Trust Board Meeting in Public: Wednesday 12 July 2017
TB2017.63

<table>
<thead>
<tr>
<th>Title</th>
<th>Quality Committee Chairman's Report Including Annual Report 2016/17</th>
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<tr>
<th>Status</th>
<th>For information, and approval of the Annual Report</th>
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<tr>
<td>History</td>
<td>The Quality Committee provides a regular report to the Board.</td>
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<td>The Annual Report summarises the activities of the Trust’s Quality Committee for the financial year 2016/17, setting out how it has met its Terms of Reference and key priorities.</td>
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<th>Board Lead(s)</th>
<th>Mr Geoff Salt, Committee Chairman</th>
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<td>Key purpose</td>
<td>Strategy</td>
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TB2017.63 Quality Committee Chairman’s Report
Executive Summary

1. The Quality Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings. The regular report is provided at Section 1.

2. In line with best practice in other sectors, the Quality Committee also produces an Annual Report to the Board summarising the activities of the Trust’s Quality Committee (the Committee) for the financial year 2016/17 setting out how it met its Terms of Reference and key priorities. This is provided in Section 2.

3. The Quality Committee’s Terms of Reference, Membership and objectives for 2017/18 are attached at Section 2, Appendix 1.

Recommendations

4. The Board is asked to:
   - Note the regular report to the Board from its meeting held on 14 June 2017 (Section 1); and
   - Review and approve the Quality Committee Annual Report 2016/17 and the revised Terms of Reference (Section 2).
SECTION 1

1. Introduction

The Quality Committee met most recently on 14 June 2017. The main issues raised and discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

a) The Deputy Medical Director provided a further update on the plan for implementation of National Guidance on Learning from Deaths. Further development of the methodology for mortality review is due to be considered at the next meeting of the Committee in August 2017.

b) The Committee undertook its regular review of the risks associated with the temporary suspension of Maternity and Neonatal Services at HGH, and the contingency plan by which a Midwifery-Led Unit [MLU] had been temporarily established at HGH. The risk register, which included non-clinical as well as clinical risks, had been updated to reflect the reduction in risks where mitigating actions had been completed. This showed reduction in most of the risks originally described, with only four remaining the same, and none increasing.

It was acknowledged that some risks will not reduce further, due to the inherent potential risks associated with childbirth that affect all maternity services.

c) The Committee also received an update on progress in on-going attempts to recruit obstetric doctors to fill the rota of 9 which is required to sustain obstetric services at HGH. It was confirmed that, at the time of report, the number of obstetric doctors in post was 5, out of 9 doctors required. A further 2 doctors were expected to commence in post by June 2017, but 1 of the doctors currently in post had indicated an intention to resign.

In respect of staffing levels required in the Special Care Baby Unit [SCBU], it was noted that there were currently six neonatal nurses in post, out of the 12 required to sustain the service. The Committee heard from the Director of Clinical Services, that recruitment efforts continue.

d) The Interim Chief Nurse presented the experience of a patient with a degenerative condition who was also a wheelchair user. His story in particular highlighted:

- The importance of taking into account individual needs and circumstances in the planning and delivery of services for patients with a disability, impairment or sensory loss, and ensuring that services provided are appropriate and responsive;
- That relevant information about an individual’s needs is communicated effectively to improve their experience and outcome;
- That the way in which patient transport services are administered is flexible;
- The importance of staff demonstrating discernment in the ways in which they apply relevant Trust policies and procedures;
- Ensuring patients with a disability, impairment or sensory loss, and their carers’ are kept informed and supported; and
- That all members of staff need to be aware of accessibility issues across Trust sites and reasonable adjustments made to better accommodate the specific needs of patients with a disability.

e) The Committee received its regular report from the Clinical Governance Committee [CGC], noting issues highlighted for its attention which included:

- Changes made in the licence of Chlorhexidine, which is classified differently for different preparations; Chlorhexidine 2% in 70% alcohol liquid in 500ml pour bottles not being licensed for pre-operative skin preparation.

  Following report of mixed practices across the Trust (theatres), and noting that the costs of using only the licensed product would be in the region of £250k, a risk assessment is being undertaken.

- The recovery plan relating to the Ionising Radiation [Medical Exposure] Regulations Improvement Notice (lifted on 1 February 2017) was reported to have resulted in high levels of staff engagement;

- The Trust was noted to be preparing for the Human Tissue Authority [HTA] to undertake an inspection in July 2017, in association with the Trust’s HTA licence for post mortem. Lessons from a recent HTA inspection of the University of Oxford’s licence will be taken into account in the preparations for this inspection.

f) The Committee considered the Quality Report, which in the main reported on data up to the end of April 2017 and, by exception, on data in May 2017. Points highlighted in discussion included the following:

- The Committee’s attention was drawn to the publication of an opinion piece produced by the King’s Fund entitled “Leading across the health and care system – Lessons from experience”, highlighting the view that the NHS was seeking to move away from competition towards increased integration.

  The Committee noted that this offered guidance to those who were leading the development of new systems of care guidance, aimed at helping them to deal with the challenges faced;

- The Trust’s 2017/18 Quality Priorities were noted, and the Committee will expect to receive updates on progress throughout the year;

- Two of the six Key Quality Indicators which were reported to have deteriorated against target since the last reporting cycle or red rated due to breaching of annual threshold were noted to be:

  o PS06 – 1 case of MRSA bacteraemia>48 hours (cumulative year to date) (noting that, once the threshold was irretrievably breached, it would be flagged as red every month for the remainder of the financial year).
The Committee agreed that MRSA bacteraemia >48 hours would only be reported in detail where a new case occurred, as the ceiling of zero cases had already been breached.

and

- PS17 – 1 case of hospital acquired thrombosis identified and judged avoidable.

A detailed analysis of hospital acquired thromboses was presented, which showed that increased detection was a factor in the results.

- It was noted that there had been an increase in crude mortality between December 2016 and February 2017, which was reported to reflect the national trend of more deaths in winter;

- It was confirmed that action was being taken to improve performance in 3 out of the 5 clinical divisions, in relation to reported compliance with the WHO surgical safety checklist;

- The Committee was disappointed to note that the Trust had not met the trajectories for improved performance in relation to the endorsement of test results and the timeliness of discharge summaries, and supported the need for significant work to continue;

- The Committee reviewed the current status of nursing and midwifery staffing across the Trust by ward, as well as by shifts, and noted the Interim Chief Nurse’s commendation of the enormous efforts made by staff to take mitigating action in respect of those the shifts which were initially identified as ‘at risk’, to ensure that patient safety was protected;

- The Trust was reported to have received 67 new formal complaints in April, which was a decrease from the previous month (at 105). This decrease in complaints received across the Trust was considered to be attributable in part to the Easter break, and was not necessarily yet indicative of a sustainable downward trend;

- It was noted that response rates to the Friends and Family Test in the Neurosciences, Orthopaedics, Trauma and Specialist Surgery [NOTSS] Division had risen to 29%, up from 19% in March;

- The Committee was informed that the Trust will be holding a Values into Action event on Wednesday 19 July on the theme of Dignity and Respect at work, with the aim of improving staff engagement, and specifically addressing bullying and harassment;

- Concern was expressed in relation to the reported impact of operational pressures in relation to the Patient Advice and Liaison Service [PALS] and the Complaints team. The Committee emphasised the importance of ensuring that these services were supported in their ability to be responsive to patient needs, and asked the Interim Chief Nurse to follow up and report back to the next meeting of the Committee;

- The Committee sought assurance that all due consideration was being given to the quality impact of operational and financial pressures, and the introduction of additional controls on expenditure which had been necessitated.
g) The Committee received its regular report on Serious Incidents Requiring Investigation [SIRI] and Never Events, noting key learning points and actions which had been identified upon the closure of SIRI, for application across the organisation.

Particular attention was drawn to a Never Event reported on 25 May 2017 in which a patient had received an overdose of insulin in an insulin/dextrose infusion, believed to be due to use of a non-insulin-specific administration device. It was noted that whilst the incident was still under investigation, immediate action had been taken, with publication of a patient safety alert on the intranet, changes to the hyperkalaemia Standard Operating Procedure (SOP), retraining for staff and a review of the guidance.

h) The Committee considered the outcome of a review undertaken of safe staffing levels in maternity, to provide assurance that there was a comprehensive system in place to manage staffing to ensure the safety of women and babies.

Whilst red flags were reported through iPAMs, the Committee heard that the application of iPAMs to maternity services was flawed, insofar as it did not recognise the fluidity of staff across maternity services, and did not allow for recording staff redeployed to a clinical area for a short period of time to cover ‘bursts’ of high activity.

The Committee heard that it was ensured that women received 1:1 care in labour, through the movement of staff from other clinical areas in the maternity hospital and community, and from non-clinical areas.

i) The Committee noted that the final version of the OUH Quality Account 2016/17 had been submitted to the Secretary of State for Health as required on 31 May 2017. It was further noted that the Trust’s external auditors had issued an unqualified limited assurance report on the Quality Account.

j) The Committee received the draft action plan developed in response to the report on the Care Quality Commission [CQC] Inspection, and noted that this had been submitted to the CQC on 7 June 2017, subject to formal approval by the Trust Board at its meeting on 12 July 2017.

3. Key Risks Discussed

The following risks were discussed:

i. The Committee highlighted the importance of guarding against the potential risk that current operational and financial pressures could have an adverse impact on patient safety and the quality of care.

ii. Risks associated with the contingency plan for Maternity and Neonatal Services at Horton General Hospital [HGH] were reviewed, as described at 2(b) above.

iii. The Committee took the opportunity offered by the attendance of the Head of Midwifery (who presented the review of safe staffing levels in maternity) to obtain assurance that there had been no identified incidence of harm to any mother or baby caused by the temporary suspension of obstetric and neonatal service at the Horton General Hospital.
iv. The risks associated with the continuing challenges to the recruitment and retention of appropriately skilled nursing staff were discussed, noting the further initiatives that had been implemented.

v. When considering safe staffing levels in maternity, the Committee received assurance from the Head of Midwifery in relation to the mechanisms that were in place to review all SIRI, and any unexpected admission to the Special Care Baby Unit [SCBU], on the basis of which it could be confirmed that none had been found to relate to unsafe staffing levels.

vi. Reported compliance with the WHO (World Health Organisation) Surgical Safety Checklist was considered, noting that actions were being taken to improve performance in relation to the rate of reported compliance in 3 out of the 5 clinical divisions.

vii. Consideration was given to the risk of adverse impact on operational performance in gynaecology at the John Radcliffe [JR], if the planned release of capacity at the JR was not being realised, because additional activity was not yet being delivered at the Horton as had been planned.

viii. The Committee considered an extract of the assigned risks from the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), and it was agreed that the risk associated with the inadequacy of current provision in the Emergency Department Resuscitation Area should be expressly recorded on the CRR.

4. Key Actions Agreed

The Committee agreed actions as follows:

- The Interim Chief Nurse will follow up on the reported impact of operational pressures in relation to the Patient Advice and Liaison Service [PALS] and the Complaints team, and report back to the Committee.

- The Committee will keep under close review the rate of unexpected transfers to SCBU reported in the maternity dashboard.

- The Trust Management Executive will be asked to sustain efforts to improve performance in relation to the trajectories for improved performance in relation to the endorsement of test results and the timeliness of discharge summaries.

- The risk associated with current provision in the Emergency Department Resuscitation Area will be recorded on the Corporate Risk Register.

- Subject to amendments agreed, the Quality Committee’s Annual Report 2016/17 will be submitted to the Trust Board on 12 July 2017.
5. Future Business

In addition to the regular review of performance against key quality indicators, areas on which the Committee plans to focus at its meeting to be held on 9 August 2017 include:

- Development of the methodology for mortality review;
- Thematic analysis of SIRI and Never Events; and
- Comparative review of performance data at all Maternity-led Units [MLUs] in Oxfordshire.
- Staff retention – the main reasons cited for leaving and action required

6. Recommendation

The Trust Board is asked to note the contents of this paper.

Mr Geoff Salt
Chairman Quality Committee
July 2017
Section 2: Quality Committee Annual Report

1. Background

1.1. Good practice states that the Trust Board should review the performance of its Committees annually to determine if they have been effective, and whether further development work is required.

1.2. This Annual Report summarises the activities of the Trust’s Quality Committee (the Committee) for the financial year 2016/17 setting out how it has met its Terms of Reference and key priorities.

1.3. The purpose of the Committee is laid down in its Terms of Reference. In summary it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety.

2. Scope of Review of Effectiveness

2.1. The review undertaken by the Deputy Director of Assurance focused on a review of the papers presented to the Quality Committee in comparison to the agreed Terms of Reference and the Cycle of Business. The review has been broken down into the following subsections:

- Responsibilities;
- Membership and Attendance Record;
- Reporting Arrangements;
- Cycle of Business;

Responsibilities

2.2. During 2016/17, the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:

- The routine presentation and consideration of the following:
  - Quality Reports, including updates and reflections from national reports, safe staffing metrics, infection control metrics and clinical audit information.
  - Patient Story Reports.
  - Clinical Governance Committee Reports and minutes.
  - SIRI Summary Reports
- Updates have been provided in relation to progress against completion of the CQC Inspection Action Plans, and CQC Intelligent Monitoring Reports where these were available;
- The Committee has considered the Quality Priorities for the Trust, the Quality Account and the plans to update the Quality Strategy during the course of the year;
- The Peer Review Programme updates were also reported to the Committee in line with the cycle of business.
- The Annual Complaints and PALS report;
- The Board Assurance Framework and Corporate Risk Register were regularly reviewed and discussed, to ensure that identified controls were appropriate to mitigate the risks to a level within the Trust’s risk appetite.
The Committee focused on the principal risks (PR) which were specifically assigned for oversight by the Committee, being:
  o PR1: Failure to maintain the quality of patient services;
  o PR6: Failure to sustain an engaged and effective workforce and
  o PR 7: Failure to deliver the required transformation of services.

Membership and Attendance Record

2.3. During 2016/17, the Committee met six times with attendance recorded in the table below. This demonstrates that every meeting of the Committee during the year was quorate.

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<tr>
<th>Role</th>
<th>13-Apr-16</th>
<th>08-Jun-16</th>
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Key: ✓ = In attendance □ = represented by deputy X = Absent

2.4. The Committee has also welcomed visitors to observe many of its meetings, including members of staff, and governors.

Reporting Requirements

2.5. The Committee reported to the Trust Board after each meeting during the year. Reports included a description of the business conducted, risks identified and key actions agreed. Key risks discussed by the Committee and reported to the Trust Board for information included:

- Issues arising from discussions in relation to patient stories.
- Issues arising from discussions in relation to the Quality Reports, including infection control risks, safe staffing issues and the need to maintain focus on the safety aspects of performance against NHS national targets. These reports made reference to national reports for example CQC report: ‘Learning, candour and accountability- A review of the way NHS trusts review and investigate the deaths of patients in England’ and ‘National Guidance on Learning from Deaths’.
- Discussions in relation to Never Events and Serious Incidents.
2.6. The following specific issues were reported to the Board as part of these reports:

- The risks associated with the contingency plan for Maternity and Neonatal Services at Horton General Hospital. Quality and performance indicators agreed with Oxfordshire Clinical Commissioning Group in relation to this issue were also monitored, and to date these have given no cause for concern that the temporary transition to a maternity led unit at HGH has had an adverse impact on outcomes for women and babies.

- The Committee highlighted that a report on Cancer Clinical Harm Reviews showed that, to date, no clinical harm had been identified in long waiting cancer patients.

2.7. The reports consistently identified areas to be raised to the Trust Board or referred to other sub-committees of the Trust Board.

**Terms of Reference**

2.8. The Terms of Reference were last reviewed and revised in July 2016, and the review of the effectiveness of the Committee for 2016/17 has confirmed that no further changes are required to the Terms of Reference.

2.9. The reviewed Terms of Reference are presented in Appendix 1.

**Cycle of Business**

2.10. The items on the cycle of business were largely delivered as planned with some minor adjustments to the timing of delivery of some papers.

2.11. A number of additional items was considered by the Committee during the year including papers on:

- Nurse Staffing levels and the Acuity and Dependency within the Emergency Department
- Annual Reports on: Review of Prevention of Future Death Reports, Claims and Inquests, Mental Health Act, Patient and Public Participation, Pressure Ulcers and Tissue Viability, Safeguarding
- Updates on recruitment and retention initiatives
- Dementia Strategy updates
- Internal Audit review of the Ionising Radiation (Medical Exposures) Regulations following the CQC inspection of this area.
- The interventions taken in response to results of the National Inpatient Survey over the last 3 years (2013-2015), to improve two key areas in relation to patient experience, noise at night and call bell responsiveness.
- A review of nurse staffing and quality metrics for the Emergency Departments showed a direct correlation of staff experience and patient experience through the Friends and Family Test [FFT] scores when considered against waiting times, with FFT scores deteriorating when the peak of operational challenges was experienced in the ED in October 2016.
- The Committee received a report on progress in meeting performance trajectories for Discharge Summaries, Clinical Test Results endorsement and Outpatient letters sent to primary care clinicians. Targets had been
realigned in discussion with OCCG, and the proposed revised trajectories for delivery of the standards were agreed.

- The Committee considered a live demonstration of the outcome of work led by the Chief Information and Digital Officer to develop an integrated dashboard/“heat map”, presenting data on staffing, operational and financial performance, quality standards and patient outcomes.

3. Key Outcomes

3.1. In discharging the Terms of Reference as described in the preceding paragraphs the Committee has also achieved the following:

- Continued to monitor the quality of the patient experience during the course of the year.
- Overseen the plans for the development of the Quality Strategy and the results of certain aspects of this have been reflected in the Quality Account, considered by the Committee.
- Reviewed the results from the recent CQC visit conducted at the John Radcliffe Hospital.

4. Conclusion

4.1. The review has identified that the Committee has delivered the responsibilities as set out in the Terms of Reference. Attendance at meetings has been good, and the cycle of business has been completed.

4.2. Areas for action during 2017/18 will include the development of the Quality Strategy and continued development of quality dashboards to develop the assurance information included in papers tailored to meet the Committee’s needs.

5. Recommendations

5.1. The Committee is asked to:

- Review and approve the Quality Committee’s Annual Report 2016/17, subject to discussions in relation to the presentation of the report; and
- Agree that the Quality Committee’s Annual Report 2016/17, including Terms of Reference, should be formally submitted to the Trust Board.

Mr Geoffrey Salt
Chairman, Quality Committee
July 2017