## Trust Board Meeting in Public: Wednesday 13 September 2017

TB2017.83

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1. Introduction

The Quality Committee met most recently on 9 August 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) Further to the National Guidance issued on Learning from Deaths, as previously reported, the Deputy Medical Director presented revisions made to the OUH Standardised Mortality Review Policy, and outlined the planned strategy for mortality review which is due to be submitted for consideration by the Board.

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, recorded no changes to the risk ratings since the update provided to the Committee in June 2017.

Data relating to the total number of admissions to the Midwife Led Unit (MLU) at Horton General Hospital [HGH] between October 2016 and July 2017 showed that there had been a total of 208 admissions to the HGH MLU recorded in that period, of which 6 had been transferred before labour commenced (including 2 for ante natal complications).

Of the balance of 202 admissions recorded between October 2016 and July 2017, it was noted that:

- 37 women had been transferred in the first stage of labour;
- 4 women had been transferred in the second stage of labour;
- 12 women had been transferred in the third stage of labour;
- 7 women had been transferred for post-natal complication; and
- There had been 16 neonatal transfers.

The transfer rate in the first, second or third stage of labour was thus 26% of admissions.

Including ante-natal, post-natal and neonatal transfers, there had been a total of 82 transfers to the John Radcliffe, representing 39% of the total admissions.

NB At the time of the Quality Committee’s meeting on 9 August 2017, the Oxfordshire Clinical Commissioning Group [OCCG] Board’s decision was still awaited on Phase 1 of the consultation on health and care services in Oxfordshire.

On 10 August 2017, OCCG decided 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.

c) The Acting Chief Nurse presented the experience of a patient who had been diagnosed with Parkinson’s disease, whose story in particular highlighted:

- kindness, support and clinical excellence shown by the consultant, the Parkinson’s Nurse Specialist and the physiotherapist;
• improved patient experience when patients diagnosed with Parkinson’s disease were quickly and proactively given an appointment with a Parkinson’s Nurse Specialist and a physiotherapist;
• positive impact on patients when communication was clear and delivered compassionately at all times;
• importance of ensuring that when tests were undertaken there was feedback to the patient; and
• the value of community support both for a patient and their relative/carer.

The Committee was disappointed to note that there had been delay in access to specialist nurse support, and that opportunities had been missed to communicate with the patient.

Consideration was given to the extent to which information could in the future be made more readily available via the patient portal, and it was confirmed that development of the patient portal as a conduit for patient information is being addressed, consistent with the standards required to ensure that the provision of information meets the needs of patients, including the needs of vulnerable patients. In particular, it is important that information is provided in a way that allows patients to make choices about what they want to discover, and when.

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

i. CGC had heard that the Tracheostomy Group considered that the high number of cohort ward areas with infrequent exposure to tracheostomy and laryngectomy patients limited the ability of staff to retain knowledge and consolidate the skills in clinical decision-making which were necessary to promote patient safety. It was also submitted that the large number of cohort areas represented a drain on the resources and finances available to support training of staff and equipment provision across all areas. The Tracheostomy Group had consequently recommended that the current number of 16 cohort wards should be reduced to 13 ward areas, and this was supported by CGC.

ii. CGC had approved the addition of sentences to Consent Form 1, following consultation at all surgical governance meetings, to include an additional prompt regarding the patient’s decision specific capacity to consent as follows:

- “In my opinion there are no reasons to doubt the patient’s capacity to make this decision”; or
- “For patients with Dementia/ Delirium or low cognitive scores – The patient’s mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision”.

iii. CGC had noted that the Human Tissue Authority (HTA) had undertaken its Inspection of Labs, Mortuary, Emergency Department (ED) and Gynaecology, the report on which was expected to be released in August. Informal feedback had been reasonably positive.

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

i. Publication of the Care Quality Commission’s [CQC’s] report entitled ‘Celebrating good care, championing outstanding care’. In particular, it was
noted that under the ‘effective’ domain, University Hospitals Bristol NHS Foundation Trust had been highlighted as the first hospital trust in England to have gone from ‘requires improvement’ to ‘outstanding’ between two inspections.

ii. Triangulation of learning points from mortality reviews, complaints and the Oncology audit had highlighted the need for raised awareness and improved skills in managing difficult discussions during end of life care. This had been particularly pertinent to patients who were transferred across specialties for specific interventions and review. There were noted to be plans in place around the implementation of learning points.

iii. Candida Auris - During June there had been just 1 new incidence of colonisation, and it was confirmed that there had been a significant reduction in new cases since the withdrawal of multi-patient use skin temperature monitoring probes from the unit following the novel finding that the temperature probes were not capable of being de-contaminated.

iv. There had been 4 post-72 hour cases of C.difficile during June 2017, which remained below trajectory.

v. The Committee welcomed action being taken to improve response rates to the Friends and Family Test [FFT], including provision to respond via SMS, which was reported to be having a positive impact on response rates, and plans to re-introduce automated telephone calls to those patients who only had a landline telephone number and therefore could not be sent a text message.

vi. The fill rates of actual shifts against those planned for June (including the supply of temporary staff) were noted to have been:

- 92.89% for Registered Nurses/Midwives
- 88.01% for Nursing Assistants (unregistered)

It was also noted that a six month review of midwifery establishment was to be undertaken against NICE guidance, the conclusions of which are due to be reported to the Committee in October 2017.

vii. Shifts ‘at risk’ in maternity services were noted to be largely within the Delivery Suite, and Spires Midwifery Led Unit (MLU), and it was confirmed that these were mitigated through the movement of staff according to the activity and acuity of women, indicated through the use of the Birthrate Plus tool which was reviewed four hourly.

viii. The Committee welcomed a reduction in the number of newly acquired pressure ulcers.

iv. Data on Care Hours per Patient Day [CHPPD] was discussed, noting that it had been one of the recommendations within Lord Carter’s review that CHPPD received by registered nurse/midwife and nursing assistants within a 24 hour period should be monitored; to be calculated by dividing the total number of actual nursing hours worked by the number of patients in bed at midnight over the month indicated. The average level of acceptable CHPPD in more generic wards was between 6-8 hours/24 hours per patient day.

The highest levels of CHPPD were noted to be reported in the intensive care units and high dependency care within ward areas i.e. Paediatric High Dependency Unit, Newborn Care and NOC High Dependency Unit. However, it was notable that there were some areas reporting low care hours in the Trust,
and it was confirmed that the Trust would be looking at a more refined process for managing this, once the new Chief Nurse was in post.

f) The Committee received its regular report on Serious Incidents Requiring Investigation [SIRI] and Never Events declared or closed in May and June 2017. Key learning points and actions which had been identified for application across the organisation were noted, including implementation of a process to alert the duty manager at the OUH when a patient required sectioning under the Mental Health Act whilst an inpatient.

In addition to the regular report, the Committee received a verbal report by exception on an incident that had been reported in July. This related to an unattended fall apparently suffered by a wheelchair-bound patient at the Oxford Centre for Enablement [OCE] at the Nuffield Orthopaedic Centre [NOC]. The incident had formally been reported under RIDDOR\(^1\), as the patient had apparently suffered the fall after gaining access to an area through doors that should have been locked. CQC had been informed, and CQC inspectors attended OCE on 9 August 2017. It was confirmed that the incident had been reviewed at the SIRI Forum held on 13 July, and a full investigation is underway for completion and report by 6 October 2017.

The Committee will expect to receive an update on the outcome of the investigation, and any feedback from the CQC inspection, at its next meeting.

g) The Committee also considered the Annual Review of SIRI and Never Events reported during the financial year 2016/17.

Following the appropriate downgrading of 6 incidents originally declared as SIRI, there had been a total of 106 during the financial year March 2016-April 2017 (compared with 179 in the previous financial year). An analysis of trends showed an increase in reporting of patient safety incidents and reduced levels of incidents of moderate or greater harm [IMOGH].

The Committee noted that comparators of incident reporting showed the Trust to be in the highest third of incidents reported per 1,000 bed days in the acute organisations category, with 44.06 incidents reported per thousand bed days. This was noted to represent a rise of 2.2 incidents per 1,000 bed days compared to 2015/16, and it was submitted that this indicated a good and improving reporting culture.

Trends in IMOGHs were described as reflecting a developing safety culture, fostered by the quality improvement work which was being undertaken in all of the work-streams mentioned in the report, across the divisions and corporate teams.

Data presented also showed high levels of compliance with the duty of candour disclosure, suggesting that cultural change was well embedded. There was noted to have been increased attendance at the SIRI forum from all multidisciplinary groups, including medics, and the CQC report had described the forum as outstanding.

h) The Interim Director of Workforce gave a presentation on staff retention, including the results of a recent trust-wide survey which indicated that pay was not the most significant factor affecting staff retention.

An analysis of the responses showed that the importance of the OUH values\(^2\) was cited as one of the main reasons why staff had joined the Trust, and respondents had

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\(^1\) Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
indicated that a failure to demonstrate the OUH values would be one of the main things that would contribute to them leaving the Trust.

Opportunities for development and career progression, along with flexible working, were cited as the top 2 things that would encourage staff to stay, and the thing named as most likely to contribute to staff leaving was a ‘general dislike of duties’.

Pay and benefits only featured ‘mid-table’ at most amongst the factors stated as having influenced staff joining the Trust, or encouraging them to stay. Cost of living, and the prospect of better pay elsewhere, were at the bottom of the table of 14 factors cited as contributing to why staff would want to leave the Trust. Lack of parking and travel costs were 5th and 6th from the bottom of that table.

i) The Committee confirmed its support for TME’s approval of the recommendation to revert to exception reporting for patients breaching 52 weeks by raising DATIX incidents, with the level of investigation to be referred where appropriate for discussion at the weekly SIRI forum.

j) An update had been provided on progress towards finalising the CQC Action Plan which was due to be submitted for approval by the Board; ensuring that actions specified were focused on outcomes that would achieve compliance.

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. The Committee commended all those involved in ensuring successful execution of the Board’s decision to move patients from the JR Trauma Unit, following consideration of a report by fire safety experts, and praised staff for ensuring that the move had been undertaken in a way that ensured patient comfort, safety, privacy and dignity. The potential risk of any adverse impact on quality over time will be kept under review by the Committee.

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

iv. The Committee heard that measures were being taken to mitigate the risks associated with the current provision in the Emergency Department [ED] resuscitation area at the John Radcliffe, pending implementation of the business case for re-provision.

v. In relation to the reporting of nurse safe staffing levels across the Trust, it was noted that national data reporting requirements measured pre-treated risk, and consideration was given to the importance of identifying any trends in residual risk after mitigation. This is to be referred for the attention of the incoming Chief Nurse.

vi. The Committee discussed what action was being taken where the level of falls was reported to be high, and heard that this included the roll-out of the Fallsafe Care Bundle, and development of the ’Baywatch’ initiative supported by the Falls Quality Improvement Nurse Educator, to provide for a constant presence of a registered nurse or nursing assistant in a ward bay.

vii. The Chief Information and Digital Officer presented a report on the lessons learnt from the NHS Cyber Attack. While OUH had been unaffected by the WannaCry RansomWare outbreak on Friday 12 and Saturday 13 May 2017, the Committee
endorsed the need for CyberSecurity activities to continue to be given high priority within IM&T Services.

4. Key Actions Agreed
The Committee agreed or supported actions including the following:

i. The incoming Chief Nurse will be asked to provide an update on the Patient Advice and Liaison Service [PALS], now based at OUH@Cowley under the supervision of the Head of Complaints.

ii. The Committee will expect to receive a report on the outcome of a review of midwifery establishment against NICE guidance.

iii. The process for managing and reporting care hours per patient day [CHPPD] is to be kept under review, and further refined.

iv. Clarification is to be sought on the extent to which contractors’ cleaning standards are in alignment with the standards set by the Trust, and future reports should include commentary to explain wherever the score reported deviates from the required standard.

v. The Committee will expect to receive an update on the outcome of investigation into an incident at the Oxford Centre for Enablement, as reported under RIDDOR, and notified to the Care Quality Commission [CQC], described under 2 (f) above.

vi. The Interim Director of Workforce was asked to disseminate the results of the trust-wide retention survey to leadership teams throughout the Trust.

vii. Risks associated with the Trust’s strategic objectives, and the level of risk appetite, are to be considered further by the Trust Board at a future Seminar, on the basis of which the Board Assurance Framework [BAF] and Corporate Risk Register [CRR] will be revised.

viii. The Interim Director of Workforce is to submit a Staff Engagement Strategy for consideration by the Trust Management Executive [TME].

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 October 2017 include:

- Review of midwifery establishment against NICE guidance;
- Review of the use of the Mental Health Act; and
- Comparative review of performance data at all Maternity-led Units [MLUs] in Oxfordshire.

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

Mr Geoff Salt
Chairman Quality Committee
September 2017