Trust Board Meeting in Public: Wednesday 14 March 2018
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Introduction

Since the Board last met in public in January 2018, the Quality Committee [“the Committee”] held its most recent meeting on 14 February 2018.

Under its terms of reference, the Committee 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. This report aims to contribute to the fulfilment of that purpose.

Background

At the meeting of the Board held in public in January, key points noted in relation to all aspects of quality included the following:

- Although pressures on the emergency care pathway were not evident in the quality metrics reported in the period up to the end of November 2017, the potential for adverse impact was recognised, and it was confirmed that a checklist had been introduced in the emergency department [ED], to record operational quality measures;

- It was noted that World Health Organisation [WHO] checklist compliance audits showed that 3 of the 5 clinical Divisions demonstrated compliance of less than 100%, and it was confirmed that actions were in place to deliver improved compliance;

- Test result endorsement and discharge summary timeliness remained an area that required improvement, with performance on both measures falling short of the targets set by Oxfordshire Clinical Commissioning Group [OCCG];

- Safe staffing levels for nursing and midwifery staff across the Trust by ward, and by shifts, reflected continuing significant efforts to take mitigating action in respect of those shifts/wards that were initially identified as ‘at risk’, to ensure that patient safety was protected.

- Additional funding was being deployed to support a number of measures designed to mitigate winter pressures. These included the staff incentive scheme, under which eligible clinical staff employed by the Trust who work an additional 24 hours per month for three months will be paid at the flat rate plus a bonus of £500 per month.

- The duty of care owed by the Trust to its staff was highlighted. In particular, it was confirmed that no member of staff should be permitted to work more than 2 consecutive 12 hour shifts.

- The Board reviewed the first quarterly report on Learning from Deaths in which it was reported that, of the deaths subjected to structured review, none had been considered to have more than a 50% chance of having been avoidable.

- A successful Quality Conversation event had been held in January, to elicit the views of members and the public on what should be the Trust’s Quality Priorities for 2018/19.

The main issues raised and discussed at the meeting of the Quality Committee in February are set out below.
Quality issues reviewed by the Committee in February 2018

a) The Committee began with a reflection on the account of a Spanish member of staff, who wanted to tell his story to convey an understanding of the experience of European Nationals, their motivation for coming to work with the Trust and the support provided by the Trust to meet their needs. It highlighted a number of areas in which the support the Trust provides for overseas recruits might have been better, including accommodation, cultural acceptance and support.

b) The Committee then discussed the process for stories upon which it and the Board reflected at the start of each meeting; it was agreed that including staff stories had been informative but the process of procuring and presenting stories would be reviewed.

c) Points highlighted in the Quality Report, which in the main reported on data up to the end of December 2017, included the following:

i. Most of the information reported in relation to Infection Prevention and Control [IPC] was encouraging, including:
   - 1 case of OUH apportioned C.difficile in December, against a monthly cumulative limit of 6;
   - No post 48 hour Methicillin-resistant Staphylococcus aureus [MRSA] bacteraemias in December; and
   - No new cases of colonisation with Candida auris on Neuro Intensive Care Unit in December 2017.

However, hand hygiene validation audits conducted in December showed a poor rate of compliance with hand hygiene (with only 2 of the 25 areas assessed meeting the 90% compliance target), and a full action plan is being implemented by the IPC team;

ii. The Committee considered the publication of NHS Improvement’s new guidance on Never Events, noting the statement that:

   learning from incidents requires timely incident reporting in a fair, open and just culture. Blame is not a useful lever for learning because: “…a patient safety incident cannot simply be linked to the actions of the individual healthcare staff involved. All incidents are also linked to the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring”.

iii. In that context, the Committee welcomed the fact that the rate of incident reporting was being sustained, while the proportion of incidents associated with moderate harm or greater was well under 1%, and reported to be falling.

iv. The Committee noted the progress that had been made and sustained over time to reduce newly acquired pressure ulcers, and considered how progress might similarly be made to change practice in areas that had so far not shown sufficient improvement, despite interventions (for, example, 14% of discharge summaries are still not sent within 24 hours).

v. Overall, it was recognised that the maintenance of safe staffing levels was fragile. Vacancies, low temporary staffing fill rates, short notice sickness and short notice temporary staffing cancellations were all noted to be elements that contributed to ‘at risk’ and ‘minimum’ staffing levels reported. The Chief Nurse reported that the
setting of nursing establishment in line with NICE guidelines, and for safe midwifery
staffing in maternity settings, is being reviewed.

vi. The Committee welcomed progress reported in the Quality Priority for Safe
Discharge, and specifically the reduction in initial errors in prescriptions for take
home medicines (e.g. omissions of medicines) from 68% to less than 10%.

vii. The Medical Director agreed to follow-up the audit of venous cannulas (which
showed that a third of cannulas were sited in the ante-cubital fossa, the inside fold
of the elbow, and a third had visual evidence of phlebitis).

c) In the regular report from the Clinical Governance Committee [CGC] (covering its
meetings held in December 2017 and January 2018) key areas highlighted included
the following:
  • Important lessons had been learned from a Mortality Review of a patient with
    learning disability and cancer, including the need for a description of the learning
disability and an agreed care plan for managing the patient’s disability to allow
maximum care and partnership with patients;
  • Delay in taking patients with fractured neck of femur to theatre have improved, but
    still only 70% have their operation within the recommended time period.
  • The quarterly review of patients waiting more than 104 days for cancer treatment
    reported that in 1 of 23 patients clinical harm could not been excluded on initial
investigation, and this would be fully investigated as a SIRI (Serious Incident
Requiring Investigation);
  • Members of CGC expressed some concern that the persistent pressure on staffing
  levels, although not compromising patient safety, was affecting patient experience,
and continued vigilance in the application of mitigating measures is required.

d) The Committee noted publication of the CQC’s report on its review of the Oxfordshire
system, the system-wide response to which will be led by Oxfordshire County Council
[OCC]. Key findings included:
  • While there were some encouraging examples of shared approaches, not all
    services are fitting together effectively;
  • System leaders need to improve how they work together more effectively to plan
and deliver health and social care services for older people in Oxfordshire;
  • There needs to be a review of how people move more effectively through the
health and social care system. Care pathways, the process of setting best
practice for a patient, should be well-defined and understood throughout the
system without any chance for confusion; and
  • It is important that system leaders continue to develop their approach to
integration and also improve their working relationships beyond local partners
and across the wider sustainability and transformation partnership.

It is anticipated that the Health and Well-Being Board would be the over-arching body
with responsibility for governance of the system-wide plan.

e) In 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 committee noted that there
had been no serious adverse events (maternal deaths, perinatal deaths, unexpected
infant admissions to intensive care, or other events causing moderate or serious harm)
reported and that the risk profile was confirmed to be unchanged.
f) The Committee received a full report from the Quality Conversation event held on 16 January 2018, attended by almost 100 patients, public, stakeholders, Governors, members and staff to discuss Quality Priorities. The four priorities that the participants supported to be carried forward for next year were noted to be:

- Partnership working;
- End of Life Care;
- Preventing patients from deteriorating; and
- Go Digital.

Support was given to a new approach for deciding all Quality Priorities for 2018/19, under which – taking into account the views of the public as expressed at the Quality Conversation event – further consideration would be given at a Trust Board seminar, to choose a smaller number of more focused quality priorities with Trust wide applicability.

g) The regular report on Serious Incidents Requiring Investigation [SIRI] and Never Events covered those declared or closed in November and December 2017.

While there were no Never Events declared in this reporting period, the Committee received a verbal report by exception of a Never Event declared on 29 January 2018, when a patient had a wrong site nerve block which was recognised prior to surgery, and considered the extent to which this reflected that more work was required fully to embed the ‘Stop before you Block’ process.

It was noted that, during the reporting period, 9 SIRI had been declared via STEIS and 9 investigations were sent to OCCG for closure.

Key learning points and actions which had been identified for application across the organisation were reviewed.

h) The Committee received a paper on the benefits of the Commissioning for Quality and Innovation (CQUIN) programme in 2017/18, showing consequential improvements that had been made to the quality of care, and outlining the current financial performance against the CQUIN targets. It was predicted to achieve overall performance at 81% of the financial plan, which was confirmed to be in line with reasonable expectations.

i) A report on Organisational Development [OD] and Workforce Performance up to the end of Q3 2017/18 was considered, highlighting the following points in particular:

- There had been a small increase in overall staffing numbers between Q2 and Q3 (by 21 whole time equivalents [wte]). A higher number of band 5 nurses was still needed, and the Trust was looking to recruit more from abroad;
- The reported vacancy rate had increased marginally further, to 7.4% in Q3, from 7.3% in Q2;
- Staff turnover had fallen marginally by 0.1% since Q2 and was currently at 14.6%. However, this was noted to be high compared to five other Shelford Group trusts outside London, whose average turnover rate was reported at ~10%. Although the turnover rate for the Trust was observed to have fallen gradually over the last 12 months, it remained a priority for improvement;
- At the end of Q3, the compliance rate for the completion of non-medical annual appraisals had decreased further (by 3.1%) to 61.4% against a target of 90%. The
overall compliance rate for statutory and mandatory training was reported at 84.4% against a target of 90%;

It was submitted that, while the Trust had demonstrated its ability to recruit in difficult operating circumstances, the focus should now shift to the development of appropriate measures to improve staff retention. To help facilitate targeted initiatives, the OD and Workforce Directorate will be relaunching the Exit Interview process to obtain valuable feedback on retention.

In addition, the Director of Improvement and Culture provided an update on development of a People Strategy. This has subsequently been considered further by the Board at its seminar held in February, and will be submitted for approval by the Board in due course.

j) Results of the Staff Survey 2017 were reviewed, noting that they were under national embargo until 6 March 2018, following which they are due to be submitted for consideration of the Board at its meeting in public on 14 March 2018.

k) The Committee reviewed latest developments in the Board Assurance Framework and Corporate Risk Register, including changes to risk scores and new or escalated risks, and supported the suggestion that consideration be given to requiring that a short statement about risk should be included in the executive summary of every paper submitted. It was proposed that this might be in two parts:

- Specification of the risk(s) that were addressed by the paper.
- The authors’ view on the consequent level of risk, given the evidence presented in the paper (and when appropriate, whether the evidence means that an existing risk level on the BAF/DRR should be modified).

Key Risks discussed included:

i. The potential risk that current operational and financial pressures could have an adverse impact on patient safety and the quality of care; to guard against which the Committee needed to remain vigilant in its scrutiny of key quality indicators;

ii. Risks associated with the fragility of maintaining safe staffing levels;

iii. The risk that the Trust may not be able to recruit the number of appropriately trained staff required to fill vacancies, and that the level of safe staffing that can therefore be maintained might not be sufficient to deliver the level of activity required to meet operational performance targets;

iv. Risks identified in the findings of the CQC’s report on its review of the Oxfordshire system, which highlighted the need to ensure that system leaders continued to develop their approach to integration, and improve their working relationships beyond local partners and across the wider sustainability and transformation partnership;

v. Risks associated with poor hand hygiene, as identified in recent audits, which it was noted were being addressed through the implementation of an action plan by the Infection Prevention and Control team;

vi. Risks associated with the temporary suspension of Maternity and Neonatal Services at HGH, and the contingency plan for Maternity and Neonatal Services at Horton General Hospital [HGH], which were found to be unchanged when reviewed;

vii. Risks associated with a failure to deliver compliance with the target for statutory and mandatory training, and for non-medical annual appraisals.
Key Actions Agreed to address risks included:

i. Measures to deal with the “fragile workforce” should be prioritised, targeting both recruitment and retention (through recognising and providing support to staff in hot-spot areas), and future planning will take more explicit recognition of workforce availability.

ii. Information and support for staff recruited from overseas should be reviewed and improved, including specific further information targeted at European staff.

iii. Every effort should be made to improve compliance with the target for statutory and mandatory training, and for non-medical annual appraisals.

iv. The Quality Committee (with the support of the Medical Director and Chief Nurse) will review the data it monitors to achieve assurance.

v. Consideration will be given to requiring that, in future, all papers submitted to the Committee should include a short statement about risk in the executive summary to specify the risk(s) addressed by the paper and confirm the authors' view on the consequent level of risk, given the evidence presented in the paper (and when appropriate, identify whether the evidence means that an existing risk level on the BAF/CRR should be modified).

Recommendation

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

Professor David Mant
Chairman, Quality Committee
March 2018