

Board of Director: 10.5.18

Agenda Item: Bo.5.18.9

Report from the Quality Committee

Presented by:	Professor Laura Stroud, Non-Executive Director	Author:	Jacqui Maurice, Head of Corporate Governance, Trust Secretary
Previously considered by:	n/a		

Key points	Purpose:
This paper provides a brief summary of the key matters that were discussed at the meetings of the Quality Committee held 28 February 2018 and 28 March 2018 .	To discuss and note

Executive Summary:
The purpose of the Quality Committee, as set out in its Terms of Reference, is to provide detailed scrutiny of the Foundation Trust's arrangements for the management and development of quality and safety in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

Financial implications:

Regulatory relevance:

Monitor:	
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Equality Impact / Implications:	<p>Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)</p> <p>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>If yes, what is the mitigation against this?</p>
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Other:	
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Strategic Objective:	To provide outstanding care for patients
<i>Reference to Strategic Objective(s) this paper relates to</i>	

Quality and Safety Committee

The purpose of this paper is to advise the Board of Directors of the key matters discussed and provide a brief summary of agenda items of the Committee which was held on 31 January 2018.

Quality and Safety Committee: 28 February 2018

1. Key Matters discussed at the meeting held on 28 February 2018

- Accident and Emergency Care Quality Commission (CQC) Patient Survey Report 2017
- Pathology Joint Venture Update
- Report on the quality of Stroke Care

2. Agenda Items

2.1 Quality Committee Dashboard

The Quality Committee dashboard was discussed in detail with a particular focus on;

- Death rates
- Venous Thromboembolism (VTE)
- Falls with harm
- Catheter associated Urinary Tract Infections
- Night-time transfers
- Theatres

2.2 Information Governance (IG) Report

Mandatory Information Governance Training is now at 91%. The Trust is expected to reach the required level of 95% by the end of March 2018.

The Information Governance Toolkit is on track for completion. Some elements of the Toolkit have improved compared to last year, following the implementation of recommendations from the Information Commissioner's Office Best Practice review.

2.3 Serious Incident (SI) Report

There had been six new SIs reported during January 2018. Three were related to hospital acquired pressure ulcers. The other incidents related to:

- Surgery to treat a recognised complication was planned in June 2017 and scheduled for November 2017. There appears to have been inadequate monitoring of the patient's condition during the intervening period. Their condition is now inoperable and they have suffered sight loss.
- During routine mortuary processes a discrepancy was identified in verifying the identity of an infant foetus. Funeral arrangements were delayed whilst further investigations were undertaken. Immediate changes were put in place to the manual system.
- A patient identified as high risk for developing a pulmonary embolism was an in-patient at Bradford Royal Infirmary for 16 days before a venous thromboembolism assessment (VTE)

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was completed and the required treatment administered. The patient developed a pulmonary embolism.

The Foundation Trust has requested and received approval from the Clinical Commissioning Group (CCG) for an extension for one ongoing investigation.

2.4 Accident and Emergency Care Quality Commission (CQC) Patient Survey Report 2017

The Accident and Emergency patient survey took a sample of patients from October 2016 to March 2017. The FT performed 'worse than expected' when compared to other Trusts in the survey. A change in the Matron has brought focus on quality and safety of patients and an action plan is submitted quarterly to the Patient First Sub-Committee.

2.5 Clinical Effectiveness 2017-18 Quarter 3 report

The Committee discussed the Foundation Trust's position in relation to implementation of NICE guidance, national and local clinical audit, national enquiries and the development and management of clinical guidance. Areas of risk in relation to the management of external recommendations, national audit, local audit and use of clinical guidance were described and mitigation identified.

2.6 Freedom to Speak Up Quarter 3 Report

In Quarter 3, 9 the committee noted the 9 concerns raised which were grouped into the following categories.

- Bullying and harassment – 2 concerns
- Dignity at work – 1 concern
- Behaviours and values – 4 concerns
- Patient safety – 1 concern
- Discrimination – 1 concern

No concerns were raised anonymously.

The main theme of the Q3 concerns was unacceptable behaviour which includes, dignity at work and bullying and harassment in the work place. Ongoing work based on values and behaviours will go some way in supporting this theme and the HR team have been involved with those concerns that required further investigation under HR policies. Recommendation and actions from an investigation will be monitored through the relevant Division.

An internal audit review of the system of Freedom to Speak Up was undertaken which provided assurance around the processes in place. Awareness raising events are scheduled to take place throughout the year.

2.7 Pathology Joint Venture Update

The Clinical Director's report was submitted to the Joint Venture Board in February which pulled together quality metrics around the Pathology service. The following key highlights were noted by the Committee.

- The Airedale turnaround times for histopathology and Bradford turnaround times are broadly similar.

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- An improving service is now being provided with many indicators demonstrating good performance.
- The Clinical Director is working on future models for histopathology and pathology across West Yorkshire.
- Monitoring and reporting will continue to the Joint Venture Board.
- Parameters and benchmarks for governance and incident reporting, developed in relation to the Integrated Team are expected to lead to better productivity.

Follow-up reports will be submitted quarterly to the Quality Committee after the Joint Venture Board.

2.8 Patient Experience Report Quarter 3 2017-18

The Committee received and discussed in detail the comprehensive report that included consideration of:

- Progress of the Strategic Work Plan.
- PRASE (Patient Reporting and Action for a Safe Environment) covering the use of recording devices to gather patient feedback in real time with the help of Volunteers; with a standard feedback report generated when twenty questionnaires are completed in an area.
- A new Patient Experience Intranet site for engagement with staff across the Trust.
- Continued development of a set of Always Events to improve patient discharge.
- Overview of Complaints data which showed an increase in requests to the Patient Advice and Liaison Service resulting in a slight increase in complaints.
- Comparison of Quarter 2 versus Quarter 3 data showing an increase in appointment related complaints and less complaints relating to care and treatment.
- There was 1 Parliamentary Health Service Ombudsman complaint during Quarter 3 and this was not upheld.
- Only 50% of complaints have been replied to within the agreed timescales. The Trust is working to put actions in place to address this.

2.9 Report on the Quality of Stroke Care

The Committee reviewed and raised concerns regarding the Sentinal Stroke National Audit Programme (SSNAP) for the period August to November 2017. The report showed a deterioration from the previous report at Level D to Level E. A report is provided every four months to help drive improvements from the admission to discharge of patients with a diagnosis of a stroke. The Committee noted that a weekly stroke service improvement group has subsequently been put in place with immediate actions agreed to improve stroke care provision. The key issues discussed and noted were:

- Deterioration in the SSNAP performance is multifactorial including the lack of staff seeing the link to the SSNAP data and delivery of stroke care
- The anticipated improvements in the functioning of the new stroke ward alongside appointments of new staff have not been realised.
- The complexity of SSNAP data, how this is recorded and information extracted.

The Committee remains sighted on Stroke Care and noted that regular reports on progress would be provided.

2.10 Patients First Sub-Committee Terms of Reference Review

The revised Terms of Reference for the Patient First Committee were approved following discussion and agreement on the Chair of the Committee.

2.11 Patient Safety Sub-Committee Report

The report identified key achievements, challenges and risks being managed by the Sub-Committee. Key items of note were:

- No patient safety risks are identified.
- The number of European workers leaving the United Kingdom has had no impact

2.12 Nurse Staffing Data Publication Report – January 2018

The Committee received details of planned versus actual staffing levels for registered nurses/midwives and care staff for January 2018. Key points highlighted

- Sickness absence rates are increasing.
- Fill rates noted over recruiting and overfilling in Healthcare Assistant roles.
- Fill rates are reduced in registered nurse posts.
- Heat map data to be produced by ward area over a six month timescale from April 2018.

The Committee requested expansion of the report to include receipt of additional data to consider Allied Health Professionals (AHP) and other staff groups to consider the impact on service safety or effectiveness of gaps in the workforce.

2.13 Dementia Annual Report – February 2018

The Dementia Annual Report was received by the Committee which noted the development of the BTHFT Dementia Framework 2017-2021. The framework had taken account of

- The national priorities outlined in the Prime Minister's Challenge on Dementia 2020 (2015).
- The local picture outlined in the Bradford Dementia Needs Assessment (2015).
- Bradford Districts Dementia Strategy aligning to the strategic direction and action driven by the NHS Dementia Well Pathway.

2.14 Review Sub-Committee Terms of Reference of the Quality Committee

The terms of reference were reviewed and approved.

2.15 Treat As One – Bridging the Gap between Mental and Physical Healthcare in General Hospital National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Guidance 2017

Guidance relates to the care of patients with mental health conditions in a District General Hospital. A working group has been established to further develop the action plan in relation to the guidance. Regular audits are being undertaken and strategies developed. A progress report will be presented to the Committee in six months.

2.16 Board Assurance Framework

A full discussion had taken place on the dashboard and included reference to the key risks.

2.17 Items for Corporate Communications

The inclusion of The UNICEF UK Baby Friendly accreditation was noted to have been featured in Let's Talk.

3 Recommendations

The Board is asked to note the above points

Quality and Safety Committee: 28 March 2018

3. Key Matters discussed at the meeting held on 28 February 2018

- Mandatory Training Compliance
- Management of Venous Thromboembolism (VTE) Update on Progress
- Trust-wide Combined Learning Report Quarter 3 2017/18

4. Agenda Items

4.1 Quality Committee Dashboard

The Quality Committee dashboard was discussed in detail with a particular focus on;

Management of Venous Thromboembolism (VTE):

Falls with Harm:

Pressure Ulcers:

4.2 Information Governance Report and Information Governance Toolkit

Mandatory information governance training compliance reached 95% during March 2018.

The Trust has completed the annual Information Governance Toolkit (IGT). Internal Audit had sampled ten requirements in the IGT and provided a 'significant' assurance option.

The Committee approved the submission of the Information Governance Toolkit on behalf of the Board of Directors.

4.3 Serious Incident Report

Two new serious incidents declared during February; one of these was in relation to a pressure ulcer. The other incident related to a patient who suffered harm following two falls. The patient died five days after the falls. Immediate actions were highlighted in the report but the report did not reflect the seriousness of the patient's condition. A full investigation will be undertaken.

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4.4 Bradford Accreditation Scheme (BAS)

The report provided an update on progress in relation to the scheme. It was noted that thirty-four wards and departments are now participating. The next steps would include reviewing and refreshing the assessment documentation. The Committee noted the further work to be done to be able to provide full assurance.

4.5 Mandatory Training Compliance

The Committee had been asked by the Board of Directors to further review the approach to the mandatory training standards for the Trust. Following receipt of a report from the Medical Director, the Committee re-affirms its view that the approach to mandatory training levels was approved as it was assured by the balanced approach and the safety nets around new starters and refresher training.

4.6 Infection Prevention and Control Report

The report covering the period November 2017 to February 2018. It was noted that there had been one attributable MRSA bacteraemia in January 2018 and a total of four cases since April 2017. Six cases of C.difficile had been reported during the period, with a year to date total of 17 against a target trajectory of 51.

4.7 Management of Venous Thromboembolism (VTE) Update on Progress

The content of the report was noted and assurance gained. Committee had reviewed as part of the Quality Dashboard discussion.

4.8 Briefing Paper: Trust Research Committee Update – March 2018

Regular updates on the work undertaken by Bradford Institute for Health Research to meet the Research Strategy and programme of research will be included in future reports.

4.9 Draft Quality Report

The Quality Report formed part of the Annual Report and Accounts. Review and comments were requested from the Quality Committee prior to presentation of the draft report to external stakeholders for comment.

4.10 Development of a real time quality dashboard – Cerner

Discussions were being progressed. A further update would be provided within six months.

4.11 Nurse Staffing Data Publication Report – February 2018

Monitoring is by exception and the Trust is continuing to see a number of challenges. There is a lot of time spent monitoring staffing levels and moving staff to different wards to ensure patient safety. It was noted that less than 80% staffing for more than three months was increasing.

4.12 Trust-wide Combined Learning Report Quarter 3 2017/18

During Quarter 3 the Trust remained focussed on the continued safe implementation of EPR and preparation for the anticipated CQC inspection. Learning outcomes from significant events were noted, including a large piece of work in relation to VTE; a focus on mortality, and near misses regarding thickening agents.

4.13 Quality Improvement Programme

The Committee noted the work being undertaken through the programme.

4.14 Quality Committee Business Work plan 2018-19

The Committee was asked to carefully consider the business work plan and feedback any comments or requests for additions. The plan would be brought back to the April meeting.

4.15 Board Assurance Framework

The Committee considered the report and gained assurance from the data provided.

4.16 Any Other Business

The Committee noted the attendant publicity surrounding The Maternity and The Royal College of Obstetricians and Gynaecologist report.

4.17 Matters to share with other Committees

Finance and Performance - Get it Right First Time.

4.18 Matters to Escalate to the Corporate Risk Register

There were no matters to escalate to the Corporate Risk Register.

4.19 Matters to Escalate to the Board of Director

There were no matters to escalate to the Board of Directors.

5. Recommendations

The Board is asked to note the above points