Board of Directors Meeting in Public - Cover Sheet

Subject:	Quality Committee Update to Board	**Date: 11/01/2021**	
Prepared By:	Patrick McCormack – Head of Regulation and Patient Safety		
Approved By:	Barbara Brady – Non Executive Director for Quality		
Presented By:	Barbara Brady – Non Executive Director for Quality		
Purpose			
To provide and update and assurance to the Board of Directors from the recent Quality Committee held in January.		**Approval**	
		Assurance	
		Update	X
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
			X	**X**

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		X		

Risks/Issues	
Financial	
Patient Impact	
Staff Impact	
Services	
Reputational	

Committees/groups where this item has been presented before

None

Executive Summary

The Quality Committee met on the 11th January 2021. The Committee was quorate and apologies were noted.

It was agreed that the agenda was truncated due to the current pressures being faced, thanks were extended to the Committee on behalf of the Executive team.

There were 5 completed actions and the remaining actions discussed and where available updates provided. The meeting completed its set agenda and work plan and is summarised in the paper below, from this the Committee would like the Board of Directors to acknowledge the following escalations identified.

- Assurance received regarding the risks relating to the PFI Contract.
- Assurance received from Cancer services in their annual report.
- The reinstating of the JAG Accreditation.
- The outstanding appointment for the Named Doctor for Adult Safeguarding

The Chair drew attention within the Committee meeting to the impressive hard work being produced by staff not only with COVID-19 and normal services but now to include the vaccine roll out as well.

Each point highlighted above is summarised in the body of the paper below

Quality Assurance and Safety Cabinet Report

The Committee had read and acknowledged the report presented.

It was confirmed the report presented covered items raised in the QASC meetings for November and December 2020 and opened for questions.

Member of the Committee referred to challenges presented with the delay in receiving COVID-19 test results prior to surgery, in addition to similar challenges faced with cancer patients and queried whether these had been addressed. It was clarified this was in progress due to the rapid testing process still being under development, this is also the case Nationally whilst waiting on approvals, validation of the machines and procurement of disposables. Unfortunately without the rapid screening process completed it would mean delaying surgery start times to 11:00 whilst waiting for results. Clinicians felt a moral obligation and have confirmed, particularly in Orthopaedics, they are uncomfortable to perform treatments with outstanding tests. This has been managed as best as possible by pushing the requirements from Regulators to complete the screening swabs on the day of admission following surgery.

Noting that the challenges remain on-going with Clostridium Difficile (CDIFF), the Chair highlighted the link to antibiotic usage and queried whether the prescribing of antibiotics had increased throughout the pandemic. It was confirmed much of the usage had been attributed to the community, though informed the Committee during wave one of the pandemic, an increase in the prescribing of antibiotics was seen by GP's as a result of the ceasing of face to face appointments. Prescriptions were therefore more readily provided and in some cases where the patient presented to hospital with CDIFF, they in fact had COVID-19 rather than an illness requiring antibiotic treatment, this has improved more recently

In relation to the Wrong Blood in Tube's (WBIT), the Chair queried whether there had since been an update on the IT Kit and trolleys expected or if this was likely to be a challenge due to errors associated with this issue. It was highlighted concerns raised by the Transfusion Committee that not all incidents had gone through scoping and as a result a significant amount of work has been completed on WBIT'S into identifying causes from a thematic approach, what remains to be put in place are definitive actions. DS suggested potential misunderstandings in the message conveyed to Divisions, as while there seems little reason to go to scoping with causes already established; investigations are to continue in the event of new contributing factors arising. It was reiterated from a Pathology point of view, WBIT's are unfortunately inevitable though measures are being put in place to solve some of the Human Factors identified, contributing to the incidents in order to reduce the occurrences.

The Committee was ASSURED by the report

Fragile Services Update

The Committee were provided a verbal update by the Medical Director

The Medical Director confirmed the Fragile Service of most concern at present is Haematology, in terms of medical staffing there remains only one Consultant and despite strengthening the team with Locum's, there is concern regarding the sustainability. Some progress had been made with assistance from Nottingham University Hospitals (NUH) though unfortunately their Consultant Haematology team are now also experiencing shortages of staff and they are requesting support from the University Hospitals of Leicester (UHL). This problem has been seen Nationally and whilst it is not easily remedied the service is managing to run despite vulnerabilities.

The Committee were updated that United Kingdom Accreditation Service (UKAS) has extended the suspension of the Haematology Laboratory Service's accreditation until February 2021, though a

date is yet to be confirmed. The highest risk remains the appointment of a Clinical Director, one candidate had applied for the post though unfortunately withdrew prior to interview, feedback from the candidate has been requested. A proposal has been put forward for a Consultant Clinical Scientist post, thus bridging the gap between the clinical and scientific elements while fulfilling the duties of a Laboratory Director. This is currently in the early stages though has gained support and is also being developed Nationally. In the next few weeks a call is expected from the UKAS Assessment Manager to determine the final outcome for this service.

The Medical Director referred to other services such as Ophthalmology and the issue with shielding consultants that had been discussed previously, in addition to Urology staffing with posts going out to advert 11th January 2021 and Critical Care being an on-going issue. However Haematology remains the top concern.

The Committee proposed providing the assurance on the impact the Haematology service difficulties are having on patients. As updates regarding impact on patients go through QASC, it was confirmed a report could be provided to the next Committee meeting.

Assurance received from Cancer services in their annual report

The Committee had read and acknowledged the report presented

The annual report for 2019/2020 highlighted the receipt of 4.3% more Two Week Wait (2WW) referrals then in the previous year, in addition to a 6% increase in treatment activity. Cancer Services also ranked the highest in the East Midland for the National Cancer Patient Survey, which is a great achievement for the department. Across 2019/2020, 97 clinical harm reviews had been flagged across the Trust, 95 of which concluded with no harm identified. Whilst Health and Wellbeing events had initially been postponed due to COVID-19 they are now delivered virtually. In relation to the Cancer Outcome Services Dataset (COSD) work has been completed with the Infoflex Development lead by the Cancer Team to improve the capture of data, this has been to great success as previously the Trust were one of the lowest in the East Midlands for audit data.

The report highlighted the plans for 2021/2022 include the development of Infoflex to deliver key milestone reports to improve Patient Pathways and allow Divisions to identify bottlenecks within their Pathway that require addressing.

Presentation of the report referred to the period of time during the first wave of COVID-19 and noted the continued focus on improvements to the patient's experience, with the introduction of welfare calls, in particular when the patient's anxiety was at an extreme high. This was found to improve the pathway while delays to diagnostics and treatment were resultant of the pandemic. This had been introduced prior to the National Guidance published in relation to welfare calls and had been very well received.

The Committee recognised the excellent service delivered by Cancer and Operational services across the two years in particular during the pandemic, where many other Trust's had made the decision to push back cancer services further earlier on, also noting the hugely important work completed surrounding Wellbeing and the hard work in attempting to reintroduce the Spring into Action programme throughout lockdown which had previously seen excellent feedback from patients.

The Committee was ASSURED by the report.

Medical Safe Staffing update

The Committee had read and acknowledged the report presented.

The report provides a view of the current position in terms of staffing numbers and the day to day escalation processes for concerns. The report also provides a summary of the difficulties and challenges staff continues to face due to the pandemic. Regular dashboard updates regarding medical staffing fill rates against what is required, are being provided through the Incident Control Team (ICT). However as of the weekend dated 9th and 10th January 2021 the Trust reintroduced the COVID-19 floor based pool rota, and as such, changes in working have not been included in this report, this is due to be reviewed in four weeks.

While this paper focuses on the Medical Division staffing, other exceptional actions include the COVID-19 rotations, the cancellation of the Trainee rotations in April 2020, the bringing forward of Medical Students giving them the opportunity to work as Foundation Year Interim One's (FYi1) and the impact this has had on the Clinical Fellow posts. A key point to address is the minimum requirement for two Doctors to be working on each ward, historically the Trust have confirmed the ward as safe with having two Doctors on site which appears to have become the accepted norm and not the minimum requirement as it should be. Work is being conducted primarily across the Medical Division to address this.

With regard to the Clinical Fellow Programme, the Medical Director reiterated the importance of this Programme to the Trust and confirmed focus is required on communication with Trainee's, previously viewed as a hard to reach group. Particularly when conveying the significant changes to protocol throughout the pandemic, the Communications Department are working on improving the communications with Trainees to highlight important and urgent updates.

Finally the report highlights the success for Sherwood Forest Hospitals Foundation Trust (SFHFT) and the Chief Registrar positions, not only with communications on all levels but also the great assistance provided with decision making. As a result they are a regular presence at the Clinical Chairs and Divisional General Management (DGM) meetings and have been integral in the decision to incorporate the COVID-19 floor based rota system. They also provided support at the Extra Ordinary Junior Doctor's Forum (JDF) meeting held on 7th January 2021, a proposal is in place to strengthen this support within Divisions.

The Committee was ASSURED by the report

Assurance received regarding the risks relating to the PFI Contract

The Committee had read and acknowledged the report presented.

The report was in response to letters from National Health Service England (NHSE) and National Health Service Improvement (NHSI) regarding the impact of the deteriorating performance of the Project Company on the Private Finance Initiative (PFI) on patient safety.

In collaboration with the Clinical Team and Chief Nurse a matrix of identified risks was devised to include water safety, infrastructure disruption, capital project delays, violence and aggression towards staff and unauthorised access to roof areas.

To ensure triangulation of risk assessments, these were scored against non-clinical ratings in discussion with clinical teams and were externally verified by Risk Leaders at the University College London Hospital (UCLH). The risk assessments highlighted in the report have now been signed off. Work remains underway with Project Co and Skanska and SFHFT are enacting contractual rights to ensure enhanced monitoring of the PFI contract. The Trust has accrued sufficient service failure points within the contract to allow review.

The Committee was asked to note, no new patient safety risks have identified and sufficient mitigations are in place for existing ones to prevent harm. They were also asked to review and comment on the risk ratings as assessed by Clinical colleagues and external Director of Quality

and Safety, to support the planned actions in place to minimise risks going forward.#

The Committee were asked to recommend to the Audit and Assurance Committee (AAC) that an Internal Audit (IA) of the PFI Contract Management is considered in the 2021/2022 Audit Cycle and to hold an annual risk awareness session to ensure all new risks are captured and the committee agreed this as an action.

The Committee was ASSURED by the report.

Regulation and Accreditation Report including the reinstating of the JAG Accreditation.

The Committee received the External Regulation and Accreditation Report. It was read and acknowledged and the Joint Advisory Group (JAG) Accreditation was highlighted for escalation.

JAG accreditation had previously been 'not awarded' to the Endoscopy department after a visit. The main findings were based around works which had not been completed in the departments which were required to meet the accepted standards.

The works were completed ahead of schedule in December 2020 and the reassessment meeting took place on the 5th January 2021. As a result the accreditation has now been reinstated with the department receiving good feedback.

Following the Quarterly Review Meeting with the CQC, virtual meetings have been completed with the specific services highlighted. Written feedback has been requested though this has not yet been provided. Talks with staff and liaisons over the last few months have been positive overall.

The Committee was ASSURED by the report.

Nursing Midwifery and AHP Board update including the outstanding appointment for the Named Doctor for Adult Safeguarding

The Nursing, Midwifery and AHP Board report was presented to the Committee. The Committee had read and acknowledged the report presented.

With regards to the Dementia Strategy, Chief Nurse advised that due to unfortunate on-going periods of sickness of key staff involved and the lack of clear governance and Quoracy of the Dementia Steering Group (DSG), the programme had been temporarily halted. The Assistant Chief Nurse (ACN) is working in collaboration with the Dementia Nurse Specialist (DNS) on this matter to ensure the group is well attended and includes the right members needed to progress the Dementia Strategy.

An increase in Falls Data presents a concern not only within SFHFT but Nationally, this is overseen by the Trust's Harms Free Group (HFG) and a deep dive will be conducted to support further learning, data is to be compiled on the Corporate Nursing Risk Register. Contributing factors include the inability to now place patients at risk of falls in a bay as a result of the pandemic, being placed in side-rooms decreases their level of visibility and workforce pressures hinder the ability to maintain supervision. This situation is being closely monitored in addition to gaining learning from others.

The Chair inquired whether the increase in falls is an indirect consequence of COVID-19 and the current surge. This was confirmed and indicated that much of the increase is due to the pandemic, with patients also experiencing post-COVID-19 delirium putting them at higher risk but it was felt the situation could not wholly be attributed to the latest surge. It was illustrated that SFHFT are not the only Organisation seeing an increase in falls and it was suggested working in collaboration with others to devise a joint action plan. .

The Committee enquired if a plan was in place for recruitment of the Named Doctor for Safeguarding Adults. Chief Nurse stated that the allotted time had been increased in an attempt to make the post more appealing and the Medical Director had also taken action to encourage others to take up the post as the situation with COVID-19 settles.

The Committee was advised feedback from the previous post holder was that the position creates a lot of work in addition to normal duties. To mitigate the Medical Director has worked to combine this role with the Champion for Mental Capacity while picking up actions from the Care Quality Commission (CQC), and increased funding to create one new role. No applications have yet been received although enquiries are being made regarding potential suitable candidates.

The Committee queried whether there was a model for the Named Doctor for a system to operate the cover of several Trusts rather than individual ones. It was confirmed there hadn't but felt this suggestion should be considered if the role could not be filled internally.

One of the escalations form the report was that there has been unsuccessful recruitment to the Named Doctor for Safeguarding.

The Committee was ASSURED by the report.

Medicines Optimisation Strategy Report

The Committee had read and acknowledged the report presented.

The committee was advised that due to the rejuvenation of medicine questions in the Friends and Family Tests (FFT), the previous data collected had been lost. A process is underway to design a bespoke audit against Medicine issues in collaboration with the Patient Experience Team (PET) and this will be piloted on the ward that was previously highlighted as showing the most negative issues.

With regards to the measurement of Medicines Reconciliation, the data presented appears negative, although the department is in a better position with recruitment. The current surge in COVID-19 has increased staff sickness and many staff members have been redeployed to assist in the distribution of vaccines. A new bespoke audit has been created to capture missed doses of medicine information, this is presenting a good picture, however the audit is to be duplicated by Pharmacy staff to ensure confidence in data output.

There is on-going work relating to medicine shortages due to time constraints and pressures in the Intensive Therapy Unit (ITU) this has been difficult, however a Pharmacy Technician has been redeployed to assist the Specialist Pharmacist in this matter.

The Committee enquired if the same level of investment and resource was being put into the Falsified Medicines Directive (FMD). It was confirmed staff and systems were in place for this to go live but the link to Europe does not work and significant amounts of money to access it have been requested. A discussion is to be held with the Chief Pharmacist as this risk is currently rated 12 on the Risk Register.

The Chair enquired as to what the most challenging aspects of the Medicines Optimisation Strategy. It was advised the Medicine Reconciliation and Discharge Accuracy are of concern with regards to ensuring the patient is discharged with the correct medicines and the appropriate level of patient safety input from Pharmacists. Medicine Reconciliation currently sits at 75% which requires improvement.

The Committee issued an action of Medicines Reconciliation and Discharge Accuracy positions to

be included in future Medicines Optimisation Strategy Reports.

The Committee was ASSURED by the report.

BAF principle risks update

The Committee had read and acknowledged the report presented.

Risk manager highlighted an amendment to Principle Risk (PR) 1. Subsequent to the circulation of this report, a request has been received to extend the deadline of the Intranet document review to end of March 2021 to enable a complete overhaul of the intranet. The rating for PR1 remains Significant. The Assurance Rating of PR2 has improved from inconclusive to positive for Strategic Threat though the Risk Rating remains at Significant.

The Committee APPROVED the amendments. Also confirming no cases to alter the ratings for PR1 or PR2 and was ASSURED by the report.

Quality Committee Maturity Matrix

The Chair confirmed work with 360 Assurance to develop a Quality Committee Maturity Matrix in consultation with Internal Audit and the Committee Chair to include completion of self-assessments. However given the current pressures and operational constraints BB proposed postponing this until the new financial year. The Committee concurred and it was deferred until May 2021.

Quality Committee Annual Report

The Committee had read and acknowledged the draft annual report presented.

The Committee were informed that the primary purpose of this report is to highlight the responsibilities the Committee has to the BOD and to identify what has been completed throughout the year on their behalf, in addition to satisfying the requirements of the Work Plan and Terms of Reference (TOR). This then forms part of the AAC's responsibilities when looking at the Annual Governance Statement.

The Committee APPROVED the draft annual report.