Sherwood Forest Hospitals NHS Foundation Trust

**Board of Directors Meeting in Public**

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| **Subject:** | Report of the Quality Committee | **Date:** 17/01/18 | |
| **Prepared By:** | Elaine Jeffers, Deputy Director of Governance & Quality Improvement | | |
| **Approved By:** | Tim Reddish, Chair of Quality Committee | | |
| **Presented By:** | Tim Reddish, Chair of Quality Committee | | |
| Purpose | | | |
| The purpose of this paper summarises the assurances provided to the Quality Committee around the safety and quality of care provided to our patients and those matters agreed by the Committee for reporting to the Board of Directors. | | **Approval** | |
| | | **Assurance** | **x** |
| | | **Update** | **x** |
| | | **Consider** | |

| **Strategic Objectives** | | | | |
|---|---|---|---|---|
| **To provide outstanding care to our patients** | **To support each other to do a great job** | **To inspire excellence** | **To get the most from our resources** | **To play a leading role in transforming health and care services** |
| | | | | |
| Indicate which strategic objective(s) the report support | | | | |

| **Overall Level of Assurance** | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| Indicate the overall level of assurance provided by the report - | External Reports/Audits | Triangulated internal reports<br><br>**x** | Reports which refer to only one data source, no triangulation | Negative reports |

| **Risks/Issues** | |
|---|---|
| Indicate the risks or issues created or mitigated through the report | |
| **Financial** | No financial risks identified |
| **Patient Impact** | Assurance received with regards to the Safety and Quality of Care through the Reports presented |
| **Staff Impact** | No staff issues identified |
| **Services** | No service Delivery risks identified |
| **Reputational** | No Trust reputational risks identified |

**Committees/groups where this item has been presented before**

None

**Executive Summary**

The Quality Committee met on 17/01/18. The meeting was quorate. The minutes of the meeting held on 20/09/17 were accepted as a true record and the Action Tracker updated.

The Board of Directors is asked to accept the content of the Quality Committee Report and the items for note highlighted below:

The Board of Director is asked to note the following:

- The extraordinary meeting of PSQB due to the cancellation of the January meeting in response to the unprecedented operational pressures
- The disappointment with the compliance performance in some areas from the Medication Safety Audit
- The positive visit by NHSI re our management of patients with a Learning Disability and the additional central funding identified.
- The forthcoming visit from the National learning Disability Lead to undertake a table top

exercise to elicit further learning and improvement opportunities
- The scrutiny of Quality Committee of the actions taken following the Never Event in Surgery
- The review of the BAF and agreement on the current risk ratings

**1. Never Event Safety Summit (Orthopaedics)**

1.1 The Division of Surgery presented the outcome of the Safety Summit held in December 2017 with the Trauma and Orthopaedic team following the 'Wrong Side Prosthesis' Never Event identified in October 2017.

1.2 In summary a female patient underwent a total knee replacement on 14/12/16. A right femur was implanted into the left knee. The Trust was notified by the National Joint Registry and a comprehensive investigation undertaken as agreed at the Trust Serious Incident Scoping Meeting on 16/10/17.

1.3 The Division gave a full account of the incident, including the immediate actions taken and changes in practice that have happened in addition to a presentation by Dr John Tansley that highlighted the wider learning opportunities and ongoing improvements to theatre practice that was presented to the Divisional Learning event on 28/11/17.

1.4 Quality Committee were assured that the Division and the individual team concerned had responded to the event appropriately and had taken robust remedial action to prevent a future occurrence.

**2. Patient Safety Quality Board Report (Monthly Report) (December 2017)**

2.1 The PSQB Report of the meeting held on 13/12/17 was presented and the issues highlighted for escalation to Quality Committee considered. Quality Committee were informed that due to the severe operational pressures currently being experienced by the Trust the PSQB meeting scheduled for 10/01/18 had been cancelled. An extraordinary meeting had been held on 16/01/18 with the Medical Director, Director of Governance and Quality Improvement and Deputy Director of Quality Improvement to review the reports provided. There were a number of management actions identified, however there were no issues of serious concern for escalation to the Quality Committee.

2.2 Quality Committee noted the following
The issue highlighted by the Urgent and Emergency Care Division in relation to the collapsible curtain rails has been resolved. The rails had been collapsing when staff were simply closing them. A health and safety check conducted across the Trust to ensure this was not a wider issue.
- The Urgent and Emergency Care Division were proud to announce the opening of the Bluebell Room, a 2-bedded dementia friendly room in ED
- Provisional feedback received following the external visit looking at how we manage Human Tissue was positive with no significant concerns noted.
- PSQB received assurance that the 'Must' and 'Should Do' actions from the 2016 CQC Inspection are on track to be fully delivered by the end of January 2018.
- PSQB received assurance that the Trust stooped using Vaginal Meshes 18 months ago and to date no concerns have been raised in relation to cases undertaken before that date.
- PSQN noted the excellent performance in the Intensive Critical Care Unit (ICCU) in the quarterly ICNARC report
- Dr Steve Rutter presented the report from the Royal College of Psychiatrists – National Audit of Dementia. The subsequent Action Plan is embedded in Programme 7 of the Advancing Quality Programme (AQP) with progress monitored through the Nursing Task Force Steering Group by the Chief Nurse. A Dementia Steering Group is now in place

reporting through the Safeguarding Steering Group to PSQB. A further focus is being placed on the consistent application and increased awareness of the Delirium Policy.

- PSQB received assurance that the changes proposed in June 2017 in relation to the management of Mattress Decontamination have been implemented. This may have contributed to the achievement of zero pressure ulcers in November.
- PSQB received the Deteriorating Patient Group Dashboard. Sepsis performance remains strong, however low compliance with Sepsis Mandatory Training for medical staff has been escalated to Surgery, Medicine and Urgent and Emergency Care. The Cardiac Arrest Rate for October was below 1/1000 performing below the national average. Although the NerveCentre roll out is progressing PSQB have escalated to the NerveCentre Steering Group that Maternity is not included within the current programme and asked for this to be reassessed.
- The Quality Dashboard was presented. This is a sub-set of the Single Oversight Framework Dashboard presented to Board. Exception reports were received and accepted for all indicators flagged as red.
- A spike in the number of 'sharps' related incidents were noted in June-August 2017. The findings are being discussed with each Division with Infection Control link trainers providing additional support and training. A review of Safer Sharps theatre trays has been instigated and the MHRA notified of the insulin pen device issue.
- The Diagnostics and Outpatients Division presented a policy designed to provide a framework for the standard approach to roles and responsibilities of different staff groups recording the results of diagnostic tests. Each Division was asked to provide within their exception reports for the January PSQB meeting an indication of the processes in place to ensure that requested diagnostic test are followed up and actioned. It should be noted that this is an action following the extraordinary PSQB meeting on 16th January as the Divisional Exception Reports did not provide adequate assurance on this matter.
- PSQB were informed, via the Hospital Transfusion Committee (HTC) quarterly report about the 4 x instances of 'wrong blood in tube' (WBIT). A root cause analysis (RCA) for each case is being carried out with the outcomes reported to the HTC in January. There were 7 SHOT reportable incidents in July-September with only 1 involving anti-D demonstrating an improvement.
- PSQB were informed that the issue in relation to Hepatitis B Vaccination was now resolved. The Medicines Optimisation Report was presented demonstrating that the Trust continues to perform well against the national measures. A focus on engagement to increase medication-related incident reporting by 30% will commence in January. The outpatient prescription turnaround time is currently 12.5 minutes = half the national turnaround time of 25 minutes and places the Trust in the top 5 Trust across the country. The average TTO turnaround time is 69 minutes against a national time of 77 minutes. The Medication Safe Storage Audit was received. PSQB noted the disappointing compliance in some areas – all of whom were immediately issues with improvement notices and re-audited. The audit outcomes have been escalated to the Nursing and Midwifery Board and will continue to be monitored via the Nursing Metrics
- PSQB received the Radiation Protection Report. There had been 6 IRMER incidents, 5 of which had been addressed and closed. All the incidents had involved failure to follow correct patient identification processes. PSQB asked for a remedial action plan to be included within the next Divisional Exception Report
- Safeguarding Q2 Report highlighted the continued progress being made in compliance with the 'Think Family' Level 3 paediatric training. The Annual NSCB Markers of Good Practice Audit saw the trust rated green in 57 out of 59 outcomes. We are fully compliant with the safeguarding Adults Assurance Framework (SAAF)

**3. Advancing Quality Programme (AQP) Report**

3.1 Quality Committee received the progress Report for the Advancing Quality Programme (AQP). The Report provided Quality Committee with the current status of each of the AQP Workstreams.

3.2 The January AQP Board considered the proposal for the 2018/19 Quality Priorities Programme. The Programme Architecture was discussed at length and accepted as a way of ensuring that all areas of the Trust could align their improvement work into one of the key headings of the future programme. The headings being considered are:

- Safer Care
- Effective Care
- Patient-centred Care
- Timely Care
- Leadership

3.3 There will be an increased emphasis in 2018/19 across all Advancing Quality Programmes on the involvement and engagement of patients and service users.

3.4 Quality Committee received assurance from the Head of Safeguarding and the Trust lead for Adult Safeguarding on the progress made and the work being undertaken in relation to the understanding and application of the Mental Health Act (MHA), Mental Capacity Act MCA), Deprivation of Liberty (DoLs) and Dementia. Quality Committee heard about the positive visit by NHSI re our management of patients with a Learning Disability. Additional central funding to support this further has been identified. A forthcoming visit from the National learning Disability Lead is scheduled to undertake a table top exercise to elicit further learning and improvement opportunities.

3.5 Quality Committee agreed to receive a more detailed progress report on 1 AQP Workstream at each of their forthcoming meetings

**4. Quality Account Quarterly Report**

4.1 Quality Committee accepted the quarterly update on progress against the key priorities within the Quality Account. The report also articulated the progress being made against the 9 further quality priorities.

4.2 A working group has been commissioned by the Chief Nurse to ensure the production of the 2017/18 Quality Account timetable within the required timeframe. This will include providing a timetable to the Quality Committee to facilitate adequate consultation and sign off.

**5. Nottinghamshire and Derbyshire Quality Surveillance Group (QSG) Letter**

5.2 The Quarterly QSG Letter stating that Sherwood Forest NHS Foundation Trust remains on **routine** surveillance was accepted

**6. Care Quality Commission (CQC) Insight Intelligence Tool**

6.1. The CQC Insight Intelligence Tool was provided for information. This document will be provided to Quality Committee as a standing agenda item going forward. An explanation of the tool was given highlighting how it is currently used within the Trust.

6.2 The Insight Tool is one of the intelligence gathering mechanisms for CQC and for the first time Trust have an ability to access the document and gain insight as to performance against specific metrics. The tool is updated periodically but offers an opportunity for the Trust to be aware of indicators that may cause concern for external regulators.

6.3 The Insight Tool is circulated to all Divisions with an expectation that they provide required actions or current performance against those indicators deemed to be 'worse' or 'much worse' via their monthly exception reports to PSQB.

## 7. Board Assurance Framework (BAF) Principle Risk Report

7.1 Quality Committee now have oversight of the following risks within the BAF:
AF1 – Safe and Effective Patient Care (current risk rating: 12 – high)
AF2 –Managing Emergency Demand (current risk rating: 16 – significant)
AF3 – Managing Elective Demand (current risk rating: 12 – high)
AF7 – Staffing levels (current risk rating: 16 – significant) – this risk has been reassigned to Quality Committee from the OD & Workforce Committee

7.2 The risk ratings were acknowledged and confirmed as correct. The demand and staffing challenges are profound, which is maintaining a high level of risk at the present time.

7.3 A revised BAF is currently being developed through the Risk Committee that includes additional elements linking Principle Risks with performance Indicators and rated sources of internal assurance. The refreshed BAF is scheduled to be presented to the Board of Director in April 2018.

## 8. Escalation to the Board of Directors

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- The review of the BAF and agreement on the current risk ratings