East Suffolk and North Essex NHS Foundation Trust

QUALITY & PATIENT SAFETY COMMITTEE

Minutes of the meeting held on 26th November 2019
Directors' Seminar Room, Trust HQ, Ipswich

PRESENT:	Hussein Khatib, Non-Executive Director (*Chair*) Carole Taylor-Brown, Non-Executive Director Angela Tillett, Interim Chief Medical Officer Eddie Bloomfield, Non-Executive Director Catherine Morgan, Chief Nurse Neill Moloney, Managing Director/Deputy CEO
IN ATTENDANCE:	Paul Fenton, Director of Estates & Facilities Anne Rutland, Associate Director of Clinical Governance Kevin Purser, Chief Pharmacist Denver Greenhalgh, Director of Governance Michael Horley, Public Governor Clare Harper, Senior Committee Secretary (Minutes)
APOLOGIES:	Nicky Leach, Director of Logistics and Patient Services Ian Marsh, Public Governor Anna Shasha, Director of Midwifery

146/19	**Apologies** 1. Apologies were noted as above.	
147/19	**Declaration of Interests** 2. None declared.	
148/19	**Minutes of Last Meeting** 3. The minutes of the meeting held on 29th October 2019 were reviewed and accepted as a true record with following amendments: • Page 3 – paragraph 12 – Clinical Audit & Effectiveness Group - Committee required further assurance in the form of an exception report on actions that are not being met.	
149/19	**Action Tracker** 4. The committee reviewed the action tracker and the following action updates were noted: • 137/19(21) - H&S Committee CKI - Smoke alarm positioning – checks completed but DG would chase a full update after the meeting. • *Redacted from public domain* 5. The Committee noted that some actions within the minutes were not reflected in the Action Tracker and queried the continuity of CKI reporting to sub-committees	**DG**

	and Board meetings. **Action:** CH to review the minutes and action tracker and circulate a revised version.	**CH**
150/19	**Matters Arising** <u>Trajectory for Compliance of Level 3 Safeguarding</u> 6. The Committee was advised that a remapping exercise was underway focussing on key medical staff and paediatric areas for compliance of level 3 safeguarding training. It was acknowledged that there were challenges in capturing some training as the requirement to achieve compliance is over a 3 year period. The safeguarding team are supporting areas of low compliance with their improvement plans. <u>Screening Board</u> 7. The Interim Chief Medical Officer gave a verbal update with regard to the national screening programme and the requirement to establish a Trust wide screening Board to provide internal oversight. A briefing summary would be brought back to the Committee in February. <u>Incident Management Deep Dive – update from ICS implementation meeting</u> 8. The Associate Director of Clinical Governance provided a verbal update on the ICS Implementation Meeting held in London recently where it was acknowledged that the new SI framework would not be implemented until April 2020 due to the general election. She added that in the meantime discussions were underway with staff with regard to preparations for piloting the new Patient Safety Incident Response Framework. Work was also continuing with the cohort of patients with a greater probability of falls and a review of care treatment pathways in areas where there had been a high number of near misses. <u>Comments/Questions</u> 9. The Director of Governance asked whether CQC legislation had been captured. It was noted that representatives from the CQC had attended the ICS Implementation meeting and the framework under which we investigate has not changed but had upgraded clarity. 10. The Chair asked what the current timeline was for investigations. The Associate Director of Clinical Governance advised that as core investigators were now in place, there was no excuse not to comply with the 60 day turnaround. The Chief Nurse added that some incidents could be investigated reasonably quickly however the important factor was the right outcome for the patient, have lessons be learnt and have we implemented the learning. 11. The Managing Director asked how we identify who we track. The Associate Director of Clinical Governance responded that she was happy to do qualitative tracking and comply where possible with the 60 day turnaround. 12. EB asked whether the teams discussed the timeline point with the patient. Feedback from some patients had indicated that had they been made aware of the timeline at the beginning of the investigation it would not make a difference how long it took to complete. The Interim Chief Medical Officer added that there appeared to be a gap between the final investigation report and feeding back	**AT**

	learnings to staff and outcomes to patients therefore it was important to support teams in this process.	
151/19	**Chairs Key Issues (CKI's) feedback from Trust Board** 13. The Committee noted feedback from the Board relating to the October 2019 QPS CKI submission and the following two actions transferred to the QPS Committee: • <u>Emergency Department Business Case</u> – The Trust Board had asked the QPS to assess clinical patient safety relating to the ED business Case. Regular updates would be added to the Committee Planner commencing in December 2019. • <u>RTT backlog</u> – review of any harm or impact on patients following any delays in treatment. It was agreed to discuss this in full at the January meeting.	**NM/** **NM**
152/19	**CKI'S from Sub Committees** 14. The Committee received the Chair's Key Issues reports from its sub-committees noting: **Patient Safety Group** • Concerns were raised regarding the number of overdue Serious Incidents 60 day reporting. Actions taking place to address this included 3 persons identified to complete the investigation and dedicated time being allocated to complete the investigation. • Issues with access to System One since the opening of the UTC at Colchester Hospital were highlighted. This was also proving to be an issue for some locums. The Division is working with IT to resolve the issues. • MSK and Specialist Surgery Division had shared learning from an incident investigation and the development of a policy to support care for patients with alcohol dependence. • Cleansing process underway to ensure only current or relevant policies, procedures and processes are available on the intranet following a number of medicine related incidents. **Clinical Audit & Effectiveness Group** • Regular audits carried out regarding interventional safety had highlighted further work required around human factors training, behaviours and culture changes in theatres. **Patient Experience Group** • Division is exploring funding for establishment and training of a maternity and gynaecology bereavement officer as this will no longer be supported by the Bereavement Officer within the Mortuary Department. • National Audit of Dementia Survey had highlighted improvement requirements with regard to nutrition on the Colchester site. Work was underway to support improvements including the introduction of finger foods. The group were considering dementia care as one of its priorities next year. <u>Questions/Comments</u>	

	15. CTB highlighted the importance of getting the dementia service provision right with regard to patient safety and experience but also from a reputational perspective. **Medicines Optimisation Committee** • *Redacted from public domain* • An MHRA inspection of the manufacturing unit at Colchester has identified four major concerns but no critical concerns. Many of the actions are due to a lack of capacity and workforce in the unit. An action plan response was being submitted to the MHRA. • In addition, a concern was expressed about the risk of cross-contamination of peanut flour with other products made in the non-sterile manufacturing area. An agreement with the MHRA had been made to suspend the manufacture of open products in the affected area and activity transferred to the Ipswich site. <u>Questions/Comments</u> 16. EB asked what the general response was for medicine shortages. The Chief Pharmacist advised that there was a specific response for specific items however it depended upon the timeframe of the shortages. He added that it was very much business but the criticality of some items were more intense than previous years and often alternative medicines were being imported from abroad. 17. The Chair sought clarity around the difference between an SI investigation and a Never Event. It was noted that both are reported through StEIS as either an SI or Never Event and investigated accordingly. 18. The Managing Director requested an update on the Business Case for Chemotherapy. It was noted that the business case was approved however the risk around recruitment of staff remained. **Health and Safety Committee** • CKI received and noted. **Safeguarding Committee** • CKI received and noted.	
153/19	**Key Quality or Safety Issues** 19. The Chief Nurse advised the Committee of the following key quality and safety issues: • *Redacted from public domain* • Inpatient areas were seeing a number of patients with Norovirus and a small number of cases of flu. Managing patients with symptoms had required some bay closures and one ward closure which presented some operational challenges with impact on bed capacity. There was currently a higher prevalence in the community which was reflected in the hospital setting. Key to managing the situation was compliance with basic IP&C principles and cleaning standards. • The number of cases of MRSA transmission was unusually high on the Ipswich site. A review of the screening process with consideration of implementation of the process in place on the Colchester site was underway led by the IP&C team. Further actions include education, gloves off campaign, and ensuring sufficient equipment on wards.	

	Comments/Questions 20. The Managing Director sought assurance that learnings from incidents were being fed back and embedded. It was acknowledged that joint investigations were difficult however there was good oversight of incidents and assurance was given that other providers had been very open about the event and were happy for ESNEFT to do a peer review. 21. The Managing Director queried whether quality reviews were being undertaken with regard to sub-contractors. The Director of Governance advised that mapping exercise was carried out post merge and the teams were working on implementation of the reviews. Further work around the escalation process was underway and would be reported to this committee.	**DG**
154/19	**Integrated Patient Safety and Experience Report** 22. The Committee received the Integrated Patient Safety & Experience Report noting: • Duty of Candour had marginally increased 86.7% (84%). • Increase in incident reporting across ESNEFT, the number of incidents reported to the NRLS has increased from 57.53 per 1000 bed days to 59.78 per 1000 bed days in the month. • 9 (12) incidents were considered to meet the criteria of being a serious incident. • Unusually high number of incidents in Maternity Services relating to PPH, Maternity Foetal incidents and one incident resulting in death which was being investigated by HSIB. High activity on the Ipswich site had resulted in diverts to other providers and the department was looking at key indicators and how this is managed going forward. There appeared to be a growing cohort of complex pregnancies which can quickly deteriorate if not recognised earlier. It was agreed that the Committee needed more assurance around these issues in the form of a comprehensive report to this committee and a general awareness of issues to be presented at a future Board seminar. Comments/questions 23. The Chair sought assurance around the number of medicine errors. The Chief Pharmacist advised that all incidents were discussed at the Medicines Safety Committee and reported to the Medicines Optimisation Committee. The Committee was encouraged that incidents were being reported and that learnings including further education and training requirements were fed back to the areas involved. 24. CTB queried the reason for the breakdown in falls data. It was noted that some falls are not witnessed and therefore the reason cannot be recorded. CTB asked how we assured ourselves that falls were being prevented sufficiently. National guidance suggests looking at RCAs, blood pressure postural drop, etc. and what actions were taken rather than focussing on falls avoidance. CTB sought further assurance with regard to how many falls were due to a dip in blood pressure or lack of staff supporting patients. It was acknowledged that generally falls are not due to one issue and the timings of falls, particularly during the night, tended to indicate disorientation as the main factor. CTB agreed to seek personal assurances outside the meeting.	**CM**

	25. The Chair commented that C-difficile figures were close to the annual trajectory and sought assurance on actions being taken. The Chief Nurse accepted the figure was high and advised that there had been a change in categorisation and following a review of key learnings the team had a plan in place to ensure more focus on the antibiotic history of patients to prevent administering the same antibiotics and prolonged usage. 26. The Chair asked how assurance would be given that action plans would be closed and none overdue when the new PSIRP model is piloted. It was noted that the department was challenged with backlogs but support was being offered in regular DAMs meetings and a programme of works was underway with the CCG including a detailed tracker of risks and actions to be undertaken. **Mortality** 27. The Committee received the Mortality report noting: • Discrepancies continue between sites with regard to Dr Foster data however nationally we recognise well. HSMR was higher than expected for August at 161 due to a significant number of uncoded episodes on the Colchester site and may be due to issues with access to records. • A number of patients had died with zero number of days stay. • Further engagement from clinical teams to complete mandatory reviews of death was key to attain learnings from death. <u>Comments/Questions</u> 28. The Managing Director sought clarity around the reporting discrepancies and asked if we needed to look to the Alliance for assistance. The Interim Chief Medical Officer advised that there was a robust coding team however access to medical records was still an issue and impacting on figures. She added that a number of patients were being brought in to the acute setting due to lack of support in the community despite the patients preferred place of care was to be at home. 29. The Committee noted the Integrated Patient Safety and Experience Report and the Mortality Report.	
155/19	**BAF – Escalated Risks** 30. The Committee received a report presented by the Director of Governance noting that the only BAF level risk was associated with NEESPS and therefore a high level summary of all risks with a risk exposure score of 15+ was presented. 31. The Committee was informed that there are 15 risks meeting this criteria associated with the Committee portfolio, and noted that risks associated with staffing resources; operational performance and finance (which may have an impact on the quality of service delivery) had been excluded from the report. 32. The work being undertaken to support attainment of the JAG accreditation, continued progress with regard to policies, procedures and processes and environment/equipment issues relating to the manufacturing of radiotherapy, CT Scanners and blood bank fridges was also noted. 33. The Committee was asked to consider if any risks needed to be brought back to a future meeting for further discussion. The Committee was assured with the mitigating actions to date and the current review process in place overseen by the EROC. It was agreed that BAF risks would continue to be reported bi-monthly.	**DG**

156/19	**Risk Assessment of the Premises Assurance Model (PAM) Action Plan** 34. The Committee received a mid-year update on progress against the PAM actions to address areas that required improvement noting the overall score of minimal improvement. It was recognised that whilst the Ipswich site had undertaken PAM assessments for the past 4 years, Colchester site had only carried out its first assessment last year and an increase in score was anticipated over the next year. 35. The Committee was sufficiently assured that there were no inadequate scores in the governance and patient experience areas. 36. Completion of the current version of the NHS PAM is voluntary, however, will move to a mandated exercise in the near future as the model will now be included within the NHS Standard Contract. <u>Comments/questions</u> 37. EB raised concerns relating to issues with panic alarms. The Director of Estate and Facilities advised that there were a number of independent systems currently supporting the internal communications and a project was underway to improve issues raised relating to the telephone switchboard communications, bleeps, crash calls, internal calls, etc. It was acknowledged that there was a level of disconnect relating to the coordination of some capital projects. 38. The Interim Medical Officer asked for an update on the Medical Devices and Equipment training. It was noted that the dashboard had assisted with Medical Devices and Equipment training taking place and an update from the Site Medical Director would be provided at a future meeting. 39. The Chair requested a timeline for outstanding actions in the next report.	**CH/ CJ** **PF**
157/19	**Safeguarding Quarterly Report** 40. The Director of Nursing presented the quarterly reports for Safeguarding Children and Adults. The Committee noted: <u>Children</u> • No significant issues reported. • A review of the Safeguarding structure had been carried out given the differing workloads on each site due to each county having its own referral set. <u>Adults</u> • Seeking additional support from Essex system for domestic abuse nurse specialist as the last post was funded via charitable funds and limited domestic abuse practitioner (DAP) service provided at present. • Refined oversight and focus on compliance of DOLS and LPS. • Several areas where mandatory training is falling short of targets but overall this was moving in the right direction. <u>Comments/questions</u> 41. EB queried whether the abuse types recorded on each site would more consistent in the future. The Chief Nurse explained that the Essex system required different data to the Suffolk system therefore the team was working with commissioners regarding alignment of reporting and levels of compliance. In the meantime they would align as much data as possible with appendices for each system requirement.	

158/19	**NEESPS Transformation Update and MHRA Update on Blood Transfusion** <u>NEESPS</u> 42. The Managing Director gave an update on progress of the transformation programme for Pathology, which included considerable progress with improving stability of the workforce, particularly in Blood Sciences; and a focus on revised international recruitment approach to Biomedical Scientists posts (particularly in Australasia) following recent inclusion of these posts on the Shortage Occupation List. 43. Two concerns were noted relating to the requirement for ESNEFT to take responsibility of the Microbiology Service in house from the Public Health of England, and the significant costs incurred for IT and equipment replacement. <u>MHRA</u> 44. The Committee received an update regarding the MHRA position following an audit of the Blood transfusion service and noted that a number of priorities and actions had been agreed to resolve issues raised from historical inspections and findings, particularly relating to the blood bank service. <u>Comments/Questions</u> 45. The Chair asked for a timeline for the deficiencies. The Managing Director advised that the team was looking at how some of the issues could be closed down more quickly however the staffing in blood transfusion remained an issue as this was a difficult to recruit post. 46. Mr Horley queried where the continuing rolling adverts were being placed. The Managing Director advised that the team was looking overseas and working with the universities for some of the hard to recruit posts. He agreed to check where the adverts where being placed and whether the returns were cost effective. 47. The Interim Medical Officer queried whether there was full oversight of clinical risks e.g. the issue with GIRFT given the challenges with differing data sets in Pathology. The Managing Director advised that the risks were highlighted on Datix and submitted to EROC but it was acknowledged that recent regulatory visits had indicated that governance arrangements were not as robust as they should be. The Interim Medical Officer sought clarity on turnaround times and where ownership of the risks sit. The Managing Director advised that the Pathology Steering Board reviewed risks regularly however the process may need strengthening.	**NM**
159/19	**Any Other Business** 48. No items were raised under Any Other Business.	
	Date of Next Meeting ***Tuesday 17th December 2019, 9.30am-12pm DSR, Trust Offices, Ipswich Hospital***	