Southend University Hospital NHS
NHS Foundation Trust

Board of Directors' Meeting Report – 4 September 2018

Agenda item 53/18

Title	Quality Assurance Committee Report from 20 June meeting
Sponsoring Director	Fred Heddell NED
Author	Fred Heddell, Chair Quality Assurance Committee
Purpose	To provide assurance concerning the QAC's fulfilment of its TOR duties and objectives as an assurance sub-committee of the Board of Directors.

Executive Summary

QAC was assured by:
Pathology - investigation into cervical screening completed – abnormalities being followed up.
Ophthalmology – new processes implemented waiting lists reducing, better governance.
CQC Compliance – all recommendations being implemented.
Clinical Audit - mostly on track.
Patient Safety Alerts – mis-reporting not a problem at SUHFT
CLIP report - 216 complaints, 3794 incidents, 998 PALS contacts, 15 legal claims and 3 new inquests in Qtr 4
Internal Audit - Infection Control Management – Reasonable assurance
Internal Audit - Discharge Summaries - Reasonable assurance
Review of mortality governance – now complete – small number of recommendations being implemented.
QAC also noted
The Complaints Annual Report
Infection Prevention and Control Annual Report
BAF - scores remain the same except BAF Risk 8 reduced from 12 to 9.

A small number of issues escalated by the Trust Committees.

Related Trust Objective	Excellent patient outcomes Excellent patient experience Engaged and valued staff
Related Risk	Risk 1 - Failure to provide adequate patient safety , quality of care and patient experience due to capacity, demand and external agency stakeholder engagement Risk 2 - Failure to meet constitutional and national performance targets Risk 4 - Inability to recruit and retain staff
Legal implications / regulatory requirements	Assurance of our standards for regulatory bodies as set out in the QAC TOR. Non-compliance with CQC outcome requirements which may result in enforcement action causing reputation damage and loss to the Trust.

Quality impact assessment	The quality impact is considered in all items.
Equality impact assessment	Equality and Diversity is a specific focus throughout the QAC agenda and specific initiatives are covered in the report. The Committee was pleased to note that the Equality and Diversity Committee is now meeting again with good admin support. The aim is to have a positive impact for the 9 protected characteristics under the Equality Act 2010
Recommendations: The Board is asked to note this report and receive assurance and information therefrom.	

Quality Assurance Committee Meeting
Wednesday, 20th June 2018

For Assurance

Pathology update

- The investigation into a cervical screening incident had been completed.
- Of 2500 women whose samples were re-examined 31 were changed to indicate an abnormal result. All affected women had been contacted and follow-up arranged. No-one had been diagnosed with cervical cancer to date.
- There were 95 indecisive results who were invited back for a repeat test.
- It had been recommended that an additional 2168 samples from women aged 25-29 should be re-examined.
- An additional governance team had been put in to deal with wider assurance concerns. Any non-conformants would be reported to QAC
- Concern was raised about the lack of data on progress on the backlog of meeting the current requirements.
- QAC noted that Yvonne Blucher was now the executive lead for pathology and screening.
- QAC requested information about the current staffing situation but this had not been received.
- The Committee raised further concerns that KPIs had deteriorated which should be seen as a warning sign.
- Updates would be provided at the next QAC meeting.

Ophthalmology update

QAC was advised that Clare Burns was the main lead for ophthalmology, with support from Celia Skinner.

- Failsafe processes at SUHFT had been mapped in line with recommendations.
- Processes at MEHT would be mapped and reviewed to bring alignment to SUHFT.
- Risk prioritisation was in place with weekly checks that no patients were “lost to follow up”.
- A sample audit would be carried out to check that there were no significant issues which had subsequently developed.
- 4,373 patients were delayed, follow up dates was being monitored on a weekly basis.
- New process included patients being rerouted to see an optician/optometrist who would be able to prescribe.
- Reconfiguration plans were currently being worked through, including the future of Orsett Hospital. It was expected that small scale service reconfigurations (for example, red eye and flashers/floaters) would go live from September 2018.
- It was agreed that a short summary of recent achievements and improvements should be circulated to the Council of Governors.

CQC Compliance (Well-led Framework)

- There was a total of 29 actions on the action plan. 3 were overdue, 10 were complete without evidence and 5 were complete with evidence. The remainder were in progress with no known risks to completion.
- The programme of internal mock CQC inspections had begun in April 2018.
- There had been no reply yet from the CQC in response to the invitation by the Trust to carry out a re-inspection of the areas previously not inspected.

Clinical Audit

- The report contained a comparison of the clinical audit strategic objectives 2018/19 with the findings from the TIAA clinical audit review and an update on progress against the plans.
- One corporate clinical audit was overdue and one corporate clinical audit report provided substantial assurance. All other corporate clinical audits were on track against the plan.
- There were no corporate clinical audit actions overdue.
- There were 50 national clinical audits and 3 confidential enquiries applicable in 2018/19 and the decision regarding participation had been received for 47 projects.
- There were currently 141 clinical audits in the directorate clinical audit plans of which 74% were complete or on track and 26% were overdue. These are followed up on a monthly basis.

- There were 26 overdue directorate audit action plans which had been risk assessed and all rated as low risk.
- QAC noted that the Women's and Children's Directorate had nine overdue action plans. This is attributable to resource issues which had been resolved in Maternity, however, Paediatrics still needed to be resolved.
- It was confirmed that all overdue action plans had been assessed as low risk.

NHSI Patient Safety Alerts and Never Events

- A recent letter to all NHS trusts NHSI raised concerns that some recently reported 'Never Events' suggested that there were issues with trust governance of Patient Safety Alerts, resulting in alerts being recorded on the central alert system as 'action complete' when this might not be the case. NHSI had also requested that trusts had assurance on the appropriate closure of two alerts. Southend is compliant and will remain so.

CLIP report Q4

- The Trust recorded a total of 216 formal complaints, 3794 incidents, 998 PALS contacts, 15 legal claims and 3 new inquests.
- Of 3794 incidents reported, 29 were declared as Serious Incidents slightly lower than the previous quarter.
- The central complaints team received 327 contacts from complainants, a small increase on quarter 3. Of these, 216 had resulted in formal investigations with 34% being managed through the rapid response process.
- The previously reported complaints backlog had decreased. However, a significant influx of new complaints received in February and clinical pressures made it difficult to clear these.
- There were 14 cases open with the PHSO, 7 were still under investigation. In 5, the Trust was waiting for confirmation of the findings. 2 cases were closed and in both cases the PHSO did not uphold the complaints.
- 15 new clinical claims were opened all reported appropriately.
- The Trust was on track to qualify for the maternity discount incentive giving up to 10% discount of the Trust's maternity contribution to the annual premium paid to NHSR (equating to approx. £500k).
- The Trust was currently involved in 4 inquests, 3 new inquests were opened this quarter.
- The Trust was visited by NHSI as part of the 'Getting It Right First Time' (GIRFT) initiative and was ranked the 5th best performing Trust of the 134 acute and specialist trusts.

Infection Control Management – Internal Audit

- The report concluded with reasonable assurance that the system of internal controls was generally adequate and operating effectively but some improvements were required.
- The majority of actions in the action plan had been addressed.

Completion of Discharge Summaries – Internal Audit

- The report concluded with reasonable assurance that the system of internal controls was generally adequate and operating effectively but some improvements were required.
- The report had been shared and improvement plans were in place.
- College tutors, as responsible officers for data on the completion of discharge summaries to be collated reported to the relevant clinical committees on a regular basis are substantively employed Consultants of the Trust who also have tutoring responsibilities.

Peer review of mortality governance

The review was commissioned by the chief medical officer in December 2017 and carried out by West Suffolk NHS Foundation Trust.

- The report was largely reassuring that the Trust's processes were appropriate and correct in addressing issues.
- An action plan had been developed to be approved at the next mortality surveillance group.
- The Trust now had a full complement of medical examiners and was, nationally, an early adopter for this. Under the new medical examiners' process, 100% of case notes would undergo initial scrutiny by the medical examiners who would select cases for a full structured judgement review according to the agreed criteria.
- QAC noted that nationally the phrase 'avoidability of deaths' was not well received.

- It was confirmed that work in relation to the treatment escalation plan would be progressed through the deteriorating patients' group and would be led by the palliative care team.
- QAC noted a comment in the report that 'the board papers do not describe the learning which has arisen from avoidable deaths' and that this was also an issue in relation to SI action plans.
- QAC was advised that a formal response to the review findings and an action plan would be developed and presented in due course.

To Note

Complaints Annual Report 1 April 2017 to 31 March 2018

- The Trust received a total of 834 complaints, slightly higher than last year.
- The number of complaints received equated to 0.11% of patient attendances (729,206), also higher than the past 2 years, but it remained under 1%.
- 847 complaints were closed during this period which included complaints received in the previous year.
- The deadline for advice from the directorates had been extended to 20 working days from the usual 15 working days, with a 'standard' complaint report now due to the complainant within 40 working days from receipt instead of 35. This process would be reviewed at the end of June 2018.
- During the past year a backlog of cases had been cleared, however, there were a further 63 cases awaiting advice from the directorates and where the final report was overdue to complainants.
- As at 31 March 2018, the Trust had 14 cases open with the Parliamentary & Health Service Ombudsman, 7 of which were still under investigation. In 5 cases, the Trust was waiting for confirmation of findings. Of the 64 complaints referred to in the past year, only 11 were accepted for investigation and after thorough investigation most complaints were only partially upheld.
- The report would be published on the Trust website for the public.

Infection Prevention and Control Annual Report 2017/18

- There were 33 cases of *Clostridium difficile* (C.Diff) during this period against a ceiling of 30 cases. None of the cases were classified as direct lapses in care.
- There were 5 cases of MRSA bacteraemia against a zero-tolerance requirement. Of the 5 cases, 2 identified that policy/protocol had not been followed.
- Cases of Norovirus were promptly identified and managed effectively

Report from Joint Quality & Patient Safety Committee meeting

- Items discussed included CQC update, Summary of quality concerns, Risk management and IQUASER update.
- It was anticipated that MEHT would be rated as green following their recent infection control inspection by NHSI.

BAF Risk 1 – Capacity, Demand & External Stakeholder Engagement

- No change was proposed to the current risk score

BAF Risk 7 – Clinical Support Services

- QAC noted that there had been no changes since the last update.

BAF Risk 8 – CQC and H&SC Regulations

- The current risk score had been reduced from 15 (3x5) to 9 (3x3).
- Controls such as mock inspections and peer reviews had been put in place to mitigate the risk and where gaps had been identified actions plans were in place.

Exception Report – Corporate Governance Group

- There were no items for escalation

Exception Report – Corporate Management Team

- There were no items for escalation

Exception Report – Quality & Safety Committee

There were two items for escalation.

- During 2017 – 2018, four Never Events occurred:

    - May 2017 - Incorrect implant: incorrect sized component used in hip replacement. An investigation and an action plan were completed.
    - December 2017 - Incorrect site surgery: incorrect breast lesion surgically marked and removed. A draft report was reviewed by the Medical Director and an update was awaited from the Directorate.
    - January 2018 - Incorrect site surgery: wrong tooth removed under general anaesthetic. A recommendation was made to implement national guidance.
    - March 2018 - Incorrect site surgery: wrong testicle explored. The investigation was on-going.

- Cancer and RTT harm reviews – processes are in place but at delivery needs to be better. A paper will be presented to QAC outlining the processes in each of the relevant areas and a method for reporting numbers, how many have reached time limits and whether they have been reviewed together with any outcomes will be presented to QAC in due course.

Exception Report – Clinical Governance Committee

There were two items of escalation:

- One Never event was declared in April due to wrong site surgery. The RCA investigation was in progress and the WHO training was already completed following breast lump excision incident reported earlier.

- **Scribenet –** MSK had reported that there remained an issue with losing letters from the system. This was an on-going issue with IT and the supplier of the Software and it was being investigated. It was confirmed that this was on the Risk Register with additional checks in place to mitigate

Health & Safety Committee

The H & C Committee reported that there are several areas requiring improvement highlighted in a recent report on Safety and wellbeing to meet Trust Health and Safety Policy (HS01) and Health and Safety statutory requirements. The ratings provided were

- Policies – Good
- Competence – Requires moderate improvement
- Assessment of Risk – Good
- Review of performance implementation of actions/lessons learnt – Requires minimal improvement
- Meeting external assurance evidence requirement - Requires minimal improvement

Equality & Diversity Committee

There were two items for escalation.

- Annual Equalities report
    - The report updated workforce equality data for 1 April 2017 – 31 March 2018.
    - The data had been reviewed and a summary of the actions to be taken was included in the report that would be added to the equality and diversity action plan.
- WRES (Workforce Race Equality Standard)
    - The 2017/18 action plan had been reviewed for progress and the 2018 findings and a revised action plan was in place for 2018/19.
    - The report and action plan were discussed and agreed at the EDIC meeting on 4 June 2018.

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Committee 2017/18 Self-Assessment Effectiveness Results

- QAC received the results of the recently conducted self-assessment and welcomed the positive outcome and 100% response rate.

Fred Heddell July 2018.