NHS
East Suffolk and North Essex
NHS Foundation Trust

# QUALITY & PATIENT SAFETY COMMITTEE

## Minutes of the meeting held on 25 September 2018
## Seminar Room 2, ICENI Centre, Colchester Hospital

**PRESENT:** Helen Taylor, Non-Executive Director *(Chair)*
Susan Aylen Peacock, Non-Executive Director
Julie Parker, Non-Executive Director
Neill Moloney, Managing Director
Barbara Buckley, Chief Medical Officer
Catherine Morgan, Chief Nurse

**IN ATTENDANCE:** Denver Greenhalgh, Director of Governance
Nicky Leach, Director of Logistics
Angela Tillett, Medical Director
Kevin Purser, Chief Pharmacist
Anne Rutland, Associate Director of Clinical Governance
Clare Harper, Senior Committee Secretary *(minutes)*

**APOLOGIES:** Paul Fenton, Director of Estates
Dawn Scrafield, Director of Finance
Alison Smith, Director of Operations – Group 3
Ian Marsh, Public Governor
Helen Vanstone, Public Governor



**ITEM** **ACTION**

**14/18 APOLOGIES/INTRODUCTIONS**

1. Apologies were noted as above.

**15/18 MINUTES OF THE LAST MEETING**

2. The minutes of the meeting held on 24 July 2018 were reviewed and accepted as a true record with the following amendment:

- *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 programme at Broomfield and Colchester and therefore a local review of clinical harm to patient would be undertaken at Colchester.

**16/18 COMBINED ACTION LOG**

3. The Committee reviewed and noted progress of actions received to date, in particular:

64/18 – *IA Safeguarding Children Chaperoning – Progress at Patient Safety Group on Chaperoning work.* The Committee agreed that if this

related to socialising and safe practice then the Site Director of Nursing for Ipswich would be asked to confirm whether this had been discussed at the safeguarding Operational Group. **CM**

82/18 – *Changes in skills mix at Bluebird Lodge had enabled improvements in the process for discharge to assess.* The Associate Director of Clinical Audit commented that there had been a lot of work around positive outcomes rolled out at Bluebird Lodge and no staffing concerns reported. Action to be closed.

101/18 – *List of deep dive items to be included in the QPS forward plan for deep dives.* Forward plan to be updated and circulated to the QPS Executive Lead and Director of Governance.

105/18 – *Patient Safety Annual Report – check the rationale for the EOLC priority as it was a patient experience rather than safety issue.* Chief Nurse / Chief Medical Officer to review this. **CM/BB**

105/18 – *Patient Safety Annual Report – Review membership to consider attendance from directors.* It was agreed that this was picked up in the new governance structure. Action to be closed.

4. The Chair thanked the Chief Nurse and Site Director of Nursing (Ipswich) for the work undertaken to complete the historic actions.

5. The action chart would be updated and circulated with the draft minutes of this meeting.

**17/18 MATTERS ARISING**

Transportation of Specimen Handling

6. A request was received to defer this item to the October 2018 meeting. The Managing Director commented that as this item was two months behind schedule he would question whether there was a lack of assurance with regard to progress of work. The Committee requested a report at the October meeting and no further slippage would be accepted. Service Manager to be advised. **CM**

Breast Screening Update (CHUFT Action 18/75)

7. The Colchester Site Medical Director presented an update on national and local issues relating to breast screening.

8. The Committee noted that following the decision to move from local call/recall arrangements to a nationally standardised process through Breast Screening Select, there had been significant issues relating to the timing of women being called for breast screening for the population served by the Breast Screening Services at Colchester and Broomfield;

the calls/recalls were either too early or too late. A new round length plan had been implemented based on 'next test due date' in May 2018 and the estimated recovery time was predicted to take 9-12 months.

9. The Colchester Site Medical Director added that approximately 18,800 women had experienced delays in screening invitations and a harm review process had been implemented by the teams across both sites (Colchester and Broomfield). Any cases of potential harm would be presented to the relevant MDT for collective view. She added that these issues had been flagged with PHE and with NHS England.

Comments/questions

10. JP sought assurance that NHS England had satisfactory governance in place to ensure that the process at Colchester was robust enough. The Chief Medical Officer was not able to respond on behalf of NHS England however she advised the Committee that as the Breast Screening Service was operated out of multiple sites and the Trust needed to be clear that the current process was right and oversight of making that decision required further work. She added that an internal governance review of all screening programmes was underway. The Committee requested a position update, including detail of divisional oversight, at the QPS meeting in January 2019. **BB**

11. JP queried why there was no agreed date for responding to the complaint received by an MP. The Colchester Site Medical Director advised that there was a strict policy of response to MPs of 14-21 days. A holding letter had been sent to the MP with an explanation for the delay and a full response was sent to the MP on 24 September 2018.

12. The Committee received the Breast Screening Service update.

**18/18 CHAIR'S KEY ISSUES – FEEDBACK FROM TRUST BOARD**

13. The Chief Nurse advised the Committee that no feedback had been received from the July 2018 CKI report.

**19/18 KEY QUALITY OR SAFETY ISSUES**

14. The Chief Nurse advised the Committee of the following key quality or safety issues:
    - Somersham Ward, Ipswich Hospital – Following safety and infection control concerns on Somersham Ward, work was continuing to address the issues raised. Refurbishment of the ward area will resolved some of the issues noting that work was underway and patients had been decanted to another ward in the interim period. However concerns remain around skills mix and staffing numbers. A plan had been drawn up and was being closely monitored. The new Associate Director of Nursing for Cancer was noted to start in October 2018 and a number of mitigating actions were in place in

the meantime. It was noted that the Hospital at Night programme should assist with staffing number issues.

**20/18 PATIENT SAFETY REPORT**

15. The Associate Director of Clinical Governance presented to the Committee the Patient Safety Report and Chair's Key Issues Report from the Patient Safety Committee (PSC) meeting which took place on 17 September 2018, noting:

PSC CKI

- Breast Screening – Interval Cancers: New process and documentation used at Colchester and Broomfield for the nationwide screening requirement would need to be rolled out with Ipswich Breast Screening Service, with appropriate oversight.
- Never Events Update – Surgery and Anaesthetics: A review of 3 recent Never Events which took place at the Ipswich Hospital site and subsequent actions taken identified early themes that related to WHO Surgical Safety Checklists. A Quality Scrutiny Summit would take place to present the outcomes in November 2018.
- Pressure Relieving Mattresses – Ipswich Hospital site: the mattress replacement scheme had been further impacted following the re-alignment of funding for replacement mattresses in the merger. This was in addition to no funded establishment for mattress cleaning at weekends. An priority business case was being developed which would include options for purchase or a managed system.
- T&O Specialist Surgery: higher than expected mortality rates for patients admitted with fractured neck of femur. Clinical Leads were agreeing actions (short and long term) across both hospital sites.

Patient Safety Report

- Incidents of Harm to patient had reduced in both hospitals (Colchester 1094 / Ipswich 1192);
- Falls had increased in August (Colchester 78; Ipswich & Community 152);
- Duty of Candour – combined compliance for August was 83% pre investigation and 63% post investigation. 213 members of staff had received RCA training at Colchester and training had commenced at Ipswich in August with a further training date arranged for September;
- 42 Grade 2-4 Pressure Ulcers (Colchester - 6; Ipswich – 9; Community – 27). Review of historic cases was completed to ensure Duty of Care was carried out – for some established PU cases, checks had been made to ensure there was adequate support for the patient at home or at the care home to provide confidence on this.
- 11% compliance on completion of Serious Incident (SI) reports within the 60 day timeframe. Noted that challenges over the summer period were mainly due to handover of roles post merge and lack of clarity

around which staff were RCA trained. The timeframe of delays was being monitored to see what was required to support divisions to improve compliance.

Comments/questions

16. The Director of Governance asked how accountability in divisions was being picked up with regard to the slippage in completion of investigation reports and what assurance there was that a robust governance process was in place. The Chief Nurse advised that regular meetings were held with divisions and performance would be included in the Accountability Framework. The Director of Governance queried whether clinical leads were aware that this was part of their portfolio. The Chief Nurse confirmed that she was working with the ADONs who had indicated that they were well sighted on their Accountability Framework. The Site Medical Director highlighted the importance of disseminating immediate learnings from serious incidents and using information within investigation reports as a good training tool.

17. The Director of Governance asked whether the national reports relating to Never Events were being considered alongside internal information and whether national benchmarking was being considered when carrying out thematic reviews. The Site Medical Director agreed to ensure this took place in future.

18. JP asked whether the Chief Nurse whether she was satisfied that, given the backlogs in producing investigation reports, she had a good understanding of how the new teams were performing. The Chief Nurse advised that in terms of incidents and concerns being raised there was confidence that timely reviews were taking place and the timing of those going through panel for review with no evidence that they were done retrospectively. She added that there was good oversight of historic cases, and the teams were conscious of keeping on top of the large workload whilst slowly working through the backlog.

19. The Chair requested a status update on the business case relating to the Mattress Replacement scheme. The Chief Nurse advised that the business case had been completed. A longer term plan was already in place at Ipswich which included an on-site decontamination process.

20. The Committee received and noted the reports.

**22/18 INFECTION PREVENTION & CONTROL REPORT**

21. The Chief Nurse presented the Infection Control Report (August 2018 data); noting:

- 0 MRSA

- 18 C.Diff (7 Hospital; 11 Community)
- 47 E.coli bacteraemia (8 Hospital; 39 Community)
- 9 Klebsiella Pneumonia (1 Hospital; 8 Community)
- 7 MSSA (7 Community)
- 2 Pseudomonas Aeruginosa (2 Community)

22. The Associate Director of Clinical Governance advised that a review of high end numbers going through panel had not identified key issues with levels of care. She added that the Infection Prevention and Control team (IP&C) continued to progress on actions and winter preparedness as this was one area that could impact on winter plans. Therefore the IP&C teams were developing some resilience and succession planning together with actively promoting infection prevention schemes such flu vaccinations in the community.

Comments/questions

23. JP asked why the CRO patients had not been screened. It was noted that one patient has slipped through the screening process and the other was screened but had not been isolated. The Director of Governance asked whether we could consider Executives visibility at all sites during the national Infection Prevention week to get the messages out.

24. The Committee received and noted the report.

Internal Audit Report – Infection Control

25. The Chief Nurse presented the Internal Audit report for Infection Control at Colchester Hospital site. A 'limited assurance' was given by the internal audit team and this report provided and update of actions taken to address the recommendations made by the audit team.

26. The Committee received and noted the report.

**23/18 MORTALITY REVIEW REPORT**

27. The Site Medical Director presented the Learning from Deaths, Mortality and HSMR report and the Committee noted:

MBRRACE Report 2016 (Perinatal Mortality):
Ipswich

- Deaths in all categories were 10% lower than national.
- Nationally, mortality rates for babies born to mothers under the age of 25 are higher; these mothers represented 20.8% versus 18.2%.
- Mothers in Ipswich were less likely to live in a deprived area.

Colchester

- Deaths were up to 10% higher for stillbirth and extended perinatal and more than 10% higher for neonatal (although it was noted that the figures included a multiple birth).

- Nationally, mortality rates for babies born to mothers under the age of 25 are higher; these mothers represented 21.7% versus 18.2%.
- Mothers lived in areas of similar levels of deprivation.

HSMR to May 2018:

- Ipswich - 105.4% in the 'as expected' category;
- Colchester - 113.9% in the 'higher than expected' category.

SHMI:

- Ipswich – 105.01 (previously 104.37) and within the 'as expected range';
- Colchester – 114.27 (previously 109.2) and within the 'as expected range';

Coding:

- 19% (1440 records) of coded activity missed the first data deadline for Dr Foster whilst 76 records were not uploaded in time at Ipswich.

28. The Site Medical Director advised that coding issues continued and the elevated HSMR may, in part, be due to delays in coding which was causing concern. She added that a review of every death of patients with learning disability had been carried out to ensure they had been reported correctly.
29. It was noted that perinatal mortality had not had sufficient focus to date and was now mapped out well for future reporting.
30. The Committee was advised that the business case for a Medical Examiner role had been approved and the recruitment process would commence shortly. The role will work closely with the Coroner which should reduce the number of patients requiring post mortems and associated delay for families.

<u>Comments/questions</u>

31. The Managing Director commented that the number of admissions compared to the number of deaths would suggest that not enough priority was being given to the coding of deaths. The Site Medical Director responded that it was important to acknowledge that not all delays had been due to coding.
32. The Director of Governance asked whether reviews of deaths were triangulated with learnings to ensure guidelines were being adhered to e.g. best practice guidance, and to benchmark against national audits so that reviews were not one dimensional. The Site Medical Director confirmed that some links had been found and where guidelines were not in place this had been rectified.
33. JP commented that the coding issues had been discussed at Finance & Performance Committee and she would be raising at Trust Board the issue around recruitment of staff in the coding team so further discussion can be had at Board.

34. SA-P sought assurance that incomplete forms relating to expected deaths were being followed up. The Site Medical Director agreed to follow this up with divisions. **AT**

**24/18 MEDICINES OPTIMISATION REPORT**

35. The Chief Pharmacist presented the Medicines Optimisation report to the Committee, noting:

- Small task and finish group was continuing to meet to harmonise medication related policies and practice across ESNEFT. Medication Policy for Healthcare Professionals should be in place by October 2018;
- Briefing paper submitted on the Pharmacy response to the Gosport Report;
- Manufacturing unit at Colchester was experiencing capacity concerns with activity – remedial action plan agreed to mitigate risks across both sites.
- Mandatory revalidation of pharmacists and pharmacy technicians was now in place by the General Pharmaceutical Council (GPhC). First round of revalidation was scheduled for October 2018.
- Challenges continue to meet compliance of medicines reconciliation within 24hrs of admission. Ipswich reported 49% and Colchester 45% for the last quarter.
- Significant concerns around unaccountable losses relating to controlled drugs on both sites. Covert surveillance was underway.

36. It was agreed that this Committee would receive exception reporting on accreditation.

37. The Committee received and noted the report.

**25/18 CANCER BREACH PANEL HARM REVIEW UPDATE**

38. The Cancer Breach Panel Update report was received by the Committee however they did not believe the report addressed the possible psychological harm to patients who had waited over 104 days.

39. The Site Medical Director advised that a refashioning of the SOP was required for reviews to focus on patients waiting over 104 days and patients with cancer waiting over 62 days. She would discuss this with the Director of Operations (Group 1) and request a report back from the Cancer Board. **AT**

**26/18 EPRR MID-YEAR UPDATE**

40. The Head of Estates Compliance and Risk Management (MF) presented the Emergency Planning, Resilience and Response (EPRR) report and

annual work plan to provide assurance that ESNEFT was meeting its statutory duties and obligations in relation to EPRR.

41. The Committee noted that an internal assessment had been completed on the 64 core standards that the Trust was required to meet (of which 57 were compliant) achieving substantial compliance and was approved by the EPRR Steering Group, Director of Estates and Facilities and the Director of Operations. In addition, the assessment had undergone a check and challenge review from Local Health Resilience Partnerships in Suffolk, due to the large percentage of services being delivered in Suffolk.

42. It was noted that the EPRR return had been submitted to NHS England by the required deadline and in line with reporting requirements the Board of Directors would receive a report at its next Public meeting. Further updated would be presented to this committee on a 6monthly basis.

Comments/questions

43. The Director of Governance asked whether the EPRR self-assessments had been linked to the internal audit plan. MF confirmed it had not been included however an EPRR audit had been completed on both sites and a programme of works was in place to maintain compliance which would be overseen by the EPRR Steering Group.

44. JP sought assurance around the constitution and whether there was sufficient oversight of contractors' business continuity plans. MF advised that all contractors were required to provide their business continuity plans as part of their contractual requirements. Need to maintain assurance on Contractual monitoring

45. In summary, the Committee:
    - Reviewed the self-assessment documents and agreed with the overall compliance score identified as 'Substantially compliant' with the score standards;
    - Agreed that the action plan for the organisation to be a position to achieve the full compliance;
    - Agreed the proposed EPRR work plan in order to provide the required assurance; and
    - Noted the works undertaken during the past year.

**27/18 PATIENT EXPERIENCE REPORT**

46. The Chief Nurse presented the August 2018 data for patient experience and advised that there had been a drop in compliance for complaint responses which was thought to be due to the handover of some roles and loss of key team members post-merge which was exacerbated by IT system issues and access to Datix. Holding letters were therefore sent

to complainant explaining the delay in service. It was noted that the Trust was meeting the 3 day turnaround for complaint telephone calls.

47. There had also been a drop in responder score for FFT surveys in Ipswich ED which was thought to be due to the re sighting of tablets in the waiting area. The Maternity department at Colchester was working on a new approach to FFT via SMS approach.

48. The Committee received and noted the report.

**28/18 END OF LIFE CARE REPORT**

49. The Committee received the End of Life Care (EOLC) report, noting:
    - The EOLC Steering Group would be reporting into the 'Time Matters' Board and was currently aligning EOLC processes across both sites, supported by the Transformation Team;
    - North East Essex Alliance EOL Board had commissioned an audit to look at failed discharges of rapidly deteriorating patients. Concerns raised around the proposed closure of EOL beds (ACE run) at Harwich and resource available to support EOL patients in the Clacton area going forward.
    - Funding agreed for 3 additional nurses in the specialist palliative care team at Ipswich site. Lead nurse still required.

50. The Committee also received and noted the Internal Audit Report of EOLC at Ipswich in which a reasonable assurance was given by the Internal Audit Team. It was agreed that an update report to track that recommendations were being delivered would be scheduled at a future meeting. **CH/BB**

<u>Comments/questions</u>

51. SA-P commented that as the reporting from both sites had not yet been aligned it was difficult to track Every Patient Every Day.

52. JP commented that EOLC activity was closely linked to Mortuary activity and sought assurance around activity and flow. The Chief Nurse advised that Eden would make a difference to the timescale of patients that remain at the mortuary. The Director of Governance added that from a quality perspective inspection reports would provide oversight at this committee and operational KPIs within the team would be escalated if needed. The After Death Group was another way to triangulate the information for this area.

53. The Committee received and noted the report.

**29/18 CKI ESCALATION – PATIENT PROPERTY**

54. The Chief Nurse provided a verbal update on the internal audit of patient property advising that compliance required improvement on both sites. She added that a wide census audit took place at Colchester this week with Matrons undertaking a regular check and challenge process. Despite the implementation of brightly coloured boxes supplied for dentures, etc. it was clear from the audit results that there was a large variant in compliance. Compliance with policy and not enough checks being done pre Surgery remained a challenge.

55. The Committee noted the verbal update.

**30/18 CLINICAL EFFECTIVENESS REPORT**

56. The Committee received the Clinical Effectiveness CKI Report and Update Report, noting:
    - The team were currently aligning all audits;
    - Re-audit of Consent register had raised concerns regarding compliance at Colchester. There was no evidence of a Consent audit register at Ipswich therefore work was underway to implement this.
    - Capturing audits and then completing actions remained a challenge on both sites.
    - GIRFT Programme Board had been established in order to implement the National GIRFT Programme at the Trust.

Comments/questions

57. SA-P commented that the report indicated that several audits had been completed which were not on the Audit Plan. The Associate Director of Clinical Governance (AR) advised that this was the case and a Clinical Audit Week was being held to raise awareness of audits and peer work going on.

58. It was noted that prior to the merger the Ipswich sites had only agreed a Q1 clinical audit plan in anticipation that there would be a review. The Associate Director of Clinical Governance would ensure that all audits were included in the ESNEFT Audit Forward Plan. **AR**

**31/18 NATIONAL AUDITS OUTLIER ALERTS**

59. The Director of Governance advised the Committee that the first ESNEFT reporting of national audits was planned for October's Clinical Effectiveness Group therefore the purpose of this report was following initial scoping to highlight areas where ESNEFT services were identified as outliers and the challenges therein.

60. The Committee received and noted the report. It was agreed that a final report would be brought back to this Committee following approval at the CEG in October.

**ITEM** **ACTION**

**32/18 HIGH LEVEL INQUIRIES – GOSPORT INDEPENDENT PANEL**

61. The Chief Medical Officer presented a response to the Gosport Report to provide assurance that processes were in place at ESNEFT to ensure that patient safety was maintained through good clinical practice and that family/carers and staff concerns were acted on.

62. The report gave a good overview of the Gosport inquiry findings and the processes in place throughout ESNEFT to safeguard against such occurrences. It was noted that the report didn't provide assurance on how these controls reported through the governance of the organisation and it was agreed that a mapping would be undertaken and where gaps and assurance identified a risk assessment would be completed. **Action:** Chief Medical Officer to work with the Compliance Team to undertake this assurance map. **BB**

63. The committee noted the proposed changes to ESNEFT Governance around controlled drugs.

**33/18 QUALITY STRATEGY**

64. The Chief Nurse advised the Committee that the Quality Strategy was not ready to be presented at this time however she would be in a position to present the approach and delivery of the Quality Improvement Strategy in November 2018 having consulted with the clinical teams.

**34/18 REPORTS BY CONSENT**

65. The Committee received the Policy Report and subsequent policies outlined below noting that they had been approved and ratified through the relevant executive governance forums:

- Policy for Management of Incidents & Serious Incidents V1.0
- Duty of Candour
- Complaints Handling Policy V1.0.
- ESNEFT Infection Prevention and Control Policy
- ESNEFT Safeguarding Adults Policy
- ESNEFT Safeguarding Children Policy

The Committee noted its role in relation to these policies and executive SROs would ensure that these were capture in future reports to ensure assurance was carried out.

<u>Comments/questions</u>

66. JP commented that she had not seen any policies relating to Pathology services. The Director of Governance advised that none had been received to date however she would discuss this with the NEEPS lead. **DG**

**ITEM** **ACTION**

67. JP asked where Quality Impact Assessments where sent. The Director of Governance advised that QIAs were signed off by the relevant Clinical Director which then flow through to committees to ensure that processes were in place and being adhered to however further consideration should be given on how we link this to the audit plan in the future.

**35/18 Date of next Meeting**

Tuesday, 23 October 2018, 9am-12pm, Directors' Seminar Room (DSR), Trust HQ, Ipswich