NHS
East Suffolk and North Essex
NHS Foundation Trust

# QUALITY & PATIENT SAFETY COMMITTEE

## Minutes of the meeting held on 24 July 2018
## Directors' Seminar Room, Trust HQ, Ipswich Hospital

**PRESENT:** Helen Taylor, Non-Executive Director *(Chair)*
David White, Chairman
Susan Aylen Peacock, Non-Executive Director
Julie Parker, Non-Executive Director
Neill Moloney, Managing Director
Barbara Buckley, Chief Medical Director
Catherine Morgan, Chief Nurse
Angela Tillett, Medical Director
Paul Fenton, Director of Estates
Nicky Leach, Director of Logistics
Claire Thompson, Site Director of Nursing – IHT
Anne Rutland, Director of Clinical Governance
Kevin Purser, Chief Pharmacist

**IN ATTENDANCE:** Karen Lough, Head of Operations - General Surgery & Anaesthetics
Andy Higby, Head of Improvement for Pathology Services
Neill Abbott, Auditor, TIAA *(Item: 2.3)*
Clare Harper, Senior Committee Secretary *(minutes)*

**APOLOGIES:** Dawn Scrafield, Director of Finance
Denver Greenhalgh, Director of Governance
Alison Smith, Director of Operations - Services Director
Simon Hallion, Director of Operations
Alison Smith, Director of Operations

| ITEM | | RESPONS-IBILITY |
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| **01/18** | **APOLOGIES/INTRODUCTIONS** | |
| | 1. The Chair introduced all attendees to the first ESNEFT Quality and Patient Safety Committee. | |
| | 2. Apologies were noted as above. | |
| **02/18** | **MINUTES OF THE LAST MEETING** | |
| | 3. The minutes of the meeting held on 13th June 2018 (IHT) were approved as a true record of the meeting. The Minutes of the meeting held on 18th June 2018 received several amendments from attendees and it was agreed to re-circulate the amended version for virtual approval. | **CH** |
| **03/18** | **COMBINED ACTION LOG AND MATTERS ARISING** | |

| ITEM | | RESPONS-IBILITY |
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| | 4. It was noted that the CHUFT action chart contained actions up to May 2018 and did not reflect actions agreed at the June meeting. A revised action chart would be circulated with the revised draft minutes. | **CH** |
| | 5. The Committee reviewed and noted progress of actions received to date, in particular:<br>• *Action 18/75 – National Issues around Breast Screening.* The Medical Director advised that national changes to call/recall arrangements in breast screening in 2016 had had a significant impact on the service at Chelmsford and Colchester and therefore, a local governance review of clinical harm to patient would be undertaken at Colchester. A telephone call had been scheduled with PHE, EOE and NHSI to discuss any communications or findings before information may be released in the public domain. JP sought assurance that any issues identified in the reviews would be dealt with as soon as they were found. **Action:** Provide update in September.<br>• *Action 63/18 – Provide report on actions being taken to rectify issues for wards triggering inadequate on the heatmaps.* Site Director of Nursing advised that a historic review of heatmaps had been requested for Ipswich; however, a new heatmap for ESNEFT would be developed and would be shared with the Committee when completed. Close action<br>• *Action 63/18 – Arrange for sub-contractors to provide a quality account document to this committee for assurance.* Quality Account from GP Federation was awaited however performance reporting to this committee had commenced (see item 2.1).<br>• *Action 99/18 – Oversight on how Clacton & District Hospital were providing one to one care.* CT to clarify this action and provide verbal update next month.<br>• *Action 99/18 – Update on performance issues relating to Somersham Ward.* CT advised that work was continuing with the ward to address safety, workforce and cultural issues to improve health and safety audit outcomes. | **AT** |
| | 6. JP queried why the CHUFT action regarding agency vetting had been removed from the action chart. The Chief Nurse advised that the action had been transferred to the People and Organisational Development (POD) Committee to commission further work required and agreed to provide an update on progress next month. | **CM** |
| **04/18** | **MATTERS ARISING** | |
| | <u>Complaint Themes</u> | |

7. The Site Director of Nursing provided an overview of the results of a thematic review of complaints relating to staff attitude/lack of communication at Ipswich Hospital.

8. The review looked at reflective cases and a total of 19 file cases were reviewed. Emerging hotspots appeared to be the language used by staff when talking to patients during preparation for theatre, particularly regarding weight loss requirements.

9. The Committee was advised that positive discussions had taken place with senior members of staff to ensure that patients are spoken to in a more sensitive manner.

10. The Chief Nurse suggested that regular updates on complaint themes were included in the Patient Experience quarterly report.

11. The Committee noted the results of the thematic review.

Quality Improvements on Saxmundham Ward

12. The Committee received an update from the Site Director of Nursing regarding improvements made on Saxmundham Ward following 2 recent serious incidents on the ward. It was noted that management of sedation protocols had been strengthened and the ward was now showing as 'good' on the ward heatmap.

13. The Committee was satisfied with the improvements made.

Transportation of Specimens Progress Report

14. The Committee received a progress update from the Head of Improvement for Pathology Services (AH) relating to the review of transportation and receipt of Pathology specimens at Colchester, following several serious incidents which had been reported as a result of the management and transportation of cellular pathology specimens.

15. It was noted that due to the laboratories at Colchester being co-located, changes to the transportation of specimens had been implemented from May 2017 however compliance with these changes had been 'patchy'.

16. AH advised that a Quality Improvement project was required to consider options to implement provision of a complete chain of custody for specimens and increased regular auditing to be undertaken to evidence improvement in accordance with the regulation and accreditation of Pathology Services.

17. The Committee was asked to consider and approve the formal establishment of a Quality Improvement Project group to oversee the

implementation of further changes required including provision of specimen transportation and reception arrangements during normal and out of hours/weekends.

18. The establishment of a Quality Improvement Project group was approved by the Committee and a detailed programme of works and timeline would be brought to the next meeting. **AH**

**05/18 CHAIR'S KEY ISSUES**

19. A discussion took place regarding the process for escalating issues to the Board for assurance. It was agreed that the current process was not quite right and the Chair would discuss possible changes to the current process with the Director of Governance. **HT**

**06/18 QUALITY PERFORMANCE REPORT**

20. The Chief Nurse presented to the Committee the separate Quality Performance reports for Colchester Hospital, Ipswich Hospital (June data) and Community Services (May data), noting:

<u>CHUFT</u>

- 1123 (1154) incidents reported of which 574 were reported to NRLS.
- 7 Grade 2–4 hospital acquired pressure ulcers – there had been a surge in complex wound referrals and assessment for Topical Negative Pressure (TNP) therapy on Wards where staff had limited competence in application. The Tissue Viability team had therefore increased their presence on the wards to provide support.
- Inpatient falls had increased to 91 (66) – the NHSI Falls Prevention Collaborative commenced in June with an initial focus predominantly on two ward areas on the Colchester site and would be rolled out on the Ipswich site in the near future.
- The number of complaints received had decreased to 52 however performance in responding to complainants within the agreed timeframe had dropped to 95% from 96% the previous month. Work was progressing on both sites around complaint themes and actions to address these.

<u>IHT</u>

- 5 cases of Clostridium difficile (to end June) - new Infection Control ward audits taking place to assess IC standards including the cleanliness of the environment and clinical practices.
- Friends and Family performance remained good with many areas achieving above national averages for both response and recommender scores. ED was the main area to focus on improving metrics.

- An Increase in the occurrence of harm in patients in June as measured in the point prevalence study Safety Thermometer, which included pressure areas, catheters and UTI's. This may be considered as part of the safety & clinical priorities for the STP.
- 15 reported developed pressure ulcers for May. 11 considered avoidable and 4 unavoidable. (3 of these were incomplete investigations). Actions to address performance included review of documentation and the framework for assessing risk of pressure damage in patients.

Community Services

- Falls had reduced to 28 from 33.
- 39 Grade 2-4 pressure ulcers, 37 community patients and 2 inpatients.
- 22 NRLS medication incidents
- 102 Survey responses, 96% of respondents were recommenders.
- 5 formal complaints received.

Comments/questions

21. The Chair commented on the documentation of screening and compliance with the Sepsis 6 bundle at Colchester and was keen to see improvements given the amount of work undertaken at Ipswich over the past year. The Chief Nurse advised that the roll out of Sentinel would significantly improve audit data capture in the future.

22. JP commented that the 'So What' response on page 11 (Tissue Viability) did not appear to answer the question. It was acknowledged that it was a challenge to provide a new 'So What' item each month and the frequency of reporting on the on-going improvement plan would need to be considered.

23. The Chief Nurse advised that she was working on the content for the combined performance report for August onwards which would be more streamlined and include more trend analysis.

24. The Chief Pharmacist advised that that it was important to maintain awareness and actions on reducing antimicrobial resistance and therefore measuring antimicrobial stewardship performance would be required on the revised Accountability Framework. This was currently reported at Colchester and the same reporting method would be undertaken across both hospital sites. He added that this would be reviewed as part of the ESNEFT Antimicrobial stewardship group in the autumn and the new Consultant Microbiologist, due to start shortly, would be asked to take on the clinical lead for this work.

25. The Chairman suggested that committee members consider the number of times the Board would be meeting in Public and the quality and amount of information in reports submitted to the Board, i.e. trends, context of actions being taken, learnings and hierarchy of reporting. He also asked that report writers were mindful of the narrative and language used in reports.

26. In summary, a review of the quarterly Board reporting cycle was required to enable in-depth assurance of Divisional themes and feedback from Committee members on what Community Services metrics would be useful in the reports to gain assurance going forward.

**07/18 KEY QUALITY AND SAFETY ISSUES**

27. The Chief Nurse advised the Committee of the following key quality and safety issues:

- 2 incidents which met the Never Event criteria for reporting at the Ipswich hospital site (one in the month of June and one in early July); in both cases an in-depth understanding of compliance with each stage of the WHO checklist is required as part of the investigation. Both incidents have been reported and will follow the Serious Incident process and terms of reference are agreed for the investigations which are in progress. The outputs of the review of both cases and any subsequent identified learning will be shared with QPS in due course.

- There were ongoing challenges across both sites for inpatients in terms of managing the heat is some clinical areas; mitigating actions are in place including staff ensuring that all patients are adequately hydrated and offered regular fluids, ice lollies/ice drinks, staff in some areas to wear scrubs, mobile air con units and additional purchase of fans for Ward areas.

- Concerns noted relating to MHRA:
    - Internal Blood Safety Quality Regulations (BSQR) audit (06/03/2018), non-compliance issues identified and corrective action plans being undertaken by the Hospital Transfusion Team (HTT), Transfusion specialists for NEESPS and the Medical Director.
    - Workforce issues in blood transfusion (nationwide issue) in particular relating to 'special bench' where complex bloods are processed. Recent complex surgery case at Colchester was cancelled as a result of the bloods shortage.

- Delays reported in processing some claims due to off-site location of some medical records for deceased patients. Discussions to take

place at e-Health Board regarding roll out of electronic storage of medical records.

28. JP asked whether there was any psychological harm to the patients involved in the 2 Never Events. The Chief Nurse advised that there was an element of psychological harm to both patients, particularly where further surgery was required.

**08/18 INTERNAL AUDIT REPORTS**

IA ESTATES MANAGEMENT PREMISES ASSURANCE MODEL (PAM)

29. The Committee received the Internal Audit report on Estates Management of PAM at Ipswich which was given 'substantial assurance' by the internal audit team.
30. It was noted that the scope of the audit included a review of the evidence available to support the Trust's self-assessment of its premises in terms of safety, efficiency, effectiveness and governance. The audit also assessed the arrangements in place for monitoring any areas marked as inadequate or needing improvement.

31. The Director of Estates advised that a similar self-assessment exercise for the Colchester hospital site and community services needed to be completed in 2018/19 before the PAM monitoring process could be embedded as part of a regular assurance/accountability framework. It was acknowledged that this was a large undertaking and an audit plan to carry out this audit was recommended for Q4.

32. The Chair commented that it was good to receive this level of assurance.

IA WARD VISIT (COLCHESTER HOSPITAL)

33. The Committee received the Internal Audit report on Ward Visit at Colchester Hospital, noting that 'Limited Assurance' was given by the internal audit team. Two priority 1 recommendations received relating to incomplete documentation in line with the Patient Monies and Property Procedure, and the obstruction of one fire exit. One Priority 3 recommendation relating to Patient Property Disclaimers notice was also received.

34. The Chief Nurse advised that hotspots appeared to be in Theatres and ED however actions had been taken to address all recommendations within the report, which had been shared with the relevant wards and teams at Colchester and also raised at local forums. An audit of compliance would be on-going.

35. JP commented that it was important to recognise an element of psychological harm to the patient particularly if the lost item was of great sentimental value.
36.

**09/18 MORTALITY REPORT**

- The Medical Director presented the Mortality reports for both sites and it was noted that:

Colchester

- The 12 month rolling HSMR to March 2018 was 109.9 – in the 'higher than expected' category.
- The Learning Disability Review Organisation (LeDeR) had still not met its objective to review deaths at Colchester however local clinical reviews undertaken were 100% to April 2018 with 2 cases outstanding for May 2018. The Learning Disability Hospital Liaison Nurse Specialist had drawn up an action plan based on local national findings and local learning.
- Approximately 1300 (17%) records missed the first coding deadline for March, including 16 deaths. Delays were due to the significant number of vacancies in Clinical Coding which were proven to be hard to fill posts.
- The findings of the Gosport report were being considered by the mortality review group.

Ipswich

- HSMR to March 2018 was 107.6 'higher than expected' range
- 2 outlying groups attracting significantly higher than expected deaths which continue to alert:
    - Other gastrointestinal disorders – continues to alert
    - Acute cerebrovascular disease - continues to alert
- Significant difference between the weekday ('as expected') and weekend ('higher than expected') HSMR for emergency admissions
- Palliative care coding rate of 4.27% vs. national rate of 4.10% (HSMR Basket – NE spells)
- Upper-quartile comorbidity rate = 26.2% vs. national rate of 25%.

37. The Medical Director advised that the LeDeR Annual Report had identified patients with a Learning Disability had an average age at death of 58 compared to a national average of 84, with a higher percentage of patients dying in hospital rather than at home. It was noted that mortality rates were particularly high in the Tendring area and the Mortality Group were keen to work with the North Essex CCG to look at patient pathways for

any trends. Other areas of focus for the group were noted to be sepsis and pneumonia.

Comments/Questions

38. SA-P asked whether it was accepted that no learnings had been identified from the incident raised in 'Slight evidence of health care' section on page 5. The Medical Director responded that a review of this incident appeared to be outstanding due to prioritisation of other work and would report findings back to the Committee. **AT**

39. JP queried whether learning disabilities in patients tended to cause delays in receiving diagnostic testing. The Medical Director confirmed that diagnostic metrics were good however this cohort of patients may require a more preparatory work before scans are taken. She added that they may present late as symptoms were often hard to diagnose early on.

40. JP asked for the 'So What' response to the gentleman with learning disabilities who had presented the Patient Experience Story at the Trust Board meeting in July, in particular evidence that actions were being taken to address the points he had raised. The Chief Nurse suggested that a brief update is provided at the following Trust Board meeting to provide assurance that actions and learnings were taken from each patient and staff experience story. **Action:** CM to pick this up with AA. **CM**

41. The Mortality reports for Ipswich and Colchester sites were received and noted.

**10/18 ANNUAL REPORTS**

Complaints and PALS Annual Report (IHT)

42. The Committee received and noted the Complaints and PALS Annual Report for Ipswich Hospital.

Patient & Carer Experience Annual Report (IHT)

43. The Committee received and noted the Patient & Carer Experience Annual Report for Ipswich Hospital.

Infection Prevention and Control Annual Report (CHUFT)

44. The Committee received the Infection Prevention and Control Annual Report for Colchester Hospital noting the process issues needed to be addressed together with cleaning and strengthening the governance structure of meetings.

| ITEM | | RESPONS-IBILITY |
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| | 45. It was noted that although many of the actions within the report had been addressed, the report writer, Dr Tony Elston (Director of Infection Prevention & Control/Consultant Microbiologist) had recently retired and the Chief Nurse would be taking on this role and subsequent outstanding actions going forward. | |
| | 46. SA-P requested that the organisational chart on page 10 is updated. | **CM** |
| | Infection Prevention and Control Annual Report (IHT) | |
| | 47. The Committee received the Infection Prevention and Control Annual Report for Ipswich Hospital noting good performance for the year despite workforce challenges. | |
| | Safeguarding Adults Annual Report (IHT) | |
| | 48. The Committee received and noted the Safeguarding Adults Annual Report for Ipswich Hospital. | |
| | Safeguarding Children Annual Report (IHT) | |
| | 49. The Committee received and noted the Safeguarding Adults Annual Report for Ipswich Hospital. | |
| **11/18** | **SUB-COMMITTEE QUARTER 1 REPORTS** | |
| | Safeguarding Children Management Group (SCMG) - CHUFT | |
| | 50. The Committee received this report noting that cover of domestic abuse services was being provided by the DA nurse at Ipswich and future reports would be streamlined as very detailed at present. | |
| | Safeguarding Adults Quarter 1 Report (IHT) | |
| | 51. The Committee received this report and JP requested further information on the incident relating to a patient with learning disabilities as the explanation in the report appeared 'protected'. **Action:** CT | **CT** |
| | Complaints, Litigation, Incidents, Coroners Quarter 1 Report (CHUFT) | |
| | 52. The Committee received and noted the Complaints, Litigation, Incidents and Coroners Quarter 1 report. The Chair commented that it was helpful to see the triangulation of information with other reports. | |
| | Medicines Optimisation Committee Report | |
| | 53. The Committee received and noted the Medicines Optimisation Committee Report. | |

| ITEM | | RESPONS-IBILITY |
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| **12/18** | **CANCER BREACH PANEL UPDATE** | |
| | 54. This item was deferred to the August meeting and the Director of Operations would be invited to present the report. | **CH** |
| **13/18** | **POLICIES** | |
| | 55. The Committee was advised that some mapping work was required to ensure all Day 1 policies had been approved and uploaded on the Intranet. | |
| | 56. The Managing Director requested confirmation of the policy approval process from the Director of Governance and sought assurance that if non-approved policies were being used then appropriate risk assessments were being carried out. | **DG** |
| | 57. The following policies would be circulated to the QPS members for virtual sign off and a sweep of any non-approved Day 1 policies would brought to the August meeting for approval:<br>• ESNEFT Safeguarding Children Policy<br>• ESNEFT Safeguarding Adults Policy | **CM** |

**DATE OF NEXT MEETING**
Tuesday, 21 August, 2018, 9am-12pm, DSR, Trust HQ, Ipswich