards received six complaints which is an increase of three from the previous quarter however less than the eight received in quarter one.



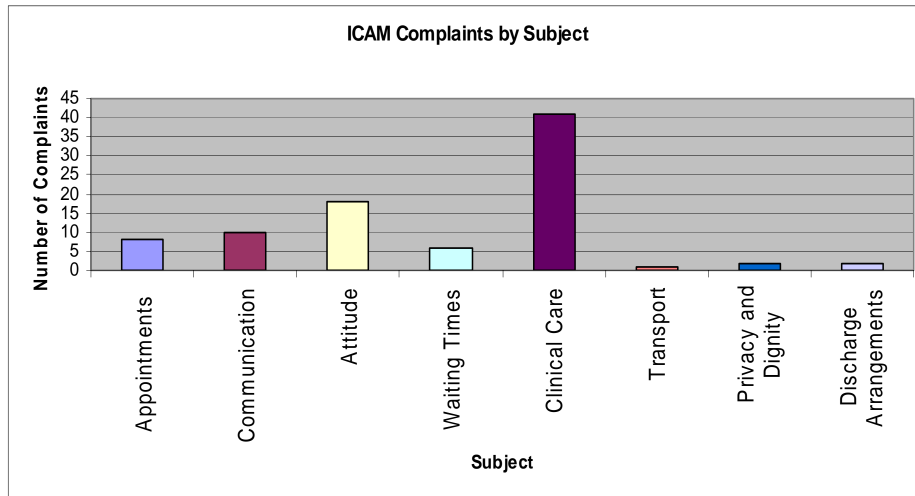
Complaints compared to Activity Levels

The table below shows the number of complaints compared to the level of activity in an area.

Service	No of Complaints	Quarterly Activity	No of contacts per complaint	No of Complaints per 10,000 activity
ED	11	21865	1988	5.0
District Nursing	4	55950	13988	0.7
Podiatry (comm.)	7	12978	1854	5.4
Physiotherapy (comm.)	4	12885	3221	3.1

There has been an increase in the number of complaints compared to activity in Podiatry and Physiotherapy in this quarter. The level of complaints to activity in the Emergency Department has remained the same as in the previous quarter.

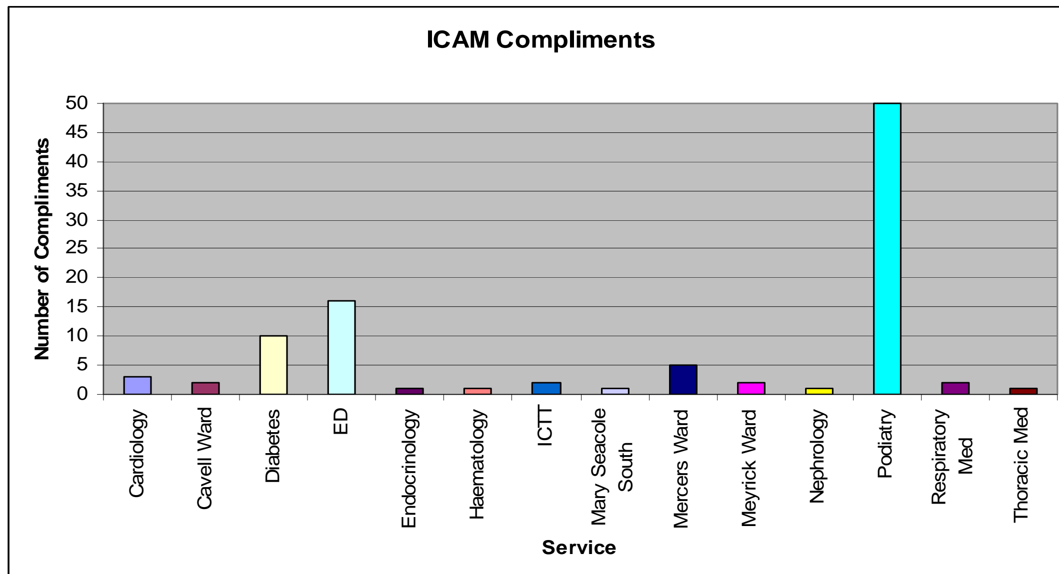
The table below shows the complaints received by subject. Some complaints contained more than one issue and therefore are logged for each issue raised. The majority of complaints raised concerns over clinical care (41). Complaints about attitude and manner of staff were raised on 17 occasions and concerns over communication were raised on 10 occasions. Difficulties with appointments were raised on eight occasions and waiting times were identified six times. These results are shown in the chart below.



When comparing with the previous quarter it may be seen that there was a slight decrease in the percentage number of times complaints were raised regarding clinical care and a slight increase in the percentage of complaints that were raised regarding communication. Attitude of staff remained almost the same. The Division previously performed poorly in relation to responding to complaints within the set timescale, this has significantly improved over the last 6 months.

Compliments

Compliments by service area for Q3 are detailed below.



Although the Podiatry service received seven complaints in Q3 they also were the service that received the largest number of compliments within this time period. The ED also saw an increase in the number of compliments received.

Issues Trends and Improvements- Emergency Department.

Historically many of the complaints in ED have related to clinical care. Quarter 3 saw a reduction in the number of complaints relating to clinical care, the department received 7 complaints, 3 fewer than the previous quarter. The introduction of the new consultants' rota in the Emergency Department which enables provision of Consultant presence in ED from 8am-8pm Monday-Friday has enabled greater supervision of the

junior doctors and a recent audit of Consultant sign off demonstrated that there is an increased awareness amongst junior doctors to ensure “high risk” patients are reviewed and seniors to identify “high risk” patient groups during ward rounds/handover between shifts.

***Issues Trends and Improvements* – Acute Wards, Care of Older People and Rehab Wards**

Mercers Ward

Mercers ward had previously had a high number of complaints in a short period of time; these related to the quality of care and attitude/communication issues particularly relating to nursing staff. This prompted a rapid review of Mercers Ward in July/August 2011 and the subsequent development of an action plan to address the issues identified as part of this review. Many of the issues on the action plan have now been completed. The action plan is monitored by the Divisional Head of Nursing and an update was presented to the Patient Experience Committee (PEC) in January 2012. Since the implementation of the action plan Mercers has only received 1 complaint.

Cloudesley Ward

Four of the six complaints received in Q 3 were from patients/families cared for on Cloudesley ward. In December 2011 the Head of Nursing reviewed all of the 6 complaints received about care on Cloudesley ward. One member of staff was linked to 3 of these complaints and this has been addressed by the matron and ward manager. There have been no further complaints for Cloudesley ward in the last quarter.

Chestnut Ward

Two complaints and an incident on Chestnut ward in January highlighted gaps in senior nursing leadership on the unit. This has been addressed with support from the Head of Nursing and includes Clinical Site Management team to provide out of hours/weekend support and support from the Resuscitation Team in relation to deteriorating patient initiatives.

***Issues Trends and Improvements- HMP Pentonville*.**

The complaints regarding healthcare within the prison have significantly reduced since Whittington Health (previously Islington PCT) have provided the contract. Historically, the complaints levels were as high as 750 per annum for a yearly prison population of 7000. The inclusion of the healthcare complaints within the remit of the Trust Complaints Team has led to the drastic reduction in these complaints to 80 in 2011/12.

36 Complaints: GP & Prescribing Issues.

The level of fully upheld (9) is low from this number and most complaints relate to prisoners unhappy with the policy of refusing to prescribe their medication of choice. Normally diazepam which is strictly managed under our medicines management policies.

19 Complaints: Nurse/ Staff Attitude Improvement.

There had been in 2009/10 high levels of complaints regarding nurse attitudes. There are now very few complaints received or upheld in this area (5 in 2011/12). This is attributed to improved training and individual supervision of staff.

2. **Incidents.**

The Divisional Head of Nursing is informed of all high risk incidents and ensures that all high risk incident reports are completed and that action plans are fully implemented. All high risk incident reports are now presented at the Divisional Board for agreement and sign off. All Serious Incident action plans are also monitored through the Divisional Board with nominations from the service involved in the incident attending the Board to provide updates. A quarterly risk report has now started to be collated by the Divisional Head of Nursing and is presented to the Divisional Board.
The Division has made the decision to set up a Divisional Patient Safety Committee which will feedback monthly to the Divisional Board. This committee will review and agree all high risk incident reports prior to them going to the Divisional Board for final approval and will also monitor all outstanding actions on any high risk reports. Given the size and range of services, some of which are high risk areas within the ICAM Division it is not possible for all high risk incidents to be scrutinised at the level required at the Divisional Board. The Divisional Patient Safety Committee will include the Divisional Head of Nursing, a Lead Clinician and a nominated risk manager and will provide assurance to the Divisional Board that all high risk incidents are completed within the dedicated timescale, that the reports are of a good quality and that all action plans are monitored in an ongoing way. The first meeting will be in May 2012 and will then be held monthly. High risk incident reports, action plans and updates will still be tabled as agenda items at the Divisional Committee for sign off but this new committee with enhance the patient safety agenda within the Division and reduce the time spent at Divisional Board correcting these reports. The Division will seek agreement from the Trust Patient Safety Committee at the next meeting in April to proceed with this new structure.

Discharge Alerts
All discharge alerts are now recorded on the Trust Incident reporting system (datix). The hospital had previously been slow in providing feedback to the community services who often raised these alerts. The process has now been reviewed and a new, more robust system is being implemented within the Complex Discharge Team, this will enable more timely feedback, enable prompt addressing of any safeguarding concerns and facilitate greater learning from those involved in the discharge alerts to ensure safer patient care.

D. Infection Control

MSRA Bacteraemia.

There has been 1 MRSA bacteraemia reported in the Division this year. This was acquired on Meyrick ward. A full RCA investigation has been completed, the root cause of this incident was poor cannula care. The action plan included:

- Re education of ward staff and local induction for temporary staffing on trust policy for the management and documentation required for peripheral lines.
- Compliance monitoring through ward level audits on both documentation and timely suppression.
- Ward consultant to ensure junior team members compliance to peripheral line insertion documentation.

The main focus within the Division in relation to Infection Control have related to the following components:

1. Ward /Department cleanliness audits
2. Hand Hygiene Audits

1.**Ward /Department Cleanliness and Hand Hygiene**

There have been some issues with some wards achieving the 95% ward cleanliness target earlier in the year but all wards received a RAG rating of green on the monthly ward quality indicators in January and February 2012.

Compliance with hand hygiene has been an intermittent problem on some wards in the Division. All wards have dedicated infection control link workers who lead on monthly study training which includes infection control for ward staff. Hand hygiene compliance and expected standards amongst temporary staff and student nurses is included as part of induction and local induction.

Wards that have scored below 95% are having daily audits of hand hygiene until they are compliant and this is reported daily through to the Head of Nursing and matron for that area. There is also a Divisional Infection Control Action plan which is being rolled out which includes nominating a Consultant Lead for Infection Control for each ward who can challenge poor compliance by medical teams which has often been the cause of poor results in the hand hygiene audits. All wards, with the exception of ISIS were RAG rated as Green in January and February 2012.

Particularly problems were identified in then ED department in October/November 2011 in relation to compliance with infection control measures and policy. An action plan was developed and implemented as a result of this which included:

-Weekly hand hygiene audits. These have continued weekly and now are consistently over the 95% target.
-Letter sent to all staff alerting them to poor compliance and significance of this.
-A hand hygiene training to all staff in department
-Infection Control notice Board
-Nominated Consultant lead for Infection Control in the ED department
-Establishment of an ED infection Control team
-Liaison with LAS to ensure greater compliance from the ambulance crews.

Some of the ED consultants are also being trained on using the Hand Hygiene audit tool so they can contribute to these audits.
This action plan and updates have been provided to the Infection Control Committee. An ED Quality Indicator Scorecard, similar to those already used for the ward areas is currently being developed and will be used from May 2012.

HMP Pentonville.

The infection control activity has focused upon improvement in quality of all clinical areas within the prison. This includes the treatment rooms which are situated upon each residential unit of the prison and the health care centre that includes the 22 bedded healthcare unit. The infection control lead within the Prison works with the organisational team to provide guidance on any issues. This directly led to key improvements in two areas of the environment which were classified as unfit for purpose. A prison wing treatment area and the dental suite were closed as a result of this joint working and both these areas have now been completely redesigned and moved to new areas of the prison

- Quality checks are reported monthly at local clinical governance
- Timetables and evidence of cleanliness monitoring have been introduced
- Assessment of fitness of clinical areas is on-going and as stated there have

been key major works to reach compliance

A review of all clinical areas is being undertaken by the local infection control lead during April and this will be used to monitor improvements and set out any programme of works for 2012/13.

The Prison Inspection of May 2011 by Her Majesties Prison Inspectorate acknowledged the improvements being made.

E. Serious Incidents (SI's SUI's)

In total the ICAM Division reported 61 Serious Incidents in 2011-2012.
There has been 1 "never event" relating to a misplaced NG tube following which the patient died. This is currently being investigated and the report is due with NHS London at the end of April 2012.

46 of these Serious Incidents related to patient who had acquired a grade 3/4 pressure ulcer predominantly in the community, all have individual action plans as a result of the RCA investigation but there is also an over-arching pressure ulcer action plan for the Community District Nursing Service which is monitored by the Divisional Head of Nursing and the Pressure Ulcer Serious Incident panel (see section G).

There were 4 SIs relating to Death in Custody (DIC) (see section F).

Two other SIs related to unexpected deaths of patients whilst in the care of the Community District Nursing service.
One SI related to the management of a patient with Type 1 diabetes. The key learning/actions from this were:

- Improve understanding/training of the management of insulin dependent patients in the community.
- Ensure risk assessment of patients who are unable to administer their own medication
- Robust clinical supervision system for Haringey district nursing is put in place to support patient safety.
- Robust management supervision of the Haringey district nursing services

The other SI relates to care received by a patient in both primary and secondary care. A patient was discharged from hospital and referred to Islington Community District Nursing Service, the referral was received but the patient was not visited for 11 days and subsequently admitted to hospital with septicaemia resulting in her death.
Key actions include an update of the District Nursing Service Work Processes and Office Systems Guidelines, adding (1) a section on checking referrals and faxes and scheduling patient visits and (2) annual review dates. Working with the acute hospital to set up a ward e-mail so that referrals can be e-mailed directly to the District Nursing service.

F. Prison Healthcare Death in Custody (DIC)

In 2011-2012 there has been a reduction in Deaths in Custody from the previous year, with 4 DIC reported this year.
Of these DIC, 3 were self inflicted and 1 was due to natural causes. All deaths in custody are reported as SIs to NHS London and a full Root Cause Analysis

investigation is carried out. The DIC due to natural causes was de-escalated by NHS London. The completed investigation and updated action plan for the first DIC was presented to the Divisional Board in December 2011. The other 2 DICs are currently in the process of being investigated.
All DICs in prison lead to a coroner's court hearing and all are fully investigated by the Prison Probation Ombudsman alongside the SI investigations conducted by Whittington Health.

New investigation procedures were introduced in 2010 for any DIC. The main improvements being the introduction of a Prison Serious Incident Panel, this panel is a key development in relation to better patient care. Any DIC will now be followed by:

- 7 day internal investigation is completed for panel
- 28-60 day review by non-prison clinician team.

The recommendations from our own investigations have led to improvements in:

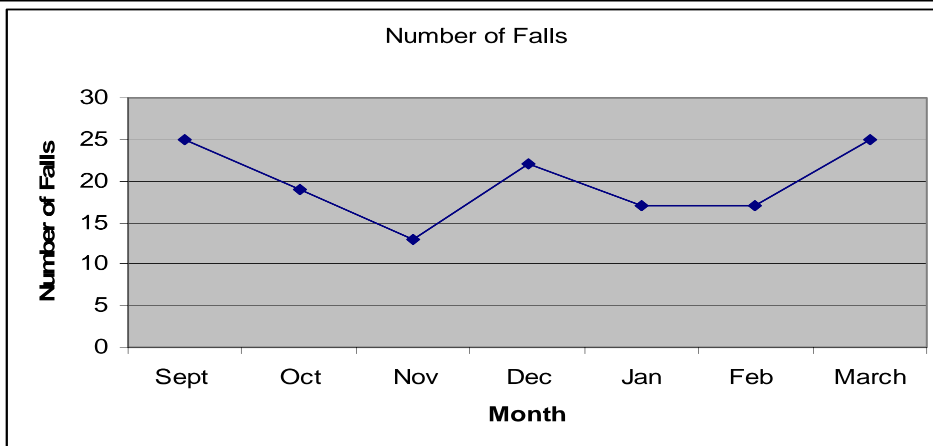
- Initial health assessments on arrival at the prison
- Faster access to mental health assessment
- Better clinical assessment tools in all areas
- Introduction of a training programme for all clinical staff within the prison
- Record keeping training and audit
- Joint prison health guidelines in movement of patients from prison to clinical areas of the prison.
- Better patient safety monitoring systems
- Review of in- patient care quality and admission procedures

Two of the DICs occurred in February and March his year and are therefore still being investigated. All SI investigation reports are presented to the Divisional Board and the action plans from these are also monitored by the Divisional Board.

G. Patient Safety (CAS Alerts, Medication errors, Slips Trips and Falls, Pressure Ulcers and Wound Management, Nutritional Screening, Essence of Care etc).

1.Falls

The measure for monitoring falls nationally in acute hospitals is the number of falls per 1000 bed days. According to the NSPA (2011) the national benchmark for acute Trusts for falls = 5.6 falls per 1000 bed days. It is estimated that for the data from April 2010-March 2011 when there were 405 falls based on 90752 bed days the Trust ratio is =4.46 falls per 1000 bed days.
The ICAM division has a significant number of falls particularly on the Care of Older People wards and as part of the Falls Group is working to achieve a 25% reduction in falls across all the Division's inpatient areas. A Falls draft falls dashboard has been developed and this will include the falls per 1000 bed day ratio as an additional measure of the progress being made on fall. The division continues to be RAG rated as red for falls.



The graph shows that since September there has been a modest reduction in falls across the ICAM wards until March 2012 when there was a sharp increase, this was largely due to the number of falls increasing on MAU (n=6) who previously have only small numbers of falls . Individual action plans for these areas are being developed by the Falls Project Team.

The Falls Group is now chaired by Head of Nursing ICAM Division. Some of the actions already in place include*:*

- Falls project physio lead (2 days a week) and ward manager from Care of Older People (1 day a week) working a part of Falls project team for 4 months
- All patient falls are recorded as a DATIX incident report and these are monitored monthly by the Divisional Head of Nursing. Any falls where a fracture is suspected as a result of the fall are immediately escalated to the HON so that immediate intervention can take place if required.
- All high risk falls or trends are assessed using full Root Cause Analysis in order to identify potential themes and issues associated with patient falls. These are presented at the monthly Falls Group and at Divisional Board.
- Falls awareness and the use of the assessment tool is included in the ward orientation for all new staff
- During the summer of this year the SAFE ward rounds project were introduced across all wards and this includes increased two hourly assessment including checking risk factors and patient call bells
- Training sessions were held as part of the Falls Awareness in January 2012. These have now been set up as a rolling programme to ensure all staff receive this training.

A recent initiative was the introduction of local action plans developed for wards with consistently high levels of falls. Cloudesely has had a local action plan in place since the start of February which has been implemented by the ward manager and falls champions on the ward, supported by the Falls Project team which has lead to a 50% reduction in their falls in February and March from a previous 6-7 falls a month to 3 falls a month in the last 2 months.

Further Actions

- Set up alert system via datix to notify Falls Project Team of any falls so they can ensure prompt follow up in these clinical areas, ensure post falls assessments are completed and enable learning for staff regarding these incidents
- Local action plans to continue to be developed by falls team, matrons and

ward managers for those wards who have high number of falls &/or have not demonstrated any reduction in falls
- Explore options for continued funding of Falls Project team &/or Falls co-ordinator as feedback from their work supports the need for ongoing dedicated time for staff involved in falls

2. Pressure Ulcers

Hospital Acquired.
There have been 3 grade 3 / 4 pressure ulcer acquisitions on the acute wards in 2011-2012. All of these were acquired from Sept-March 2012. Whilst these numbers are low given that the Division cares for some of the most vulnerable patients who are admitted to the hospital the Division acknowledges that this is 3 too many and has a negative effect on both the quality of care received, the patient's experience and results in a longer length of stay and significant additional resources both whilst in hospital and on discharge from hospital. The Division aims for zero pressure ulcer acquisitions in 2012-2013.
All grade 3 /4 pressure ulcers acquired in the hospital are escalated to NHS London as Sis and have a full RCA completed, these are then agreed by the Divisional Head of Nursing before being presented to the Pressure Ulcer Serious Incident panel.

Learning/Actions as a result of the SI Investigations.

Safe rounds have been introduced across all wards (Summer 2011) and one of the components of the safe rounds includes changing the patient's position, if required, during the two hourly review.

All ward managers to ensure that their staff attend the Pressure ulcer training days planned throughout the year.

All patients to have their pressure areas reassessed as soon as they are transferred from one clinical area to another.

New pressure ulcer cushions and mattresses have recently been approved by capital monitoring committee and purchased and are have now been distributed (November 2011) across the wards to support patient management and reduce risks of pressure ulcers by improving the availability of pressure relieving equipment. This will enable 75% of all ward chairs to have access to pressure cushions.

All patients admitted to the Emergency Department now have their Waterlow Score documented as party of their admission in ED. Pressure relieving mattresses are available in ED so that patients assessed as high risk can immediately be placed on a bed/mattress. The Emergency Department now reports all pressure ulcers (2, 3, and 4) on datix whilst the patient is in the department. This means we now have accurate records of patient's pressure areas/skin integrity as soon as the patient starts their pathway in ED.
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Community Acquired.

The target of 30% reduction (Safety Express) in community acquired pressure ulcers has not been achieved in 2011-2012. Reducing the number of pressure ulcer acquisitions in the Community is a significant challenge, it is often compounded by the fact that personal care is not delivered by the Community District Nursing Service and it is much more difficult to ensure patient compliance with treatment and interventions. However, the Community District Nursing Service has implemented a

robust action plan aimed at achieving a reduction in pressure ulcer acquisitions in the community setting.
This includes:

- A complete review of pressure sore management has been undertaken and an overarching pressure ulcer prevention action plan in place
- Pressure ulcer and service escalation reporting procedure have been introduced
- 86 percent of staff have attended pressure ulcer training, with the remaining staff booked to attend, includes specific training for HCAs
- HCAs no longer visit patients with skin damage above grade 1 ulcer instead a registered nurse will visit.
- MUST tool and training introduced in Haringey (and training) and Patients of concern process rolled out to Haringey
- Tissue Viability Nurse Specialist meets with DN Team Managers on rotation to discuss all patients at risk of pressure ulcers on their caseload
- Monthly pressure ulcer audit rolled out across Haringey as well as Islington.
- Patient/carer information leaflets introduced
- Equipment ordering for North Middlesex and Whittington discharge teams introduced so no delay in receiving pressure equipment on discharge form hospital
- New band 4 role being introduced (one in Islington, one in Haringey), to further standardise and improve monthly pressure ulcer prevention checks
- Monthly pressure ulcer prevention checks introduced across Haringey as well so that all patients with pressure prevention equipment are monitored
- DN/CM Teams where pressure ulcer incidence appears to be high have been scrutinised and actions put in place where necessary

3. Nutritional Screening

Audits of compliance with the “red tray initiative” are undertaken monthly on all medical wards to ensure patients with increased nutritional and feeding requirements are receiving the additional support they require. The plan is to include these audit results in the divisional quality indicators reports.

4. District Nursing.

District Nursing is a high risk service. Systems have been put in place to monitor quality and risk. These are regularly reviewed by the Divisional management and nursing team. Systems for monitoring include:

- Service wide audit programme has been introduced (particularly record keeping, pressure sores and infection control)
- Integrated quality dashboard and joint outcome indicators introduced
- Service process for responding to clinical incidents and complaints introduced, work on cultural change in reporting, openness and service learning from incidents introduced particularly through facilitated team building sessions
- Learning has been undertaken following recommendations from a recent SI report
- Patient daily handover has been introduced across teams
- Skill mix review has been undertaken which has included budget allocation against skill mix

- Process to identify patients with complex needs and ensure that they are discussed and monitored in management supervision and a clear process for escalation of concerns introduced

H. Safeguarding.

HMP Pentonville

Traditionally within the prison there has been a lack of leadership within this area. A local safeguarding lead for adults and for children has been appointed within the prison and the lead for the Prison Inspectorate for Health has agreed to work with us to review our procedures and she will also be acting as the national lead in this area for HMCIP.
All incidents of safeguarding are reported to the local lead who currently works with local authority and NHS locality services as well as linking into local prison management structures such as MAPPA.
However the Prison Healthcare Service will be reviewing all current procedures and amending local procedures in liaison with the Trust Adult Safeguarding lead in 2012.

Domain (2) Quality:

A. Care Quality Commission:

- Registration
- Ongoing monitoring of compliance
- Internal service reviews of evidence both at local and divisional level
- Visits planned & responsive by the CQC.
- Visits planned & responsive by the organisation.

The Divisional Head of Nursing is operationally responsible for the ongoing implementation and monitoring of the action plan developed by the Head of Nursing in response to the visit by CQC in April 2011 as part of their targeted inspection programme in acute hospitals to assess how well older people are treated during their hospital stay, especially in relation to whether they are treated with dignity and respect and whether their nutritional needs are met. The action plan was based on the recommendations outlined in the CQC report and identified what actions the Trust would take to ensure that the Trust maintained compliance with the essential standards of quality and safety in relation to maintaining the dignity and nutrition of older people.
Actions included:
-Implementation of the “safe rounds” across all wards
-Development of ward information leaflets specific to each ward which are given to all patients on admission to the ward.
-De-cluttering of day rooms
-Assessment of food preferences as part of the admission process
-Rota for senior nurses to undertake out of hours/night shifts to provide reassurance regarding care provision out of hours.

Regular updates on this action plan are reported via the Patient Experience Committee.

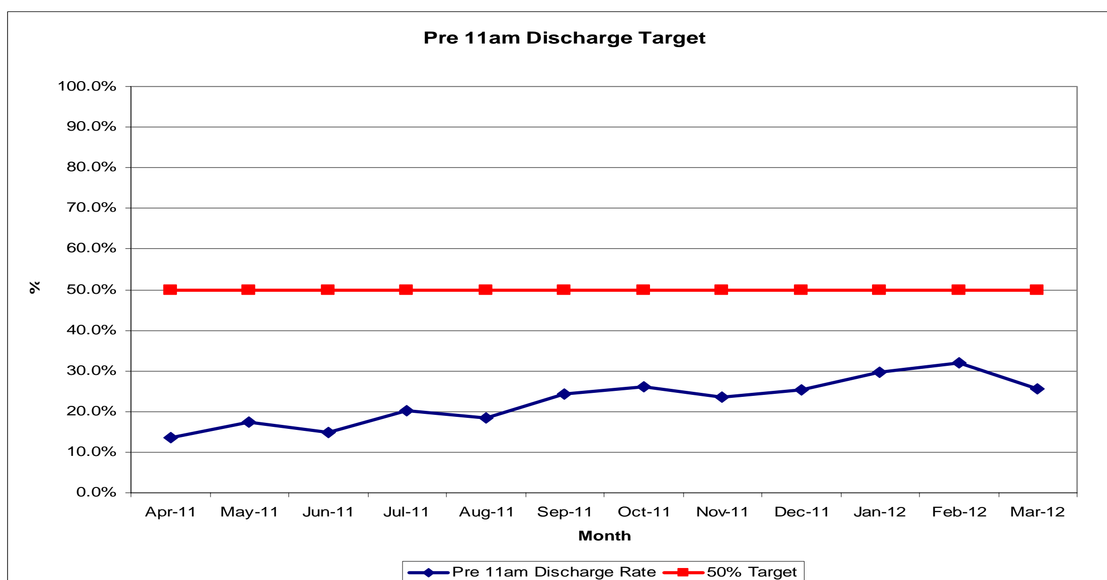
B. CQUIN/Quality Frameworks (Standards, Benchmarking).

The main CQUINs that the division is leading on are the following:

1.Discharge
2.Care Closer to Home
3.COPD
4. Long Term Conditions.

1. Discharge (Pre 12am Discharge and weekend)

The CQUIN relates to Discharges across all adult wards before 12am and the percentage of weekend discharges. However, the Trust has agreed an internal target of 50% of discharges being pre 11am. Although the 50% target has not yet been achieved there has been a steady improvement from 14% in April 2011 to the 29% average for January-March 2012.



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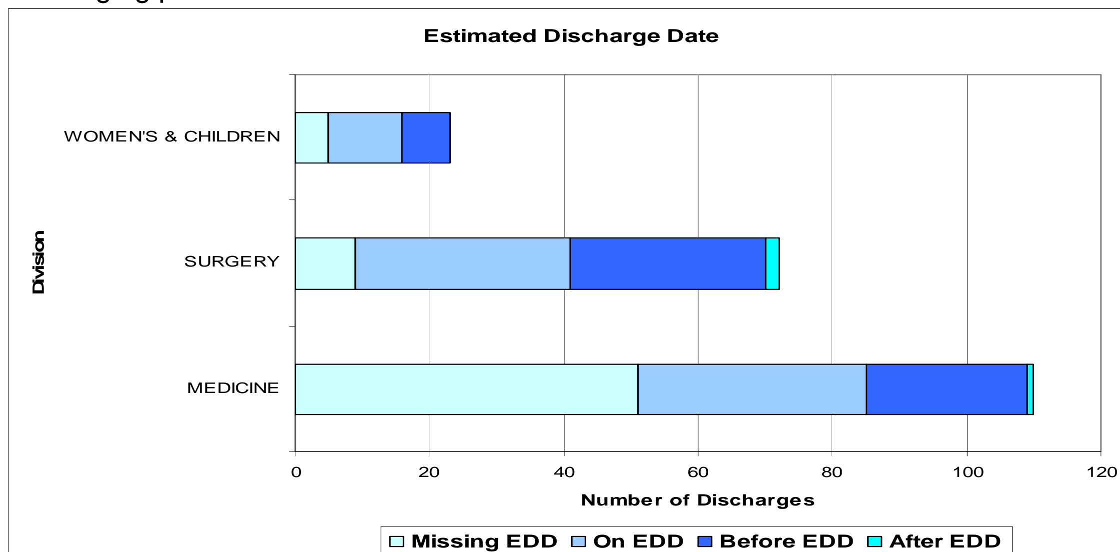
This has significant benefits to patient safety and quality. By ensuring that bed capacity is freed up earlier in the day the Trust can ensure that patient transfers from MAU to the wards for those patients requiring longer admission can take place in the morning thus facilitating admission from ED to the MAU for patients requiring admission. ED activity builds up throughout the day and ensuring the flow of patients through the hospital enables the ED department to manage the increased activity in a more co-ordinated way. Earlier ward discharges enables patients from ITU who are suitable to be transferred to the wards to be moved out thus freeing up the ITU beds for the elective surgical admissions and enabling an Emergency ITU to be available at all time for patients requiring emergency admission.

The number of weekend discharges has not improved significantly in 2011-2012 however the presence of therapists over the winter period did have an impact on overal weekend discharges as referred to in sec 3.6 Approval of the Business case for additional consultant , pharmacy and therapy funding to meet the the Acute Commissioning Standards will undoubtedly faciliate an increase in safe and timesly weekend discharges and a further reduction in lengths of stay by supporting 7 day working across all Divisions

The graph below demonstrtaes that the Trust is making good progress around discharging patients on or before their EDD.



Care Closer to Home.

The aim of this CQUIN is to promote innovation, improve efficiency and deliver care in more convenient settings for patients. New ambulatory care pathway has been developed for cellulitis, pylonephritis, Elderly care and low risk PE providing patients with an alternative to hospital admission.

COPD Bundle.

The aim of this CQUIN is to improve the care of patients with COPD; all patients should be discharged with a completed care bundle. Completion of the care bundle aims to increase efficiency and improve COPD patient experience.

Long Term Conditions

The aim of this CQUIN is to promote innovation, improve efficiency and deliver care in more convenient settings for patients. This is a two year CQUIN to reflect the timescales required for design, full implementation and impact measurement of the transformation work. This work is being progressed by the Head of Long Term Conditions.

C. Quality Innovation Productivity Prevention (QIPP).

Care of Older People.

This project aims to deliver transformed care for older people, with integrated multidisciplinary working to support effective management by primary care, with consultant support as part of this. Older people say that they prefer not to be admitted to hospital or to stay in hospital any longer than necessary, and the evidence from the National Support Team is also that many older people ‘decompensate’ and decline on admission to hospital, partly due to reduced mobility, disorientation etc. The focus on admission avoidance and reduction in length of stay is expected to enable closure of in-patient beds and to release resources that can be re-invested in strengthening the community response and resources to manage and treat older people in their own home.

The therapies and discharge functions of the hospital are being remodelled to increase the resource available at the 'front end' of the hospital for admission avoidance and early discharge, and also to improve coordination and planning of discharge of patients with more complex needs who have been on the main wards.
Seven day working by therapists within the ED and MAU has been in place since January 2012 and this compliments the in-reach service from Islington Re-ablement Service. Although in it's infancy this has led to good outcomes to date in relation to increasing weekend discharges from these areas and in admission avoidance or reducing lengths of stay. Information from the IT department has shown that the work to reduce lengths of stay (on Care of Elderly wards) has not impacted adversely on re-admission rates, in fact, it has shown the reverse with readmissions rates reducing.
The care of older people project is continuing with a pilot of MDT integrated working around 2 pilot GP practices in North East Haringey underway.

Transformation of the Long Term conditions pathways (Heart Failure, COPD and Diabetes)
In order to shift care appropriately into the community for patients with long term conditions and to continue to provide high quality care, there needs to be improvement in services, develop people and reform systems. This project aims to:

- Understand and risk stratifying the health needs of the population and planning services accordingly
- Create effective partnerships particularly with GP's
- Implement new evidence based service approaches and pathway redesign
- Deliver education and training

End Of Life Care

The aims of the project are to:

- Better identify and recognise of people who are approaching the end of life.
- Assessment and care planning to facilitate preferred place of care and preferred place of death
- Delivery of high quality services ensuring that the services are NICE compliant.
- Improve the generic care for patients in the last days of life
- Reduce number of admissions from home &/or care home for patients in the end stages of their disease thus freeing up bed capacity
- Reduce number of predictable deaths in the Acute Trust by 20% (approx 300 deaths annually in the Trust, excluding ED and ITU)

HMP Pentonville

A new project is commencing in 2012 aimed at reducing the number of incidents when patients are sent out of the prison for treatment to the Whittington. The project aims to introduce better patient management and improved use of telemedicine/IT based care. This will improve quality to patient care and will relieve pressure on resource for both Whittington Health in terms of pressure on appointments and the Prison by reducing financial expenditure involved in moving patients/prisoners from Pentonville to the Whittington Hospital. The project will also focus on reducing the length of bed stay at the Whittington for any patient leaving Pentonville for in-patient based treatments. There will be attention to target of bed stay to be within remit of national best practice.

Ambulatory Care/30 Day readmission

The project plans to focus on four main areas:

- To prevent readmissions within 30 days
- To support the management of patients with Long Term conditions effectively across primary and secondary care
- To provide consultant level input and support in the community
- To offer increased support to patients and staff in care homes to prevent readmissions

At the centre of the projects plan sits the Integrated Care Rapid Access Clinic acting as a hub to the surrounding project 'spokes'. This clinic commenced in February 2012

F. Productive Series (NHS Institute for Innovation and Improvement)

The productive ward series are due to be re-launched trust wide in early 2012 by the Deputy Director of Nursing and Patient Experience. The responsibility for the lead for the roll out of the Productive Ward Programme has been written into the new matrons' job descriptions as a core part of their remit within the ICAM division.

Chestnut Ward at Greentrees, St Ann's Hospital, continues to maintain gains from Productive Community Hospital.

Productive work is starting in the community therapy teams, with benchmarking of patient contacts and using best practice to improve productivity in 2012-2013. The Haringey Integrated Community Therapy Team is following the Productive Community team module and this has been reflected in the team overall productivity

The productive Community has been rolled out in one District Nursing team and there are plans to roll this out in 2 additional teams and across whole service by the end of this 2012.

G. Transforming Community Services (DH Programme)

Funding has been identified to progress I integration of front line community services in Islington for the coming year 2012-2013. This will support/compliment the development of integrated care networks. This project will be led by the Associate Director for Integrated Community Services and the Head of Service Rehabilitation.

H. National Institute for Clinical Excellence (NICE)

There is a robust mechanism is place for responding to NICE guidance that is issued across the division led by Sarah Crook and supported by the divisional management and clinical team.

I. Audit Programme: Local, Regional, National.

The division is actively involved in both local and national audits. There are nominated audit leads for some specialty area and the division is currently identifying clinical leads within the community services.
Examples include:

- Care Plan Audit in Substance Misuse
- Consultant Sign Off – Royal College of Emergency Medicine
- National Care of the Dying Audit (hospitals)
- Community base optimal ACE inhibitors therapy

- Royal College of Physicians National Audit of Falls

Domain (3) Patient Experience:

A. Patient and Public Involvement (PPI)

There have been a number areas of positive PPI within the division but as indicated in the summary at the start of this document this is an area that the divisional management team feel the division and Whittington Health as a whole need to improve further to ensure PPI is embedded into all clinical services.

Wheel chair services
Wheel Chair Service has a very active Wheelchair user Group.

IAPT
IAPT work closely with the Turkish speaking PTSD group who are involved in the design of patient satisfaction questionnaires.

EOLC Board
The EOLC Board has a patient representative who is living with a life limiting illness and provides useful advice around patients' perception of advanced care planning, DNAR etc.

B. Patient Experience and Patient Satisfaction

Patient Experience Group —The Division is in the process of setting up a Divisional Patient Experience Group to pull together and co-ordinate the various patient experience initiatives which are already in place or are being developed to gain patient experience feedback. A key aim for the Division is to ensure that this feedback is incorporated into all service re-design and developments. This newly formed Divisional Patient Experience group will report into the Trust wide Patient Experience Committee via the Head of Nursing who already attends the Trust PEC as the Divisional representative. The elements of this report associated with patient experience will also report through to the Patient Experience Group.

Current Patient Experience Initiatives include:

Matron's drop in clinic- this is held weekly by the Matron for Acute Care. It offers patients and carers an opportunity to drop in and discuss care, concerns.

Matron Invitation Posters- These have been rolled out in the Emergency Department and provide an invitation for patients to contact the matron about their care. This has been in place since January 2012 and is proving successful with patients emailing and telephoning the matron with comments about their care. Feedback on issues raised is provided through the "We are Listening" posters which outline issues highlighted by patients and what has been done as a result of receiving these comments. These posters are clearly displayed in the department.

MSK Service - This service also uses the "You said, we did" posters very successfully

District Nursing Service - A patient questionnaire is undertaken by the Lead District Nurses on visible leadership days. The questionnaire is currently being adapted to incorporate the Whittington Health standard questionnaire.

Medical Wards - All wards have electronic patient devises for the collection of patient experience and the net promoter. Ward managers are actively encouraged to ensure that their patients are asked to complete this.

Chestnut ward- - PALS meet with patients and relatives on Chestnut ward on a regular basis with feedback captured on the new datix system. The responses over the past year are very positive which is impressive given the uncertain future that the unit has faced.

Patient Experience Survey in the Emergency Department
In December 2011 95 patients were interviewed about their experience in the ED (see appendix). Patients were asked 4 questions relating to their care and experience in the department. The results were very positive. Key actions which were implemented as a result of the questionnaire included:

- All staff to be issued with a name badge which must be worn when on duty, this is in addition to the Trust ID badge already worn by all staff.
- All staff have been reminded at Departmental and team meetings of the importance of always introducing themselves
- Establishment of a "patient liaison role", this means that when a patient has been waiting 2 hours they will be individually informed of the rationale for the wait, what will happen next and the timescale for this. This role will be linked to the Health Care Assistant role within the Department.

Future Initiatives:

The Division is rolling out a "Your Care "questionnaire across all its inpatient wards adapted from a questionnaire used in South West England. The questionnaire covers communication, attitude, respect and environment. The questionnaire aims to focus the wards on key elements of the service which patients have identified we can improve.
The questionnaire will be undertaken on each ward, sampling 10 patients and will be undertaken by the Volunteers service. The feedback data from these questionnaires will be provided to the Ward manager and their nominated patient experience lead (in most wards this role will be undertaken by the Deputy Ward Manager) and local action plans will be developed and displayed on the wards using the "You said, we did" posters.
Initial discussions with the ward managers have been positive and it is hoped that this initiative will facilitate local ownership by the wards of patient experience.

Ambulatory Emergency Care (AEC) - As part of the AEC work being undertaken patient experience feedback about the model has been incorporated into the work stream.

Other Dashboard KPIs & Concerns

Other Initiatives not covered in the template relevant to the ICAM Division which will improve the quality of service delivery and patient safety

1. Redesign of Community District Nursing in Islington.

Within the District Nursing Service in Islington there is a need to:

- Improve communication with practices
- Deliver care closer to home
- Offer rapid access to District Nursing
- Prevent unnecessary admissions / reduce length of stay

In order to deliver on the issues highlighted above there needs to be changes to both the structure and location of the District Nursing teams. Additionally, this will improve efficiency and productivity to meet increasing demand. The aim is to develop a triage and assessment service. This service will triage all of the new referrals into the service, carry out a full assessment of each patient and keeping patients on their caseloads for a maximum of two weeks. They will work closely with the social services access and resource service and once the new model has been embedded will also provide a rapid response function to prevent unnecessary hospital admission. This new model of care delivery for District Nursing in Islington is being progressed in consultation with the local GPs and Commissioners.

Consultant Presence.

One of the major quality and patient safety initiatives only briefly touched on in the template relates to achieving the 12/7 consultant presence. A business case for the funding for the appointment of three additional full-time consultants in Medicine and one additional full-time consultant in Emergency Medicine, in order to meet the required standards set out in NHS London's Adult Emergency Services Acute Medicine Commissioning Standards (September 2011), and to meet the recommended minimum level of ED consultant shop-floor cover, and to meet the national and local ED key performance indicators was agreed by the Executive Committee in March 2012. This business case also included the funding for additional physiotherapy, occupational therapy and pharmacy staffing which are needed to meet the Commissioning Standards with regard to weekend availability.

These new appointments for medical and AHPs which will take place in 2012 will significantly enhance patient safety and patient experience for patients with emergency medical admissions and patients attending ED as well as:
:

- Enabling the ED consultants "pit-stop" which is a recognised way, approved in the recent ENIST review, to bring forward the time to first assessment and the time to first senior decision making to be sustained. Reinforcement of the resources needed to sustain and expand this approach is likely to have a positive impact on ED performance against national and local key targets, thereby facilitating our progression to Foundation Trust status
- Increasing number and percentage of weekend discharges (CQUIN target)
- Increasing pre-12 midday discharges (CQUIN target)
- Delivery of QIPP Transformation Project CT7 – Transforming Care of Older People Services

Report completed by:
Dr Richard Jennings- Clinical Director Carol Gillen- Divisional Director of Operations Kara Blackwell- Divisional Head of Nursing

Date of report: 11th April 2012

APPENDIX

Review of Patient Experience in the Emergency Department (November-December 2011).

1.0 Background.

The Emergency Department at Whittington Health has over 82,000 patient attendances annually and of these attendances over 9100 patients are admitted as emergencies.
Over 100 staff are employed within the Emergency Department, this includes the Urgent Care Centre which was opened in April 2011 consisting of a partnership between Whittington Health and the WISH limited GP Group.

2.0. The Patient Experience Review.

Gaining real-time patient experience data in the Emergency department is often more difficult due to the fast turn around of patients within the department.
The Emergency Department has a kiosk to enable collection of patient feedback used for the net promoter score. Between 30-140 patients provide feedback via this device every month, the net promoter score has shown a steady improvement over the last 4 months in relation to patient experience feedback in the Emergency Department. WISH limited, who provide the GP services to the Urgent Care Centre also undertook a survey of patients' satisfaction in the Urgent Care Centre in December 2011, the results demonstrated 94% of patients were happy with the service they received.
The decision was taken to undertake a small 'real-time' patient survey, the results of which could contribute to the development of the patient experience agenda for the Emergency Department.

3.0 Method of Data Collection.

A simple questionnaire consisting of 4 questions asking patients about their experience and the quality of care they received in the Emergency Department was developed (see Appendix 1).

Two members of the patient experience team collected the data using this questionnaire. One interviewer collected data from patients in the Emergency Department itself. The other interviewer collected data from patients who had been admitted to the Medical Assessment Unit following the decision taken in the ED to admit the patient. Patients routinely stay on the MAU for 24-48 hours when they are either discharged or admitted under on the specialities. These interviews took place on separate days to those undertaken in the main ED to ensure that data was not collected from the same patients. Patients on the MAU were asked specifically about their experience in the Emergency Department.

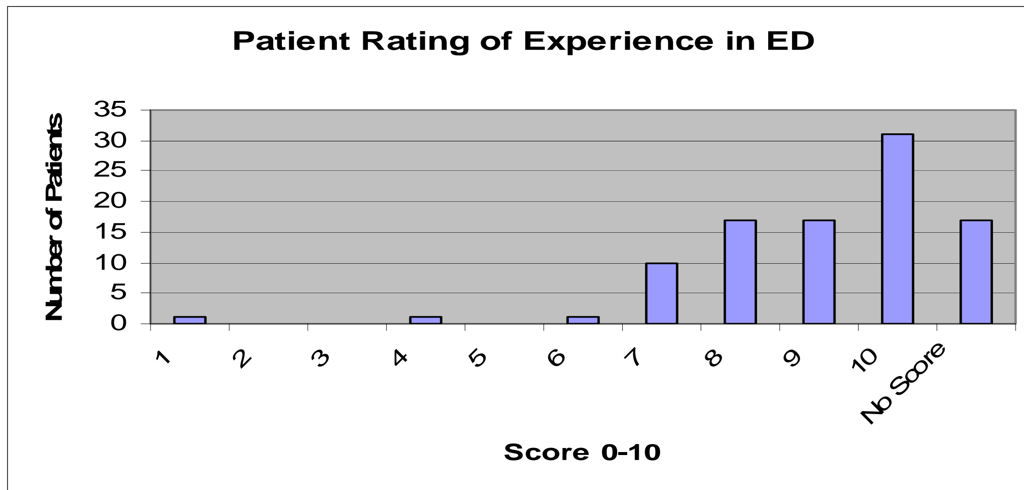
4.0. The Results.

Interviews were undertaken in November and December of 2011. In total 95 interviews took place. Forty-seven of these took place in the Emergency Department and the remaining forty-eight were undertaken on Mary Seacole North or Mary Seacole South Ward (the Medical Assessment Unit). The results are presented and discussed below.

1. The experience of the care received in the Emergency Department.

a. Can you rate your experience in the Emergency Department?

Respondents were asked to tell the interviewer about the experience they had in the Emergency Department. They were specifically asked to rate the care they received with 0=Terrible and 10= Excellent. A total 79% of patients (n=75) rated their experience as 7 or above.



2. Where you treated with Kindness and respect?

Respondents were also asked about whether they had been treated with kindness and respect. Overall, 61% (n=58) responded that they had been treated with kindness and respect; the remaining 37 respondents did not answer this question directly but did comment on their experience narratively. Some of the comments given by patients are outlined below:

"*Very happy with the care and treatment ….been here before and it has not always been a good experience, I feel things have improved". (Rated 10/10).*

"Received quality care, efficient…" (Rated 10/10)

"Staff very polite, seen quickly..." (Rated 10/10)

"It's been okay…nurses have been busy. I asked for help but it took time for them to come back" (rated 7/10)

"Okay… very professional". (Rated 8/10)

"Waited a long time….was not sure why I was waiting. I came in at 5am and was not seen until 7am". (Rated 9/10)

"Did not wait too long but did not get any information…would like to have known how long I would have to wait". (Rated 4/10).

"Came back for further treatment…good treatment, waiting time too long and lack of communication". (Rated as 1/10).

"Care received not bad…rating is good…no score".

2. Do you feel that there is clear communication between staff and patients?

Respondents were then asked about the level of communication between themselves and the staff. A majority of the respondents reported that the communication was good 69% (n=66). However, 17% (n=12) reported that communication was average and 2 respondents reported that it was poor.

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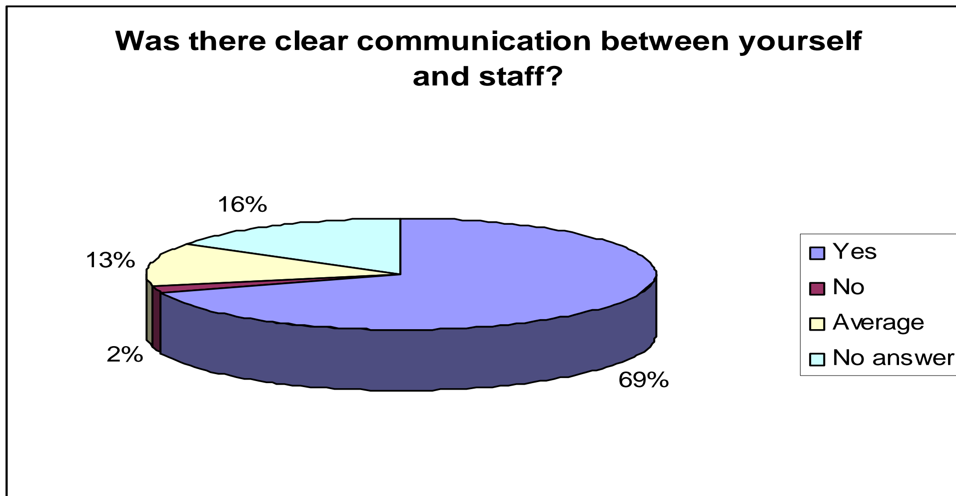
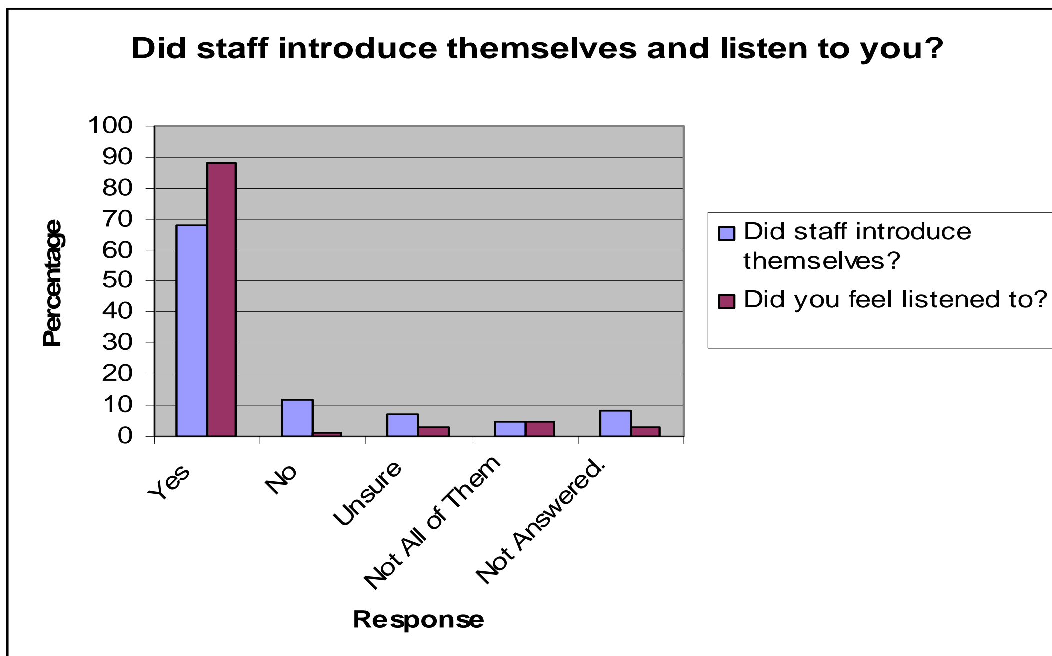


b. Did staff introduce themselves?

Respondents reported that a majority 68%, introduced themselves, however, 12% said that staff did not introduce and another 5% reported that not all staff introduced themselves. These results demonstrated that improvement is needed in relation to staff ensuring that they always introduce themselves to patients attending the ED.

c. Did you feel listened to?

An overwhelming majority of respondents, 88%, felt they had been listened to by staff with only one stated that he /she did not feel listened to.



3. Did you feel safe whilst in the Emergency Department?

All respondents reported they felt safe in the Emergency Department.

4. Do you have any further suggestions on how to improve the care given in the Emergency Department?

Overall 66% (n=63) of respondents reported that they had no suggestions about how to improve the care in the department, several made very positive comments about why they had no suggestions;

"Continue doing the good work".

"Everything is good as it is".

"Keep it up…seen a change..."

"Nothing. Good listening, good access, clean area, good staff…"

The main themes identified by respondents in relation to how thinks could be improved are shown in the table below:

Theme	Number of respondents
Clear and regular communication, information and updates	6
Better Signage	3
Something to watch on the television	3
Magazines/water machine	5
Improvements to reception	2

Conclusion.

Overall, the respondents' feedback to the interviewers was very positive. A few areas for improvement were identified and are in the process of being implemented as part of a wider review of patient complaints and incidents in the Emergency Department.

These include:

- All staff to be issued with a name badge which must be worn when on duty, this is in addition to the Trust ID badge already worn by all staff.
- All staff have been reminded at Departmental and team meetings of the importance of always introducing themselves
- Establishment of a "patient liaison role", this means that when a patient has been waiting 2 hours they will be individually informed of the rationale for the wait, what will happen next and the timescale for this. This role will be linked to the Health Care Assistant role within the Department.

The Division plans to undertake this survey bi-annually in the future. The results of this survey will feed into the overall review of patients' experience of the Emergency Department. This data, alongside the other patient experience feedback data collected, patient complaints themes analysis and patient safety incidents will be triangulated to give an overall view of the patient safety and experience issues within the Emergency Department and incorporated into the Divisions Quality, Risk and Patient Experience programme.