

**QUALITY AND PERFORMANCE COMMITTEE  
MINUTES OF THE MEETING  
25 August 2016**

Present

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| Antony Kildare   | Interim Chairman (Chair)                     |
| Graham Hodgson   | Non-Executive Director                       |
| Steve Holmberg   | Medical Director                             |
| Mark Smith       | Chief Operating Officer                      |
| Faith Button     | Interim Director of Performance              |
| Helen O'Dell     | Interim Chief Nurse                          |
| Lois Howell      | Director of Clinical Governance              |
| Helen Weatherill | Director of People                           |
| Niall Ferguson   | Chief Pharmacist                             |
| Steve Drage      | Deputy Medical Director (Safety and Quality) |
| Dominic Ford     | Director of Corporate Affairs                |
| David Owers      | Directorate Manager Perioperative (item 4.2) |
| Elma Still       | Associate Director of Quality (item 4.3)     |

**1. PROCEDURAL BUSINESS**

**1.1 Welcome and apologies for absence**

There were no apologies.

**1.2 Declarations of interest**

There were no declarations of interest

**1.3 Minutes of the previous meeting**

The minutes of the meeting held on 28th July were approved as a correct record.

**1.4 Matters arising**

The Chief Operating Officer reported that immediate action had been taken following the Committee to close a number of balcony beds in the Barry Building, but this action was exacerbating the very significant challenges on beds as a consequence of the closure of the Newhaven Down beds and the further loss of beds as part of 3Ts decant. The Medical Director added that the Hospital at Home project which was designed to supersede Newhaven Downs had not done so to date and Newhaven Downs had provided significant value in supporting patient flow.

The Chair noted the continuing frustrations and limited progress which had been made in the broader health and social care system in resolving the issues around capacity.

## REGULATORY

### 2.1 Quality and Safety Improvement Plan

The Director of Clinical Governance reported on progress with the Quality and Safety Improvement Plan. A number of areas had improved including compliance with comfort rounds in the ED which had reached 100%. However hand hygiene scores had deteriorated from the previous week. The Communications and Infection Prevention and Control teams were working on a poster campaign as part of broader awareness-raising. There was also a plan to survey staff on their hand hygiene practice to understand better the impediments to good practice. CQC had advised that the action plan in response to the Warning Notice would need to be produced weekly until 16<sup>th</sup> September, which was also the date by which the Trust was required to submit its Improvement Plan in response to the inspection report. CQC would review this Plan week commencing 19<sup>th</sup> September and would be reviewing progress on site. Future reports would include exception reports both to the Committee and the Board.

Graham Hodgson asked for information in future reports to focus on areas in the plan where performance had deteriorated.

The Chair asked how the discussion from the previous meeting regarding the integration of risks and alignment with the performance report was being taken forward. The Director of Clinical Governance advised that the Board Assurance Framework (BAF), risk register and risk management strategy would all be submitted to the Committee in September for consideration.

Graham Hodgson asked about the likelihood grading on the risk register of 4 regarding progress against the CQC warning notice. The Director of Clinical Governance advised that progress was not binary and depended on what inspectors found on the day and the Medical Director advised that the underlying capacity and flow issues had not changed, but were being mitigated day by day.

The Chair noted that the CQC re-inspection was imminent and the Trust would be required to demonstrate tangible improvement and the problems with capacity and patient flow remained a significant risk to demonstrating improvement.

The Director of Performance asked if mock inspections were planned prior to the CQC re-visit and the Director of Clinical Governance noted that there was no plan for a formal mock inspection but a series of senior visits to services would take place as part of enhancing the connection of the senior team with front-line staff.

Graham Hodgson noted that staff were raising issues with CQC out of frustration that their issues had not been resolved locally and the Medical Director agreed that there was sometimes a passive response in some areas of middle management.

**In conclusion the Committee noted the report and progress with the Plan and the risks to delivery and agreed on the importance of improving the visibility of the senior team with front-line services and in demonstrating traction with those issues which could be resolved in the short-term.**

### 3. PERFORMANCE

#### 3.1 Integrated Performance Report

The Director of Performance introduced the Integrated Performance Report advising that the latest iteration of the report included exception reports in relation to RTT, cancer and histopathology. The Chair noted the importance of focusing on the red areas in discussion.

The Chief Operating Officer reported on RTT performance advising the Committee that a full validation was being undertaken of all Patients of Unknown Status (PUS) waiting longer than 18 weeks and all long waits were reviewed by a harm review panel to assess whether patient harm had arisen from long waits. The key challenges were in paediatrics, Trauma & Orthopaedics and ENT, where recruitment was underway to provide additional capacity, Digestive Diseases, Neurology and Spinal Surgery.

Accident and Emergency performance had deteriorated in August, with significant challenges around patient flow and system support. Delayed Transfers of Care (DTCs) were 7% in July against the standard of 3.5% and improving DTC performance had been discussed at the System Resilience Group (SRG) with particular issues identified around discharges in East and West Sussex.

Cancer performance was in line with the agreed trajectory, with performance of 94.37% against the 2 week standard in July and 98.3% against the 31 day standard. Performance against the 62 day standard was 72.3% in July, but in line with the trajectory.

The Medical Director reported on the 'safe' KPIs noting that hand hygiene compliance was poor at 60% and VTE risk assessment below the standard at 84.3%. However the latter was a reflection of problems with data capture rather than undertaking the risk assessments. The Director of Performance noted the importance of resolving this issue as ongoing poor performance would attract adverse external scrutiny. The Deputy Medical Director advised that there were potential electronic solutions for recording VTE risk assessments, which would also support work with deteriorating patients in recording NEWS scores. The costs to deliver these solutions would need to be explored before being considered further.

The Director of Clinical Governance agreed to review how the recording of VTE risk assessments could be improved.

#### **Action: Director of Clinical Governance**

The Chief Operating Officer also reported that histology reporting within 7 days was only 19% in July, arising from problems around staffing and IT and reporting from the pathology Joint Venture (JV).

Graham Hodgson asked about the governance and accountability of the JV and the Director of Corporate Affairs advised that a Board discussion was planned on 29th September, however there was a need for more frequent reporting from the JV to the Trust. The Chief Operating Officer also advised that the recently appointed Chief Information Officer would also be reviewing the pathology IT systems.

The Chair also asked for the Committee to be updated on the outcome of the SMT discussion on pathology.

**Action: Chief Operating Officer**

The Chair noted the under-performance regarding the direct admission to stroke beds indicator and the Medical Director advised that this related to poor patient flow, noting however that CQC had found stroke care to be outstanding in its inspection report.

The Interim Chief Nurse advised the Committee of poor performance in relation to mixed sex accommodation breaches and noted that this was a hospital-wide problem with the Medical Director advising that this also arose from poor patient flow and high bed occupancy. Improvements in early discharge and the effective use of ambulatory care would enable improvements in this area. The Chair noted the importance of this indicator in respect of poor patient experience.

The Deputy Medical Director (Safety and Quality) noted the importance of aligning the work of the Improvement Academy with the CQC actions which would be reviewed with the Chief Operating Officer.

**Action: Deputy Medical Director (Safety and Quality) and Chief Operating Officer.**

#### **4. QUALITY, CLINICAL AND PATIENT ISSUES**

##### **4.1 Infection prevention and control annual report**

The Interim Chief Nurse introduced the draft annual report for Infection Prevention and Control for 2015/16.

The Chair noted that the report predated the CQC inspection and the subsequent visit by NHS Improvement which identified poor hand hygiene practice and cleaning standards in the Barry Building. The Medical Director agreed that there were concerns around infection prevention and control practice which were not identified in the report, however the report did reflect the considerable range of activity in this area. The Medical Director also noted the importance of monitoring practice in relation to hand hygiene, whereas previous performance reports had focused on the number of cases of MRSA and C. difficile only.

**The Committee noted the draft infection prevention and control report and agreed that it would be reviewed and updated prior to submission to the Board.**

**Action: Interim Chief Nurse**

##### **4.2 Theatre review**

The Director of Clinical Governance advised that a previous review of theatre safety and culture had been commissioned in 2014 from Professor Reid, following a number of Never Events and this report had been commissioned by the Chief Nurse following the Never Events in 2015, also advising on progress from the previous report, with a particular focus on the role of human factors in relation to patient safety in Theatres. An

action plan had been produced following the first report and this report described the prevailing culture in theatres at the time of the review.

The Chair noted that he had previously worked closely with the Perioperative Directorate including observing Theatres, following which he had submitted a report to the Board which was not referred to in this review. There were a number of inaccuracies in the report which was unhelpful, notwithstanding the importance of acting on the findings of the report.

The Directorate Manager advised on the Directorate response to the review noting the context in which there were far too many cancellations and last-minute changes in theatres and variations in clinical engagement. Perioperative staffing of the obstetric theatres was a long-standing issue but funding had now been found and the new staffing arrangements would be effective from January. The action plan focused on support for theatre staff including resolving the confusion identified about who was in charge of shifts in the level 5 theatres at RSCH. This had now been addressed with the whiteboards clearly identifying who was in charge. Staff remained frustrated by last-minute changes to the theatre schedule but would now proceed with the first patient on list regardless of bed state subject to conclusion of the debate in this area. The Trust had also been working closely with *Four Eyes* on theatre scheduling introducing the 6/4/2 approach to lock down theatre sessions with compulsory attendance from relevant specialties, which would enable the avoidance of dropped sessions.

The Medical Director advised that the overall finding of the review was that fundamentally theatres were safe but some of the processes were unhelpful and made error more likely and therefore organizational development and human factors were important to reducing risk. The Committee was also advised that the Clinical Director Perioperative was also creating time-out space for team-building within the Directorate and appropriate administrative space secured for the anaesthetics team. The Directorate Manager added that there were still too many cancellations, with multiple causes, but work was ongoing to address this and the Chair noted the impact of cancellations on patients.

Graham Hodgson added that the plan needed clear target dates for delivery rather than ongoing dates.

**Action: Directorate Lead Nurse**

**The Chair concluded by noting the importance of learning from the review which was also aligned with work to improve theatre efficiency and utilization. The action plan would be monitored by the Directorate and reported to the Committee by exception.**

#### **4.3 External reviews**

The Associate Director of Quality advised that the policy on external visits, inspections and accreditation was under review. A schedule of external visits was submitted to the Committee and further work would be undertaken to update the schedule and the status of the action plans.

The Committee agreed that the schedule would be revised in date order; organizational learning would be added to it; and a simple RAG rating agreed by the Executive lead.

The Chief Pharmacist would also include medicines management visits in the schedule.

## **5. RISK**

### **5.1 Strategic Risk Register**

The Director of Clinical Governance advised that the development of the risk register continued to be work in progress, and had been further refined following the last meeting. Appendix 1 of the report included the risks rated 15 and above and their level of control. 2 new risks had been added concerning the CQC warning notice and histopathology performance. There were also a theme in the risk register in relation to the long term lack of maintenance and/or investment.

The Committee discussed the risk assessment of the capital programme noting that the Finance Business and Investment Committee would receive a report in September on the backlog maintenance programme.

The Chief Pharmacist also noted the interface between the maintenance and replacement of equipment. Graham Hodgson noted the risk around the pharmacy robot and asked what programmes were taking priority over its replacement. The Medical Director agreed that the capital programme prioritization needed to be informed by an assessment of risk which would also inform the Board regarding priorities and how risks around equipment which could not be afforded would be mitigated. The Deputy Medical Director also noted the usefulness of the risk register in supporting the prioritization of investment and the communication of decisions with staff.

**The Committee supported the work to date and noted the importance of prioritising backlog maintenance and the replacement of essential equipment. The Committee also noted the importance of the Board overseeing the prioritization and decision-making in relation to equipment.**

## **6. ANY OTHER BUSINESS**

There was no other business.

## **7. KEY RISKS AND ISSUES TO REPORT TO THE BOARD**

The key risks and issues to be reported to the Board would include:

## **8. DATE OF NEXT MEETING**

The next meeting of the Committee will be on Thursday 22<sup>nd</sup> September.