Quality & Risk: October – December 2021

University Hospitals Dorset NHS Foundation Trust

Welcome to the quarterly update on all things Risk and Governance!

In this issue:

Department News:

- A fond farewell to Tracey Cooper, Directorate Manager and Quality Assurance Lead who is leaving UHD at the end of February for pastures new.
- A warm welcome to Sherri Paul, Health & Safety Risk Advisor. Sherri will be predominantly based at Poole Hospital.
- A warm welcome to Teresa North and Alison Pearce who join us as Medical Examiner Officers at the end of February and early March.
- We are delighted to welcome Maria Zerega to our Clinical Audit team. Maria will be working as a Clinical Audit Facilitator and Service Development Lead. We say a fond farewell to Sandra Courtiour who has moved on to a new role in the Innovation Team, Craig Murray will now cover all sites as Clinical Audit and Effectiveness Manager.

Health and Safety - Welcome

Hi Everyone,

My name is Sherri and I am the new Health and Safety Advisor at UHD and will be predominantly based at Poole Hospital.

I am a passionate, hardworking professional with a bubbly personality and have extensive experience in many areas of Health and Safety ranging from assisted living care premises to construction sites. I have created and taught numerous Health and Safety courses at all levels of business and have worked on many projects with teams of trades and expertise. A few of my claims to fame are looking after construction projects for some of our local celebs including a few well known footballers and Lord and Lady Fellowes Manor House renovation near Dorchester and yes they really do live in a property like Downton Abbey!

In my personal life I am a wife and a mummy to our gorgeous little girl, who is almost 5 years old. My free time is spent mostly with my family and I love spending my weekends with my daughter doing baking, drawing/painting and the odd shopping trip (we love a girly shopping day!)

I'm extremely excited to have the privilege of joining your fantastic team and I'm very much looking forward to meeting you all in person soon.

Medical Examiner's Office

- A warm welcome to both of our new Medical Examiner Officers to our rapidly expanding service and look forward to their combined knowledge enhancing the service we are able to provide to UHD and the wider healthcare community as we move out to primary care. As of March 2022 we will have 13 Medical Examiners (MEs) regularly working for us and 7 MEOs across three offices – a huge increase from our initial start in 2018/19.
- Teresa North joins us as an MEO on 28 February 2022. Teresa comes to us from Dorset Healthcare where most recently she was working in the Complaints & PALS team as an advisor. Prior to that she was Matron at Wimborne Community Hospital for 15 years.
- Alison Pearce joins us as an MEO a week later on 7 March 2022. Alison is moving to Dorset from Cheshire where she worked for an NHS Trust as an Assistant Directorate Manager in Obs & Gynae / Paediatrics; however her clinical background is in midwifery.

Medical Examiner Office Update:
749 deaths scrutinised across UHD in Q3 – 100% scrutiny of all deaths.

In Q3, we had our new Lead Community Medical Examiner, Dr Mandy Evans, join us who has been instrumental in helping us plough forward with the roll-out of the ME Service into the Primary Care Settings. Mandy's background is a Legal Executive and GP by training, spending the last part of her career as a GP Partner in Bournemouth. In the last quarter, we've made significant progress with the preparation for expanding the ME Office into the Community. We have finalised all of our processes on how the service will work, including instructing the CCG IT Team to create a specific module for the ME Service on Systm1. We have agreed how referrals into the service will work, how we will be allocating cases and our suggested turnaround time for deaths. We've also agreed our Clinical Governance processes and our KPIs for the team.
Alongside the above, both of our acute offices have kept on top of all acute deaths, scrutinising 100% that occur within our hospitals.

Learning from Deaths Project Update:

During Q3, we launched an extensive Learning from Deaths Project across UHD. The LfD Project has two key aims:

1) Streamline the verification of death, Mortuary admission, Medical Examiner review and Mortuary release process across the three hospital sites.
2) Establish and standardise Learning from Deaths Reviews (LfD) and/Mortality & Morbidity (M&M) process across University Hospitals Dorset.

The Project Board was agreed in October and the first meeting held, where we agreed the scope and terms of reference for our project, alongside with our key stakeholders who are part of the Project Board. After the first meeting, we agreed the Task and Finish Groups required to move forward specific parts of the project, such as Verification of Death and Mortuary Admission. These groups are booked in for January and February.

Learning from Deaths – new intranet page!

A new Learning from Deaths page is now available on the intranet which includes the mortality leads toolkit and a link to the current version of the Learning from Deaths Policy. The page can be found under L on the A-Z ruler of the intranet, either Poole or Bournemouth or by using the link below.

https://intranet.uhd.nhs.uk/index.php/quality-risk/risk-management/learning-from-deaths

Quality Governance

Governance Audit

The Quality Governance team would like to thank everyone who has contributed to submitting data for the governance audit. The team have collated the information and are in the process of mapping the findings in preparation for submitting a report to the March Quality Committe meeting. The report will detail areas of good practice and areas for focussed improvement.

Quality & Risk department

The landing page on the intranet for Quality & Risk has been reformatted – please take a look:

https://intranet.uhd.nhs.uk/index.php/quality-risk

Risk/Serious Incident/Datix

LERN Review Toolkit – update to the Investigations toolkit

In preparation for changes to National policy/process and framework within the incoming 'Patient Safety Incident Response Framework' – the existing UHD Incident Investigation toolkit, that provides the guidance, documents and templates for the processes of incident investigation, has been updated. This further embeds the positive culture of Learning from LERNs and proportional, effective investigations for improvement
The process remains broadly unchanged; however, we have taken the opportunity to encourage a just culture by refreshing the language associated with process. It is hoped that this will ease future transition when the new national framework is introduced across the ICS. Guidance on the new national framework is expected in late Spring 22.

Summary:

Previous	Updated Terminology
Incident investigation Toolkit	LERN review Toolkit
Externally reportable SI	LERN review – External report
Internal SI	LERN review – Board report
Local RCA	LERN review – Care Group report
	LERN review - Directorate report
SI Scoping Meeting	LERN review - Scoping meeting
SI Panel meeting	LERN review - Learning Panel
SI Post Event review	LERN Review – Update
SI Synopsis	Key Learning Synopsis from LERN review
Communication templates all updated to reflect updated terminology	
Link: https://intranet.rbch.nhs.uk/uploads/quality-risk/documents/incident/LERN-review-Toolkit-20220110.doc	

Thank you to all who took the time to attend the two LERN launch events – at a time of huge challenge to the trust! For those of you unable to attend at the time – please watch the video here: 'What happens after a LERN form has been submitted' RBCH Hospital Intranet
or a quick read please go to: https://intranet.uhd.nhs.uk/uploads/quality-risk/documents/lern-forms/documents/which_lern_form_20211102.ppt
We are very happy to come and speak to any teams, in meetings, huddles, briefings, to update regarding the LERN forms and their use! Just call Ex 4014 and we will make arrangements for tailored sessions for your teams

You may be aware that we are closing down the legacy RBH Risk Management system (Datix). Whilst the trust will have access to the data held we will no longer have web access to the system after the 31/03/2022. The team currently are approaching all relevant staff to close remaining incidents and any breaching actions. Please contact us on Ex 4014 if you have any queries.

Support the processes and principles of openness, transparency and the appetite to learn and improve Trust wide safety despite continued significant challenges to operational capacity,
In the calendar year from 01/01/2021 to 31/12/2021;

- **95** LERN reviews for External or Board Report were commissioned from incidents submitted in that timeframe (59 closed)
- **165** LERN Review **-**Scoping meetings were held
- **90** LERN review -Learning panels were held reviewing completed reports
- **19** LERN review update meetings were undertaken reviewing and supporting the delivery of actions

A huge thank you to all our amazing attendees, chairs, investigators, contributors and action leads!

Synopsis of all LERN review outcomes can be found here: https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/key-learning-from-serious-incidents and are grouped under broad themes and are in SBAR format
Trust safety Alerts can be found here: https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/key-learning-from-serious-incidents/trust-wide-learning-and-safety-alerts again following SBAR format
Quality & Risk weekly update can be found at https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/key-learning-from-serious-incidents-by-month and provides an update on the outcomes of the previous week's activity

Clinical Audit

- **Audit Team** We are delighted to welcome Maria Zerega to our team. Maria will be working as a Clinical Audit Facilitator and Service Development Lead. Sandra Courtiour has left, and Craig Murray is now covering all sites as Clinical Audit and Effectiveness Manager.

- **UHD Clinical Audit Plan** Work is underway to collate the Audit Plan for 2022/23, which should be ready for review by the Clinical Audit and Effectiveness Group on Feb 28th. At the end of Q3, 78% of audits on the 2021/22 plan had been started or completed

- **National Audits**. At the end of Q3, UHD was participating in **98%** of eligible (n=50) national audits.

- **New project approvals** During Q3 2021/22, there were 75 clinical audit projects approved by the Clinical Audit Approval Group (30 registered via the RBCH office, 45 via Poole).

- **UHD Clinical Audit Database** We are continuing to develop our new UHD database, aiming to launch in April 2022.

Clinical Audit – Welcome

Hello Everyone,

My name is Maria Zerega, newly appointed Clinical Audit Facilitator and Service Development Lead working across sites.

I am a change champion with a passion for quality improvement, people interaction and day-to-day challenges. I have confidence in my ability to deliver high standards with over 20 years of managerial experience from the private sector and NHS.

Personally, I'm committed to make our NHS a better place for our community, and I'll do everything I can to help. I believe in my values and strive to role model all the time

In my personal life I'm a widow with two handsome boys aged 26 and 17 years old. I'm half Italian/ half Chilean, fluent in four languages, very passionate, enthusiastic and positive.

I love water sports…You can find me every weekend (rain or shine) swimming in the sea and when the weather allows me...paddle boarding. Cold water gives you energy and strength… just try! You will definitely love the experience - I also take ballet lessons and do yoga for my wellbeing.

Interesting facts about me, I took Michelin star cuisine lessons for a month in France, I am a qualified wine Master and I was motocross rider as a child. Thank you so much for making me feel so welcome! I look forward to meeting and working with you.

Litigation and Inquest

The Litigation and Inquest function has been extremely busy in the last twelve months with continued high numbers and complexity of inquests and claims. The team continues to work with staff, supporting them through the legal processes. The engagement of clinical staff is of great importance during investigations. Learning from inquests and claims continues to improve and be disseminated

Overview of Inquest Activity 1st July 2021 – 31st December 2021

- 79 notifications of new inquests
- 72 inquests held as follows:
  - 32 witness inquests via Microsoft Teams
  - 40 documentary inquests
- No Prevention of Future Death Recommendations were received

The Inquest team continue to work closely with the Quality and Risk team and where a serious incident has contributed to the death of a patient the Trust has been open and provided the findings of the incident investigation to the Coroner.

The robust investigation process provides an in-depth report for the Coroner which they acknowledge they find invaluable in helping them understand the incident and the actions taken. Learning from inquests is often in conjunction with the SI process.

The Coroner has advised that from 1st January 2022 she will return to her pre-pandemic process of listing the inquest final hearing date at the point of requesting statements. This may be nine months or so from the date of the statement request and staff providing statements are required to keep this date free of clinical commitment. Also, the Coroner has decided that she will resume in person inquests for all new matters opened from 1st January 2022. Although this is likely to commence in the latter half of 2022 it is worth noting Microsoft Teams attendance will only be considered in exceptional circumstances.

SPOTLIGHT

Risk and Governance Trust Link – Freedom to speak up Guardian

'Speaking up keeps our patients safe'

Helen Martin is the Freedom to speak up Guardian for UHD. Helen leads our speaking up team at UHD, supporting our people across UHD by providing impartial and confidential advice about something related either to their working environment or patient and staff safety. The FTSU service is another route for people to come and speak about something that is worrying them in a safe and holistic way. This service has been in place since April 2017 and has become well established across UHD with over 700 people having used it. Feedback from those that have used it is always positive with 95% saying they would speak up again if they had to.

Key information and responsibilities:

- UHD are committed to developing a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.
- Speaking up is a key UHD value "being open and honest". Speaking up is everyone's business.
- Typically, your line manager should be the first point of contact if you have a concern.
- The FTSU team will also listen to your concern and provide you with confidential, impartial advice or signpost you to right person.
- 'How to speak up' policy can be accessed on the FTSU intranet pages but there is also access via the @UHD app.
- You can refer to the FTSU team by
  - Emailing freedomtospeakup@uhd.nhs.uk
  - Leaving a message on the confidential answerphone 0300 019 4220
  - Via the @UHD app (there is also an anonymous function here too)
  - In person

- The FTSU team will always give you feedback regarding your concern and always be there to support you. The situation isn't 'just left'.
- There is a comprehensive national training programme which can be accessed via our BEAT called "speak up, listen up, follow up". The modules are interactive and excellent sources of information for all staff but also line managers
- The FTSU team and risk and governance team share speaking up themes and work on issues together.