

Item: 12

Operational Board

minutes

Date of Meeting: Friday 20th November 2015.
Time: 8am-1.30pm
Venue: Conference Room, Liverpool Heart & Chest Hospital

Present: Jane Tomkinson (Chair), Chief Executive
 Tony Bennett, Divisional Head of Operations (Clinical Services)
 Steven Colfar, Divisional Head of Nursing (Clinical Services)
 Carolyn Cowperthwaite, Divisional Head of Nursing (Medicine)
 Jim Davies, Deputy Chief Finance Officer
 Debbie Herring, Director of Strategy & OD
 Mark Jackson, Director of Research and Informatics
 Hayley Kendall, Divisional Head of Operations (Surgery)
 Lucy Lavan, Director of Corporate Affairs
 John Morris, Associate Medical Director for Medicine
 Aung Oo, Associate Medical Director for Surgery
 Sue Pemberton, Director of Nursing & Quality
 Raph Perry, Medical Director
 Lisa Salter, Divisional Head of Nursing (Surgery)
 Nigel Scawn, AMD for Clinical Services
 Johan Waktare, Clinical Lead for EPR & Caldecott Guardian
 Tony Wilding, Director of Operational Services
 Robin Wiggs, Divisional Head of Operations (Medicine)

In Attendance: Sarah Bradley, Executive Assistant
 Marga Perez Casal, LiA Lead
 Glenn Russell, Director of Medical Education &
 Clinical Stakeholder Lead
 Mike Shackcloth, Clinical Lead for Thoracic Surgery

Apologies for Absence David Jago, Chief Finance Officer
 Jay Wright, Clinical Lead for Research

1	Apologies for Absence Apologies were noted as above.	Action
2	Declarations of Interest Relating to Agenda Items The Operational Board (OB) had nothing to declare in this respect.	
3	HALT Process Sue Pemberton (SP) opened the OB with a presentation on the benefits of the HALT Process, a safety tool proven to be a highly effective measure in Whiston Hospital supporting patient safety. Karen Wafer & Adrian Morris,	

	<p>LHCH Patient Champions were working on implementing this tool at LHCH.</p> <p>Lisa Salter (LS) confirmed she would be meeting staff to promote HALT and reiterate the importance of feeling comfortable in speaking out safely. The HALT tool would be incorporated into the Human Factors Work Policy for 2016. Posters displaying pictures of the AMDs and other staff stating their values would tie in with this and link in with Accountability Values and Patient Care. Matt Back from PR would carry out work on these.</p> <p>SP requested the support of the AMDs in implementing HALT and getting teams on board. All AMDs confirmed their full support and commitment to ensuring staff compliance and awareness.</p> <p>Half an hour would be dedicated each quarter at OB to such initiatives.</p>	SB
4.	<p>4.1 Medical Cover and Deliver ITU/POCCU</p> <p>Nigel Scawn gave an update on the on-going difficulties with meeting the National Service Specification requirements for medical cover and delivery of service on ITU/POCCU.</p> <p>The first step towards compliance would be to split the rota providing intensive care cover 7 days a week for ITU with general anaesthetic cover for purely theatre and emergency work.</p> <p>Six options were presented to the OB highlighting the urgent requirement to appoint in the region of 5-6 consultants for the long term and to provide more trainee and nurse practitioner cover.</p> <p>The preferred option would be to continue to offer extra sessions in the short term with a view to appointing the additional required staff and looking at overseas recruitment for SHO's at registrar grade. This would attract doctors requiring training in cardiothoracic anaesthesia however must not impact on the training of the Deanery Doctors.</p> <p>Tony Wilding (TW) confirmed that a business case for 2 anaesthetists would be signed off for advert that week. The final plan would need to be agreed by Christmas.</p> <p>Jim Davies (JD) requested sight of a 2-3 year trajectory to be compiled by the Division. This should state the compelling reason to look at this now and explore how the costs would be managed. JD offered his full support. The plan would require the advanced signed up of staff to ensure safe cover as well as outlining the medium to long term strategy.</p> <p>Jane Tomkinson (JT) summarised this is the third time this area had been discussed at OB but emphasised that safety of staff and patients was paramount. Extra sessions could be taken forward and consolidated on a rota but the long term plan with a trajectory over 2-3 years would be required. Debbie Herring (DH) would aim to make the rotas as flexible as</p>	

	<p>possible in terms of agreed hours at weekends for consultants.</p> <p>A hospital policy to standardise consultant body extra sessions would be required and Raph Perry (RAP) would action and standardise this.</p> <p>4.2 Feedback on CQC Mock Inspection</p> <p>SP shared feedback with the OB from the mock CQC inspection that took place at the Trust in October 2015.</p> <p>The 2 day inspection was carried out across a variety of teams and provided good insight into what was happening around LHCH. Participants included staff, patients and volunteers. Three focus groups were led by Mary Douglas and Steven Colfar outlining Trust values.</p> <p>The inspections followed the CQC model based on previous information, not up to date figures. Outcome was good with the full engagement and enthusiasm of staff and feedback from patients was also favourable. The LHCH Vision and Values were seen to be widely known and demonstrated across the Trust.</p> <p>One area of concern was that good practice did not come through and people focused on issues rather than positive aspects of their work and experience. SP identified the contribution of community services would be seen as an example of excellent practice.</p> <p>Each section would receive their individual report by 11th December 2015.</p> <p>4.3 CQC Inspection</p> <p>SP confirmed a further mock inspection would take place in January/February 2016 prior to the CQC inspection on 26-29 April 2016.</p> <p>SP would work with the OB to look at areas to focus on and the OB were asked to share the information and feedback to front line teams.</p> <p>RW would prepare a summary on CQC work with TG.</p> <p>4.4 Risk Register</p> <p>Mark Jackson presented the Risk Register. This summarised whether risks were specific to one or more Division and provided assurance that these were being addressed or where improvements were being made.</p> <p>Clinical decision making had been tied in with the audit process.</p> <p>The future of community services had an EPR requirement that was being addressed.</p> <p>Following feedback from the Quality Committee, compliance around septic</p>	<p>TB/NS</p> <p>RAP</p> <p>All</p> <p>SP</p> <p>RW/TG</p>
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	<p>bundle would be added to the performance dashboard.</p> <p>Two issues decreasing on the risk register were specific to surgery, one being fibrillating leads not CE marked but they were considered safe and in good supply. The other was heater cooler units, the risk being mitigated by replacement items.</p> <p>A new risk, not new to organisation but articulated through IPC, was income for next year and tariff reforms. David Jago (DJ) was optimistic about some 'top up values' had been highlighted.</p> <p>Incident reporting was noted to be rising but there were some issues around the governance structure. RAP and Mark Jackson (MJ) would refresh this and meet early December 2015 to resolve the matter.</p> <p>It was reported back that the pandemic flu table top exercise went well. EPR downtime in July was reviewed and a lot of improvements were being delivered with a particular link to business planning.</p> <p>LHCH was noted to have had an uncharacteristic run of claims which had proven extremely costly. Premiums were based on previous claims history affecting subscriptions. MJ stressed the importance of organisational learning, especially in the current climate of 'no win no fee claims.</p> <p>4.5 Risk Management and Corporate Governance Report</p> <p>The Risk Management Exception Report was presented by MJ. This demonstrated the Risk Management Committee had robust key performance indicators in line with Risk Management Policy improving continually.</p> <p>4.6 Feedback and Action Following Deanery Visit</p> <p>Glenn Russell (GNR) presented a paper on Medical Staffing at LHCH in August 2016 following feedback from the recent Deanery Visit.</p> <p>As of August 2016 the F2 doctors in Medicine would be reduced by 4 in medicine and 4 in surgery. This would result in an additional risk in surgery as four trainees may be removed.</p> <p>GNR suggested a 3 fold approach by aiming to recruit to 10 trainees for this year and 10 for the next year. Another alternative would be to look at ANPs and pharmacists bearing in mind they take 2 years to train but are in short supply. It was stressed that the Trust could not rely on recruitment coming to fruition by 2016 however there was also a risk that there would be difficulty in recruiting 10 trainees.</p> <p>Recruitment would come from community posts in medicine which would satisfy the Deanery requirements. An application had been made through</p>	<p>All</p> <p>SP</p>
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	<p>the school for some of these posts.</p> <p>In surgery the aim would be to recruit overseas and locally with local candidates being doctors not on the speciality training rota. Recruitment would be timed to coincide when there would be no core training or ST1 jobs. It would be vital to adhere to the timeline as failure to do so would pose a risk of losing the opportunity to recruit locally. A process was in place to recruit at tier 1 level in August 2016.</p> <p>Cardiology would be slightly different looking at community based posts and asking them to come up with other suitable posts to provide good training but also cover tier 1 work.</p> <p>Recruitment of an alternative workforce to do TTOs and general care on the ward excluding the night cover had been considered. CNPs had been considered with aim to recruit 6 to being however it proves timely to get them in post.</p> <p>The week commencing 23rd November 2015, 7 ANPs had been shortlisted for interview. Funding was in place to recruit 3 giving a total of 10 excluding IT. This would leave a shortfall of 6 full time equivalents behind.</p> <p>Serious consideration would be given to appoint all 7 applicants if they met the criteria due to the historical difficulties in recruitment in this staff group. A decision would be required urgently in time for the interviews on 26th November.</p> <p>The final work stream to review was education. In the past good quality training was highlighted as not being provided. The Trust focused on trainees in surgery which was the high risk area. Feedback had been good so far and GNR was confident that LHCH would not lose their 4 trainees in surgery bearing in mind that more work on education would need to be focused on. Feedback in cardiology was less favourable. The Trust needed to be mindful that the Trust was in competition with other Trusts for Deanery posts and all efforts should be made to retain them.</p> <p>August 2016 would prove challenging depending on how many ANPs and trainees were in post. Planning dual running for the year had been considered but could not be relied on due to difficulty in recruitment. If double running was considered DH suggested looking at which other departments the staff could be utilised in and the wider range of competencies.</p> <p>DH expressed her support of the work being carried out and confirmed LHCH are well ahead of other organisations in forward planning. DH emphasised that the action plan would require discussion with the recruitment team to ensure they were aware of expectations from the forthcoming interviews. Consideration would be given to retention over the</p>	
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	<p>next few years with the possibility of a retention premium. Jeni Davies in HR would be looking at international recruitment.</p> <p>JD stated the requirement to understand the financial implications of appointing beyond the three funded ANP posts in view of the tight financial position LHCH was in and the implications this would cause. JD would call a meeting with GNR & Steven Colfar SC to draw up a sensitivity model of 'what ifs' and a decision would be made prior to the Interviews.</p> <p>DH would invite GNR to attend the People Committee on 8th December 2015 to give an update.</p>	<p>JD/GNR</p> <p>DH</p>
5	<p>5.1 Financial Performance, Forecast and Action Plans</p> <p>JD reported that the LHCH was £0.9 million off plan with a 0.2% deficit for 2016. Income was down by £900K in year to date. The Trust had incurred costs due pressures around activity, agency spend and extra sessions.</p> <p>In terms of the remaining 5 months, focus would be on delivering the current schemes and looking at areas to develop. Work would need to be carried out on discretionary spend and the importance of cash coming in was stressed.</p> <p>There was also emphasis on activity and income to reduce cancellations. Opportunities to generate income in diagnostics and radiology were being reviewed by the Division. Letters had been sent to budget holders regarding action plans and CIP but there had been a low response rate. JT stressed this must be followed-up. The Trust would be required to present a plan that would be deliverable for next year.</p> <p>JT expressed her concerns that if the Trust does not bring down the deficit, it would be detrimental to the Trust and its long term plan.</p> <p>It was noted that Commissioners would be imposing fines of up to £120K for the whole year for RTT, mixed sex and the Never Event. JT requested JD to obtain a list of transgressors who had not responded to the CIP letter.</p> <p>JT implored OB members to take responsibility regarding finance. All ideas would be welcome but improvement was required for month 8 and failure to do so would lead to consideration for more extreme measures.</p> <p>RAP confirmed work had already been carried out around the aortic tariff.</p> <p>It was noted that Wythenshawe Hospital had ambition to deliver more cardiac services. Discussions took place as to whether the threat of another service being set up would drive efficiencies at LHCH. JT stressed that LHCH were required to respond to financial pressure robustly</p> <p>Robin Wiggs (RW) noted that plans were being made for extra resources eg</p>	<p>JD</p> <p>JD</p>

	<p>Critical Care without the cash to fund this and queried whether thought should be given to additional income rather than making cuts where possible.</p> <p>RAP would ensure consultant engagement on savings.</p> <p>Tony Bennet (TB) commented that staff should be made aware of there was no reserve fund.</p> <p>DJ & JD would write to budget holders to save 3% by 2016. By December 2015 a high level indication would be required on how a 3-4% CIP would be delivered. The OB were asked to discuss this with their teams.</p> <p>5.2 Strategic and Operational Dashboard Performance Overview</p> <p>TW Presented the Strategic & Operational Dashboard. In terms of quality and experience this was positive and the market share within catchment area was up in terms of core NHS work with an increase in trend for out of area work. Recruitment reported red with trials being highlighted up however MJ confirmed the gap was closing on this.</p> <p>Length of stay for CABG and single valve patients had come down. Workforce was green for the current month starting with good performance. Work was still required on bank and agency spend and appraisals. There was an increase in LHCH being recommended as a place to work.</p> <p>DH stressed the importance of finalising appraisals. The figures were noted to be incorrect as Carolyn Cowperthwaite was confident Elm Ward were 100% compete. Discrepancies would need to be reviewed.</p> <p>It was confirmed that staff on long term sick leave of 3 months or more were not included in the appraisal figures.</p> <p>Stakeholders against NHS activity plan were slightly under par for in-patients. Private Patient was reviewed with a deep dive of the first 6 months of 2014. Cardiac surgery numbers were the same. This identified 50% reduction in PP thoracic work and catheters.</p> <p>With regards to performance and finance surgery are borderline. Work would be carried out on the mini-MVR service and out-patient pathways.</p> <p>Cancer targets were satisfactory.</p> <p>Surgery had seen an increase in cancelled operations, more recently because of the problems on CCA. The Division had started to look at how to reduce clinical cancellations for patient experience and planning. With regards to mixed sex breaches Lisa Salter was review complaints to identify any pattern.</p> <p>In relation to infection prevention 1 c difficile case was under investigation.</p>	<p>RAP</p> <p>JD</p> <p>All</p> <p>LS</p>
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	<p>Clinical quality saw an increase in hospital deaths which were going through mortality review. Medication errors were up from the 6 expected to 7 which were due to prescribing. The OB were assured that no patient harm was incurred.</p> <p>5.3 Divisional Reports</p> <p>5.3a Surgery</p> <p>Hayley Kendall (HK) informed OB that performance against the contract for the Division was under performing mainly in cardiac surgery, 80 cases behind plan. A revised forecast had been submitted for future months to be included in the performance figures. Thoracic surgery is currently offsetting the under performance in cardiac surgery.</p> <p>HK described actions to reduce expenditure and maximise income and the focus on finance at Divisional and team meetings. Upper GI work would be moving to RLBUH earlier than expected from the 1st December 2015 so the forecast required readjusting. As the baseline capacity for surgery was incorrect this had resulted in premium sessions being utilised to keep up with demand. No TAVIs had been suitable for surgery that month.</p> <p>There had been an improvement in mandatory training and PDRs within the division.</p> <p>The top 5 risks of the Division were outlined and plans to address these risks discussed.</p> <p>HK stressed the importance for the Division to share the activity and capacity plans for next year so that everyone is sighted on the potential gaps. A costing review would be required in terms of the Never Event. Upper GI would be adjusted from December 2015 with the move to RLBUH.</p> <p>The theatre capacity vacated by UGI will be reviewed and redistributed where required; more than likely to cardiac surgery although Aung Oo (AYO) noted that perfusion cover would be an issue in utilising these lists for cardiac surgery.</p> <p>RAP discussed the terms of the locum post being 1 day fixed and 1 day flexible with AO. As this job plan had not been finalised pending further discussion, the position was advertised with a view to discussing at interview.</p> <p>AO expressed his view that robotic surgery would need to be considered in thoracic and cardiac surgery in 2016/17. The Division are looking at potential options, one being sharing the robotic system used in urology in RLBUHT.</p> <p>AO and HK are organising to meet the mitral team to discuss the pressures regarding breaches. LS added there would be consultation with nursing staff in January 2016 with regards to moving theatre staff to seven day working to support the demands to the service. Timely urgent and elective</p>	
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	<p>surgical care continued to be challenging due to the underlying shortfall in operative capacity. AO suggested same day admission would pave the way forward for an improved and efficient elective patient pathway.</p> <p>A discussion took place with regards to the planned culture work within theatres and the requirement to improve the current situation. AO expressed his concern that when colleagues call upon a colleague for help it was seen as a sign of weakness and the culture would need to change. Work would start in January 2016 towards a high performing theatre team led by the divisional triumvirate.</p> <p>The Division outlined plans to develop a nationally recognised Fellowship Programme in Cardiothoracic surgery – this would be a development for 2016/17 to attract quality trainees.</p> <p>SP raised the fact that medical mortality reviews were only 44% compliant for October 2015. These figures need to rise in order to be compliant for the CQC as they would look at how this was managed at OB. It was noted that not many consultants have incorporated this in their job plan however RAP's view was that this would class -as SPA time. RAP will follow this up through the Mortality Review Group (MRG).</p> <p>JT asked for greater clarify on RTT and speciality compliance, cancelled operations, workforce stats, CIP and finance with the exclusion of the patients that have been moved to Stoke – the Division confirmed these would all be discussed as part of the divisional review scheduled for later today.</p> <p>TW asked the Division to be mindful of underlying cancer performance breaching the 42 day rule.</p> <p>JW expressed his desire to be involved in the documentation processes through EPR with regards to the development of the ACHD service.</p> <p style="text-align: center;">• 5.3b Medicine</p> <p>In terms of month 7 exception reporting green however medication errors and falls reported red. JLM confirmed the vast majority of work fell within the 18 week target as cardiology no longer provide as much activity for Wales. Breaches had come down to 40 in the last month and work would continue in this respect.</p> <p>There had been a sudden dip reported in day cases for cardiology but this was not a major concern. The new patient to follow-up ratio was performing well.</p> <p>Tony Grayson would be attending a Performance Meeting in December to focus on the figures which reflect intended management when in fact the patient could stay overnight.</p> <p>CC confirmed there were no mixed sex breaches or infections to report. Falls remained an issue however 1 patient fell on 5 occasions due to non-</p>	<p style="text-align: center;">JW</p>
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	<p>reporting workflow which had been added to the risk register.</p> <p>Financial position for end of month was £479K ahead, income £121K ahead £359K behind where we should be in terms of FP. This equated to being approximately £100K behind plan but EP income would ensure recovery.</p> <p>Annual planning issues had commenced for 2016/2017 including development of cath lab with refurbishment and expansion. The ASC network meeting on 18th November inferred they would like LHCH to take an increasing portion of moderate to high risk patients. This would improve activity but there was a risk with the patients taking up beds whilst waiting for procedure. The tariff was associated with a surgical operation. JT requested this matter be addressed to understand the implications.</p> <p>Move pacing out of theatre B into cath lab for next year to support surgical colleagues. Rotational programme wards and cath labs ACHD 100 cath lab cases. Looking hard at formalising inherited cardiac conditions. Respiratory services expansion and cardiac diagnostics looking at capacity. In terms of development for next year city wide single cardiology pathway & Carter review in terms of process and benchmarking.</p> <p>JT noted it was good to have an understanding of the VTE plan as this proved a significant risk. Falls plan good to hear more. Reference was made to the 'Amanda Unit' still being referred to on slides and this would require changing to Cherry Ward. JLM stated he would like to see some numbers rather than percentages regarding VT prophylaxis.</p> <ul style="list-style-type: none"> • 5.3c Clinical Services <p>Tony Bennett presented the overview from clinical services.</p> <p>Ares of concern were radiology breaches but work was being done to mitigate this with weekend work. The Division were confident that this was a short term problem that could be rectified. AB would work closely with Dr Binu Sukumaran, Consultant Radiologist to address this.</p> <p>Other concerns included mixed sex breaches and patient flow within POCCU. SC would be working with the Matron to get real time information. Reporting around MSB would be reviewed.</p> <p>There was a discussion around medication errors in pharmacy. No patient harm had been incurred although recording/documenting errors on PRISM would need to be addressed. LS confirmed that other meetings groups were working on addressing this.</p> <p>In terms of income clinical services is above plan by £704k although above plan by £986K relating to expenditure. This was mainly due to increased agency staff on POCCU, non-pay to support activity and anaesthesia and radiology additional sessions. All other areas were underspent or balanced. The forecast contribution for the year end was £57K deficit to date although approval of Anaesthesia additional sessions to support Critical Care staffing would increase this. In terms of CIP, 5 additional schemes to the value of</p>	<p>RW</p> <p>AB</p>
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	<p>£130K were being focused on. The Division were pushing to find new CIP methods.</p> <p>Mandatory training was slightly below the required level. Workforce had improved and there was an 8.8% increase on CCA which reflected the improved culture in that area.</p> <p>The primary risk was pharmacy and EPR. Another concern was nutritional support for lung cancer for OPD services. Julie Wilkins is working to address this to provide mitigation and a group had met to discuss national requirement. Nigel Scawn articulated the concern being when outpatients are seen they could have nutritional problems but have no follow up which is a quality issues. JT requested work be done on this. HK confirmed a meeting would be set up within the next few weeks to formalise the governance. SC would investigate whether a tariff was associated with this.</p> <p>To conclude the item on Divisional Reporting the Divisions would work closely with regards to workforce planning around how to use SLM better to get an understanding of true costs. SC concluded that pain had been an issue and the pain service would be extended from December. SP requested a detailed report on preparation from CQC actions.</p>	<p>SC</p> <p>All</p>
6	<p>Delivering Strategy</p> <p>6.1 Strategic Planning 2016/2017 following on from 6th October Extended Strategic Development Day.</p> <p>Due to time limitations this item was deferred to the next meeting. Debbie Herring stated awareness that HR were working on workforce and planning and an update was due on 7th December 2015. A draft plan would be ready by February 2016 with the real plan being available by April 2016.</p> <p>JT deferred the Innovations Workshop to the OB on 18th December 2015 which would be a 'business light' meeting with a real focus on strategy and innovation'.</p> <p>6.2 LiA Update</p> <p>Marga Perez Casal (MP-C) updated the OB on a LiA session held the previous evening identifying issues that required addressing at LHCH. Of note time had proven to be an issue in getting people together to decide what needed to be addressed. Work would be carried out with Liz Pritchard, Karen Wafer and Joan Mathews to include LiA in Human factors and simulation.</p> <p>HK confirmed she had met regularly with theatre staff to discuss issues on how to improve start times and management of the case mixes passing through.</p> <p>EPR had been put on hold until a final decision had been made to create a</p>	<p>DH</p> <p>MJ</p>

	<p>specific user group. The EPR team had been inundated with suggestions and the group would focus on priority issues.</p> <p>The next steps would be focused on the 10 new LiA projects as outlined in the presentation. All ideas would be discussed in detail at the LiA Pass it on Event in December 2015.</p> <p>The OB supported the proposed list of future LiA projects.</p>	RAP
7	<p>Learning from 'Never Event'</p> <p>Raph Perry updated the OB on on-going work in relation to the recent 'Never Event'.</p> <p>A parallel investigation of the RCA needed to be reported and an external investigation was taking place which would conclude that week. HK confirmed a standard operating procedure and a robust audit plan were in place.</p> <p>The OB discussed the seriousness of the event and the measures taken from learning from this event to prevent any such reoccurrence including a planned learning summit scheduled for 27th November 2015.</p>	
8	E-Pack	
9	<p>Approval of Minutes of Last Meeting</p> <p>The minutes of the previous meeting of 2nd October 2015 were approved with one change to the attendance list.</p>	
10	<p>Chief Executive's Briefing</p> <p>The OB noted the CEO report prepared for the Board of Directors on 24th November 2015.</p> <p>The main item of note was Junior Doctors industrial action. Plans had been sent out to everyone concerned to complete a timeline and proposed dates. Contingency plans would be required to summarise at the Executives Meeting on 25th November 2015.</p> <p>Three templates would be uploaded after the Division of Operations meeting on Monday 23rd November 2015.</p>	
11	<p>Date of Next Meeting</p> <p>Friday 18th December 2015, 8am – 1pm Conference Room</p>	
12	<p>Organisational Learning</p> <p>MJ welcomed Mike Shackcloth (MS) to the meeting informing the OB of his interest in the field of organisation learning and his National responsibilities on surgical reporting. MJ outlined the starting points for the day's learning and the plans to work with the Division. He stated that healthcare was a safety critical industry with organisational learning being very difficult.</p>	

	<p>MJ went on to present the 'mind map'. LHCH had two Never Events in 18 months relating to wrong drugs and the completion of TTOs before treatment etc. All the items highlighted in the presentation were due to poor communication or documentation.</p> <p>Mike Shackcloth went on to present a case he was involved in that despite looking relatively straightforward, culminated in the death of the patient. This was due to a series recording errors, poor handover and a failure to flag a radiology alert appropriately.</p> <p>Improved documentation and handover was an obvious area the Trust would need to focus on. By February 2016 a plan would be in place across the organisation. MJ would work with the three Divisions to raise awareness about what was happening within their Divisions.</p> <p>One key item on the action plan following this case was around the radiology alert process. SP remarked that the Quality Committee had been monitoring this alert process and not all staff followed protocol. JM challenged the process for radiology alerts as to its effectiveness and was there a better way to do this.</p> <p>JT stressed the radiology alert process in place was the one that should be followed by all. If a recurrence happened and the alert system had not been followed due to poor compliance, the consequence would be severe.</p> <p>RAP would lead a piece of work to come up with a process for colleagues to use and follow in this regard. The importance was reiterated that every member of staff needs to sign up and follow the radiology alert reporting process to provide assurance that protocol was being followed. Feedback would be given to the Executives.</p>	RAP
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