

Trust Board Meeting in Public: Wednesday 12 September 2018

TB2018.78

<b>Title</b>	<b>Quality Committee Chairman's Report</b>
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<b>Status</b>	For information
<b>History</b>	The Quality Committee provides a regular report to the Board.

<b>Board Lead(s)</b>	Professor David Mant, Quality Committee Chairman			
<b>Key purpose</b>	Strategy	<b>Assurance</b>	Policy	<b>Performance</b>

**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 8 August 2018.

## Introduction

Since the Board last met in public in July 2018, the Quality Committee [“the Committee”] held its most recent meeting on 8<sup>th</sup> August 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 July, the Board reviewed the Quality Report which in the main reported on data relating to the reporting period up to the end of May 2018. Key points noted in relation to all aspects of quality included the following:

- A programme of clinical harm reviews for patients undergoing care for cancer whose pathway exceeded 104 days had been extended for patients waiting longer than 52 week waits in non-cancer-specialities. This process was overseen by the OUH Harm Review Group chaired by the Medical Director. At the time of report, over 60% of harm reviews had been completed. Once embedded, it was intended that this process be used to review patients who had waited for shorter periods and would be embedded within the electronic patient record.
- Three Never Events had been declared in May and a further one in June 2018. The Trust was reported to be implementing a Never Event Improvement Plan in response to these events, including a workshop to enhance learning from investigations with NHSI and a visit from the National Patient Safety Team.
- NHSI had set a national target to halve healthcare associated Gram-negative bloodstream infections (GNBSI) by March 2021. An Annual Plan for 2018/19 had been developed to reduce GNBSIs.
- It was confirmed that the Graseby syringe drivers (Models: MS16, MS16A, MS26), as used at Gosport Memorial Hospital during the tenure of Dr Jane Barton, had not been in use at the Trust for a number of years. A recent review of Medical Equipment Inventory showed none of these pumps were in store or in use.
- Safe staffing levels reported for nursing and midwifery staff across the Trust by ward, and by shift, 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. It was noted that the Trust had recently procured additional functionality to its e-roster system which would enable “safe staffing” to be monitored via the system using CHPPD (Care Hours per Patient Day) rather than planned numbers.
- Actions taken to mitigate additional winter pressures included a staff incentive scheme for a flexible pool of ten registered staff nurses and health care assistants.
- Recruitment of registered nurses worldwide continued, with nurses starting to arrive in OUH from the previous two recruitment events in India and the Philippines in October and December 2017. The Trust was reported to be supporting nurses in training for their Objective Structured Clinical Examination (OSCE) and IELTS (International English Language Testing System) exams.

- A robust winter resilience plan would be developed with the aim of providing additional capacity to enable registered staff to deliver clinical care.
- The 70-day #EndPjparalysis Challenge had, in many instances, resulted in patients shortening their length of stay.
- There had been a steady increase in the number of reported category 2-4 Hospital Acquired Pressure Ulcers [HAPUs] since November 2017. The Trustwide Improvement Plan for pressure ulcer prevention had been reviewed and updated and an annual pressure ulcer audit was currently underway and due for publication by the end of July 2018, providing further details of care delivery standards.
- A ward accreditation programme was under development to enable wards/departments to understand their own care quality data and drive up the quality and consistency of care provided along with the experience of patients.
- An open visiting pilot had been proposed for a period of two weeks (towards the end of July) on two ward/day case areas on each OUH site. The official launch of Trustwide open visiting would be at the Annual General Meeting in September 2018.
- Significant improvements were expected in the Trust's response to complaints following the introduction of a new KPI whereby all complaints were investigated and responded to within 25 working days.
- New guidance issued in relation to the Delivery of Same Sex Accommodation (DSSA) would no longer allow for local arrangements to be accepted, which would have a considerable impact on the Trust's DSSA breach reporting to NHS Digital. Changes had already been reviewed by the Trust and local implications together with an action plan were due to be completed and reported to the Quality Committee on 8 August.

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

### **NHS Improvement Undertakings**

The August meeting of the Committee had a particular focus on scrutiny and assurance related to the Trust's plans in response to the NHS Improvement Undertakings and particular issues reviewed by the Committee included those outlined below:

#### Workforce Programme

- a) The Committee considered the plans being developed as part of the Workforce Programme which were grouped under six workstreams.
- b) The Committee was briefed on the approach that was being taken to define and assess the maturity of different projects.
- c) It was noted that a key focus of the strategic planning work was to ensure the availability of agreed and accurate data regarding the current and required workforce and the gap between the two for which additional support and expertise was likely to be required.
- d) The Committee underscored the need to clearly track interdependencies with other plans, to ensure that actions were prioritised, to capture the associated risks and to ensure that projects had clearly quantified targets. In particular, the need to ensure

that immediate actions to tackle the Trust's current workforce challenges were a central part of plans.

#### Governance Programme

- a) The Committee considered these plans and recognised that this programme of work was in an early stage of evolution and primarily represented the coordination of a number of existing plans with the overarching elements a response to the Deloitte and CQC well-led reviews.
- b) The Committee noted that the required new Well-Led Review had already been initiated.
- c) The areas of work relating to leadership development, performance management and quality governance systems were all recognised to be very important but very substantial pieces of work. The importance of prioritisation and focus were emphasised and it was noted that additional resource might be required to develop some elements of the programme. The need to move quickly to incorporate changes into business as usual was also highlighted.

#### **Other Quality issues reviewed by the Committee in August 2018**

- a) The Committee received and reflected on the contents of the paper on lessons learnt from a complaint and the processes used to respond to it. The paper highlighted the need for a bespoke Early Pregnancy Assessment Unit (which had been put in place) and for this service to be available over the weekend (towards which progress was being made).
- b) The Committee received its regular report from the Clinical Governance Committee Report (covering its meetings held in June and July 2018) and the following points were highlighted:
  - a. Links with the safe staffing team had been strengthened and minutes were being reviewed by Andrew Carter and his team, one of whom was now in attendance at CGC meetings;
  - b. The June and July meetings had considered the handover of theatres governance from the Clinical Support Services Division to Surgery and Oncology and NOTSS;
  - c. 104 day cancer reviews had been undertaken and had not revealed any harm; and
  - d. A SIRIs and Never Events workshop was to be delivered by an expert from NHSI although the date for the session had been deferred due to illness.
- c) It was brought to the Committee's attention that national guidance had been issued for the adoption of the new version of the National Early Warning Score (NEWS2) as the early warning system for identifying acutely ill patients being treated in hospitals in England. There were concerns that the NEWS2 was not as well evidence-based as that employed by the Trust through SEND (System for Electronic Notes Documentation) and risked raising spurious alerts. This issue was to be discussed further by the Trust Management Executive.
- d) The Committee's consideration of the Quality Report (which, in the main, reported on data up to the end of July 2018) included discussion of the following:
  - a. The change (from June 2018) to the national requirements on the reporting on mixed sex accommodation breaches which were expected to result in an increase

in the number of these being reported within the Trust (with a similar impact anticipated at national level).

- b. Bed days lost due to bed closures were highlighted and work to mitigate this by supporting nurses to work to the top of their licence was described. Implementation of the new safe staffing system was also described.
- c. Consideration was given to the organisation's ability to deliver on its quality priorities given other pressures. The desire for the Trust to continue to be ambitious in this regard was underscored as were the links between many of these priorities and the NHSI undertakings.
- d. The Committee was advised that reporting on hospital associated thromboses would be revised to focus on instances resulting in moderate or greater harm in line with other reporting to the Quality Committee.
- e. The Committee was informed about the protocols that were in place to support improvements in hand hygiene based on a defined algorithm which would target interventions to areas of low compliance.
- e) The Committee was informed that the Care National Quality Board had published new guidance for working with bereaved families. It was agreed that work would be undertaken to map this against current practice and assess the extent to which the Trust was compliant and where additional work would be required.
- f) In its consideration of the paper on Serious Incidents Requiring Investigation and Never Events, the Committee was advised of the actions that were being taken to prevent these. The Committee noted that a Never Event Improvement Plan had been developed and that a Never Event risk summit would take place at the end of August.
- g) The Committee received the Patient Experience, PALS and Complaints Annual Report. A reduction in the overall number of complaints was noted and the role of relocating the PALS teams back to the hospital sites to assist with the informal resolution of concerns was noted.
- h) Mary Miller, Consultant in Palliative Medicine, attended the Committee to update it on the Trust's End of Life Care Programme. The Committee was updated on the pilot of end of life care plans on the electronic patient record. The importance of supporting patients to be able to die where they wished was emphasised.
- i) The Committee received the Adults and Children Safeguarding Annual Report. In considering the report, the Committee noted the importance of system-wide working and the increasing workload in this area.
- j) The Committee's discussion of the Update on Harm Review Process for Long Waits highlighted the importance of an understanding of harm that went beyond physical harms and encompassed psychosocial harms. This included psychological harm and adverse impact on the ability to work. It was agreed that future reports would include more detail on these aspects of harm.
- k) An update was provided on the approach to be used to assess the quality impact of the constrained 2018/19 capital programme, outlining mitigations that could be pursued. It was agreed that specific QIAs would be considered by the Committee in the future.
- l) The Board Assurance Framework and Corporate Risk Register were reviewed with updates to be made based on issues highlighted during the Committee's discussions.

**Key Risks** discussed included:

- i. Risks associated with the fragility of maintaining safe staffing levels which were to be a particular focus of the Workforce Programme, noting the interdependencies of these with other programmes of work to deliver the requirement of the NHSI undertakings;
- ii. 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;
- iii. Risks associated with poor hand hygiene, with the Committee informed about action being taken to target interventions to areas of low compliance;
- iv. An increase in the number of mixed sex accommodation breaches being reported within the Trust as a result of a change to the national requirements on reporting;
- v. Risks that the requirement to implement the National Early Warning Score (NEWS2) as the early warning system for identifying acutely ill patients being treated in hospitals in England might have an adverse impact by generating spurious results in comparison with the Trust's existing approach through the SEND system; and
- vi. Risks that there was a quality impact as a result of the constrained 2018/19 capital programme, with an approach to carrying out quality impact assessments outlined along with a summary of approaches to pursuing mitigations.

**Key Actions Agreed** included:

- i. The further development of plans related to the NHSI undertakings, with a particular focus on work to strengthen prioritisation, better understand interdependencies, recognise where system-wide support was needed and to assess where additional resource was needed to support the development and delivery of plans;
- ii. The development of the workforce programme with an particular emphasis on capturing the associated risks and ensuring that projects had clearly quantified targets, recognising the need to ensure that immediate actions to tackle the Trust's current workforce challenges were a central part of plans;
- iii. To continue to receive updates on the Harm Review Process for Long Waits including detail on the psychosocial aspects of harm;
- iv. To continue to develop and implement the Never Event Improvement Plan and to hold a Never Event risk summit;
- v. To undertake work to map the Care National Quality Board guidance for working with bereaved families against current practice and to assess the extent to which the Trust was compliant and where additional work would be required; and
- vi. To receive information regarding specific QIAs regarding the quality impact of the constrained 2018/19 capital programme, outlining mitigations that could be pursued.

**Recommendation**

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

**Professor David Mant**

**Chairman, Quality Committee**

**September 2018**