Oxford University Hospitals NHS Trust

Trust Board meeting: Thursday 6 September 2012

TB2012.92

Title	Quality Committee

Status	A paper highlighting key areas of discussion at the Quality Committee meeting held on 26 June 2012
History	This is a regular report to the Board

Board Lead(s)	Mr Geoff Salt, Committee Chairman			
Key purpose	Strategy	**Assurance**	Policy	Performance

Summary

1	The Quality Committee met on 26 June 2012.
2	This paper sets out the key decisions, actions, risks and matters for future consideration as raised by the Committee, and attaches the minutes of the meeting.
3	Recommendation: The Board is asked to note the contents of this paper.

1. Introduction

The Quality Committee met on 26 June 2012. Detailed minutes are provided as Appendix 1 of this report. These minutes are draft and subject to formal approval at the next Quality Committee meeting.

2. Significant issues of interest to the Board

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

- Reporting on data quality was discussed and the challenges in getting information from clinical areas to the data warehouse were highlighted.

- The three separate risk, assurance and quality strategies were considered in detail to inform further development. Collective observations were made on each of the strategies and required revisions were noted.

- The Quality Impact Assessment process was discussed and the need for NEDs to see some complex quality impact assessments relating to CIPs which outlined the debate in divisions and how issues were taken forward was discussed was highlighted.

- Following the occurrence of two never events, a series of spot checks on compliance with the Who surgical checklist have been conducted, this process has now been devolved to the Divisions.

- The Trust has received positive verbal feedback from the CQC in relation to the Internal Compliance Report for Trauma Services.

- Annual Reports in relation to Safeguarding, Clinical Audit and Research Governance were received.

3. Key Risks Discussed

The following potential risks were discussed:

- The significant increase in the number of complaints received during quarter 4 compared with the previous quarter was highlighted as part of the review of the Quality Report, it was noted that concerns in relation to patient care / experience, communication and delays were consistent themes. It was highlighted that they were connected to the implementation of EPR and the figures should decrease in the first quarter of 2012/13.

- The impact on the quality of care received where a patient's discharge is delayed was discussed, it was agreed that this should be further considered by and a report be taken to the next meeting.

- The lapse of training roll out in relation to Information Governance was highlighted as a significant risk in preventing the Trust achieving level 2 compliance, this will be subject to continued monitoring.

4. Key decisions taken

The following key decisions were made:

- Patient Experience Framework was approved subject to amendments to reflect the Committee's comments.

- The Quality Accounts for 2011/12 were formally approved by the Committee.

- The Patient Safety/Quality Walk round Visits Programme was approved, subject to amendments to reflect the Committee's comments.

5. Agreed Actions

- The Patient Story Programme is to be updated following discussions at the Board and a Non-Executive Director member of the Committee is to be involved in future interviews for the production of the patient story.

- Information about complaints within the Quality Report is to be enhanced to include instances of harm to patients and outcomes

- An outcome report on progress against the action plan following the Patient Survey is to be brought to a future meeting.

- The Clinical Audit Report is to be included earlier in the agenda in future meetings

- The Terms of Reference of the Committee were approved subject to an amendment to reflect that one of either the Medical Director or the Chief Nurse must be in attendance for the Committee's meetings to be quorate.

6. Matters deferred for future consideration

- A report is to be presented to the September meeting demonstrating use of the CIP quality assessment tool.

7. Assurance required from/actions required by other Board sub-committees

- The Committee did not require assurance from another Board sub-committee on any specific issues, and it did not require action by another sub-committee.

8. Matters referred to the Trust Board

- The draft Risk, Assurance and Quality Strategies were discussed and comments were referred to the Board for consideration at its July meeting.

Geoff Salt, Quality Committee Chairman
September 2012

Quality Committee

Minutes of the meeting of the Quality Committee held on Thursday 26 June 2012 at 10 am in the Board Room of the John Radcliffe Hospital.

Present	Mr Geoff Salt	GS	Non–executive Director, Committee Chairman
	Professor Edward Baker	EB	Medical Director
	Mr Paul Brennan	PB	Director of Clinical Services
	Dame Fiona Caldicott	FC	Chairman
	Ms Sue Donaldson	SD	Director of Workforce
	Mr Chris Goard	CG	Non-executive Director
	Professor David Mant	DM	Associate Non-executive Director
	Mr Andrew Stevens	AS	Director of Planning and Information
	Mrs Elaine Strachan-Hall	ESH	Chief Nurse
	Ms Eileen Walsh	EW	Director of Assurance
	Mr Peter Ward	PW	Non–executive Director
In attendance	Mrs Judith Lawton	JL	(Minutes)
	Heather House	HH	Research and Development Lead (for item 33)
	Mr Ian Reckless	IR	Assistant Medical Director
	Mrs Anne Tutt	AT	Non-executive Director
Apologies	Sir Jonathan Michael	JM	Chief Executive

QC23/12 Welcome and Apologies

The Chairman extended a welcome to everyone and noted the apology for the meeting from Sir Jonathan Michael, Chief Executive.

QC24/12 Declarations of Interest

No member of the Committee disclosed, or had disclosed since the last meeting, any interest deriving from the business of the Trust or from the agenda of the present meeting.

QC25/12 Minutes of Previous Meeting

The minutes of the meeting held on 20 March 2012 were approved as an accurate record of the meeting, subject to an amendment on page 4, second paragraph, first sentence to read: *Mr Peter Ward found the SHA feedback on the Quality Governance Self-Assessment submission interesting and…….*

QC26/12 Action Log

The action log was reviewed and the completed actions noted.

QC27/12 Matters Arising from the minutes

Members received an update on the following matters:

QC18/12 – Reporting of data relating to quality within OUH: Confirmation of work was being taken forward and the challenges in getting information from clinical areas to the data warehouse were highlighted. Improved reporting to assist in benchmarking and trend analysis was also being explored and it was anticipated that a new IT system would be piloted by September.

QC20.12 – Clinical Governance Committee minutes: The Chairman noted that a series of minutes from previous Clinical Governance Committee meetings had been included for consideration later in the meeting. It was emphasised that minutes should be circulated to Quality Committee members immediately following sign off by the Chairman of the Clinical Governance Committee. The Director of Assurance remarked that Standard Operating Procedures for the Board, Board Sub Committees and associated groups were being drafted and this requirement would be included in those procedures. The revised sequence of meetings would also ensure that the Board Sub Committees receive timely minutes.

QC28/12 Chairman's Business

The Chairman asked for everyone to be mindful when reporting on their topics that papers had been read in advance as there was a considerable agenda to be covered for the meeting.

QC29/12 Patient Story

An apology was offered to members concerning the difficulty experienced by all on advanced viewing of the DVD for the patient story. As a consequence, the DVD would be reissued. A request for an accompanying note to be included with future distribution of DVDs stating the viewing methodology was made.

Members were referred to the written report concerning the patient story from the Emergency Department, John Radcliffe Hospital, relating to a lady involved in a cycling accident. The Chief Nurse reported that the original approach had been to capture patient experiences in real time in the Emergency Department using a video diary approach. This intention was to create a short collection of patient experiences to be incorporated into the patient story video. She reported that the Assistant Chief Nurse had agreed this approach with the Emergency Department and was felt to be an innovative method.   A designated room had been set aside with the video camera and information leaflets explaining the purpose of the recording of patient feedback produced and supplied to the triage nurse of patients and their relatives attending the minor end of the department.

Members were informed that on the day of filming the department was fairly busy and waiting times were in excess of four hours. Only one patient during six hours agreed to be interviewed and spoke for approximately 40 seconds. Other patients that had initially agreed to be interviewed, when approached by the Assistant Chief Nurse, who re-affirmed the process, subsequently declined. However, they were more comfortable to talk face to face without the presence of the recording equipment. Whilst this method of capturing patient experience was considered innovative it was emphasised that there was also a degree of risk with patient participation, due to the type of clinical area where patients were at heightened vulnerability. The Chief Nurse reported that the senior clinical staff in the Emergency Department were supportive of the recording and welcomed the opportunity of patient feedback being captured. The nurse consultant had already undertaken a series of discovery interviews of patient experiences whilst visiting them in their own homes, a patient panel member had agreed to become a mystery shopper and would attend departmental governance meetings to report on experience.

The Chief Nurse stated that the lady cyclist during her interview had been positive about her care and had made particular reference to the good communications and surroundings throughout her experience. Chris Goard commented that during the process he had observed the person interviewing leading the questions, and whilst this was not a major issue, the Trust needed to be mindful that this could distort the picture. He expressed an interest in being directly involved in the interview process for future productions of the patient story and this request was very much welcomed by the Chief Nurse.

It was noted that the programme of patient stories to look at specific issues on the patient pathway would be updated following confirmation of the Board Committee scheduling and dates. Members were reminded the September meeting would receive a patient story from Sobell House relating to a mother and daughter experience of end of life care.

It was **resolved** to receive the report on the patient story

Action: [ESH]
- *Plan for the year to be updated following Board discussions on Board Committee scheduling and confirmation of dates*
- *Chris Goard, Non-Executive Director, to be involved in future interviews for the production of the patient story*
- *September meeting to receive a patient story from Sobell House relating to a mother and daughter experience of end of life care*

QC30/12 Strategies – Risk, Assurance, Quality

The Director of Assurance explained that the purpose of presenting the proposed three strategies which underpin the Trust's risk management, quality, and assurance agendas, was to enable members to discuss the documents in detail to inform further development. She highlighted that the strategies would form an

important part of developing risk, quality and assurance in the Trust, as a means to support continuous quality improvement, improved management of risk, and assurance provided to the Board on the effectiveness of the system for internal control. Feedback from all meetings involved in the review process would be collated in an overarching document for the Board to consider.

Members, in reviewing the three documents, following presentation of the risk and assurance strategies by Director of Assurance and the quality strategy by the Medical Director, made a number of collective observations:

- the strategies should set a clear vision for the next five years, defining clear and measurable goals;
- implementation plans would need to include timescales which are achievable and realistic with consideration given to resource requirements, including the provision of training for staff;
- the inter-relationship of the strategies should be better described within the documents;
- the strategies should be written in a way that gives context and set out clearly how they are relevant to each staff group;
- the final documents should be of the highest quality in terms of style, format, and content.

In addition to the above, other points raised relating to the **Risk Strategy** were:

- the addition to the risk register of a column noting the proximity of a risk occurring was discussed and agreed using another colour grading scale was considered not be appropriate and should be removed.
- the timescales for noting the proximity of a risk occurring should be revised to 'within 3 months', '3-6 months' and '6-12 months'
- the common currency for risk registers should be service rather than clinical directorate level
- mechanisms needed to be clearly described for how risks across the organisation
- the strategy should refer to clinical directors as opposed to divisional general managers
- mechanisms needed to be clearly described for how risks across the organisation are aggregated and the process de-escalation
- an overview was required on how risks were captured at ward level and how the system fitted together.
- training requirements needed to be further reviewed and planned
- implementation plans should describe how the transition from old to new registers would take place

In addition to the collective observations above, other points raised relating to the **Assurance Strategy** were:

- how the impact of the strategy would be measured should be included

- the strategy should clarify further how assurances would be used and how they could be used for different audiences
- how assurances would be linked back to risk registers should be explained
- assurance level definitions should be reviewed in comparison to similar measures
- within the healthcare setting an additional mechanism of assurance should be defined encompassing the various mechanisms for capturing patient assurance, i.e. through the patients' experience framework, reactive processes such as complaints and PALS contacts and surveys

In addition to collective observations above, other points raised relating to the **Quality Strategy** were:

- vision to be further defined to reflect what will be the year on year improvement
- how the Trust aims to deliver an enhanced quality of care through specialist services and the relationship to DGH services should be described
- Greater emphasis should be included regarding the Trust's leadership of quality and interfaces with partners within the AHSN
- Breadth of the strategy could be wider
- Improvements were required to diagrams showing committee reporting linkages
- to ensure all the Trust values were included in the document as one had been missed out
- before approval the strategy should be checked against the Quality Governance Framework

The Medical Director acknowledged that ambitious quality goals had been set with the Quality Strategy and the importance of developing ways of measuring quality of care in a meaningful way was recognized. He highlighted that the strategy had been well supported by staff and external stakeholders had been involved in its development.

The Director of Assurance thanked members for their contribution to the review of the three strategies and indicated that once approved by the Board, the implementation of the strategies would be overseen by Executive Directors, with senior staff from the teams' responsibility for implementation.

It was **resolved** to receive the draft three strategies and to put forward the feedback for the Board as outlined

Action: [EW]
Feedback presented to the July Board

QC31/12 Patient Experience Framework

The Chief Nurse reported that the framework had been developed as a result of an earlier decision to take a different approach to taking forward the previous draft

documents written in 2011 relating to patient and public involvement and patients experience. She reminded everyone that at the second of the Board development days in May, the patients' experience had been debated and discussed and the Board had endorsed the importance of a structured approach to improving the experience and capturing timely patient feedback. It was highlighted that the framework presented set out the rationale for developing the framework together with a suggested approach to implementing the work programme.

Members considered and approved the framework, subject to
- changing 'patient' experience to 'patients' experience' throughout the document
- Page 11, para 3.10.4 statement to be reflected at the front of the document (statement refers to CQUIN / electronic feedback systems)
- Document to cover a five year period to link with the Quality Strategy
- Inclusion of a high level succinct account around staff experience
- Outline what the aspirations are and to highlight a couple of examples

It was **resolved** to approve the Patients Experience Framework, subject to amendments outlined above

Action [ESH]
Framework to be amended reflecting the comments made

QC32/12 Quality Accounts 2011/12

The Quality Accounts were received and approved on behalf of the Board.

It was **resolved** to approve the document on behalf of the Board.

QC33/12 Quality Report

The Quality report was presented to members during which it was highlighted that:
- incident reporting had been reduced this quarter on the previous quarter and that this was probably due to a decrease in reporting over the holiday period
- the report contained an analysis of all trends for complaints that occurred or were investigated in quarter 4 of financial year 2011/12
- the report contained a summary of patients' experience activity, themes and actions taken by division.

Members noted the significant increase in the number of complaints during quarter 4 in the divisions compared with the previous quarter. They were informed that this increase was connected with the implementation of EPR and was reflected across all divisions apart from Children's and Women's and Emergency Medicine, Therapies and Ambulatory, who had a reduction of 5 and 7 complaints respectively on the previous quarter's total. It was highlighted that the number of Trust complaints referred to the Ombudsman, as highlighted in their Annual Report, 'Listening and Learning', compared favourably with the national figures. The main themes in the

seven clinical divisions continued to be patient care/experience, communication and delays/waiting times.

Members considered it would be helpful to understand if there were any clinical governance issues arising from the quarter 4 complaints. The Chief Nurse explained that the Trust now had a process which looked at all risk assessments by all divisions - each division had a process to review the complaints received and to ensure that appropriate changes of improvement were implemented as a result of concerns highlighted through the complaints process. Concerns relating to patient care/experience, communication and delays/waiting times were consistent themes within complaints received by the Trust. The concerns appeared comparable with complaints received by Ombudsman and the number referred was for the second year low in comparison with national figures.

Members were informed that following improvements being made to the EPR system that an expected decreased was anticipated in complaints received in the next quarter (quarter 1 2012/13). It was suggested and agreed to include 'instances of harm to patients 'as a further themes category as well as a narrative outcome within the report for all themes.

It was **resolved** to receive the report and note the actions being taken

Action: [ESH/EB]
Instances of harm to patients to be included within the themes for figure 7 and a narrative outcome to be included in the report for all themes

QC34/12 Quality Assessment of CIPs

The paper was received and noted. Members were informed that there was now a robust process in place to look at risk assessments of all divisions and to record and mitigate risks affecting delivery of the programme. The Committee Chairman requested a report for the next meeting giving some examples of the tool in use and a description of some of the CIPs that had not progressed following quality impact assessment. There was agreement for changes to the summary page assessment template - the comment box and sign off to be included on the front page. The Chairman felt the case presented was an 'easy case' and it would be important for Non-executive Directors to see a complex case outlining the debate in divisions and how issues are taken forward. It was suggested and agreed that there should be story boards developed to prepare the Trust in challenge by Monitor.

It was **resolved** to receive and note the report.

Action: [ESH/EB]
A report is to be presented to the September meeting giving some examples of the tool in use, including descriptions of cases where CIPs had not progressed following quality assessment. . Changes to be made as outlined to the summary page assessment template

QC35/12 Quality Impact of DTOCs

The paper was received and noted. The Committee discussed the impact of delayed transfers of care within the Trust and steps being taken for improvement. It was recognised that the Board needed assurance on what steps were being taken to address clinical issues relating to patient care and that patients are receiving the treatment required in the Trust's hospitals given the delay to their discharge. The Director of Clinical Services was asked to consider what issues the Committee should focus on as a discussion item for the next meeting.

It was **resolved** to receive and note the report.

Action: [PB}
Issues the Committee should focus on as a discussion item to be presented to the September meeting

QC36/12 Patient Safety/Quality Walk rounds Visits: Refreshed Programme

Members discussed the programme. There was agreement for the programme to be updated to capture the role of the Non-executive Director and to include announced and unannounced visits, with feedback within 24 hours, as well as capturing the role of the director/ divisions for other visits and how to report on it.   There was agreement that a log should be kept so that the Chairman and other NEDs were aware of previous visits, outcomes and how improvements have been addressed. It was highlighted that deputies should be included so that visits were not cancelled. The updated programme was to be re-circulated to members as soon as possible.

It was **resolved** to receive the programme and agree revisions.

Action: (ESH)
- *Programme to be updated to capture the role of the non-executive director and to include announced and unannounced visits, with feedback within 24 hours, as well as capturing the role of the director/ divisions for other visits and how to report on it - once updated, to be immediately re-circulated to members*
- *a log to be kept so that the Chairman and other NEDs are aware of previous visits, outcomes and how improvements have been addressed.*
- *Deputies (for Executive Directors) should set aside time in their diaries such that visits are not cancelled at short notice.*

37/12 Patient Survey – update

It was reported that the result of the survey had been provided to each division, with the action plan and the Chief Nurse was asked to bringing back an outcome report on progress to a future meeting.

It was **resolved** to note the verbal report.

Action: [ESH]
An outcome report to be presented to a future meeting

38/12 Safeguarding (Adults, Children and Vulnerable People) Annual Report

The Chief Nurse presented the report. Anne Tutt noted that on page 6 of the report within paragraph 17, reference had been made to three standards that had been self-assessed as partially compliant. She asked why only two (standards 5 and 6) of these three standards had been fully reported on in the document. The Chief Nurse stated that she would look into the matter and provide an explanation before the end of the meeting.

It was **resolved** to receive and note the report

39/12 Adverse Events

The Medical Director presented the report. He confirmed that the second event final report had been circulated to members and the resulting action plan, a combined action plan resulting from the two never events, had been presented to the Clinical Governance Committee. An external review of safety cultures in OUH theatres was taking place shortly to give external validation across the organisation about the wider picture.

It was **resolved** to receive and note the report.

40/12 WHO Surgical Checklist

The Medical Director reminded that following the occurrence of the two never events in theatres within three months of each other, the Trust had undertaken focused work around compliance in respect of the checklist. He stated that spot checks on compliance with the checklist had demonstrated much improved compliance across the Trust and referred members to the results of these checks in his report. He indicated that the programme of spot checks had now been devolved to the divisions and was being monitored through the monthly divisional quality reports. The ongoing actions within paragraph 4 of the report were noted.

It was **resolved** to receive the report and note the actions taken to date, the results of four rounds of spot checks and future plans with regard to the WHO Surgical Checklist.

41/12 Clinical Governance Committee

The Quality Committee received the minutes of the meetings of the Clinical Governance Committee held in February, March, April and May. The Chairman of the Trust highlighted that only one divisional director was attending the CGC meeting. The Medical Director stated that divisional directors received feedback from representatives at the meeting and that divisional reports had a strong focus at the meeting.

It was **resolved** to receive and note the minutes of the Clinical Governance Committee meetings held in February, March, April, and May.

42/12 Annual Clinical Audit Report

The Chairman of the Quality Committee welcomed the Clinical Audit Report and asked in future for the item to be included earlier in the agenda to enable a more detailed debate.

It was **resolved** to receive and note the report.

Action: [EB]
Clinical Audit Report in future to be included earlier in the agenda

43/12 Quality Governance Framework

Members were reminded that the framework had been discussed at the March meeting and following feedback from the SHA self-assessment submission an action plan had been put in place and taken forward to meet the requirements of the FT element and Board Governance Assurance Framework assessment process.

It was **resolved** to note the update.

44/12 NHSLA Project update

Members were informed that work was underway to prepare for the next assessments at level 2 in the autumn 2013. Work had been undertaken, within acute services, to amend the policy documents to reflect the changes within the organisation and the new NHSLA standards. Evidence to demonstrate implementation of the policies was anticipated to be collected from the beginning of July. Within maternity services, improvement in the guideline development process had been essential to ensure engagement of the team in progressing with the NHSLA project. The Steering Groups for both services would be monitoring the project plans for the level 2 assessments. An informal visit by the NHSLA assessor for maternity services and acute services had been arranged for 20th August and 23 August respectively.

It was **resolved** to receive and note the update.

45/12 CQC

(i)   Quality Risk Profile

The report was welcomed and members were pleased to see the work being taken forward.

It was **resolved** to receive and note the work being taken forward

(ii)   Internal Compliance Report for Trauma Services

It was highlighted that the report took account of the activities that needed to be taken forward from an assurance point of view following a request by the CQC.

Verbal feedback had been received on the Trust's approach from the CQC who were pleased the Trust had developed a more rigorous approach.

It was **resolved** to receive and note the report.

46/12 Information Governance Report and Work Programme 2012/13

The report and work programme was received and noted. It was highlighted that the lapse of training roll out was a significant factor in preventing the Trust achieving level 2 compliance, and training compliance was a key focus for the Trust this year.

It was **resolved** to receive and note the report and work programme.

47/12 Research Governance Annual Report
The Committee received the report reflecting the work being delivered by the Research and Governance Team and of particular note was the change in finances over the recent months. A Head of Finance was now reporting to the Research and Development Director and work was underway to review all the financial statements over the recent months. There was currently a governance approach to increase the amount of controls in all Trusts.

It was **resolved** to receive and note the report.

48/12 Board Committee Terms of Reference

The draft Terms of Reference was considered and approved, subject to the quorum reflecting that one of the two directors should be either the Medical Director or Chief Nurse or their named Deputies. The importance of one clinical member of the executive team attending the meeting was recognised.

It was **resolved** to approve the terms of reference for the Quality Committee subject to amendment outlined.

49/12 Dates of future meetings

It was noted that dates of future meetings would be confirmed to everyone following the Board discussion in July.

Action: [JL]
Dates of future meetings to be circulated following consideration and approval by the July Board