REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 SEPTEMBER 2016**
SUBJECT:	**QUALITY COMMITTEE CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE QUALITY COMMITTEE**
PURPOSE:	**Approval**

BACKGROUND AND EXECUTIVE SUMMARY

The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety.

The following provides feedback from the August Quality Committee meetings. The report seeks to answer the following questions in relation to the quality and safety performance:

1. What went well over the period reported?
2. What concerns were highlighted?
3. What action has the Committee taken?

MEETING HELD ON 7 SEPTEMBER 2016

The following went well over the reporting period:

- While crude elective mortality has increased in July (registering 29 deaths per 1000) broader Trust indicators continue to show a favourable position, HSMR continues to fall and remains below the national average and SHMI remains static at 96.
- There have been no new never events reported in July 2016;
- While complaints response times require continued focus, response within agreed timeframe and response within 30 working days continues an upward trend registering at 96% and 33% respectively in July. Despitr this there are some issues (see under concerns);
- The measure directly relating to harm experienced in our care (Harm Free Care: New Harms only) remains better than the national average which means that our patients are receiving care that causes less harm than is reported nationally;
- The number of avoidable grade 2 pressure ulcers fell to 0.12 per 1,000 bed days, achieving the Trust trajectory. There were no confirmed category three or four pressure ulcers reported in July 2016.

Concerns highlighted over the reporting period:

- Serious Incident delays were identified in July - there is a need for continued focus on ensuring the quality of SI investigation and timeliness of completion (within 60 days);
- The year to date position for C-Diff cases increased to 16 cases in July, now exceeding trajectory;
- E.Coli incidence increased by one case in July. While it is recognised that there has been an increase in incidence nationally (2015 compared with 2016), an increase in infection is a potential indicator of HCAI practice. Action is required to maintain and ensure good HCAI practice;
- A decrease in the reporting of medication incidents, is being received cautiously pending assurance that this is a genuine reduction in harm rather than a decrease in the positive reporting behaviour previously identified as supportive of a patient safety culture;
- Mixed sex breaches have increased to 29 in July (representing an increase of 18 cases)- this is largely triggered by the need to place patients in a safe environment rather than

ED;
- Continued improvement is required in the percentage of VTE risk assessments recorded;
- As reported above, overall Harm Free Care (HFC) remains below both the overall national average of 94.16% and the acute hospitals only national average of 94.06%. In mitigation the Trust is reporting in real time honestly rather than snapshots as some Trusts do;
- Complaints response times had been sustained but the improvement work continues. Complaints performance requires maintained focus to improve a) the number responded to within 30 working days; b) the quality of the complaints responses (to address the reasons for a sharp increase in returner complaints) c) embed learning arising from the complaints and d) ensure a consistently positive experience for complainants.

Other topics discussed where concerns or actions were taken:
- There has been a change in the way risks are reported. The report presented was thematic, consolidating the risks in five top themes. Assurance was provided that this methodology was understood by staff and provided a wider understanding of the complexity of risks.
- Mixed sex breaches reported in CDU related to operational risk based decisions at that time. Assurance was provided that a new task and finish group has been set to monitor mixed sex compliance.
- The Committee was appraised of the number of tools used within the Trust to identify and monitor deteriorating patients. Effectiveness of these tools is also monitored.
- The data provided as part of the safety thermometer is a 'snap shot in time' and denominators were small. The Committee received assurances that this data is triangulated on a regular basis (through governance structures) with other key measures/triggers available in the Trust.
- The Heat map will be reviewed to improve presentation, especially for areas where data is unlikely to be available (currently coloured grey).
- Work is ongoing to review procedures following an incident linked to a work experience placement. This is being discussed and monitored by the Patient Safety Board.
- VTE assessment reported 85% as at August 2016, an improved position. However, there is varying performance by specialty. This is partly a data recording issue and partly due to individuals failing to record the assessment. Messages around recording of assessments are being reinforced at divisional level.
- Assurance was provided that mental health patients presenting in ED were being more efficiently and effectively managed, although there was further work to do. The Trust was actively working with partner organisations to sustain improvements in the long term. The Quality Committee will keep this as a specific item for discussion.
- Richard Earland attended the Trust's End of Life Board as NED representative. He reported that there was good evidence of progress being made. He had tested this evidence by visiting wards. It was recognised there was further work needed, but was moving in the right direction.
- Patients transferred to the Trust from Nursing Homes, particularly for end of life care, had now been added to the Trust's improvement plan. Work would continue with partner organisations.
- There was a concern around clinical audit (behind schedule). The Quality Committee would receive a formal monitoring report in October 2016. The IAGC would receive a paper to scrutinise controls in place.
- The Trust's Management Board had made a decision not to fund the Global Trigger Tool for mortality monitoring as a national system (Mazaars) was due to be rolled out. The methodology of the global trigger tool would be used to support serious case note reviews.
- Concern was expressed in August as to whether the Trust was learning from incidents. A report was received detailing the type of information available corporately and at divisional level highlighting lessons learned from incidents. The Quality Committee was keen to ensure that these lessons were embedded and acted upon. This will form part of the refreshed Quality Strategy which will come to the Board for discussion.
- The Clinical Support Services Division was looking at demand and capacity within the

radiology team. The Committee was assured around the appointment, quality and management of locum staff.
- The Committee agreed to look at one or two corporate risks as a deep dive exercise in December. In addition, a cross-cutting risk would also be looked at in detail.
- There were a number of 100 day breaches within the cancer pathway. The Surgical Division is looking at ways to ensure, with key partners, appropriate referrals.
- The Quality Committee requested that Divisional Governance Board minutes be reviewed to comprehensively record conversations in governance terms. Two new Quality Risks were reported: Governance around patient group directions; Training compliance for adult safeguarding above level 1. The latter was partly due to recording issues.
- The live register was reviewed by Barry Wilding, NED after the meeting concluded. This will feed into the Board discussions on 9 September 2016.

MEETING HELD ON 3 AUGUST 2016

The following went well over the reporting period:

- HSMR continues to fall and remains below the national average. SHMI remains static at 96.
- Elective crude mortality shows a reduction compared to last month following an increase in May 2016.
- There have been no new never events reported in June 2016.
- Incident reporting has risen, due diligence is underway to seek assurance that this is due to an increased reporting awareness.
- FFT response rates continues to improve as a result of targeted action. Overall FFT recommendation of the service has increased marginally to 96.
- While complaints response times increased to 94% and the backlog accrued by the corporate Patient Experience Team has been addressed.
- Overall Harm Free Care improved in June to 93.6% compared to 92.3% in May but remains below both the overall national average of 94.16% and the acute hospitals only national average of 94.06%).
- New Harms only has gone up to 98.5% (better than the national average which means that our patients are receiving care that causes less harm than is reported nationally;
- There has been a decrease in pressure ulcers reported in June (with a decrease of eleven ulcers and three avoidable ulcers compared with the previous month).

Concerns highlighted over the reporting period:

- The Committee requested a decision around the future of the Global Trigger Tool be taken to the Trust's Management Board. An update would be provided in September.
- The Committee requested a further report in October around compliance with the recommendations in the Mazars Report.
- The Committee will be inviting the Director of Strategic Development and Capital Planning to a future meeting to present assurance around equipment maintenance/training needs analysis.
- The Committee asked for detail around implications of missing the Sepsis CQUIN. This will be received at the September meeting.
- A replacement programme was in place for MRI equipment, to be in place by January 2017. The current equipment had been risk assessed and back up plans were in place.
- The Committee was concerned around the level of staff understanding of their roles, responsibilities and accountabilities within the Urgent Care and Long Term Conditions Division and asked that the Management Team review the Divisional organisational structure.

Other topics discussed where concerns or actions were taken:

- Results from the National Cancer Patient Experience Survey were received. The

Committee proposed that improvement work being undertaken in terms of patient experience link to the work of the clinical strategy and key findings from the survey should be shared with the CCG.

- **The Committee received the Infection Prevention and Control Annual Report and is recommending this to the Board for Approval.**
- The Committee recognised work being undertaken in the Surgical Services Division to monitor the clinical audit programme. Methodology would be shared across divisions.
- The Committee would be reviewing the quality risk register 'live' at the next meeting. The focus would be on risk mitigation.
- A report would be received at the September Committee to provide assurance around different mechanisms of learning from serious incidents.
- The Safeguarding Children Annual Report 2015/16 was received. The Committee noted the increased workload of the team. There had been a positive increase in the number of interactions with the team.
- The Adult Safeguarding Annual Report 2015/16 was received. The Committee noted the revised requirements of the Deprivation of Liberty Safeguards as a key challenge. There had been a positive increase in the number of interactions with the team.

MEETING HELD ON 6 JULY 2016

The following went well over the reporting period:

- HSMR remains below the national average (albeit a historic position);
- SHMI is improving;
- Incident reporting has risen showing a culture of openness and willingness to report and raise issues;
- Non-elective crude mortality continues to fall (registering green, falling below the 27.1 threshold);
- There was a drop in MRSA bacteraemia;
- Hospital acquired harm free care remains high (good);
- Decrease in the falls rate;
- No avoidable deep ulcers reported;
- Safe staffing is further improved this month;
- A further slight improvement in the Friends and Family test star rating;
- While complaints response times require continued focus, an accrued backlog is being positively and actively managed. It is of note that 145 complaints were closed during May 2016 compared with 69 in April 2016. This improvement is being driven by a comprehensive review of the complaints process with development of new ways of working and greater support and outreach to the Divisions.
- Improved position for mixed sex accommodation (with no breaches in May).

Concerns highlighted over the reporting period:

- An increase in the number of serious incidents reported;
- We remain on limit for the monthly C-Diff trajectory;
- Old and new harm free care remains below where we would like;
- We are above trajectory for category 2 avoidable ulcers;
- Mixed sex breaches, although reduced this month are still occurring. There is a potential for breaches to occur in future.
- Recognising that there has been a step increase in the number of episodes of care, the complaint / episode of care ratio shows a deteriorating position in May 2016. The number of Complaints continues to rise, albeit at a less severe rate than for previous month (April). Focused action is underway to recover this position, see above reported relative improvement since April 2016.

Other topics discussed where concerns or actions were taken:

The IPR was considered by the committee with a focus on quality metrics (domains of caring, safety and effectiveness. There was also consideration of the performance od the

Emergency Department.

- Recording of VTE assessments reported an improved position. Governance around this has been strengthened at both a corporate and divisional level.
- Legibility of doctors signatures. Discussion took place around the use of stamps (with name & GMC number) versus a drive to insist doctors sign, write name & number legibly. The current situation is unsatisfactory & the Medical Director was requested to bring further details to the committee. There was uncertainty as to whether there would be an improved performance to justify the cost of stamps.
- A new maternity risk dashboard is up and running. There is also the need for a co-ordinated Uro-Gynaecology activity log. However, there was a concern around resources to collect data. The Chief Nurse and Director of Quality will be taking this forward in order to produce an estimate of ongoing costs .
- Increased serious incidents in maternity compared to the previous year associated with CTG monitoring. Key driver unknown but could be a result of increased scrutiny. As an interim measure, all twin CTGs will be reviewed by a registrar or consultant.
- Eligible consultant signatures within medical records was discussed. The Committee has asked for a report on options to resolve this at its August meeting.
- The Committee welcomed the new format Integrated Performance Report and agreed further work was required to refine thresholds and explanations of data presented in order for the Committee to draw attention to outliers in performance and form its own judgements.
- Data for Cambridge L and CDU reported some patient experience metrics lower than expected. The Committee recognised that case mix could be an element. More detail would be provided to the August Committee.
- The significant increase of the number of ED attendances was noted. This is a nationwide problem for the NHS. The Committee was concerned around the delivery of the Emergency Recovery Plan having missed the ED trajectory. RTT performance was also a concern. The impact on access to the Sustainability and Transformation Fund was unknown. This issue was discussed in more detail at the Finance and Performance Committee.
- Pressure ulcers reported a downward trend compared to the previous year.
- The outcome of the learning Disabilities Mortality Review was noted. Actions put in place:
    - Develop training for staff and raising awareness sessions. Events are planned and some have already taken place as part of Learning Disabilities week;
    - A spot check audit on documentation is planned;
    - A Learning Disabilities lead is to be identified;
    - The formation of a multi disciplinary group was proposed. The group would review the report so far, consider all the learning, actions already taken, confirm a comprehensive and SMART action plan which included targeted and trust wide action, and thereby provide assurance that learning was being taken forward.
- There is greater focus on assisted mealtimes, especially for patients with dementia, led by the Nutrition Steering Group. Assurance was provided to the Committee around risk assessments for patients and the use of the red tray and red mat systems, particularly for patients with dementia.
- Assurance was provided to the Committee that significant progress had been made on the appropriateness and completion of clinical audits. The Committee is due to receive a formal update against the plan at its September meeting.
- Aging equipment in pathology and radiology was noted. The former was linked to the Kent Pathology Partnership transformation plan. An action plan was in place for the latter and the committee noted possible cost implications.
- Increase in MRIs and CT scans was noted. The backlog for the former has reduced. The Trust was outsourcing CT scan reporting.
- The Aseptics write off position (monitored by the Integrated Audit and Governance Committee) has significantly improved.
- Public Health England had confirmed they were content with actions put in place to address obstetric scanning issues reported through STEIS.
- Assurance was provided to the Committee that Corporate Teams and Divisions were

sighted on compliance with locked drug cupboards.
- Emerging risk regarding Interventional Radiology Cover. A Kent wide solution was being explored.
- An audit was taking place to ensure all end of life care forms were properly documented.
- There had been significant progress in the development of the corporate and strategic risk register. This would enable the Committee to focus on mitigation more closely.
- Relaunch & implementation of the Global Trigger Tool required more debate at Management Board around resource (in terms of time, funding & commitment). There was a split in the opinions of the Exec Officers present. A recommendation would be brought to a future Committee.
- An update report on nasogastric tube incidents concluded NHS England was content with the action taken by the Trust following a visit week commencing 27 June 2016. Internal work will be undertaken to check no further incidents had been reported and to ensure consistent reporting as part of the national reporting learning system.
- Divisions were asked to confirm whether staff would recognise the issues recorded at their Governance Board meetings. Overall, Medical Directors present felt this to be the case but recognised that there were pockets where further work was required (top to bottom).

As a general point, the Committee felt overall performance (in terms of the quality agenda), when contextualised within the significant challenges and pressures the Trust was faced with, was a positive story. The Committee was confident the Management Team and Board were aware of the challenging areas, what mitigating actions were being put in place and that there had been more traction on issues such as VTE.

RECOMMENDATIONS AND ACTION REQUIRED:

Discuss and note the report.
To approve the Infection Prevention and Control Annual Report.