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

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 November and December 2016 Quality Committee meeting. 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 DECEMBER 2016

The following went well over the period:

- The mortality figures for the month of October continue to show that we have a lower mortality than the national average.
- Complaints performance (response within agreed timeframe) remains green registering 94% compared with 92% in September.
- There has been an decrease in the number of SI's reported compared to September
- There has been a decrease in the rate of category 2 pressure ulcers compared to September.
- There were no category 3 pressure ulcers reported during October.
- No new cases of MRSA bacteraemias were reported and assigned to the Trust during October.
- Harm free care improved compared to September.
- Ward staffing had demonstrated an improvement in actual Vs planned levels.
- Considerable progress had been made in Divisions with regard to implementing NatSSIPs.
- The Committee received the Patient Experience report that highlights; The high frailty and challenged patient flow requires greater focus on repositioning patients and ensuring effective pressure relief; Consistent release of the link nurses for training and to attend QII hub sessions requires careful rostering; Improvement in PU performance is not achieving trust trajectory for category 2 and 3; Ensuring the risk assessment of patients within 6 hours of admission occurs; Collaborative work is to be developed with community providers to ensure the Trust receives feedback on patients discharged with unstageable pressure ulcers; Consideration of how we can mobilise the wider trust resource going forward to support the Tissue Viability Team given the pending maternity leave service.

Concerns highlighted over the reporting period:

- A wrong side block (never event) was declared as a serious incident in October
- SI delays - there is a need for continued focus on ensuring the quality and timeliness of SI

investigation (completion within 60 days).
- Continued improvement is required in the percentage of VTE risk assessments recorded.
- Continued focus is required to ensure improvement in the complaints responded to within 30 working days, and to address the reasons for a sharp increase in returner complaints.
- The Committee recognised the need to improve timeliness of completion of investigations following a serious incident and poor attendance at training events. The Trust had moved forward in terms of awareness and embedding of processes (and shared learning) but further work was required. The Trust was waiting for the final report following an internal audit into the effectiveness of serious incident management. This would be reported through the Integrated Audit and Governance Committee.

Other topics discussed where concerns or actions were taken:
- An action from a previous meeting around tighter processes for work placements in the Trust was discussed. The Deputy Medical Director provided assurance he would be strengthening processes.
- The Committee received a detailed report from the Director of Strategic Development and Capital Planning providing assurance around Health and Safety issues raised at the November meeting. The Committee took assurance from the report that processes were in place to identify, monitor and address health and safety issues and the response to issues concerned at the November Quality Committee was exemplary. The Committee asked that the next Board Development focussed on risk assessment across all hospital sites.
- Further work was required in improving the presentation of the data in the Integrated Performance Report (and heat map) together with clarity around monitoring of strategic objectives. The Committee asked for someone from the Information Team to attend the next meeting to discuss this further.
- Consultant attendance at Mandatory Training is poor and patchy with resus role-specific training being a specific concern. The Deputy Medical Director is reviewing the situation alongside job planning and appraisal.
- The Trust was working to managing risks around CQUINs.
- Engagement from Women's Health at the Patient Safety Board was raised as a concern. The Committee recommends a review of Women's Services to understand the issues and support required; and, more widely, which services within the organisation were 'stressing' and associated plans.
- Performance against the Quality Strategy (as at Quarter 2). Metrics were being refreshed.
- The imaging service and recent issues in Radiology present an element of risk to patient outcomes. This has not been quantified to date.
- The Quality committee would urge caution in the interpretation of any user surveys in the next few months bearing in mind the context of the STP debate.
- The committee was reassured, via a cross cutting deep dive reviewing Corporate risk CRR3 (Inability to respond in a timely way to changing levels of demand for emergency and elective services), that the Trust has tested policies and plans in place to cope. A major obstacle will be the integration and cooperation of external partners.
- There is encouraging evidence that Medical Devices training is both in place and is recorded. The committee was reassured that ongoing work will ensure that there are no breaches under the Health & Safety at Work Act. Progress will be reported to PSB on a quarterly basis.

MEETING HELD ON 9 NOVEMBER 2016

The following went well over the reporting period:
- Performance around VTE assessments has improved across all divisions reaching 90% in September and 89% in October. Piloting VitalPac assessments in ED early November. Latest Vital Pac performance module has been implemented and is better with improved accuracy;
- The Friends and Family test result for Accident and Emergency showed a 14% increase to 82%;
- The Mortality Steering Group has been established and members of the group are

piloting mortality review tools to evaluate which to recommend for standardised reviews across the Trust, with a view to commencing the review of all deaths that occur in the Trust as per the recommendations of the Mazars Report. The Trust's HSMR rate is lower than the national average;

Concerns highlighted over the reporting period:

- The October 2016 Board report from this Committee highlighted the delays in SI investigation, there seemed to have been little improvement in November. 17 out of the 43 STEIS reports were breaching. The Committee understands that the main issue is the rigour in the report in terms of ensuring all root causes are understood and have appropriate actions before they are discussed at the Root Cause Analysis meeting. The Committee received assurance that SI's are discussed at the Divisional Executive Performance Review's. The Committee requested action was for an improvement trajectory from each Division and a review of the training to those undertaking the investigations;
- The investigation into the most recent never event, wrong site block, showed the cause to be a lack of adherence to policies and procedures;
- In September the Trust had 2 new cases of C.difficile compared to 3 cases in August. The total number of C.difficile cases is 21 which is line with trajectory for this year but it is noteworthy that this position is worse than last year, as such there is a heightened awareness of this quality indicator;
- The Trust re-audited adherence to the pleural safety checklist. Out of 26 cases, 14 (54%) did not have pleural safety checklist completed. Actions are in place to address this and a re-audit will take place to ensure continuous monitoring. The committee looks for assurance that this re-audit will be reported back at a future meeting;
- In September 2016 there were 181 patient falls. While this remains relatively consistent with previous months, it represents an increase in Falls rate when analysed per bed day. It is also of note that within this overall falls figure QEQM showed an increase of 7 reported falls compared with WHH and K&CH which shows a decline in reported events;
- Mixed sex breaches has risen to 28 mixed sex accommodation occurrences in total, affecting 134 patients. This number has increased since last month when there were a total of 15 occurrences affecting 71 patients. The increase is due in part to better reporting, the root cause is mainly the flow through the hospital;
- In September 2016 a total of 31 category two pressure ulcers were reported and 10 were confirmed as avoidable. There was 1 confirmed category three pressure ulcer acquired in September 2016, however this was unavoidable. There were 10 potential deep tissue ulcers and two were avoidable. The Committee noted the actions in place to reduce the number of avoidable pressure ulcers;

Other topics discussed where concerns or actions were taken:

- The Committee received the Patient Experience report that highlighted a recent quality visit to the Children's Assessment Centre, overall the report was positive and the recommendations would be implemented. In addition, the End Of Life Board reported a good uptake on the training programme. Conversely, it was reported that the EOL link Staff have not met their target of online learning and subsequently the Trust has missed its CQUIN target on e-learning that may yield a financial penalty;
- The Committee received assurances in relation to a number of NICE standards. Risks in relation to pharmacy and microbiologists staffing and to implementation of the Sepsis guidelines were noted;
- C. difficile cases for July-September have increased from 8 to 10 compared with 2015-16 when cases numbers were exceptionally low. The Q2 total is 2 below the DH limit. A case of MRSA bacteraemia acquisition in September was found to be related to competencies surrounding the taking of the blood cultures. Assurance was received in relation to the cleaning contract with Serco, the Chief Nurse and Director of Quality and the Medical Director had oversight of the cleaning audits and took action as required;

- A concern was highlighted in the External Visits and in the Clinical Support Services Divisions report in relation to health and safety / fire safety, the Executive will provide assurance to the Committee before their next meeting. The issue may need to be considered by the full Board, depending on the response of the Executive to challenges from the Quality committee
- A common theme in the Divisional reports was performance against delivery of clinical audit, a short paper on the current position was requested ahead of the Integrated Audit and Governance Committee meeting in January 2017 where there was a substantive item on the agenda;
- The Committee sought and received assurance in relation to the backlog in MRI / CT, urgent scans were prioritised, however cancer was found in some cases where routine scans had been ordered;
- The quality corporate and strategic risks were noted.

The perception was that there had been an overall decline, using the safety thermometer as the barometer, and this was due, in part, to the current pressures the hospitals were under. There were a number of wards where a decline was notable and the Deputy Chief Nurse & Director of Quality and the Deputy Medical Director were working together to secure improvement.

RECOMMENDATIONS AND ACTION REQUIRED:

For the Board to consider whether Health and safety issues need more prominence given the way Fire safety issued had emerged at this sub committee of the Board.

Discuss and note the report.