Wrightington, Wigan and Leigh NHS Foundation Trust

Chairpersons Report

Chairpersons Name	Tony Warne		
Committee Name	Q&S Committee		
Date of Meeting	08.03.17		
Name of Receiving Committee	Trust Board		
Date of Receiving Committee meeting	March 2017		
Strategic Items for referral to Trust Board	Issues in relation to PFD actions: the delay in response from GMP with regard to piloting a record to be used for escorted patients and the lack of evidence that the pro-forma for patients transferred between WWL and 5 Boroughs was being used		
Items for escalation?	**Yes**	**No** **x**	**If yes, to which Committee**

Please detail up to 3 key successes or achievements discussed at the meeting
1. The Quality Strategy presentation
2. The formation of the Mortality Group
3. The response from REMC in relation to urgent risks
4. Good progress being made with the CQC action plan
5. The SEC report
6. The progress being made in relation to the Safeguarding teams
7. The positive progress being made in relation to Anna's case

Details of the top three risks identified during the course of the meeting and initials of primary member of staff actioning		
1.	HSMR / SHMI	
2.	The challenges around implementing an internal inspection	

Attendance at the meeting (please highlight):	**Excellent (well attended)** **X**	**Acceptable (some apologies)**	**Unacceptable (quorate)**	**Unacceptable (not quorate)**

Was the agenda fit for purpose and reflective of the Committees terms of reference?	Yes

Narrative report of the key issues of the meeting
It was a very packed agenda but well supported by some excellent papers and reports. The main focus of the presentation was the quality strategy which illustrated the relentless focus on quality within all areas of WWL business. There was some debate over the smart target that formed the headline of the strategy and the authors and Executive were asked to revisit this in light of the discussion. The strategy was immediately followed by a presentation of the quality accounts, which whilst showing improvement in many areas being measured, there were still some areas where this was not the case. For those areas that were to be retained, further work was required in defining what it is that was being measured – so for example discharge planning and communication needed to be further deconstructed into its elemental parts, and further analysis was required around falls. Further discussion was generated following the PS PFD report. Whilst the report was a very good one charting actions taken around four cases, it was disappointing to note that agreement had not yet been reached with GMP over the multi-agency risk assessment and planning tool. Whilst it was agreed that WWL colleagues should continue to risk assess all patients, particularly those admitted from custody, the lack of progress with GMP should be escalated to the Accountable Office via the full Trust Board. Amongst the other reports was an up-date on Anna's case. Although this was generally positive, there were still

risks in how similar situations might be managed in the future. Whilst these are being addressed, the discussion once again revisited the earlier points made in the context of avoidable harm.

Key outcomes from the reports taken at the meeting

Quality Accounts – revisit the descriptors.
BAF – Work ongoing to determine why WWL remains an outlier – a comparator Trust to be identified in order to explore what bets practice might look like.
CQC – acknowledged that good progress was being made against action plan – internal CQC review to be commissioned before July 2017
SEC Report – high in detail and quality of analysis to be disseminated to Divisions.
Safe Guarding Report – a good action plan described and presented. Notification of external audit - and notification given of a review to see whether the adult and child teams can work closer together and share best practice.
Deteriorating Patient Report – Big improvement noted in rates of escalation and continued improvements in 8 hour observations being undertaken.

Agreed actions from the meeting	Name of primary lead for the actions
C Alexander to consider the comments made by the Committee in relation to the Quality Account priorities for 17/18	C Alexander
P Law to bring the ToR for the new mortality group to the Q&S Committee for information	P Law
An internal inspection, focusing on areas that had been scored as inadequate or requiring improvement, to be arranged to take place before June	D Pullen
Divisions to consider the actions specified at their DQECs	Divisional Governance Leads
G Smith to look into the potential funding of ECG machines via charitable money and the rationale for this	G Smith
R Forster to discuss attendance and deputies at meetings at ECC	R Forster

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

MINUTES OF A MEETING OF THE QUALITY AND SAFETY COMMITTEE HELD ON WEDNESDAY 8th MARCH 2017 AT 9.30AM AT TRUST HEADQUARTERS

PRESENT	2017										
	11 01	08 02	08 03	12 04	10 05	14 06	12 07	13 09	11 10	08 11	13 12
Andrew Foster, CEO	APOLS	√	APOLS								
Dr Sanjay Arya, Interim MD	√	√	√								
Christine Parker Stubbs, NED	√	√	√								
Prof Tony Warne, NED (Chair)	√	√	√								
Robert Armstrong, Chairman	√	√	√								
Richard Mundon, Director of Strategy	√	√	√								
Alison Balson, Workforce Director	√	√	√								
Jon Lloyd, NED	√	APOLS	√								
Mary Fleming, DOP	√	APOLS	APOLS DE								
Rob Forster, DoF	√	√	√								
Pauline Law, DON	√	APOLS	√								
IN ATTENDANCE											
Gillian Edwards, Associate DoF	√	√	√								
Lynda Hancock, Minutes	√	√	√								
David Evans, Associate Director of E&F	√	APOLS S Clancy	√								
Stephen Dobson, Head of IM&T	APOLS	-	-								
Tracy Joynson, Governance Lead Surgery	APOLS	√	APOLS								
Gill Smith, Governance Lead SS	√	√	√								
Lesley Boyd, Governance Lead Medicine	√	√	√								
Claire Alexander, Associate Director of Governance and Assurance	√	√	APOLS								
Linda Sykes, Governor	√	√	√								
Deborah Pullen, Compliance Lead	√	√	√								
Head of Nursing (on rotation)	JP /AB	D Lee	JP								
Cathy Stanford, Governance Lead for Maternity & Child Health	APOLS	√	√								
Allison Edis, Deputy Director of Nursing	√	√	√								
Martin Farrier, Associate Medical Director	√	-	-								
Pam Green, IM&T	-	APOLS MS	√								

In attendance: C Greenhalgh – Head of Quality Improvement, Jennifer Hovington – Trust Solicitor, N Compton Jones – Adult Safeguarding Team

1. QUALITY STRATEGY 2017 – 2021 PRESENTATION

C Greenhalgh was in attendance at the meeting to present the Quality Strategy 2017-21 to the Committee. This would form part of the overall Trust strategy and the strategic narrative work that was being undertaken.

Over the past three years there had been a number of improvements, particularly around harm free care, infection rates and A&E waiting times. There had been investment in the new theatres at Wrightington and the HIS and the Trust continued to score well on the Friends and Family Test for both staff and patients. However, the landscape around WWL was changing and it would be important for the Trust to remain financially viable whilst also working in partnership with others.

The aim of the Quality Strategy 2017-21 was to move towards zero avoidable harm by 2021. This would be achieved by looking at excellence in clinical care, engagement and networking, quality improvement, measuring / monitoring of safety and culture. Monitoring would be undertaken via annual targets set through the Quality Accounts.

The strategy had been to Corporate QEC for discussion and had received sign off from A Foster. Following presentation at Q&S Committee, this would then need to go to Trust Board for final sign off.

T Warne thanked C Greenhalgh for her presentation and invited questions from those present.

A Balson felt that the strategy was excellent and that the aim to move towards zero avoidable harm was a great message. She noted that the Trust had not performed as well in the Staff National Survey 2016 with regards to staff reporting incidents and this was something that would require work. She felt that Talksafe would form part of the solution but it would be important to consider how initiatives such as this could be effectively brought to life.

R Armstrong noted that, as well as the focus on zero avoidable harm, it would be important to also link in the delivery of staff and patient satisfaction. He felt that the delivery of the Quality Strategy could form part of the Board objectives. P Law agreed and advised that she had selected this as one of her suggested objectives.

S Arya was concerned that aiming for zero avoidable harms by 2021 might be unachievable. He felt that it would not be possible to remove harms in the organisation entirely and was keen that the Trust did not set an impossible target.

P Law noted S Arya's concerns but felt that a target of zero was something the Trust should aspire to. She emphasised that this was around avoidable harms which had processes and procedures in place to prevent occurring. She agreed that there would always be some element of unavoidable harms. R Armstrong strongly supported the aim for zero and noted that if it couldn't be achieved by 2021, then the Trust would have to consider another timescale / target.

J Lloyd was pleased to note that progress was being made on using leading indicators rather than lagging indicators.

T Warne thanked all for their contribution to the discussions. He noted that the Quality Strategy 2017-21 would proceed to Board for sign off, pending final agreement from the EDs that the aim of zero avoidable harm by 2021 was appropriate.

2. QUALITY ACCOUNTS ANNUAL PRIORITIES UPDATE FOR 16-17 AND QUALITY ACCOUNT PRIORITIES PROPOSED FOR 17-18

C Greenhalgh presented this paper in the absence of C Alexander.

The paper provided an update on the current year's priorities and whether or not these had been achieved.

The priorities that had not achieved were noted to be:

- HSMR of no more than 87 / SHMI of no more than 100 – there were a number of factors which had impacted on this. Focused work was being undertaken around mortality, including the creation of working groups both internally and with external parties.

- VTE risk assessments for 99% of patients admitted – there had been issues around HIS which were in the process of being rectified. It was anticipated that the Trust would achieve over 90% by the end of March.

- Falls reduction by 10% - whilst this had not achieved, it was noted that the harms caused by falls had reduced. This would remain a priority for next year but with a slightly different focus on falls that resulted in moderate, severe harm and death

- 50% reduction in delayed discharges – this priority consisted of several different parts and whilst the majority had not been achieved, improvements had been made and achievement had been close

- Correct anti-coagulation for 95% of patients – this priority had been led by QUEST and had been slow to start.

- 90% of patients agreeing that they had been involved in their discharge – whilst this priority would not achieve, it was noted that improvements had been made compared to performance last year

Priorities that had achieved were noted to be:

- 100% compliance with the identification of the deteriorating patient
- Recruitment of 100 clinical staff as dementia champions
- To create a comprehensive register of all Trust electronic information assets
- To achieve an improved benchmark position for patients reporting issues with noise at night
- Achieve 90% of patients aware of the Consultant treating them

C Greenhalgh took the Committee through the proposed priorities for 17/18 and noted that there had been a stakeholder engagement event that had taken place the previous day which had generated a few further suggestions:

Safe
- A revised HSMR / SHMI indictor
- VTE risk assessment (retained from 16/17)
- Reduction of falls resulting in moderate / serious harm or death

Effective
- Correct anti-coagulation treatment (retained from 16/17)
- 100% compliance in identifying the deteriorating patient (retained from 16/17)
- Development of a ward accreditation scheme
- An indicator around uDNACPR

- An indicator around 'Right Patient Right Ward'

Caring

- Involvement in discharge (retained from 16/17)
- To improve the benchmark position for patients knowing who to contact following discharge with concerns

C Parker Stubbs noted that C Greenhalgh had reported that falls seemed to have plateaued. She felt that falls were actually reducing and suggested that the calculation was re-considered to take into account the increased level of frail, elderly patients. She would also be interested to understand how many patients scoring low on a falls risk assessment went on to have a fall.

C Parker Stubbs noted that discharge involvement had been a long standing issue that never seemed to be resolved. She queried whether it would be possible to look into what patients perceived not to have been involved in and drill down into these areas. P Law advised that she had asked MIAA to undertake a face to face audit with patients for this purpose.

R Armstrong suggested the use of threshold, on target and stretch when setting targets. He felt this would help the Trust to avoid setting demotivating targets.

D Pullen noted that IV fluids had been raised as an issue at the mortality event in February and queried whether this should be included.

T Warne thanked all for their discussions around this. The Committee supported the priorities suggested with consideration to be given to the comments made by the Committee.

ACTION: C Alexander to consider the comments made by the Committee in relation to the Quality Account priorities for 17/18

3. COMMITTEE CHAIR'S OPENING REMARKS

T Warne welcomed all to the meeting and advised that it was great to be celebrating International Women's Day. He went on to provide some comments from an event he had co-hosted in GM last week.

4. APOLOGIES

As noted in the table above.

5. DECLARATION OF INTERESTS

There were no interests declared.

6. MINUTES OF THE Q&S COMMITTEE MEETING 08.02.17

The minutes were agreed to be an accurate record.

7. MATTERS ARISING

a. Action log from 08.02.17

Action updates were received and noted.

b. **Work plan 2016/17**

The work plan was received and noted.

c. **Work plan 2017/18**

The work plan was received and noted.

8. BAF SCORING

Achieve HSMR of no more than 87 / SHMI of no more than 100

S Arya noted that there had been some improvement in the HSMR figures but there was much to do as WWL was still above 100. A mortality group had been set up including a variety of staff from across the Trust. Terms of reference were in place and the first meeting had been scheduled for April. A report would be brought back from this first meeting.

P Law felt it would be useful for the Committee to have sight of the terms of reference for the group.

R Forster noted that the mortality presentation given by M Farrier had not yet been shared with the Health and Wellbeing Board but discussions were taking place to get this on the agenda.

The Committee agreed to retain the scores at 20 (HSMR) and 16 (SHMI).

ACTION: P Law to bring the ToR for the new mortality group to the Q&S Committee for information

9. RISK ESCALATIONS FROM REMC AND RISK TRACKER

R Mundon provided an update around his action from the previous meeting which had been to discuss at REMC how unexpected risks could be captured and escalated immediately. This had arisen in relation to the issues at Wrightington theatres and the delayed escalation to Sub Committee / Board level. He advised that discussions had taken place around pipeline risks and this took place at every meeting. It would also be ensured that there was explicit mention of this issue in the risk policy and ToR.

Whilst there were no formal risks to escalate to the Committee, R Mundon highlighted that there was a risk around the Taylor Unit which remained scored at 20. The risk was around ensuring there was sufficient staffing available to provide a service. This was currently being mitigated by matching the number of beds to the number of staff but if this was not successful, the risk would likely be formally re-escalated.

T Warne noted the need to be mindful of risk share with partners around this.

C Parker Stubbs noted that the concern of the Committee had been around the immediate escalation of newly emerged risks. R Mundon agreed and noted that REMC was trying to cover this by taking copies of reports taken at DQECs.

C Parker Stubbs noted that the risk around staffing levels on Lowton and MAU had been reduced in score but there was no justification in the narrative section. P Law advised that it had been reduced as staff had now been recruited and safe staffing levels were being maintained in the meantime. A Balson advised that there had also been targeted work around sickness.

The risk tracker was received and noted.

a. StEIS REPORT / SERIOUS INCIDENTS IN MONTH

D Pullen advised that three incidents had been uploaded since the last report. These had been in relation to violence and aggression from a patient, the incorrect use of high flow oxygen on a patient and the closure of beds on Ince ward due to D&V. A further incident had been submitted in March in relation to a hospital acquired grade 3 pressure ulcer. This was being fully investigated.

10. PFD UPDATE

J Hovington was in attendance to provide an update on all PFDs with ongoing actions.

In relation to the PFD that was given to WWL regarding the transfer of patients between the two organisations, it was noted that all actions were complete with the exception of the use of a standardised pro-forma for transferring patients. J Hovington advised that, whilst the pro-forma had been devised and circulated, there was not much evidence of it being used. An audit had been requested and there would be further communication with 5 Boroughs around the transfer of patients.

In relation to the PFD that was given to WWL regarding the lack of risk assessment for patients brought into the Trust under police escort, J Hovington advised that the action around this was still to be completed. A document had been put together for patients under escort which had been approved by WWL but not by GMP as yet. Until this was agreed, it could not be piloted. Confirmation from GMP continued to be sought.

In relation to the PFD that was given to WWL regarding weekend staffing levels and the use of the MEWs chart, J Hovington advised that all of the actions had been completed with the exception of the one relating to the MEWs and fluid balance. This was being looked at and a rolling programme of teaching was in place. Work was ongoing.

In relation to the PFD that was given to WWL regarding communication between the coronary care and surgical teams, J Hovington reported that Dr A Wardman had developed a Shared Care Guidance Note for clinicians. This was awaiting approval at the next CAB meeting.

J Prescott noted that the action in relation to the patients under escort had been on-going for some time. D Pullen advised that, as GMP also worked with other Trusts, they needed to approve the form with them too.

C Parker Stubbs also had concerns around the length of time being taken to clear this action. She noted that WWL continued to receive a great number of escorted patients and was concerned that there could be a repeat incident.

R Armstrong agreed and suggested that this was escalated to the Board as a risk. He suggested that it was put to the Board for A Foster to write to the Chief Constable of the GMP about this.

J Lloyd similarly noted issues with the shared pro-forma between WWL and 5 Boroughs and suggested that this was also flagged at Board.

The Committee supported these suggestions.

11. CQC ACTION PLAN UPDATE

D Pullen provided an update to the Committee in relation to the CQC action plan. She advised that there had been 14 must do actions, 11 of which had now been completed. There had been 57 should do actions, 54 of which had now been completed. She thanked the Divisions for their hard work in achieving this.

In terms of actions that had not yet been completed, D Pullen advised that these were in the following areas:

Must do

- Taylor Unit
- PDRs and mandatory training in the Division of Medicine
- APLS trained staff on Rainbow Ward

Should do

- Endoscopy
- Oxygen prescribing
- Compliance with DNACPR standards

D Pullen noted that progress was being made against all of the outstanding actions. She further noted that the CQC had expressed their intention to visit Taylor Unit in April. This would not be an inspection but a more informal visit.

A Balson queried if arrangements were in place with NHSP if an APLS trained member of staff was off sick. J Prescott advised that NHSP staff did not have the training but the aim was usually to have 2 APLS trained members of staff on each shift and, as more staff were trained, this would be easier to have in place.

S Arya advised that he had spoken to M Parks around oxygen prescribing and would be looking to encourage medics to prescribe going forward.

R Armstrong felt that the progress being made was great. He noted on the dashboard that there were areas rated as 'inadequate' or 'requiring improvement' and queried the timescales for moving these to 'good'. P Law advised that the CQC were due back to reassess paediatrics but had given WWL time to put actions in place. She anticipated that the Trust would be ready for reassessment in the coming months.

D Pullen asked the Committee for their thoughts on holding an internal inspection. She advised that the last one had been held in June 2015. The Committee supported this suggestion and felt that it would be important for this to take place as soon as possible before June with a focus on the areas that had been rated as 'inadequate' or 'requiring improvement'. It was further suggested that it would be helpful to perhaps have some independence in the process from an external party.

A Edis suggested that MIAA could undertake a review of the actions or it could be done by peer review.

ACTION: An internal inspection, focusing on areas that had been scored as inadequate or requiring improvement, to be arranged to take place before June

a. *DEEP DIVE INTO CQC ENGAGEMENT MEETING MINUTES*

D Pullen advised that these were very detailed meetings with a great deal of scrutiny and appropriate challenge.

12. SEC Q3

The report was received and noted.

D Pullen advised that there were specific actions for the Divisions in the report on pages 11, 12, 24 and 30. These should be taken forward by the Divisions at their DQEC meetings.

T Warne thanked D Pullen for an excellent and accessible report which contained a great deal of information.

C Parker Stubbs was pleased to note the number of claims successfully defended had improved.

J Lloyd congratulated D Pullen and team on the excellent preparation of these papers. He was pleased to note the good progress being made.

ACTION: Divisions to consider the actions specified at their DQECs

13. ADULT SAFEGUARDING MIAA REPORT AND ACTION PLAN

N Compton Jones was in attendance to present the report to the Committee. She advised that the team had put back challenge on some of the risks identified by the audit as there were some that were out of the remit of the Trust. Issues had been identified in relation to referrals into the team. The audit had identified that there was no formal process in place. Work was being undertaken with the HIS team to get this on the system but there were challenges in terms of prioritisation. There had also been some issues raised with regard to the recording of activity and the capacity of the team. A Edis advised that a colleague of hers had agreed to undertake a review of the safeguarding teams with a view to making recommendations around the structure. This would be taking place in March.

14. ANNA'S CASE UPDATE

C Stanford provided an update on the actions that were being taken forward as a result of Anna's case. She advised that work had been undertaken with surgical colleagues to produce new clinical guidelines for children with suspected appendicitis. There was now a greater level of collaboration between surgical and paediatric teams. In response to the issues around the flushing of cannulas, Dr Saad had undertaken work around this. Checks now formed part of the sign out element of the WHO checklist. There was also a checklist in place for completion on handover of the patient from theatre to ward. This would be held with the patient notes. It had been agreed that an APLS trained member of staff would collect patients from theatre to return to ward. Simulation training was being provided for nurses in theatres. She felt that this was a much improved position and this would be audited in time to ensure that it was embedded.

C Parker Stubbs was concerned that there would be a gap on the ward if the APLS trained member of staff was collecting patients from theatre. J Prescott agreed that this was an issue but everything possible would be done to minimise the amount of time away from the ward and more staff continued to be trained for APLS.

R Armstrong felt that this case confirmed that the Trust aim for zero avoidable harm was correct. This was an incident that needn't have happened.

15. DETERIORATING PATIENT REPORT

P Law presented the report which provided an update on the work being undertaken around the deteriorating patient. There had been significant improvements in escalations and lots of work done around 8 hourly observations. She advised that there was some resistance to 8 hourly observations but she continued to pursue it further.

16. ITEMS RECEIVED BY THE COMMITTEE FOR INFORMATION

C Parker Stubbs noted reference in the Specialist Services DQEC minutes to ECG machines possibly being purchased by charitable funds. She queried this as it was standard equipment that should be provided by the Trust. G Smith advised that should check this.

J Lloyd flagged attendance levels at some of the meetings and noted the need for deputies. R Forster agreed to flag this at ECC for cascade through senior management.

ACTION: **G Smith to look into the potential funding of ECG machines via charitable money and the rationale for this**

R Forster to discuss attendance and deputies at meetings at ECC

17. STRATEGIC ISSUES FOR REPORT

It had been agreed to escalate PFD issues to the Board.

18. ANY OTHER BUSINESS

There were no further matters for discussion.

19. KEY SUCCESSES / RISKS

Key successes were agreed to be:

- The Quality Strategy presentation
- The formation of the Mortality Group
- The response from REMC in relation to urgent risks
- Good progress being made with the CQC action plan
- The SEC report
- The progress being made in relation to the Safeguarding teams
- The positive progress being made in relation to Anna's case

Key risks were agreed to be:

- HSMR / SHMI
- The challenges around implementing an internal inspection

20. COMMITTEE EFFECTIVENESS FEEDBACK

T Warne thanked all for their participation in what had been excellent discussions.

21. DATE AND TIME OF NEXT MEETING

This was noted to be on the 12th April 2017, 9.30am, THQ Boardroom.