Kingston Hospital NHS Foundation Trust

Quality Assurance Committee Update

Trust Board	**Item: 20**
Date: 11th July 2018	**Enclosure: P**
Purpose of the Report: To report on the main areas of discussion at the Quality Assurance Committee meeting held on the 28 June 2018.	
For: Information ☒ Assurance ☒ Discussion and input ☐ Decision/approval ☐	
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	
Legal / Regulatory / Reputation Implications:	Regulatory and compliance implications
Link to Relevant CQC Domain: **Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒**	
Link to Relevant Corporate Objective:	All Objectives
Document Previously Considered By:	

Report for Board and COG

- Scrutiny of integrated performance report: assured by the data that there are no areas which should give us significant concerns. Particularly notable that nursing staffing levels are good and that all indicators in the well led domain are positive. Ophthalmology continues to audit their processes to ensure patients are all on a pathway of care following concerns after a number of breaches were detected. There is a continued focus on a range of issues including management of pressure ulcers. The committee heard an update on the management of pressure ulcers which assured us that this important indicator of quality care continues to receive attention. A band 7 tissue viability nurse has been appointed as well as an administrative/HCA post. A new bed and mattress contract is rolling out. NHSI has just issued new standards in relation to pressure ulcers. KH expects to be compliant with these and QAC we will get a more detailed report at a future meeting. There continues to be a focus on improving our complaint response times however QAC was assured that patients are kept informed of the progress of their complaint.
- We had a report on the comprehensive audit programme of REU services. This demonstrates that, over a range of services KH is achieving outcomes which are equivalent to or better than national data.
- On the FTT there are increasing response times. There are currently some system problems which are being addressed. These relate to the company that contacts service users to encourage their feedback.
- QAC had asked for a report on the major fire risks detailed on the Trust risk register. This was with the aim of assuring ourselves that patient care was not affected as these were addressed. Assurance was provided and indeed the committee is impressed at how smoothly the major work to address this significant risk is proceeding.
- The principle deep dive at QAC was into the Maternity Sign up to Safety Project. This is a national initiative designed to reduce the number of babies in the UK who either die in labour, shortly after birth or sustain severe brain injury. It was initiated after work by the RCOG demonstrated that 76% of babies with these outcomes might have had a different outcome if standards of care had been better. The particular initiative at Kingston has been aimed at improving standards of intrapartum fetal heart monitoring. The initiative started in 2015 and a detailed programme of education of all maternity professionals into CTG interpretation has been in place. The result is that in 2017/18 KH had no cases of severe or early neonatal deaths which could be attributed to a failure of intrapartum fetal monitoring. This is a significant achievement. QAC was assured that improvement has not resulted in any unintended outcomes such as an increase in the emergency caesarean section rate. The challenge is now to sustain the improvements and to ensure an ongoing programme of education. The team believe that a centralised fetal monitoring system would enhance their work. The team will update QAC on progress on this important initiative in six months time.
- Finally QAC continues to receive updates on KH financial improvement programme. QAC seeks to assure ourselves that there are no unintended consequences for clinical quality of our FIP particularly the three major programmes of transformation ie theatre utilisation, outpatient news to follow ups and work around A&E/length of stay/delayed discharge. Currently no unintended consequences are noted. The committee is however aware that the third piece of work is likely to result in an increase in readmissions. QAC will monitor this to ensure that we learn from any readmissions and ensure that we reduce avoidable cases.