NHS Improvement

MINUTES OF A MEETING OF THE QUALITY COMMITTEE HELD ON WEDNESDAY 17 JANUARY 2018 AT 10.30am AT WELLINGTON HOUSE, 133-155 WATERLOO ROAD, LONDON SE18UG

Present:
Sarah Harkness, Non-Executive Director (Chair)
Dale Bywater, Executive Regional Managing Director (Midlands & East) (by telephone)
Vincent Connolly, Regional Medical Director (North) (by telephone)
Lord Ara Darzi, Non-Executive Director
Sue Doheny, Joint Regional Director of Nursing (South)
Ruth May, Executive Director of Nursing
Kathy McLean, Executive Medical Director
Emma Whicher, Regional Medical Director (London)
Richard Wilson, Director of Quality and Intelligence & Insight

In attendance:
Jessica Dahlstrom, Head of Governance
Jacqueline McKenna, Director of Nursing – Professional Leadership
Hazel Watson, NHS England Director of Nursing & Deputy Chief Nurse(South)

1. Welcome and apologies (oral item)

1.1. Apologies for absence had been received from Maggie Boyd (Director of Clinical Quality (Midlands and East)), Rachel De Caux (Regional Medical Director (South)) and Celia Ingham-Clark, Interim National Director of Patient Safety.

1.2. There were no declarations of interest.

2. Minutes and matters arising from the meeting held on 26 October 2017 (QC/18/01)

2.1. The minutes for the meeting held on 26 October 2017 were approved and matters arising were noted. The Quality Committee (the Committee) requested that the final version of its Terms of Reference would be sent to the Board for information

ACTION: JD

3. Incorporating the Patient Voice in the work of the Committee (QC/18/02)

3.1. The Director of Nursing presented a paper which set out options for incorporating the patient voice into the work of the Committee. The advantages

and risks of the options presented were discussed and consideration was given to the possibility of having both a patient member of the Committee and a patient story included at the start of every meeting.

3.2. The Committee emphasised the importance of following a robust process in the selection of a patient member. A job description would be required and a recruitment process would be followed.

3.3. A discussion took place on the amount of time available on the Committee agenda to dedicate to a patient story. It was noted that around 15 minutes was usually allowed for such stories, which included time for the Committee to discuss the story. The possibility of including staff stories was also considered. It was noted that the Committee would not be required to comment on or resolve individual cases, but that the patient story would give Committee members a mental frame in advance of the discussion of Committee business.

3.4. The Committee gave consideration to ways in which it could ensure that the patient or staff stories it heard were not centered on London, and the possibility to see patient stories on video or via a video conference call was discussed.

RESOLVED:

3.5. The Committee resolved that at its next meeting, scheduled for 26 April 2018, a patient story would be presented. The Committee also resolved to commence the recruitment process for a patient member of the Committee. If an interim patient member was identified in advance of the next meeting, the Committee would be content for that person to attend the meeting.

ACTION: JM

4. Updated Quality Dashboard (QC/18/03)

4.1. The Director of Quality and Intelligence & Insight introduced the paper, which provided the Committee with an updated dashboard overview of key quality indicators. The key changes and trends that had developed since the report had last been presented were outlined with a particular focus on venous thromboembolism, mixed sex accommodation and infection data.

4.2. The Committee commented that the data presented in the dashboard was approximately 2-3 months out of date, and it was explained that this was due to the fact that the report was based on published information. The advantages of using this approach was that there was no additional data collection burden on providers, and that there were no issues in publishing the dashboard should the Committee wish to do so. It was noted that regional colleagues attending the Committee meetings would have access to more up to date unpublished data and would be able to update the Committee in relation to recent developments.

4.3. It was noted that work was ongoing to expand the dashboard to include more data on community and mental health services, and that some of this data would be available ahead of the next meeting on 26 April 2018.

ACTION: RW

4.4. It was noted that mortality would be discussed in depth at the next meeting. End of life care was also discussed as a topic of interest for a potential deep-dive discussion.

ACTION: JD, RW

4.5. The Committee discussed the possibility of including outcome as well as process measures in the report as more outcome measures became available. The Getting It Right First Time programme was a potential useful source of outcomes data.

4.6. A discussion took place on Never Events. The difference between a Serious Untoward Incident and a Never Event was discussed and it was noted that there was a nationally agreed list of Never Events. The Committee expressed concern with regard to the frequency that Never Events continued to occur and discussed the investigation processes which were in place to ensure learning from Never Events. The Committee requested that a representative from the Patient Safety team would be invited to come and present to the Committee on this subject.

ACTION: JD, KMcL

4.7. Venous thromboembolism (VTE) trends were discussed and the Committee noted that there were no particular themes or issues, but that the NHS needed to refocus on VTE. The advantages of prescribing medication to prevent VTE to all relevant patients were discussed and it was noted that the prescribing process needed to be simplified. It was noted that the Director of Nursing – Professional Leadership would liaise with the VTE national nurse network regarding the performance. The Committee requested that additional data on VTE outcomes would be included in the dashboard.

ACTION: RW

4.8. Consideration was given to the data on pressure ulcers and the importance of ensuring the NHS continued to focus on these was emphasised. It was also noted that it may be of interest to review data on prevalence of pressure ulcers by ethnicity.

RESOLVED:

4.9. The Committee resolved to approve the Quality Dashboard for submission to the Board of NHS Improvement in the private session as a work in progress. From March 2018 onwards, it was expected that the Quality Dashboard would be a standing item on the public Board agenda.

ACTION: JD

5. Update from the regions (QC/18/04)

5.1. The Committee considered four reports from the regions setting out, for each region, the governance structure for quality and the current trends and issues. The Committee confirmed it was content with the governance structures as

presented. In relation to the Midlands and East, it was the report contained a factual error and the Regional Quality Meeting had been in place since 2013 (not 2003).

5.2. Representatives from each of the regions provided an overview of current trends in each region. The South region provided an overview of the regional issues in relation to the provision of mixed sex accommodation (MSA). The region was an outlier in this regard which was partly the result of a different interpretation of national guidance and local agreements which had been reached on the subject. This related, for example, to delays in transferring patients from mixed sex critical care units to single sex wards after patients had regained consciousness. New reporting arrangements were being put in place from February 2018 onwards and it was expected that these would initially result in an increase in the number of MSA breaches. It was also expected that there would be lessons learned for other regions and the Committee requested that an item on MSA would be placed on the forward planner.

ACTION: JD, SD

5.3. The Regional Medical Director for London provided an overview of the key trends in the London region, which included an issue around the capacity of mental health services which had resulted in a number of mental health service users waiting for beds or presenting at emergency departments. Work was also ongoing in the region on addressing the issue of stranded patients to alleviate winter pressures and on the Learning from Deaths initiatives.

5.4. In relation to the Midlands & East, the Committee received an update on the safety hub created in the region to identify and resolve safety risks arising in the delivery of urgent care through the winter period. The hub was praised by the Executive Medical Director and the Committee requested that the learning from the safety hub would be shared with the National Director of Urgent and Emergency Care.

ACTION: DB

5.5. Further updates from the Midlands & East region were provided in relation to VTE, Never Events and assurance processes around quality and safety in financially challenged trusts.

5.6. An update was received from the North region and it was noted that the focus of the region was on supporting trusts that were in Special Measures for quality reasons and other challenged providers.

6. Infection prevention and control update (QC/18/05)

6.1. The Executive Director of Nursing provided an overview of progress made in relation to infection prevention and control. The Committee considered the progress that had been made against targets which were difficult to achieve.

6.2. A discussion took place on the increase in E. Coli infections and the likely causes. It was noted that such infections were often acquired in a community or

primary care setting. The importance of establishing a baseline of data against which to start measuring progress was emphasised.

6.3. It was noted that a meeting would be organized between Lord Darzi, the Executive Director of Nursing and the relevant colleagues at NHS Improvement to examine the data in more detail.

ACTION: RM

7. Any other business

7.1. The Committee requested that time would be dedicated at the April meeting to a session on lessons learned from winter. In particular, the Committee would consider the review conducted by the Patient Safety Team of the impact on patients of the emergency pressures over winter. Patient and staff experience, and the differential impact of the pressures on different parts of the population would also be discussed.

ACTION: KMcL, JD

Close