East Suffolk and North Essex NHS Foundation Trust

QUALITY & PATIENT SAFETY COMMITTEE

Minutes of the meeting held on 24th September 2019
Directors' Seminar Room, Trust HQ, Ipswich

PRESENT: Hussein Khatib, Non-Executive Director (*Chair*)
Carole Taylor-Brown, Non-Executive Director
Eddie Bloomfield, Non-Executive Director
Angela Tillett, Interim Chief Medical Officer

IN ATTENDANCE: Anne Rutland, Associate Director of Clinical Governance
Mr Kevin Purser, Chief Pharmacist
Michael Fuller, Estates & Facilities Assurance Manager and Head of EPRR
Neill Moloney, Managing Director
Denver Greenhalgh, Director of Governance
Melissa Dowdeswell, Director of Nursing (Colchester Hospital)
Anna Shasha, Director of Midwifery
Jessica Bishop, Executive Assistant (Minutes)

APOLOGIES: Paul Fenton, Director of Estates & Facilities
Catherine Morgan, Chief Nurse
Nicky Leach, Director of Logistics & Patient Services

ITEM **ACTION**

118/19 APOLOGIES/INTRODUCTIONS

1. Apologies were noted as above.

119/19 MINUTES OF THE LAST MEETING

2. The minutes of the meeting held on 26th July 2019 were reviewed and accepted as a true record with the following changes:
3. To note Dr Tillett as absent from the meeting.
4. Page 3 para.14 - *CTB asked what the improvement trajectory was for the falls*.

120/19 ACTION LOG

5. The committee noted the actions for September were on the agenda for discussion.
6. The committee agreed for all blue actions to be closed.

121/19 CHAIRS KEY ISSUES (CKI's) feedback from Trust Board

7. Noted

113/19 CKI'S FROM SUB COMMITTEES

- The Committee received the Chair's Key Issues reports from its sub-committees noting:

Patient Experience Group –.

- Complaint response within timeframe and courtesy call compliance had both continued to increase. The new Friends and Family Test (FFT) guidance has now been issued to be implemented by April 2020. A summary had been provided for the committee in Integrated Patient Safety and Experience Report.
- A complaints deep dive was conducted and 100 complaints coded as 'Communication' reviewed. Although correctly coded using the current subjects in place on the ESNEFT Datix system, when benchmarked against the NHS Digital subjects and sub-subjects, 43 had, the potential to be more accurately coded which would enable the Divisions to review trends and themes to identify where issues lie. The group agreed the subject codes should be aligned to NHS Digital Codes, with the Divisional Governance Managers support to assess how this supports the Divisions.

Comments/Questions

8. The committee noted the CKI.

Patient Safety Group –.

- The number of overdue SI Reports continues to cause concern and the Divisions were asked to provide assurance of progress and trajectory for completion reporting through divisional management meetings. Trajectory to be reported at both the Divisional Accountability Meetings (DAM) and Trust Executive meeting (TX).
- Overdue Action Plan update given to group regarding support from CCG and thematic review of action plans which will be incorporated into the Trust Falls Improvement plans, Maternity Study Day and Deteriorating Patient Group.
- The group received the report with focus on Patient Safety Alerts. There are 5 alerts in progress, one alert is overdue for completion due to confirmation that the software update has been put on hold by Philips as there is a further safety update which supersedes this one. It is expected to be another couple of weeks before Philips release the new safety notice and latest software update but there is no firm date for this release as of this morning. No clinical risks were identified in the report as a result of this delay

Comments/Questions

9. The committee noted that further information regarding the issues raised in the CKI were included in the Integrated Patient Safety and Experience report and would be discussed later on in the meeting.

Safeguarding Committee -

- There had been issues with achieving compliance with Children's Safeguarding Level 3 requirements and data captured on portal as the requirement is for a minimum amount of hours of training of 3 years. The forward L3 training plan is to deliver L3 adults and Children training together in the one day and then use a passport to capture any additional training to meet the three yearly requirements. This will require evaluation as to the practical implications of a full days training for some clinical teams e.g. medical staff
- It had been recognised that there was a need to increase supervision for some team/specialities. There had been particular challenges on how to achieve supervision for adult safeguarding; there was a robust system for children. The Head of Adult Safeguarding agreed to contact NHS England Safeguarding lead regarding Supervision training courses for the adult safeguarding team.
- Deprivation of Liberty Safeguards (DoLS) will be changing in the spring to Liberty Protection Safeguards (LPS). Significant changes in the way the process is managed with responsibilities moving from Local Council to Health (CCG's and provider Trusts) Additional resources will be needed to achieve this. Lack of clarity remains nationally regarding implementation therefore date to achieve implementation of LPS pushed back to October 2020. The Health Executive Forum (Essex) will have a deep dive into this at the next meeting.

Comments/Questions

10. The Director of Governance queried what the trajectory was for 100% compliance for Level 3 safeguarding training. The Site Director of Nursing explained that the trajectory was still being mapped and agreed to bring it back to the committee once complete. **ACTION:CM/MD** **CM/MD**

Clinical Effectiveness Group

- The Group received two presentations for approval of the use of new products following approval at CDG and Divisional Governance. Rumi Uterine Manipulator to support safer Laparoscopic Hysterectomy and Localizer for use in Breast Cancer Surgery. The Localizer replaces the requirement for insertion of a guidewire under ultrasound on the day of Surgery. It can be undertaken up to 30 days prior to surgery, is a better experience on the day for women and result in less theatre delays on the day, possibly enabling an extra case on each theatre list. Outcomes will be presented to the group in 6-9 months
- Quarter 1 update showing 111 relevant NICE guidance's awaiting confirmation from the Divisions to determine relevancy and/or undergo baseline assessment. The National Audit Team are supporting the Divisions with monthly meetings and providing one to one support

wherever possible. The Divisions were asked to respond to 2 or 3 each week in order to clear the backlog. No **clinical** risks were identified within the report due to non-compliance in relation to any specific NICE guidance. The Divisions were asked to ensure they were planning their 2020/2021 annual audit plan when reviewing NICE Guidance.

Comments/Questions

11. The Committee noted the information in the CKI.

Infection Control Committee

12. The committee noted the CKI and agreed for the information to be presented as part of the Integrated Patient Safety and Experience report.

Medicines Optimisation Committee

- Medication Safety – Good practise when writing any new prescription chart would be to have another health professional, for instance another prescriber, a pharmacist or nurse, to double check the prescription. This would be added in to the next version of the Medication Policy for healthcare Professionals. A group had been set up to revise all drug charts to harmonise them across ESNEFT.
- There had been a recent serious incident review of patients who had been discharged on Amitriptyline suspension with the incorrect strength on the bottle label. A number of errors unfortunately contributed to this including wrong strength annotation by a pharmacist on the discharge summary and lack of final check of the discharge prescription by nursing staff. Lessons learned included the need to ensure there is a thorough final check of the discharge prescription by the nursing staff using the Safe-Dis checklist and for clinical pharmacists to self-check when validating strengths of medicines on drug charts and discharge summaries

The CKI Reports were received and noted by the Committee.

122/19 Key Quality and Patient Safety Issues

The Associate Director of Clinical Governance informed the committee that:

- There had been a recent Never event that involved a wrong site injection of a nerve block. She explained that there had been immediate mitigations put in place and support given to the team.
- The National Arthritis audit would be publishing its result in October/November and ESNEFT would be reported as an outlier. She explained that the Trust had already increased clinics and received good engagement with clinicians to ensure that there was immediate focus on improvement.

Comments/Questions

13. The Managing Director expressed his concern that the Trust had reported several wrong site Never Events and he felt that the committee needed a far more robust assurance that the prevention and mitigations that were being implemented are correct and working. The Site Director of Nursing agreed that the initial review of the event had been a positive one with better understanding of g contributory issues

14. The Director of Governance noted that by triangulating where the Trust was in achieving LocSSIPs (Local Safety Standards for Invasive Procedures) and national guidance along with reviewing where the Surgery division was within the Trust audit schedule it would help to recognise areas of improvement.

123/19 NEESPS Clinical Strategy

The Managing Director and Director of Clinical Strategy Implementation presented the report and highlighted:

- The strategy had been developed with a large level of engagement and support from ESNEFT and West Suffolk.
- There had been several clinical strategy workshops, working groups and reviews within each discipline. All the disciplines were asked to look at and document their feedback, which would then be good supporting evidence of why any decisions were made.
- The wider clinical engagement included primary care, GP groups and CCG and ensured their feedback was used to support the strategy's development.
- The strategy outlines the plan to bring microbiology services back in house.

Comments/Questions

15. The Chair queried how challenging accreditation for UCAS would be. The Managing Director confirmed that there would be challenges to ensure full accreditation however, this would have been more difficult if Microbiology was managed by PHE.
16. EB noted that there had been a significant miscalculation of the finances and asked how the committee would be assured that these issues would be addressed and not happen again. The Managing Director explained that NEESPS are under a huge amount of scrutiny due to the history of TPP. He assured the committee that the Governance arrangements are robust. The Managing Director noted that the Trust had direct control and expertise to ensure the service lives within the financial envelope that it has.
17. The Managing Director informed that committee that the team were working closely with commissioners to ensure GP work was being sent through to NEESPS as this business was critical to financial success.
18. The Director of Governance suggested that she should share the original paper with EB to give a good oversight of the historical issues relating to NEESPS. **DG – ACTION**

19. The committee recommended the paper to the Board for approval. **DG**

The committee thanked Mr McLaughlin and he left the meeting

124/19 INTEGRATED PATIENT SAFETY AND EXPERIENCE REPORT

20. The Associate Director of Clinical Governance presented the report and highlighted the following:

- Duty of Candour had seen improvement this month and the divisions had put in steps to ensure a good level of support for this.
- **SI and overdue incidents** – ESNEFT would be attending a network conference around the new structure for report and approving SIs. The initial information suggests there will be a change to the way the action plans are written with more focus on transient themes and immediate learning. A Divisional Governance manager for Integrated Pathways had been appointed to support inpatients and community SIs. The main challenge being raised from all divisions is the lack of clinician time.
- **Sepsis –**There had been good engagement with the Ipswich team in emergency department. Due to Ipswich, using a different audit tool is therefore the data is slightly different per site. There was a need to triangulate the data with mortality and SI's relating to Sepsis, and when this was done, the numbers were very small. Colchester ED had had workforce challenges August/September 2019 however; there had currently been no impact on mortality/SI.
- **Complaints –** The Dermatology backlog had been cleared and there was a plan for closing down the hot line. There had also been a review of how complaints were being coded. The new Datix system provided a more comprehensive set of subjects, which would allow complaints to be logged with a wider variety of themes. This would make identifying themes easier.
- **Mortality -** presented by Interim CMO
- There had been improvements in coding however, there was still a need to improve data capture with Ipswich Lorenzo system and ensure HSMR was truly reflected. The crude mortality was being tracked to ensure the Trust had good oversight. There was an expectation that the HMSR data would be slightly higher than presented in the report due to the delay in coding. The ME role had made a positive impact in the mortality review process on the Colchester site and although roll out had been delayed due to training challenges; roll out in Ipswich was planned for November.

Comments/Questions

21. The Chair expressed his concern again regarding how many outstanding and overdue SIs the trust is reporting and the associated wasted clinical time. He also questioned whether there would be a deep dive into the SIs as he was expecting that to have been presented. It was confirmed that the deep dive would be presented at October's committee meeting after the initial meeting regarding the new SI framework.

22. The Managing Director emphasised that the deep dive needed to demonstrate the actions the Trust would undertake to ensure that these issues were rectified and more importantly managed appropriately moving forward. The Interim Chief Medical Officer noted that although there were still challenges to deliver the action plans in a timely way there had been improvement in the immediate actions. She also noted that ESNEFT were not the only large trust that struggled with the 2 tier level of information and there had been work done to make the action plans more meaningful, looking at key thematic issues and including in the trust wide improvement programmes..
23. The Director of Governance clarified that the deep dive provided should show the corporate management of SIs and suggested the divisions be invited to present to the committee to review the issues they are having. The Associate Director of Clinical Governance explained that a review had been done with the divisions and the feedback had been used to mould the immediate actions however supported the idea of the divisions being invited. It was agreed that this would be discussed outside of the meeting and the relevant deep dive presentation to be given in October's meeting. **ACTION: DG/AR/CM/AT** **DG/AR/ CM/AT**
24. The Chair emphasised the need for SIs to have priority and that the Trust should be focused on quality of learning and ensuring that the patients were being put first. He queried whether there was an element of over commitment. The Associate Director of Clinical Governance agreed that the SI process needed to be reviewed and clarified that this was a contributing factor to the Trust agreeing to pilot the new SI structure.
25. CTB noted that she had raised serious concern with the fall rate over the past year and had not seen any significant change and that she had asked for an improvement trajectory to be shared with the committee, which it had not. The Site Director of Nursing assured the committee that there would be a deep dive presentation into falls across the Trust at the October committee. She noted that there had been a delay in implementing some of the mitigations on to the Ipswich Site however good oversight had now been established and the harm free team had reviewed the falls data. She noted that culture continued to be a contributing factor, and that there had not been a robust focus.
26. The Managing Director gave assurance on behalf of Chief Nurse and explained that the committee had been sighted in the issues pertaining to the Ipswich site and that improvement was expected October/November. He agreed that the information presented to the committee did not show consistent improvement and he hoped that the deep dive in October would give a good level of assurance to the committee and clarity on the issues that need to be addressed by the Trust.
27. CBT raised concerns around the Trusts caesarean rate. The Director of Midwifery explained that there was a national concern regarding the increased number of C-sections and that although the Trust were above the national average there were many contributing factors that are not considered within the national audit. These included patient choice, demographic and number of previous sections the woman has had. She

explained that women were 70% more likely to have a caesarean section for subsequent birth if they have had one before.

28. The committee noted the report.

125/19 Quarterly Maternity Update

29. The Director of Midwifery presented the report and highlighted the following:

- There had been significant improvement in the last 18 months during which time both Hospitals had reviewed their midwifery teams. NHSE had conducted an audit in June 2019, which showed that 16.8% of women booked with the LMS were booked with a continuity of carer.
- The Trust had received positive feedback from the women being looked after by the LMS, noting the personalisation of care and personal care plans.
- Continuity of Carer had been implemented in Clacton and had been well received.

Comments/Questions

30. The Chair queried whether the changes made to the teams and the increase in WTE had been included into the financial plans for the Trust, noting that the funding ceases in March 2020. The Managing Director confirmed that when the financial review process began in November for the next financial year 202/21, the division would have time to highlight this for consideration.
31. The committee noted the report

126/19 CNST Standard 1 and 9

32. The Committee noted the report and were pleased with the submissions. The Director of Midwifery noted that moving forward there would be an open channel of communication with staff, ensuring that any concerns raised are listened to and immediately dealt with.

Comments/Questions

33. The Chair asked that the dashboard have a column added to show the date actions were closed. The Director of Nursing agreed to update the dashboard.

127/19 Quarterly Infection Control Update

34. The Associate Director of Clinical Governance presented the report and highlighted:

- [redacted]. [Redacted as item not about ESNEFT]

- There had been an increase in MRSA incidences on Shotley ward, Ipswich Hospital. There had been 9 patients identified as MRSA positive in a period of 6 weeks. The outbreak was declared as over on 8th July after a period of 3 weeks of negative screening was reported.

Comments/Questions

35. The Chair noted the handwashing audits were very positive and asked what assurance was there that this was the case all the time. The Site Director of Nursing confirmed that the Infection control team review wards on an adhoc basis. These reviews were unannounced and usually unexpected. She also confirmed that the IP7C team were very visible on the wards and regularly raise awareness in infection control issues immediately
36. CBT queried whether the retirement of the Head of Infection Control had been planned. The Associate Director of Clinical Governance confirmed that it had been planned, that the Trust had advertised the post twice previously and that there had been a shortage of applicants.

128/19 Community Services

37. JT, Head of Business Development and Integration presented the report and highlighted:

- There had been a significant improvement in incidence management since the team started using Datix.
- The main area of concern were the number of pressure ulcers. There had been a change reporting for moisture lesions. The initial feedback from the Community Matrons was that the changes would support prevention. There would also be a focus for the integrated teams working with social care to ensure that there was continuity in the care of patients.
- There had been a poor level of returns from the community friends and family test. The team were looking as reviewing when this was conducted with the suggestion that it be completed on the initial visit.

Comments/Questions

38. The Director of Governance queried whether the issues with pressure ulcers were related to the type of equipment being used in the community settings. JT confirmed that equipment use related to patient choice however the team were beginning to document conversations with patients to give assurance that the appropriate advise had been given.
39. The Chair noted that the pressure ulcer collaborate gives good advice for non-concordant patients. JT confirmed that Rebecca Pulford, Associate Director of Nursing for Integrated Pathways, had been challenging teams to note conversations with non-concordant patients and to ensure issues with accessing equipment were addressed promptly.
40. The Chair asked why the staff were administrating insulin for patients and whether the Trust assesses the self-capability of the patients to administer for themselves. JT confirmed that there was a need for the team to refocus on patients to give them their own insulin and the team were already

working with nursing homes domiciliary care providers to administer insulin for patients.

129/19 Cancer Patient Experience Survey

41. Sarah Orr, Lead Cancer nurse presented the report and highlighted:

- The first ESNEFT iteration shows combined data and not site specific. There has been a request to separate the information however; this had not yet been completed.
- The Trust had had a good response rate, reporting above average nationally. A new way of reporting around CQC standards had been adopted.
- No major concerns had been identified however an area of improvement was the advance communication around the initial cancer conversation.
- The Trust had had high praise for the Mary Baron ward for the overall consistent care delivered.
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Comments/Questions

42. EB was pleased to note the positive comments from patients and queried whether those comments were shared with the staff. SO confirmed that they were. EB also questioned how the Trust planned to maintain the high level of engagement and feedback from patients. SO explained that the information would be shared with the Cancer Board and the learning would be shared and actioned. She did note that the overall feedback for the Trust was very positive however, it would be helpful to have site-specific data to support a more specific improvement plan.
43. The Chair questioned whether the Cancer Board would follow up with issues relating to information regarding radiotherapy. SO explained that these issues were subjective and although advance communications training would support this there were times when a definitive answer could not be shared with the patients.
44. The committee thanked SO and noted the report. SO left the meeting

129/19 Reports for Consent

45. **Annual Security Report 2018/19 – The** committee noted the report.
46. **Annual Fire Safety Report 2018/19** – The committee noted the report. MF confirmed that the Trust would be delivering bespoke training by fire advisors into specific areas. The Trust would also be increasing the number of fire risk assessor it has as there had been a pressure on fire assessing resources since the merger. , there is a draw since the merger on fire assessing resources.
47. **Medicines Optimisations Committee Annual Report** – The committee noted the report and the Interim Chief Medical Officer commended the team for the level of detailed work which had been undertaken since the merger.
48. **Clinical Negligence and Litigation Annual Report** – The committee noted the report and the Director of Governance agreed to share the ESNEFT dashboard with the committee. **ACTION: DG** **DG**
49. **Research and Innovation Annual Report –** The Committee noted the report.

ITEM		ACTION
130/19	**ANY OTHER BUSINESS**	

50. Circulate the Forward plan once approved by the Chair, the Chief Nurse and the Interim Chief Medical Officer.

Date of Next Meeting

Tuesday 29th October 2019, 9.30am-12pm DSR, Trust Offices, Ipswich Hospital