Southend University Hospital NHS Foundation Trust

Board of Directors Meeting Report – 4 December 2018

Agenda item 78/18

Title	Quality Assurance Committee Report - 17 October 2018
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:

Ophthalmology Audit – waiting lists reduced – priority for greatest risks.
Harm reviews - RTT & Cancer – long waiting patients carefully monitored
Serious Incident Report - 15 SIs in quarter 2 – the 3 Never Events from last year actions have been closed. No Never Events YTD
Mortality update - SHMI now stands at 1.10
Pathology update – good progress being made
Cervical Screening – double reading of screens is continuing.

QAC also Noted

BAF 1 & 8 - no changes in scores
BAF 7 removed as risks covered elsewhere.
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.
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, 17 October 2018

For Assurance

Ophthalmology Audit

- The Trust ensures that overdue follow ups are prioritised according to clinical risk as well as length of time for waiting. Weekly capacity meetings are held where all patients waiting for an appointment are prioritised.
- An audit of 375 patients was undertaken. There were 30 unstable glaucoma patients (extreme risk), none were overdue a follow up appointment, and of the 148 stable glaucoma (high risk) only 1 had a due date in the month of the audit without an appointment date.
- There was a reduction of 20% to 5,243 in the 5 months to March 18. (In December 2016 there were almost 18,000 overdue follow up patients).
- There has been no further SIs in ophthalmology since February 2018.
- QAC discussed the implementation of the ophthalmology reconfiguration across msb and that the service will be operated under a single management structure.
- QAC congratulated the team on the progress made.

Harm reviews - RTT

- Patients who are waiting over 52 weeks are assessed for potential harm. If the patient is at risk of harm a face to face review with the patient is undertaken. At this review actual harm is assessed. The harm is also assessed at the time of treatment.
- The outcomes of the reviews are reported to the Planned Care Board, and a summary to the Quality and Safety meeting.
- 5 patients who were treated in August had waited over 52 weeks; of these patients one was considered to have suffered harm due to the wait, as the patient had to be treated as an emergency. A full investigation is underway to understand if the harm was reversible and for lessons to be learnt from the incident.
- 10 patients, who were waiting for treatment at the end of August, had been waiting over 52 weeks. None of these patients were identified as being at risk of harm. 4 of the patients have now had treatment.

Harm reviews - Cancer

- Any patient whose pathway is longer than 104 days has a route cause analysis to assess harm.
- Harm Reviews are carried out from a clinical perspective. QAC asked for information about assessment of psychological harm.
- The review of harms is tabled through the monthly performance review process.
- Where harm is identified a meeting is be held with the patient and the Duty of Candour process followed.
- Since 1st January 2018, 122 patients breached the 104 day standard. Most of the reviews of Southend only patients have been completed though only 5 of the 68 requiring other site input have yet been completed.
- A cross site MSB review of the process took place in October 2018 and a cross MSB review process has been agreed.

Serious Incident Report Quarter 2

- 15 SIs were declared in quarter 2
- KPIs for completion of SI reports - 3 day reports 100% compliance, 60 day compliance 40%

- All Never Event investigations have been completed for the previous financial year and there have not been any NEs YTD.
- Compliance with verbal Duty of Candour compliance improved this quarter with one confirmed breach for clinical reasons.
- Patient Safety Review Panels continue for hospital acquired pressure ulcers and patient falls that result in moderate or above harm.
- It was confirmed that learning from pressure ulcers are shared across the wards.
- The process for hospital acquired thrombosis continued to be embedded.
- QAC raised concerns about the outstanding actions from the learning from SIs. We were advised that some of these actions have now been implemented.

Mortality update

- SHMI now stands at 1.10 down from 1.13
- The data suggests that the R-coding at the Trust has continued to improve at almost the same rate as the SHMI, suggesting that this is a key driving factor.
- We are compliant with the NQB Learning from Deaths Guidelines and time between death and readiness to collect has improved.
- The Medical Examiners initial scrutiny of all inpatient adult deaths began in May 2018 and early data suggests that the introduction of the Medical Examiners model has led to an improvement in the death certification and registration process.
- Collaboration between mortality leads across the MSB has allowed mortality review processes to align.
- An action plan had been produced following the external review of mortality governance.

Pathology update

- The pathology governance structure has recently been revised. Executive leadership is now from SUHFT.
- The ToRs for the key committees are being reviewed.
- Laboratory staff (IPP) recruitment and retention remains a priority for the organisation with particular focus on the lower band staff. Staffing levels have improved for IPP.
- The contractual KPIs are green for August 2018 with exceptions for a) Cytology which is currently at day 61 but will be within target by Jan 2019, and b) CSF Microbiology samples which are not consistently meeting the 2hr target although this relates to a very small number of samples.

Cervical Screening

- The SQAS team visited in respect of the Cervical Screening Programme in 25 September. Verbal feedback was positive - issues specifically highlighted:
  - Double reading of screens is to continue to provide additional assurance.
  - More consultant interaction with laboratory staff for cytology is required.
- Further details will be provided when we have received the official feedback which is anticipated within the next 2 weeks.

To Note

Cervical Screening Programme Annual Report

- The annual report of the cervical screening programme was received. It was noted that this report will be sent to PHE and NHSE.

BAF Risk 1

- The current risk score and the target risk score had remained at 20 and 15, respectively.

- A new KPI - Stranded, has been added and improvements are being seen.
- There are a number of mitigating actions which have been introduced.
- An extensive winter preparedness template has been issued by NHSE for local communities to complete. This should provide an additional assurance.
- There is also no notification yet on additional monies for winter.

BAF Risk 7

A proposal was discussed at the SLT to remove BAF risk 7 as the risks relating to radiology and pathology at Southend and already included in the corporate risk register. This was agreed.

BAF Risk 8

- There had been no change to the current risk or target score.
- A group is in place to support the Trust in maintaining high standards and preparing for any forthcoming inspection.

Exception Report – Corporate Governance Group

- Issues discussed included:
    i) Corporate Risk Register
    ii) Board Assurance Framework
    iii) Internal Audit progress report

There were no items for escalation.

Exception Report – Corporate Management Team

- The Committee was advised that business is now presented to the ADs and HONs meeting instead of CMT.
  Issues discussed included:
  - New MSB Group Contract
  - CIP Progress
  - Quality & Safety
  - Directorate Updates
  - Winter pressures and patient flow

Exception Report – Quality & Safety Committee

- A wide range of issues were discussed and there were 4 items for escalation:

  PLACE report

  The PLACE results for SUHFT for 2018 have dropped compared with the results in 2017 in the areas of condition, appearance and maintenance, privacy, dignity and wellbeing and disability. The results of the PLACE survey will be considered in the Estates and Facilities Strategic Plan which will be presented at the next meeting. It was noted that the Quality & Safety Committee was not assured by the report. Progress will be added to the QAC Action Tracker.

  CQC action plan

- There was one overdue action relating to considering the preference of young people aged 16-17 years old. This has been escalated within the Women and Children's Directorate.
- There are a further four actions rated as amber due to slight slippage in the plan.

  Cancer and RTT harm reviews – these were reported earlier in this report.

.

Ophthalmology Update

- It was noted that since the report presented earlier in this QAC Meeting the number of ophthalmology patients overdue for review had slightly increased.
- Two of the three consultant posts have been successfully recruited and the final post is currently out to advert.
- The Eye Unit build is underway and on track. This will give more consulting space and enable the service to expand and use the clinical space more effectively. The build is due for completion in December 2018.

Concern was expressed about a new national process where the Healthcare Safety Investigation Branch will be undertaking all investigations relating to intrapartum stillbirth, early neonatal death, babies diagnosed with severe brain injury within the first seven days of life and maternal deaths (within 42 days or the end or pregnancy) and there was concerns that there would be a delay in the Trust being aware of the actions to be taken. It was noted that an early management preliminary investigation will still be conducted by the Trust to mitigate this.

Exception Report – Clinical Governance Committee

The key issues discussed were as follows:

- Resuscitation and Deteriorating Patient Committee Q1 exception report
- Medical devices quarterly exception report
- Safeguarding Adults and Children Quarter 1 report
- Child Safeguarding Annual report
- Emergency Planning Resilience and Response (EPRR) report and annual report
- Medical Revalidation Annual Organisational Audit
- DIPC report
- People and OD quarterly report
- VTE Committee Quarterly report
- Complaints, Litigation, Incidents and PALs (CLIP) Q1 report
- Central Alerting System (CAS) compliance report
- Duty of Candour process
- SOP for the management of external agency reviews - update
- Directorate clinical governance group monthly exception reports

One item was escalated to the QAC relating to venous thromboembolism. VTE risk assessment compliance is consistently above 98% however the number of hospital acquired venous thromboembolism suggest that lessons are not being embedded. A quality improvement project has been carried out on the Medicine for Elderly wards which will be rolled out to other wards.

Health & Safety Committee

Issues had been discussed include:

- Sharps management
- Fire safety arrangements
- External construction works at Southend Hospital site
- Electrical systems upgrade and testing assurance
- Safe gaseous and anaesthetic agent management arrangements

There were no issues for escalation.

Equality & Diversity Committee

Issues were Include:

- Diversity Network Groups
- WRES action plan

- Review of EDS2
- NHSI FTSU self-review tool
- FTSU month

There were no items for escalation.