Trust Board Meeting in Public: Wednesday 16th January 2019
TB2019.05

<table>
<thead>
<tr>
<th>Title</th>
<th>Quality Committee Chairman’s Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>For information</td>
</tr>
<tr>
<td>History</td>
<td>The Quality Committee provides a regular report to the Board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board Lead(s)</th>
<th>Professor David Mant, Quality Committee Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
</tr>
</tbody>
</table>

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 12 December 2018.
Introduction

Since the Board last met in public on 14 November 2018, the Quality Committee [“the Committee”] held its most recent meeting on 12 December 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 November 2018, the Board reviewed the Quality Report which, in the main, reported on data relating to the reporting period up to the end of October 2018 and, by exception, on data relating to November 2018. Key points noted in relation to all aspects of quality included the following, among others:

- It was noted that among both acute admissions and hospital inpatients, the vast majority of documented cases of “red flag” sepsis occurred in the Emergency Department [ED] and Acute Medicine [AGM]. The majority of the available resources had subsequently been focussed in these two priority clinical areas, however, work to strengthen sepsis recognition and management in clinical areas continued, including among inpatients.
- The Trust was reported to undertake regular WHO Surgical Safety Checklist compliance documentation audits. However, on the advice from NHS Improvement [NHSI], WHO checklist observational audits had started. At present, a hybrid of these audits would continue to be carried out although the Board would need to consider whether both formats were required in the future.
- Safe staffing levels reported for nursing and midwifery across the Trust by ward, and by shift, reflected continuing effort to take mitigating action where shifts/wards were initially identified as “at risk,” in order to ensure patient safety was protected. SafeCare (a new system for managing daily operational staffing levels), had commenced live on 17 September 2018, the new process having been successfully rolled out across inpatient areas in the Trust.
- Rostering for nursing was reported to be under review in line with Lord Carter’s recommendations. Rostering KPIs were expected to be reported to the Board alongside safe staffing from January 2019.
- The number of falls incidents in October was 162, of which 124 provided no physical harm to patients. Strategic plans to further mitigate incidents of falls included: increased availability of low beds Trust-wide; Falls Prevention Practical Skills Workshops; “Low Before You Go” campaign to keep beds at the right height for patients and encouraging staff to debrief on falls incidents to prevent repeated falls.
- Significant pressures were reported in respect of children’s safeguarding activity in both the number of referrals and increase of children involved in violent crimes, requiring a multi-agency approach. Maternity safeguarding issues also remained higher than usual at 17.8% (average was usually around 10%) for the third consecutive quarter. Given the level of referrals and increase in the complexity of cases, it was anticipated that a Business Case proposing expansion of capacity for the Children’s Safeguarding team would need to be submitted to the Trust Management Executive.
• There had been a significant rise in mixed-sex accommodation. A recent change in national reporting guidelines had initially led to some confusion, hence, the increase in breaches within the Critical Care Unit [CCU]. However, the Trust was still a low reporter nationally.

The key agenda items that were covered in discussion at the December meeting included the following:

**NHS Improvement Undertakings: Workforce Plan**

In consideration of the update on the Trust’s progress against the Workforce Improvement Plan (forming part of the undertakings made by the Trust to NHS Improvement), the Committee was informed that the Trust’s staff turnover figures were reducing whilst numbers of substantive staff were increasing. The Committee was informed that the Neurosciences, Trauma and Orthopaedics Specialist Surgery and Children’s and Neonatal Services [NOTSSCaN] had halved its staff turnover. It was anticipated that the approach used could be replicated in other areas.

Whilst sickness rates remained constant, it was noted that incidents of mental health issues were increasing. The Committee was informed greater focus would be placed on mental health and staff wellbeing in the workplace, including preventative measures to support and protect staff mental health.

The Committee noted that staff appraisal rates remained low (1 in 3 staff did not have an appraisal) although with significant variation between divisions. In order to have a more effective appraisal system, key changes would need to be made to drive up appraisal rates Trust-wide.

The Committee was also informed of the launch of additional staff incentive schemes to enable the Trust to safely open more beds, and included a ward-based incentive to encourage substantive staff to work additional hours, to primarily support urgent care flow.

It was noted that the Interim Director of Workforce was working with Human Resources Business Partners to identify areas with the highest nursing vacancy rate to gain an estimate of how many new joiners were expected over the coming months. In addition, other areas would be considered beyond recruitment such as skill mix issues.

External support had also been commissioned to focus on the following three areas:

- Challenges to recruitment and retention strategies in all staff groups;
- Implementation of Agenda for Change; and
- Divisional and Corporate HR resources

**NHS Improvement Undertakings: Governance Plan**

In its consideration of the Governance Plan (also forming part of the Trust’s NHSI Undertakings), the Committee heard that although the Improvement Plan was making good progress, due to a shortage of resources, there had been difficulties in attaining an in-depth review of the Trust’s quality governance arrangements. That said, it was highlighted that additional resources would be in place in January 2019; and assistance had also been sought from one of NHSI’s experts in relation to Quality Impact Assessments [QIAs].
The Committee was informed that a medical engagement survey had commenced in respect of leadership development. It was anticipated that the feedback would provide further scope for development.

The Well-Led Review undertaken by Deloitte (commissioned by NHSI) had been completed and the importance of providing a timely response to the action plan was emphasised.

The Committee was also informed that the CQC System-Wide Review had now been completed. It was expected that the Trust would be in receipt of the draft report in January 2019.

Other Quality issues reviewed by the Committee in December 2018

a) The Committee received a paper outlining the lessons regarding repeated cancellation of surgery, which highlighted the need for clinical prioritisation and review, and the importance of honest and transparent communication with patients and their carers about the reason for delays to alleviate anxiety and stress. The reasons for repeated cancellation, and efforts being made to avoid this, were discussed. It was agreed that the relevant Executive Leads would be asked to review the process of dealing with cancellations, identify avoidable causes, and provide data to allow improvement to be tracked.

b) The Committee was provided with a Patient Experience Delivery Plan, noting the improvements involved eight different aspects of Trust care and services, identified from the national patient surveys and complaints received by the Trust over the previous year. The aims of the delivery plan were to improve the Trust’s patient and staff experience, which would be featured in turn in a monthly patient experience focus in the Board Quality Report, patient perspective and published on the Trust website. Given the Trust’s commitment to embedding national guidance on learning from deaths, the Committee considered this topic should also be incorporated into the delivery plan.

c) The Committee received its regular report from the Clinical Governance Committee (covering its meetings in October and November 2018) and the following points were highlighted:

   a. Nationally cases of harm and death by feeding through a misplaced feeding tube had occurred despite previous National Patient Safety Agency (NPSA) alerts regarding misplaced nasogastric feeding tubes. This was a Never Event but had not occurred at the Trust in recent years. However, audit had demonstrated poor uptake of NG/Orogastric feeding tube eLearning training, and therefore, it had been agreed that in order to ensure the Trust adhered to NPSA alerts all registered nurses working in clinical areas, identified as high frequency users of NG/Orogastric feeding tubes, must complete the competency assessment by making the training mandatory to the role.

   b. Of the 29 patients on a 62 day cancer pathway treated over the 104 day target in Quarter 1, two reviews did not exclude harm and were referred to the SIRI process.

   c. The National Cardiac Arrest Audit (NCAA) – the national, clinical, comparative audit for in-hospital cardiac arrest, showed that there had been more cardiac arrests in 2017/18 compared with previous years (1.24/1000 admissions compared to 0.90 in 2016/17, 1.18 2015/16 and 1.03 2014/15); however, the
percentages of patients with return of spontaneous circulation for more than 20 minutes, and for survival to hospital discharge, were higher than nationally.

d. The proportion of patients with delay in repair of fractured neck of femur had been reduced from 38% to 25%; as this is still too high, Quality Committee will continue to monitor.

d) The Committee’s consideration of the Quality Report (which in the main, reported on data up to the end of October 2018) included discussion of the following:

a. The National Strategy update considered a report from Sir Ron Kerr on ‘Empowering NHS leaders to lead’, the central tenet being to foster a “learn not blame” culture.

b. Six indicators had either deteriorated against target or had breached an annual red-alert threshold: radiology (plain film, CT, MRI) turnaround times; preventable HATs; medicines reconciliation; single sex breaches; and EUA length of stay.

c. Cardiac arrest reduction targets had been missed (increase of 8% against a planned reduction of 25% in general ward areas); possible explanations and the existence of a detailed action plan to address the situation were noted.

d. The overarching NatSIPP Policy was approved and had been uploaded to the Trust intranet. The emphasis on human factors learning in developing LocSSIPs to avoid never events and the ‘At a Glance’ initiative were welcomed.

e. The sepsis deep-dive had shown that 64% of newly admitted patients with red-flag sepsis (35/56) had received antibiotics within one hour. The relatively small numbers of cases of red-flag sepsis identified among in-patients in directorates other than acute medicine/ED has raised questions about ascertainment. However our best estimate of mortality in patients with suspected sepsis suggests OUH is performing above the national average (7.8% vs. 9.2%)

f. The midwifery staffing position has improved slightly (to 1:31); the slight increase in ICU admissions, unexpected SCBU admissions, and complaints were noted and are being investigated but it was also noted that there have been no HIE grade 2/3 cases.

g. The number of hospital-acquired category 2/3 pressure ulcers rose slightly in the last reporting month (0.41%, Sept 18), but no category 4 ulcers have been reported in the year to date. All category 3 ulcers have been investigated and lessons discussed and disseminated at the PUPCIG (the pressure ulcer clinical improvement group). QC will continue to monitor the situation.

h. The open fracture BOAST audit showed the Trust’s performance has improved this year and is better than the national average (96% surgical stabilisation of fracture and 79% soft tissue coverage of fracture audit meeting optimal time-to-operation standard)

e) In its consideration of the paper on Serious Incidents Requiring Investigation (SIRI) and Never Events, the Committee’s attention was drawn to two Never Events which related to a retained guidewire and wrong site surgery. Immediate action had been taken to raise awareness of good practice and learn lessons from these events.

f) The Committee was informed that the Trust was in receipt of a deep dive review into the harm review process for extended waits, which had been conducted by NHSI,
together with OCCG and NHS England. It noted that actions had already been taken against the recommendations, which included appointing an independent Chair of the Harm Review group and amendments to the Terms of Reference (ToR) to include 104 day cancer breaches to be reviewed quarterly ahead of reporting quarterly to the OCCG.

g) The Committee noted the Trust continued to fulfil the principles included in the new Guidance, “Learning from Deaths – Guidance for NHS Trusts on working with bereaved families and carers,” issued by the National Quality Board in July 2018.

h) The Committee received an update on maternity staffing, including the immediate, and long-term actions that had been put in place to ensure the maternity service could continue to provide safe care for women and their babies.

i) The Committee received the Tissue Viability Annual Report, providing an overview of the service to reduce the number of Hospital Acquired Pressure Ulcers [HAPUs] and improve wound assessment and management at a clinical level. The team provides a 6 day a week service and comprises 4.6 WTE nurse specialists. In 2015/16 they had 900 electronic referrals from clinical areas and in 2017/18 there have been 4,113 referrals.

A strategic action plan for the Trust has been reviewed to reflect necessary remedial actions to address shortfalls in compliance and need to improve patient safety and clinical outcomes in relation to HAPUs, with a specific focus on category 2 damage.

The ambition of the Trust is to continue to work towards zero avoidable Category 3 and 4 HAPUs. This is to be reflected in Divisional quality standards and QC will continue to monitor this through the Quality Report.

j) The Committee noted that although there had been a significant increase in attendance through the ED, the number of 4 hour standard breaches had decreased; however, the Trust was yet to achieve the 90% trajectory for ED 4 hour performance.

Each of the schemes within the Winter Plan had been reviewed and were noted to be falling short of where they were estimated to be on a month-by-month basis. Consequently, a system-wide review of opportunities to reduce bed gaps had been undertaken which had reduced gaps to some extent but not enough to deliver the required 92% trajectory.

k) The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and noted the improvements that had been made to the CRR.

**Key Risks** discussed included:

i. The Committee continued to recognise the risks associated with the fragility of staffing levels which were a particular focus of the Workforce Programme, noting the improvements that had occurred with turnover and substantive staffing levels as well as the work to initiative additional staff incentive schemes.

ii. The risk that activity pressures experienced across Oxfordshire over the winter period were greater than could be managed by the arrangements with the Trust’s Winter Preparedness Plan.

iii. The potential risk that current operational and financial pressure could have an adverse impact on patient safety and quality of care; to guard against which the Committee remained vigilant in its scrutiny of key quality indicators.
iv. An increase in the number of mixed-sex accommodation breaches reported within the Trust as a result of change to the national requirements on reporting.

v. 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 along with a summary of approaches to pursuing mitigations.

Key Actions Agreed included:

i. The further development of plans relating to NHSI undertakings, with a particular focus on assessing where additional resource was needed to support the development and delivery of plans;

ii. The further development of the workforce programme with a particular emphasis on capturing associated risks and ensuring 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 the proportion of revised harm review ratings;

iv. To continue to implement and monitor the principles set out in the guidance on “Learning from Deaths” and to identify further opportunities for working with bereaved families and carers;

v. To receive information regarding specific QIAs regarding quality impact of constrained 2018/19 capital programme, outlining mitigations that could be pursued;

vi. To receive a robust action plan addressing the concerns around standards in respect of Patient-Led Assessments of the Care Environment (PLACE).

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

Professor David Mant
Chairman, Quality Committee
January 2019