AGENDA ITEM 13 – REPORT OF THE QUALITY & SAFETY COMMITTEE
BOARD OF DIRECTORS 07 FEBRUARY 2019

Report title	Report of the quality & safety committee
Report from	Ros Given-Wilson, chair of the quality & safety committee
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Attachments	Quality & safety six-monthly summary
Link to strategic objectives	We will pioneer patient-centred care with exceptional clinical outcomes and excellent patient experience Research - We will be at the leading edge of research making new discoveries with our partners and patients We will innovate by sharing our knowledge and developing tomorrow's experts We will have an infrastructure and culture that supports innovation

Brief summary of report

Attached is a brief summary of the quality & safety committee meeting that took place on 15 January 2019.

Action Required/Recommendation.

The board is asked to note the report of the quality and safety committee and gain assurance from it.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

QUALITY AND SAFETY COMMITTEE SUMMARY REPORT

Tuesday 15th January 2019

Committee Governance	• Quorate – Yes • Attendance (membership) - 75% • Action completion status - 98% • Agenda completed – Yes
Current activity	• There was a discussion about the format of the **committee summary reports**, followed by a review of the **committee's actions**. • Four **committee summary reports** were received from the clinical governance committee, the risk and safety committee, the information governance committee and the patient experience and participation committee. • The committee received an update about **medical devices**. • The **quality and safety update** focused on incident completion progress, the quality strategy, policy and other procedural documents management and a CQC update. • The committee received the **six-monthly quality and safety report** for 2018-19 Q1 and Q2 (summary attached). • The latest **SI tracker** was presented and it was noted that there were no issues. • One **SI report** (misdiagnosis of a retinal detachment in A&E) was presented. • A report about **Fire Safety** was presented. • **WHO audit reports** for November and December 2018 showing strong compliance were presented, together with an update about improvements to procedures. • The committee received a deep dive presentation about **Clinical Audit** from the clinical lead for clinical effectiveness.
Key concerns	• With regard to the format of the committee summary reports, clarity was required about what is a 'concern' and what is an 'escalation'. Q&SC would, in future, include 'escalations' as part of any other business. • Currently, complaints are reported to the committee via the 6-monthly Q & S report. It is felt that this is too long a time lapse, and quarterly reporting is needed and will be introduced. • The 6-monthly Q & S report highlighted an increased trend in the numbers of complaints and PALS enquiries. Patient telephone communication and appointment management was identified as an issue, as was the limited board visibility of this matter. As a result this is being escalated. • The report also highlighted a rise in the numbers of clinical complaints. Further analysis of the reasons was required. This will be the subject of a future deep dive. • It was noted that there was no executive lead for the fire safety committee. • Fire evacuation and having sufficient numbers of trained staff to move people in the event of an evacuation was discussed and it was noted a training programme was being put in place. This concerned locations in City Road. • A concern was expressed about the current accommodation for the clinical audit team and its record storage capacity.
Key learning	• Following a deep dive review in 2018, an update about complex surgery will come to the committee's May meeting. • The CQC has been informed about the HTA report. • A proposal for a quarterly patient experience and participation (including complaints) report will be presented to the management executive. • An internal audit about GDPR actions would be presented to January's audit and risk committee.

	• The requirements of the Data Security and Protection Toolkit (formerly the IG toolkit) were being met by 31 March 2019. • The patient experience and participation committee is attended by patients. There is also patient participation in locality groups. • The medical devices committee is now the medical devices and new techniques committee. The committee is currently reviewing its terms of reference and membership. • The medical devices policy is being reviewed and will encompass training (the mechanisms for delivering and recording training are also being reviewed). • It is felt that the incident closure process is much better controlled but improvements can still be made. Focus was needed on local improvement mechanisms to learn from incidents. • It was noted that the draft CQC reports are imminent. • An annual rolling programme of executive-led walkabouts is being developed commencing in February. • The outcomes from Moorfields Middle East are being monitored. • The remit of the SI panel had been expanded (from October 2018) to include a monthly focus on learning and improvement. • The CQC has just published its report about Never Events. This is now being considered and any actions implemented. • A new IT audit tool (part of *Safeguard*) has been introduced to support the management of clinical audits. • The efficiency of the clinical audit and effectiveness committee has improved. • Attention is being given to how Moorfields Private monitors core outcomes. Some outcome data is published and work is underway to improve how those messages can be distributed more widely to staff and patients.
Escalations	• Increase in complaints and overall year end trend: patient communication by telephone particularly relating to changing appointments • The appointment of an Executive to chair the Fire Safety Committee (now in place)
Items for discussion outside of committee	• This summary to be distributed to the Board and Membership Council.
Date of next meeting	• 12th March 2019

1. Executive Summary

At Moorfields quality underpins everything we do. The quality and safety of our services is our top priority. Our quality strategy, launched in November 2017, drives our quality priorities. This report is a six monthly (Q1 and Q2 2018/19) review of the quality and safety data and information fundamental to care provision focusing on learning and improvement actions. The full report has seven sections and this executive summary. Five sections are summarised below. Moorfields Private (MP) has a patient experience report (safety data is included in the main report) in section 6. A report from UAE (United Arab Emirates) is included in section 7.

Patient Safety

a. **Serious incidents (SIs)/Never Events (NEs):** Moorfields continues to have a low rate of SIs with a total of 4 declared during the first 6 months of 2018/19. To date only 2 SIs, 1 of which is a NE, have been reported during Q3 therefore the 2018/19 annual total may be lower than seen previously (range of 10-16 over the previous 5 years). More analysis will follow in the next report. In May 2018 we participated in the CQC's review of NEs; the outcome of this review is awaited and will be included in the Q3/Q4 report. The Healthcare Safety Investigation Branch (HSIB) national investigation into the implantation of incorrect intraocular lenses (IOLs) produced their report in Q3. There were no immediate actions. Any learning will be reflected alongside CQC's findings/recommendations in the Q3/Q4 report. In July 2018 a NE associated with strabismus surgery was declared. Since then 2 further similar incidents have been reported, one of which was reported as a NE; a second was not required to be declared as it occurred in the UAE. The latter two cases remain under investigation; an update will be provided in the next report.

b. **Incident reporting:** Plans and trajectories have been in place to reduce the numbers of open incidents that are older than 28 days, across divisions since the beginning of Q3 2017/18. All divisions have made substantial progress and are demonstrating that the routine closure of incidents is becoming embedded as business as usual; further improvement is still required to achieve full control of incident management. Following risk assessment approximately 1600 open health records incidents were closed. Incidents associated with the unavailability of health records continue to be reported. Processes should improve when the new health records provider and management processes are introduced early in 2019. Divisional learning and identified improvements are set out in the detailed text.

   As part of the quality priority about learning, the central quality & safety team has initiated a review of the ways in which local and organisational learning occurs, with a view to identifying areas of good practice, transferring these and also where improvement is required. A flow chart has been developed. An update will be provided in the Q3/Q4 report.

c. **Duty of Candour (DoC) requirements:** A new bespoke duty of candour e-learning training package, which is mandatory for all clinical staff, has been launched and has been welcomed; compliance is currently 59% and increasing rapidly. The risk & safety team, in conjunction with

quality partners, is working to ensure that incident reports are updated to include information recording that duty of candour requirements have been satisfied.

d. **Legal claims:** The trust has completed its review of claims brought in the last 5 years as part of the Getting It Right First Time (GIRFT) programme and the findings have been shared across the organisation. A working group has been established to consider the learning and recommendations in more detail with a number of work streams. All services are reviewing the GIRFT findings and providing feedback about how they can, or have, made improvements to the ways in which they deliver and record care. Each service is identifying areas of good practice that can be shared. Publication of the national GIRFT findings is awaited and the trust will benchmark itself against other ophthalmic units.

e. **Infection control:** Infection control rates for serious infections (for example MRSA) remain at zero. Other infection rates including endophthalmitis are at, or better than benchmark performance. As the infection rate post cataract surgery had remained below the benchmark since 2015/16, the benchmark was reviewed and was lowered to 0.4 or 1 in 2200 cataract procedures from 1 April 2018. Hygiene audit performance and other infection control audits are all above target.

f. **Site and service safety:** Moorfields has a central walkabout programme which expanded to include local divisional walkabouts in Q2. Walkabouts help the organisation understand how well knowledge and information is embedded within local teams and are used to receive feedback from staff. Walkabouts also help local teams understand what progress they have made and what gaps remain. Findings from walkabouts support the organisation's Quality Improvement programme. A new comprehensive programme of walkabouts commenced in Q2 and contributed substantially to CQC inspection preparation. A regular programme of walkabouts (both local and central) will continue in Q4 and throughout 2019/20.

g. **Information governance (IG):** During Q1/Q2 there were 82 IG related incidents which shows a 30% increase from the previous reporting period. This is attributed to increased awareness of the need to report incidents and improved awareness of the definition of IG incidents from the work undertaken as part of the GDPR project. The causes were mainly due to human error: paper based information disclosed in error and information disclosed in error electronically; however as the trust has now moved to NHS.net email these incidents should decrease. The IG team strongly supports departments and is committed to providing extra support and training to learn from these incidents and prevent reoccurrence or data loss. Examples include communications sent via the Moorfields weekly bulletin and increased information/guidance available on the intranet. None of these incidents were required to be reported to the Information Commissioner's Office (ICO).

- Over the reporting period the trust has achieved on average 93% information governance training compliance (target 95%), a solid achievement. In order to increase compliance, targeted correspondence is regularly issued.

- The trust completed 69% of the actions detailed within the GDPR action plan during this reporting period. The remaining substantive actions relate to data flow mapping, contracts and third party consent.
- NIS (Network & Information Security) Directive is a piece of EU legislation about cyber security. To provide assurance of compliance with NIS Regulations, in May 2018 the trust submitted a self-assessment to NHS Improvement detailing its current level of compliance with the data security standards outlined in the 2018/19 Data Security Protection Toolkit (DSPT – the replacement for the IG toolkit).
- In September 2018 the trust received and responded to a NIS Directive information notice from the Department of Health & Social Care requesting additional information in relation to an assessment submitted in May 2018, particularly around unsupported systems and Cyber Essentials Plus. Assurance continues to be provided by the CIO (trust Cyber-lead) that the relevant plans are in place and are monitored. In October 2018 the Trust received an enforcement notice requiring plans to be completed by 31 March 2019.

h. **Medication safety:** The incident reporting rate in pharmacy has improved by 34% (282) compared to the same period the previous year (211). The majority of incidents reported were near misses followed by no harm. This marked increase implies increased awareness of staff to report all medication related incidents and near misses. The concerns of previous low reporting were raised at the Medication Safety Group Meeting and cascaded to Divisional Quality Partners to encourage incident reporting amongst clinical staff.

- Pharmacy has also encouraged reporting of incidents particularly at sites with no on-site Moorfields Pharmacy by displaying posters within clinical areas encouraging clinical staff to report medication related incidents including examples of what type of incidents to report.
- The pharmacy led ocular inflammatory therapeutic service continues to ensure improved use of systemic immunosuppressant medicines and the process of ensuring consistency in how these medicines are prescribed, monitored and supplied is embedded in current practice.
- Antimicrobial stewardship continues to be promoted and the lead Antimicrobial Pharmacist continues to play a key role in the review and update of relevant policies and guidelines and the use of new technologies and innovative initiatives to ensure the safe and effective use of antimicrobials.
- Pharmacy led initiatives such as the #KnowYourDrops campaign and changes in prescribing practice in relation to ocular lubricants continue to ensure that learning is shared within and beyond Moorfields and that medicine optimisation is improved within all ophthalmic patient pathways.

i. **Safeguarding children and young people, 0-18years**: Moorfields remains committed to ensuring safeguarding children and young people is part of its core business and its responsibilities to promote the welfare of children and young people are fulfilled under mandatory Section 11 (Children's Act) duties. The Trust recognises that safeguarding is a shared responsibility with the need for effective joint working between partner agencies and professionals. Understanding the impact of safeguarding in terms of effectiveness is helping to keep children and young people safe, the quality of work required to safeguard, improving outcomes and to do things differently

where needed to improve safeguarding practice is integral to Moorfield's commitment to fulfilling their Section 11 duties. A number of learning and improvement actions are set out in the main text.

j. **Safeguarding adults:** Patient information to support keeping vulnerable adults safe has been improved across Moorfields and easy read documentation has been published. A Mental Capacity Act (MCA) flowchart was developed to further support the robust implementation of the MCA. Partnership working with key agencies including Islington Safeguarding Adults Board, Mencap and Alzheimer's Society has been strengthened. Consultation and engagement with learning disability service users and carers was strengthened and involvement in events, meetings and training was facilitated and welcomed. The safeguarding champion's model was embedded to support excellent safeguarding practice, and bespoke training was provided by internal and external trainers, including the Metropolitan Police. Bespoke training was delivered to services and teams in response to learning identified in incidents. Over the reporting period training compliance significantly increased for Mental Capacity Act, Prevent, Learning Disability and Dementia.

Clinical Effectiveness

k. **Clinical outcomes:** Moorfields delivers good clinical outcomes which are recognised nationally and internationally. Full details are published annually in the quality account. During Q1/Q2 2018/19, outcome data continued to be collected and formed part of the annual results. Improvements in electronic patient records have enabled better data collection in some services; this will be expanded further with the new version of OpenEyes implementation in 2019. The Trust Management Committee and Quality and Safety Committee continue to receive regular updates about clinical audit performance. In terms of learning, more awareness of our excellent clinical outcomes needs to be raised with staff, patients and the public.

l. **NCE:** In relation to NCE (National Confidential Enquiries), the trust have not been actively involved in providing data during Q1/Q2, but have continued to consider projects that may be of relevance to the organisation.

m. **NICE guidelines:** In relation to NICE (National Institute for Health and Care Excellence) guidelines, the Trust is either fully compliant, fully compliant with aspects relating to Moorfields, or progressing with compliance (partially compliant). At the time of writing 6 NICE guidelines remains partially compliant (2 identified during Q1/Q2 2018-19, and 4 prior to this time). Further work to address compliance is taking place monitored by the Clinical Audit and Effectiveness Committee (CAEC).

n. **Clinical audit:** A high number of clinical audit proposals and reports continue to be received centrally, indicating a sustained effort and improved communication and engagement. During Q1/Q2 the Safeguard audit module has been used to improve efficient submission of proposals

and reports and further capability to support improved audit management will be increased in 2019.

Patient Experience

o. **FFT results** remain good with the following percentage of patients extremely likely or likely to recommend the trust in Q1: 99.9% of Day Care; 96.2% of Outpatients; 97.7% of Accident and Emergency and Q2: 99.3% of Day Care; 96.3% of Outpatients; 94.4% of Accident and Emergency.

p. In relation to the results for the **National Cancer Patient Experience Survey**, 2017, the headline figures from the survey are that of 41 questions were relevant to Moorfields and of these, 23 received a positive score of 80% or above, and 16 of the questions scored higher than the national average score.

q. Implementation of the **Patient Participation strategy** is going well with good progress in Q1/Q2. The focus is on divisional ownership and local participation activities.

r. The number of **complaints** has increased in Q1/Q2 by about 30% compared to Q3/Q4 2018/19. The overall complaints trend is up with more complaints overall expected by the end of the year compared to previous years. The increase in the number of complaints is in three categories: appointments management, communication and clinical care.

s. The number of PALS queries has been consistent for the last three quarters. 30% of PALS queries (947 for Q1/Q2) are due to appointment management queries.

Quality and Compliance

t. **CQC action plan**: With 84% of actions completed, the focus for the CQC action planning process during Q1 and Q2 was establishing the on-going monitoring of the completed actions as 'business-as-usual'.

u. **CQC inspection**: Preparation focused on Divisional self-assessments, executive-led walkabouts, and the establishment of the inspection readiness project. In August 2018, the PIR was received, whilst the unannounced inspection took place in November, followed by the Well-led assessment in December.

v. **Policies and procedural documents**: This has been another area of considerable activity, with the policy breach rate being very low at 4% (as at end of September), well below the 10% target. The policy and procedural review group has been established and is functioning well.

w. **Quality Strategy and quality improvement:** Moorfields' quality strategy was launched in November 2017. A number of priorities were identified in the 2018/19 business plan and good progress was made with these during Q1/Q2.