QUALITY COMMITTEE

Minutes of the meeting held on 16 May 2018

Present: Helen Taylor, Non-Executive Director *(Chair)*
Elaine Noske, Associate Non-executive Director
Claire Thompson, Interim Director of Nursing
Denver Greenhalgh, Director of Governance
Crawford Jamieson, Medical Director
Paul Fenton, Director of Estates

In attendance: Neill Abbott, Auditor, TIAA *(Item 2.2)*
Michelle Appleby, Interim Risk Manager
Liz Hearne, Senior Nurse Integrated Pathway Development
Clare Harper, Executive Assistant to Director of Governance *(minutes)*

Apologies: Laurence Collins, Non-executive Director
Neill Moloney, Managing Director
Simon Hallion, Director of Operations
Clare Edmondson, Director of Human Resources
Alison Smith, Community Services Director
Kevin Purser, Chief Pharmacist
Fiona Whitfield, Head of Nursing and Professional Practice

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80/18	**Apologies/Introductions** 1. Apologies were noted as above. 2. The Chair advised that she had received positive feedback from the Associate Director of Grant Thornton, following his attendance at the last Quality Committee meeting, with regard to the assurance detail provided at these Committee meetings.	
81/18	**Minutes of the Last Meeting** 3. The minutes of the meeting held on 24 April 2018 were approved as a true record of the meeting.	
82/18	**Action Log** 4. The Committee reviewed and noted progress of actions on the Action Log, in particular: • 115/17 – *Nursing quality metrics to be included in Quality Dashboard.* The Interim Director of Nursing advised that she had met with LC/EN to discuss the nursing sensitive metrics. The conclusion was that this Trust was not under reporting compared to other trusts and whilst the Board was well sighted on metrics such as falls, pressure ulcers, etc. there were red flags in delays in observations, medication, and analgesia therefore further work was required on how to capture those metrics at board level. It was also noted that capturing the energy and commitment to care on a daily basis would be useful. EN commented that the crux was the	

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	professional judgement call and fundamentally were patients safe from an assurance perspective, given that some wards were triggering 'inadequate' in performance. It was agreed that Actions 15/17 and 115/17 would be merged and closed on the proviso that a formal written request to the DoF requesting that this was included in the new BAF build process. **Action**: DG to arrange. It was noted that there may be a gap in performance reporting at the beginning of the merge and the Committee sought assurance on what would be reported to ensure there was no harm to patients. **Action**: CT. • 77/18 - *Provide report to next meeting on committee planner for items pre/post-merger, design of reports and process for bringing these forward*. The Director of Governance suggested that the proposed NEDs for the Quality Committee in the new merged organisation be invited to attend the June Quality Committee meeting to discuss the new committee Terms of Reference disclosures, how the committee intends to meet the standards of the Terms of Reference and move these forward into the new organisation. The Committee agreed to this proposal and the deferral of this item to June. 5. The Action Log would be updated and circulated to Committee members with the draft minutes.	**DG** **CT** **DG**
83/18	**Matters Arising** <u>Wards being assessed through the heat maps as 'inadequate'</u>: 6. The Interim Director of Nursing advised that a review of ward data over the past 12 months revealed that the change in reporting processes for pressure ulcers to 3 months in arrears had skewed the data for some wards which were reported as 'none submitted' rather than 'none required'. This had contributed to the 'inadequate' performance metrics. It was noted that 4 of the 9 wards continue to report as inadequate in some KPIs and in-depth discussions and weekly reviews of action plans were being held with the divisions to improve the quality metrics. The Interim Director of Nursing felt assured that some cultural, skills mix and leadership competency issues had now been dealt with. **Action**: circulate all action plans. <u>Effectiveness of Sepsis Training for Doctors</u> 7. The Medical Director advised the Committee that the Sepsis training module had been reinstated in the annual mandatory training programme and educational clinical training supervisors were taking on this training however in the new organisation this	**CT**

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	training would move to bi-annual. He added that there had been an improved response rate for use of Sepsis 6, and embedding compliance in practice in ED. It was noted that over 400 clinical staff and 60 students had been trained to date however there were delays in uploading completion of training on ESR.	
84/18	**Quality Performance Report – Quality Section (March Data)** 8. The Committee received the Quality Performance Reports for Hospital based services and for Community based services, noting: <u>Hospital</u> • 98% of patients on the day of study in March were free from new harms; • Predicted year end position for Clostridium Difficile was within threshold; • 19 developed pressure ulcers (7 avoidable) • Falls increased from 128 to 160 – 3 of which were high harm/severe falls and were being investigated. Falls per 1000 bed days was relatively stable in March at 5.5 and in line with national average. The Community Falls Practitioner was now involved in the Falls Prevention Group and working on improvements in the community; • Audit on post-partum haemorrhages concluded that good practice was in place but documentation was lacking. Interim Director of Nursing had very positive discussions with clinical leads on how to take this forward. • VTE compliance was improving since moving to paper based forms. <u>Comments/Questions</u> 9. EN commented on the discharge of a patient with sepsis from Woodbridge Ward and asked whether this was an example of slippage with sepsis training. **Action:** CT to check. 10. The Chair requested further information on what had caused the delays regarding the one overdue complaint. **Action:** CT. <u>Mortality</u> • HSMR was 109.9 'higher than expected' range; • Crude rate within HSMR basket was 3.4% (East of England Peer group rate was 3.60%) • There are 3 outlying groups attracting significantly higher than expected deaths (Acute Cerebrovascular disease, Pneumonia and other gastrointestinal disorders).	**CT** **CT**

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	• The gap between week and weekends was no longer trending an increase. • Improvements in coding, particularly sepsis should improve HSMR however the learning from deaths was an important piece of work to embed. <u>Comments/Questions</u> 11. EN queried as the HMSR was higher than expected rate, was this more than the Trust would expect and by how many. The Medical Director responded that the crude mortality rate was 1200, which was 100 more than expected per year. He added that looking into the reasons for people not having the flu vaccination would gain insight to possible learnings from outcomes. <u>Community</u> • Falls decreased slightly from 41 to 40 • 9 Medication incidences, one relating to an insulin dosage. All incidents resulted in no harm to patients. • Pressure ulcers had risen to 40 - 7 out of the 26 Grade 2 pressure ulcers were in residential care with 24hr staff on site. • Training compliance for Dementia Care had fallen from 93% to 91% (target is 95%) and MCA/DOLs had risen from 85% to 88% (target is 95%). <u>Comments/Questions</u> 12. The Chair sought assurance on the increasing number of insulin errors. The Interim Director of Nursing agreed to check if similar learnings could be gleamed from acute and community hospital incidents. The Medical Director added that it was the Diabetes UK 'Insulin Safety Week' focusing on the importance of supporting diabetes patients with administration of insulin in the acute and community hospital setting. 13. The Director of Governance queried whether the changes in skills mix at Bluebird Lodge to enable discharge to assess had improved the process. She also asked whether the GP Federation would be submitting an Annual quality Account Report. **Action:** LH to check.	**LH**
85/18	**Internal Audit – Appraisal Review of Patient Safety (MCA 16/17 year olds)** 14. The Committee received the internal audit report on Appraisal Review of Patient Safety, in particular MCA for 1617 year olds, in which a 'reasonable assurance' opinion was given. 15. The Committee noted that:	

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	• The MCA and Deprivation of Safeguards (DOLS) Policy had been updated to include procedures specifically for 16/17 year olds, but this was still in draft; and • That initial concerns raised by the CQC regarding the application of MCA rules for 16/17 year olds had not materialised in the final CQC report. • A complex case review for a 16 year old showed that the principles of MCA had been applied. • Quarter 3 figures showed that the Trust was 1% below the national MCA mandatory training target of 95%. However policies and training material viewed made it clear that MCA rules had been applied to all patients of 16 and over. 16. The Committee was sufficiently assured by the report.	
86/18	**Internal Audit – Patient Experience End of Life Care** 17. The Committee was in receipt of the internal audit report for Patient Experience End of Life Care. 18. A 'reasonable assurance' opinion from the internal audit team was received for this audit which covered 'End of Life' services across the Trust, reviewing Trust procedures and how they are operating across selected wards, the bereavement department and mortuary. 19. The audit concluded that: • the Trust has End of Life processes in place which were monitored by the End of Life Programme Board; • DNACPR forms were completed for all 20 End of Life patients tested and testing of 20 death certificates confirmed that these were issued in line with the Trust's Key Performance Indicators; • A review of 20 medical files highlighted that Individualised Care Plans were not being consistently used. Where exceptions occurred, a record was on file to reflect discussion with relatives regarding the patients' needs; • End of Life Strategy and other policies and procedures relating to End of Life care were available to all staff members; • After life care services were available in the Trust, as were information leaflets on bereavement and spiritual support. 20. The Committee was sufficiently assured by the report.	
87/18	**Cancer Breach Panel Quarterly Update** 21. The committee received an update from the Cancer Breach Panel which included the themes derived from the cancel breach reviews with the following issues being highlighted:	

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	• 8 breaches (7 unavoidable and 1 avoidable) • 4 cases where patient unfit for surgery – having failed pre op assessment • 2 cases clinically driven in that cancer had not been either ruled in or ruled out (NB: clinicians asked for the patients to remain on the list) • 1 complex patient needing additional multifactorial support for the consent process • Late diagnostic (avoidable) 22. It was also noted that the division was working on improving communication with patients to reduce psychological harm and a GP coordinator was working in the division to provide an informed explanation to patients on why they are on the 2wk wait list. <u>Comments/Questions</u> 23. EN commented on the importance of positive patient experience and good communication to patients regarding the waitlist and treatment process to prevent psychological harm.	
88/18	**Winter Plan** 24. As apologies had been received by the Managing Director and Director of Operations, this item was deferred to the June meeting.	
89/18	**External Quality Visits Report** 25. The Director of Governance presented the External Quality Visits Report explaining that it had been submitted to the Quality Committee for Board assurance as the Clinical Audit and Effectiveness Committee had not met this month. 26. The Committee noted details of visits which had taken place since January 2018 and an action plan which contained 494 milestones in response to 364 recommendations. Of these, 395 milestones (73.3%) were now complete. 27. The Committee was sufficiently assured of progress on outstanding actions which were reviewed regularly by the Quality Matters Steering Group.	
90/18	**ESNEFT Quality & Patient Safety Committee - Terms of Reference** 28. The Committee received and reviewed the draft Terms of Reference for the proposed ESNEFT Quality and Patient Safety Committee (successor of the Quality Committee) noting that key assurance reports would be received from sub committees rather than meeting minutes. The key assurances would be included in the planner for sub committees. 29. It was noted that the titles of the Executive team had changed since receipt of this document and would therefore be amended	**DG**

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	accordingly. 30. It was agreed that the Directors of Operations would be invited to attend the meetings for a short period to provide assurance on transitional issues for acute, community and aggregate. Sufficient oversight of contracted services would be included on the planner twice annually via a global services report. 31. The Committee approved the draft terms of reference.	**DG**
91/18	**Quality Committee Risks** 32. The Committee received the risk report detailing the quality associated risks scoring 12 and above and was satisfied that there was sufficient assurance that the controls were working effectively and that there was sufficient progress on actions. 33. The Committee focused on risk to patient safety with regard to local safety systems for invasive procedures. The Medical Director explained that safety procedures were in place with a shift in focus now on the quality of the assessments being undertaken to provide assurance.	
92/18	**Highlight reports:** <u>Medicines Optimisation Committee</u> 34. The Medicines Optimisation Committee minutes were received and noted. <u>Clinical Audit & Effectiveness Committee</u> 35. The Committee noted that the last 2 meetings had not been in quorate 2 however a separate meeting had been held to discuss NICE guidance. <u>Trust Safety Group</u> 36. The minutes from the Trust Safety Group were received and noted. <u>Safeguarding Children Operational Group</u> 37. The minutes of the Safeguarding Children Operational Group were received and noted. <u>Safeguarding Adults Operational Group</u> 38. The minutes of the Safeguarding Adults Operational Group were received and noted.	
93/18	**Policy Register** 39. The Policy Register was received and a review of clinical guidelines was underway to ensure all Day 1 policies were	

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	reviewed and approved for the merged organisation. These policies would be available on the new intranet by clicking on the relevant place of work and it was anticipated that a harmonised version would be available within 12 months. 40. A decision would need to be made as to which committee would provide board assurance on the policy review process moving forward, i.e. this committee or the Executive Management Committee.	
94/18	**Serious Incidents Briefing Report** 41. The Serious Incidents briefing report was received by the Committee noting that there had been an increase in serious incidents reported and regular reviews of trends continued. 42. The Chair suggested that it would be useful to have a discussion on learnings from outcomes at a future committee meeting. 43. EN commented that 2 serious incidents had taken place on Saxmundham Ward and requested an update from the Interim Director of Nursing on improvements made.	**DG** **CT**
	Date of Next Meeting Wednesday, 13 June 2018, 9:30am-12pm, Edith Cavell Room	

Signed: …….

Date: ……