Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 11 July 2018

TB2018. 57

Title	**Quality Committee Chairman's Report**

Status	For information
History	The Quality Committee provides a regular report to the Board.

Board Lead(s)	Professor David Mant, Quality Committee Chairman			
Key purpose	Strategy	**Assurance**	Policy	**Performance**

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.

2. 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.

Recommendations

3. The Board is asked to:

- Note the Quality Committee's regular report to the Board from its meeting held on 13 June 2018.

Introduction

Since the Board last met in public in May 2018, the Quality Committee ["the Committee"] held its most recent meeting on 13 June 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 reports aims to contribute to the fulfilment of that purpose.

Background

At the meeting of the Board held in public in May, the Board reviewed the Quality Report which in the main reported on data relating to the reporting period up to the end of March 2018. Key points noted in relation to all aspects of quality included the following:

- The potential risk that on-going operational and financial pressures could have an adverse impact on patient safety and the quality of care was highlighted, noting that the Committee remained vigilant in its scrutiny of key quality indicators, particularly in relation to measures taken to ameliorate the potential impact of fragility of workforce capacity on the quality and safety of patient care;
- The Board also noted that it remained the case that, where shifts were initially identified as 'at risk', mitigating measures might include the redeployment of nursing staff from another area, and/or the temporary closure of beds where necessary to maintain patient safety. Recognising that ad hoc redeployment was not popular with all nursing staff, it was proposed that a pool be developed of staff who were willing to be deployed as appropriate, and who would expect to be so, as had been successfully developed in Cambridge.
- 4 of the 5 clinical Divisions reported 100% or 99% compliance with the World Health Organisation [WHO] checklist, but the Children's and Women's Division reported compliance at 91%;
- The number of C. Difficile cases had breached the ceiling for 2017/18, but the Medical Director confirmed that through case review with feedback, typing and/or sequencing of isolates, and with the continued promotion of antimicrobial stewardship and good infection prevention practices, the Board could be assured that the Trust continued to educate staff and promote a reduction in cases. In all but one of the cases investigated, it was confirmed that the case was not due to within ward transmission;
- The Board heard that the Trust was consulting with staff and key stakeholders about the benefits of open hospital visiting, recognising that support from family and friends, in the form of hospital visits, was an integral part of many patient's recovery. Open visiting would allow more flexibility for relatives to visit their loved ones at a time that suited them, and a Visitors' Charter was being developed to provide guidelines on issues such as the number of visitors allowed around a patient's bed, preventing the spread of infection and protecting mealtimes.
- The Board also heard that the Trust was in the process of drafting a new policy to support the Trust's aim to make its hospitals more dementia friendly by giving relatives and carers the chance to spend more time with their loved one and have an active role in their care while they were in hospital.

The main issues raised and discussed at the meeting of the Quality Committee in June are set out overleaf.

Quality issues reviewed by the Committee in June 2018

a) The Committee began with a reflection on the account of a 43 year old dialysis patient who, having undergone a kidney transplant, developed a recurrence of the disease and recommenced on haemodialysis.

It highlighted the importance of effective communication and engagement with patients, to establish an effective working partnership between patients and staff throughout the different processes and decisions made about the patient's care and treatment; and recognised the beneficial effects that a patient's positive attitude could have on their care and treatment.

b) Points highlighted in the Quality Report, which reported in the main on data up to the end of April 2018, included the following:

i. A review of current quality metrics and dashboards is to be undertaken as part of quality governance monitoring, to maintain appropriately robust quality measurements;

ii. It was noted that NHS Improvement [NHSI] Model Hospital data showed that overall the total number of OUH Care Hours per Patient Day [CHPPD] total was higher than the national average, but lower than the average of other trusts in the Shelford Group. Total registered nurse/midwife hours were high in comparison to other Shelford Group Trusts, and Care Support Worker hours significantly lower, which appeared to be in line with the vacancy rate for Care Support Workers in particular;

iii. The particular fragility of Band 5 nursing workforce capacity was recognised, and the Committee emphasised the importance of undertaking Quality Impact Assessments [QIA] of the budget-setting process, stressing that the 'bottom-up' setting of budgets to reflect realistic workforce numbers should not result in a reduction in the nursing establishment in any area without proper review and QIA;

iv. A Global Hand Hygiene Awareness Day had been held on 5 May 2018, and in the week leading up to this, the Infection Prevention and Control [IPC] team had held a Hand Hygiene Promotional week across all Trust sites.

v. The Nuffield Orthopaedic Centre [NOC] was reported to be piloting electronic nurse care planning documentation. There had been good staff engagement, making a valuable contribution to the evolution of the documentation process;

vi. It was reported that of the 114 Hospital Acquired Pressure Ulcers [HAPU] Category 3 and above incidents reported in 2017/18, 27% were related to the use of a variety of medical devices. A specialist working group has been established to investigate issues surrounding these incidents with the aim of developing an action plan to reduce unwarranted variation in care practices relates to medical devices;

vii. Delays in receiving draft responses to patient complaints from some of the divisions/services had led to breach of the key performance indicator [KPI] requiring that complaints be responded to within 25 working days (or a specific extension agreed). Data for Quarter 4 showed that 83% of all complaints had been responded to in this timescale, against a requirement of 95%. This was reported to be the second quarter where the KPI had not been reached, and work is underway to improve performance through a better understanding of the underlying causes of delay in divisions/services providing a response.

c) In the regular report from the Clinical Governance Committee [CGC] (covering its meetings held in April and May 2018) key areas highlighted included the following:

a. The importance of undertaking Positive Patient Identification [PPID] before any patient intervention had been emphasised by the CGC Chair, and Divisional representatives had been asked to reemphasise to all staff the importance of making sure of the patient's identity, particularly in the light of a recent case of mistaken patient identity when undertaking an endoscopy.

b. The DNACPR Form [Do Not Attempt Cardio Pulmonary Resuscitation] was reported to be ready to be launched in the electronic patient record [EPR], which should aid communication of the decision to GPs;

c. CGC had supported a proposal to embed statutory radiation safety training into the Trust's Learning and Development processes via an auditable e-learning package that was auditable, and this had subsequently been approved by the Radiation Protection Committee;

d. CGC had noted the unprecedented high number of cervical smear samples sent for reporting in February, due to the combined effect of GPs' reminders and 'Jo's Trust' campaign, which had led to a reduction in the percentage of samples reported by the lab within 10 days of smear during February and March;

e. CGC will expect to receive a report at its next meeting to confirm the position as reported verbally that 104 day cancer clinical harm reviews undertaken showed that no clinical harm to patients had resulted out of the delay in treatment.

f. CGC will be following up on NICE Technology Appraisals [TAs] that had exceeded the 90 day limit for implementation. It had been confirmed that no patients had been denied access to medication because of outstanding responses.

In following up on NICE TAs that had exceeded the 90 day limit for implementation, the Committee asked that CGC ask each of the clinical divisions expressly to check and confirm that any delay in the implementation of NICE TAs had not resulted in any clinical harm to patients.

In considering CGC's report, the Committee welcomed the assurance provided, and asked that future reports expressly identify whether or not further action was required to provide assurance, wherever an issue had been raised that gave cause for concern about any aspect of the safety or quality of patient care.

d) In its regular review of the risks associated with the suspension of obstetric and neonatal services at the Horton General Hospital [HGH], the Committee noted that there had been no neonatal or maternal deaths nor cases of neonatal morbidity requiring SCBU admission.

The Committee asked that the assessment of risk associated with implementation of the contingency plan be refreshed to ensure that it adequately reflected inter-dependent issues of relevance, such as those that were being addressed through divisional re-structuring and the strengthening of leadership in the maternity and children's directorates.

Despite on-going efforts to recruit middle-grade obstetric doctors and Special Care Baby Unit [SCBU] nurses to work at HGH, there were insufficient obstetricians to maintain the middle-grade rota, and no applications had been received in response to the most recent advertisement for SCBU nurses.

e) The Committee received the OUH Quality Account 2017/18 which reported on the content of the quality priorities for 2018/19 and summarised progress against the 2017/18 quality priorities.

f) The regular report on Serious Incidents Requiring Investigation [SIRI] and Never Events covered those declared or closed in March 2018 and three reported by exception in May 2018. Themes from recent Never Events included:

- lack of use of positive patient identification [PPID] and reference to records;
- distraction and loss of sterile cockpit environment at key times in a procedure; and
- occurrence in the environment of outpatient procedural areas.

A programme of actions, including wider aspects to support and promote safety culture, was noted to have been implemented across the Trust.

The Committee also discussed the importance of instilling a culture of multi-disciplinary professional accountability for acts and omissions in clinical decision-making.

g) The outcome of the Women's Directorate annual governance review of the service was presented to the Committee, which included a review of the implementation of the Saving Babies Lives Care Bundle, designed to reduce the risk of stillbirth and early neonatal death by 50% by 2030.

It was noted that the care bundle brought together four key elements of care that were recognised as evidence-based and/or best practice, which formed part of the total of ten maternity actions incorporated into the Clinical Negligence Scheme for Trusts [CNST] maternity incentive scheme (noted further under paragraph **h** below).

These key elements of care were:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth
- Raising awareness of reduced fetal movements
- Effective fetal monitoring during labour

The Committee reviewed each of the results in turn, noting that these demonstrated that OUH's maternity department was compliant with all four elements of the Saving Babies Lives Care bundle, and highlighting the following positive outcomes in particular:

- There had been a reduction in the Hypoxic-Ischemic Encephalopathy [HIE] rate, with the number of cases of babies who have developed HIE 2/3 and required protective cooling as result of this intervention falling from 62 in 2014 to 31 in 2017;
- There had been a reduction in the perinatal mortality and still birth rate of term babies, with the perinatal death rate of babies over 36 weeks having significantly reduced by 60%; and
- There had been an increase in the detection of babies with fetal growth restriction which was significantly above the national average rate. (OUHFT demonstrating a detection rate of 58% vs National rate of 30%).

h) The Director of Assurance provided the results of a self-assessment undertaken to demonstrate compliance in relation to the ten actions developed under the CNST incentive scheme for maternity safety, the aim of which was to incentivise the delivery of best practice in maternity services, though a link to CNST contributions.

Progress had to be demonstrated against ten strict criteria agreed by the National Maternity Champions. Findings of the assessment had concluded that each of the ten criteria had been met by the Trust, as could be demonstrated by detailed supporting evidence. The Committee supported the self-assessment and recommended that it be submitted for consideration and approval by the Board.

i) The Chief Nurse presented an analysis of 12 hour trolley waits from July 2017 to April 2018, which identified the following positive findings in relation to the total of eighty-eight 12hr trolley waits that had been reported during this period:

- Patients had received a rapid initial assessment by a senior clinician within 15 minutes of arrival in ED;
- There was evidence that patients had been offered pain relief, had undergone regular reviews, had been offered hydration and nutrition, and had received care to mitigate the risk of pressure ulcers;
- There was evidence of regular clinical reviews, including recording of the patients' vital signs; and
- There were no delays in diagnostics or treatment.

j) The Committee noted that the Director of Improvement and Culture would be providing a written update on workforce planning to the Finance and Performance Committee, but welcomed the verbal update that focused specifically on measures that were being taken to ensure that there was no adverse impact on the quality of patient care.

The Committee supported the approach of working with the divisions to identify and then focus efforts specifically on departments and staff groups where shortfalls were starting to constrain the amount of activity which the Trust was able to provide.

k) The Committee reviewed the Inpatient Survey Results 2017 which were noted to be positive, with high scores for questions surrounding communication between staff and patients, and the provision of information, including that relating to discharge when prescribing medicines.

Key Risks discussed included:

i. The potential risk that current operational and financial pressure 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. Risks associated with the suspension of Obstetric and Neonatal services at HGH, and relevant inter-dependent issues;

iv. Risks identified in the findings of the report on SIRI and Never Events relating to the lack of PPID and distraction and loss of sterile cockpit environment at key times in a procedure, which it was noted were being addressed through the implementation of an action programme, which included the development of monitoring of an improved safety culture through the use of a "Just Culture Guide" endorsed by NHS Improvement [NHSI].

v. Risks associated with poor hand hygiene, as identified in recent audits, which it was noted were continuing to be addressed in the divisions, supported by the Infection Prevention Control Team [IPC].

Key Actions Agreed included:

i. The Committee asked CGC to follow up further on NICE TAs that had exceeded the 90 day limit for implementation, to ask each of the clinical divisions expressly to check and confirm that any delay in the implementation of NICE TAs had not resulted in any clinical harm to patients.

ii. Future CGC reports will expressly identify whether or not further action is required to provide assurance, wherever an issue has been raised that gives cause for concern about any aspect of the safety or quality of patient care.

iii. The assessment of risk associated with implementation of the contingency plan that has been in place since the temporary suspension of obstetric and neonatal services at HGH is to be refreshed, to ensure that it adequately reflects inter-dependent issues of relevance, such as those that are being addressed through divisional re-structuring and the strengthening of leadership in the maternity and children's directorates.

iv. The Committee supported results of a self-assessment undertaken to demonstrate compliance in relation to the ten actions developed under the CNST incentive scheme for maternity safety, and recommended that it be submitted for consideration and approval by the Board.

v. The Committee will continue to receive regular updates at each of its meetings to report on the impact of measures being taken to ameliorate the potential impact of fragility in workforce capacity on the quality and safety of patient care;

vi. Consideration needs to be given to how best to instill a culture of multi-disciplinary professional accountability for acts and omissions in clinical decision-making.

vii. The Committee has asked to receive a detailed report relating to the root causes of poor hand hygiene.

Recommendation

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

Professor David Mant

Chairman, Quality Committee

July 2018