Trust Board Meeting in Public: Wednesday 8 November 2017
TB2017.101

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1. Introduction

The Quality Committee met most recently on 11 October 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 meeting was Mr Peter Ward’s last as a member of the Committee and Mr Geoff Salt’s final meeting as Committee Chairman. Both were commended on the contributions that they had made to the work of the Quality Committee.

b) The Chief Nurse updated the Committee to explain that the Patient Advice and Liaison Service [PALS] team was currently still based at OUH@Cowley and providing a telephone service. The team was dealing with 17,000 contacts per year of varying complexity. Work was currently underway with the Appointments Team to streamline the escalation of booking issues so that these placed less of a burden on PALS. In addition, PALS was trying to ‘skill up’ reception teams to be able to deal with many of the more simple enquires. Positive progress had been made on recruitment and it is hoped that teams may be brought back on site soon.

c) The Chief Nurse presented the experience of a child who was a carer for her two siblings and who had felt disregarded in the care of their father. The story in particular highlighted:

- the need to focus on how carers are identified on Trust systems;
- the need for the Trust’s approach to safeguarding to be one of ‘think family’.

The Committee considered the extent to which coordination with primary care was an issue as GPs might know more about the family situation. This was recognised to be particularly significant where attendance was via ED and not a GP referral. It was suggested that the Trust should emphasise to the Oxfordshire Clinical Commissioning Group [OCCG] the importance of communicating the family situation in the initial referral and noted that it would be helpful to have a prompt regarding this on the admission screen to ensure that it was considered.

The need to ensure that changes in policy were reflected in practice was highlighted. The Committee recognised that the approach to implementation needed to be considered and emphasised the importance of teams reflecting on these topics in their meetings and being aware of the procedures to be followed.

d) 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 Director of Clinical Services reported that the risk profile was currently unchanged. The relevant key Key Performance Indicators [KPIs] were reviewed and it was agreed that these indicated that the level of risk remained low.

e) The Director of Clinical Services provided an update regarding three processes relevant to plans for the Trust’s obstetric and midwifery services:

i. The referral by the Secretary of State for Health of the temporary suspension of obstetric services at the Horton General Hospital to the Independent
Reconfiguration Panel [IRP]. The Secretary of State has accepted the recommendation of the IRP that no further action be taken.

ii. Judicial review of the decision by OCCG to employ a two stage consultation process for its proposed changes to health services across the county. The Trust is not currently involved in these proceedings and the Director of Clinical Services emphasised that the Trust had done all that it could to enable a one stage process of consultation. A three day hearing is due to commence on 7 December 2017.

iii. The referral by the Joint Health Overview and Scrutiny Committee [JHOSC] to the Secretary of State of the decision to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a permanent MLU at HGH.

f) The Committee considered the appropriate scope of an assessment to be undertaken of the performance of all free-standing Midwifery-led units [MLUs] in Oxfordshire, to support a better understanding of whether the presence of a dedicated ambulance had an impact on key metrics of safety and quality, and whether or not the provision of a dedicated ambulance at the MLU at Horton General Hospital [HGH] should be continued.

The outcome of this assessment is due to be considered by the Board at its meeting on 8 November 2017.

g) The Committee received its regular report from the Clinical Governance Committee [CGC]. Points raised in discussion included the following:

i. The impact of the closure of 16 beds within the Medicine, Rehabilitation and Cardiac [MRC] Division had been highlighted, especially in light of imminent winter pressures and the need for emergency stroke beds. It was suggested that stroke capacity would be improved by the anticipated CCG funding that was to be provided to support early supported discharge, enabling patients to move back home directly from acute stroke beds.

ii. Significant issues were highlighted with nursing in neurosciences, where a 38% vacancy rate had been reported. The impact on attendance of tissue viability training had been noted. It was emphasised that the important measure should be whether there was an impact on outcomes rather than gaining assurance simply through numbers of individuals trained.

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

i. The fill rates of actual shifts against those planned for August (including the supply of temporary staff) were noted to have been:
   - 92.02% for Registered Nurses/Midwives
   - 90.07% for Nursing Assistants (unregistered)

It was reported that there was no evidence that quality was deteriorating due to staffing pressures. The Committee was informed that there was a need to look at the staffing information available and assess how this could best be used to provide assurance. This was likely to be based on Care Hours per Patient Day [CHPPD]. It was agreed that the Chief Nurse would bring proposals to the Committee.
ii. The Summary Hospital-level Mortality Indicator [SHMI] for the data period April 2016 to March 2017 was 0.94. This was rated 'as expected' based on NHS Digital's 95% confidence intervals, adjusted for over-dispersion, and the value was the same as the previous publication. The Hospital Standardised Mortality Ratio was 94 for the data period July 2016 to June 2017, which was 'lower than expected' based on Dr Foster’s 95% confidence intervals, and a decrease from 98 for the previous publication period.

iii. In August 2017 there had been 7 cases of C.difficile. Overall, C. difficile infections were noted to be above trajectory but it was expected that this was recoverable.

iv. It was noted that Newborn Care seemed to show high levels of medication error and that this appeared worrying. It was agreed that the Deputy Medical Director will look into this data to provide additional information.

v. The Trust’s quality target for medicines reconciliation was currently that 80% of patients should receive medicines reconciliation within 24 hours. Compliance was noted to be plateauing out at 73% against a national average of 68%. The Committee was informed that the best approach to improving performance was the project that was underway in relation to drugs ‘to take out’ [TTOs], which involved TTOs being written by pharmacists and signed off by a doctor.

vi. It was noted that high risk cleaning scores remained of concern. Noting the frequency with which issues have been raised in relation to cleaning, the Committee has asked that a report be provided to its next meeting on the accuracy of cleaning scores recorded, and action being taken to address any sub-optimal performance.

i) The Committee received its regular report on Serious Incidents Requiring Investigation [SIRI] and Never Events declared or closed in July and August 2017. Key learning points and actions which had been identified for application across the organisation were noted.

Two Never Events were reported to the Committee, including one that had occurred in September 2017. Details were outlined as follows:

i. On 9 August 2017, a cystoscopy had been carried out on the wrong patient (who was waiting for a different outpatient procedure).

ii. On 2 September 2017, a patient undergoing a vaginal surgical procedure was discharged with a pack in situ without a clear plan for removal.

j) The Committee received a report from Dr Helen Higham, the Director of OxSTaR (Oxford Simulation, Teaching and Research), on the lessons and achievements of the human factors CQUIN (Commissioning for Quality and Innovation). Dr Higham was commended on the delivery of this programme, and she expressed appreciation for the support that it had received from the organisation.

The programme had trained 228 staff using a didactic model plus simulations. 50 staff had also been included in the ‘train the trainer’ element of the programme. An Advisory Group had shared relevant work across the organisation and quality improvement training courses had also been delivered in collaboration with the Patient Safety Academy.

The Committee noted the strength of this model and, in particular, how it was differentiated from other training by its use of simulations. It was agreed that consideration should be given to how this could be incorporated sustainably into the
Trust’s wider training programme and the Director for Improvement and Culture was asked to develop some initial proposals for how this could be done.

k) The Director of Clinical Services gave a presentation on contingency planning for winter pressures, outlining the current context within the Trust, and the actions that were being planned to respond to anticipated pressures with the onset of winter, which was recognised to represent a significant challenge.

Given the current staffing position, it was recognised that opening additional beds could not form a significant element of contingency planning.

l) An update was provided on the Action Plan submitted to the Care Quality Commission [CQC] following its inspection of the Trust in October 2016, the recommendations presented within which were noted and approved.

m) The Director of Assurance informed the Committee of the work that had been undertaken in response to the possibility of regulatory action intimated by the CQC, following an incident at the Oxford Centre for Enablement. Those involved were commended on having undertaken a quick, thorough and impressive piece of work to investigate the incident and provide a response to the CQC.

The seriousness of the situation, and the importance of learning from it, was recognised, and the Committee will be closely monitoring implementation of the resulting action plan and its impact.

n) The Chief Nurse presented the Annual Report on Safeguarding of Adults and Children. It was noted that assurance around compliance was required and that the report presented went as far as was currently possible in relation to this. The Committee recognised that three different pieces of legislation currently related to different groups of vulnerable patients and that it would be preferable to take a coherent approach to all vulnerable patients, understanding the elements that were relevant in each individual case.

o) The Committee received the Claims and Inquests Annual Report, noting in particular that the link to the Clinical Governance Team had been made more explicit which had led to an improved use of claims information.

p) The Committee received a paper on the use of the Mental Health Act for the detention of patients with mental health problems within the Trust. The paper highlighted the need to exercise the powers of detention in full compliance with the law, and for trusts to be registered with the CQC for use of the powers. It was further reported that the CQC had commenced the pilot phase of a framework for the review of the provision of acute care services for those with mental health needs, and it was expected that CQC inspections would in the future cover these arrangements.

It is intended that the internal audit plan for 2018/19 will include a review of this potentially high risk area.

In the meantime, recommendations are to be submitted for endorsement by TME, and an update on progress in the implementation of actions identified will be reported to the next meeting of the Committee.
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 noted at 2(d) above.

iii. The Committee considered the risk that delay in capital expenditure might impact adversely on the quality of care, and asked that the Deputy Medical Director give further consideration to how this could be kept under review, and assurance provided.

iv. Planning for winter pressures was recognised as a significant risk, which might potentially be exacerbated further if the impact of ‘flu was particularly severe.

v. The Committee considered that further assurance was required in relation to compliance with the requirements for Safeguarding Adults and Children, including review of what were the appropriate thresholds for escalation.

vi. The Committee considered the risks associated with application of the Mental Health Act within the Trust, highlighting that the legality of detentions depended on paperwork being completed correctly.

4. **Key Actions Agreed**

The Committee agreed or supported actions including the following:

i. The Committee will expect to receive proposals from the Chief Nurse and the Medical Director regarding a revised approach to the presentation of the patient perspective.

ii. The outcome of an assessment of the performance of all free-standing Midwifery-led units [MLUs] in Oxfordshire is to be submitted for consideration by the Board, to support a better understanding of whether the presence of a dedicated ambulance has an impact on key metrics of safety and quality, and whether or not the provision of a dedicated ambulance at the MLU at Horton General Hospital [HGH] should be continued.

iii. The Deputy Medical Director will give further consideration to how assurance may be provided that any impact on quality caused by delays in capital expenditure will be kept under close scrutiny.

iv. The Committee will expect to receive initial proposals for a revised approach to the presentation of nurse staffing data based on the number of care hours per patient day.

v. The Committee will expect to receive a paper reporting on the accuracy of cleaning scores, and action being taken to address any sub-optimal performance.

vi. The Director for Improvement and Culture will consider how human factors training may be incorporated sustainably into the Trust’s wider training programme.

vii. Proposed contingency plans for anticipated winter pressures will be further developed and submitted for consideration by the Board.

viii. The Board is asked to give further consideration to the potential implications for the wider organisation of findings made by the CQC in a targeted inspection that followed an incident at the Oxford Centre for Enablement.
ix. Recommendations in relation to the use of the Mental Health Act will be submitted to TME and an update on progress in the implementation of actions identified will be reported to the next meeting of the Committee.

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 in December 2017 include:

- Proposals for a revised approach to the presentation of the patient perspective;
- Proposals for a revised approach to the presentation of staffing data;
- Review of an Action Plan to address sub-optimal performance against cleaning standards;
- Update on progress in implementation of the recommendations related to use of the Mental Health Act within OUH.

6. Recommendation

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

Mr Geoff Salt
Chairman Quality Committee
November 2017