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Date	9/5/2019	Agenda item	Bo.5.19.12

A report from the Chair of the Quality Committee

Presented by	Laura Stroud, Non-Executive Director
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Lead Directors	Bryan Gill, Medical Director; Karen Dawber, Chief Nurse
Purpose of the paper	This paper is to provide the Board of Directors with an overview of the work of the Quality Committee in March and April 2019.
Key control	This paper is a key control for the strategic objectives to provide outstanding care for patients and to be a continually learning organisation
Action required	To note

Background

The purpose of the Quality Committee is to provide detailed scrutiny of the Foundation Trust's arrangements for the management and development of safety, effectiveness and patient experience in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

The Quality Committee uses the assurance presented throughout its meeting, which is aligned to key controls for identified risks associated with delivering the Trust's strategic objectives

- to provide outstanding care for patients and
- to be a continually learning organisation

in combination with a review of the relevant risks on the strategic risk register to review the Trust's Board Assurance Framework. At the end of each meeting consensus is achieved in relation to the assurance level and associated statement. This is presented in the Board Assurance Framework.

Key Matters Discussed

1. Are our Services safe?

1.1 Strategy: Quality Dashboard

The Quality Dashboard is reviewed at every meeting and specific areas of quality performance considered have been:

- There has been sustained improvement on the **sepsis** indicators following the improvement programme, noting the positive impact of the EPR and the appointment of the sepsis nurse, the committee were informed that the funding for this post has been extended for a further year.
- Strong performance has been maintained on a number indicators including **VTE assessment**, **Clostridium difficile**, **MRSA** and the Hospital Standardised Mortality Ratio (HSMR).
- Whilst the Committee agreed there was no evidence for specific concern in relation to the Trust wide data, the Committee were assured that the root cause of the incidence of **pressure ulcers** occurring on the Intensive Care Unit had been fully explored and appropriate action taken.
- The Committee noted the continuing improvement trajectory related to **complaints**.
- The Committee noted that the **readmission** rate has increased significantly post Electronic Patient Record (EPR) implementation. The Committee were informed of and assured that there was work being undertaken to understand this data, particularly in relation to the coding of planned readmissions. The Committee were informed that the Finance and Performance Committee receives this data and it is under consideration to assist benchmarking.
- The Committee discussed the indicator (used to assure progress in relation to effective governance) relating to **risks not mitigated**. Concern that this indicator reported on all risks not mitigated where the current risk score exceeds the residual score, the Committee agreed that a more appropriate indicator would be for those risks as described above but had exceeded their expected mitigation date. The Committee were advised that this, and other indicators, would be considered in the work to refresh the integrated dashboard.
- The Committee received a description of the systems and processes which are in place to ensure

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that the governance associated with **Trust wide and local procedural documents** is effective, and that the target set for compliance is 100%, for nearly 1,400 documents.

1.2 Governance: Quality Oversight System

The Committee was informed of the work of the Quality Oversight system and noted the quality summit programme which includes: Stroke, Maternity, Theatres, Haematology and Accident and Emergency services. It was assured that the appropriate level of scrutiny was in place and that the risks described corresponded with those that are currently being managed on the Strategic Risk Register or had been highlighted previously to the Committee. The Committee agreed that the summit process in relation to Maternity should be stepped down, particularly in light of a positive engagement visit to the service by the CQC in April 2019.

1.3 Key Control: Serious Incidents

The Committee receives a report detailing serious incidents declared and serious incident investigations completed at each meeting. The Committee was assured the governance associated with management of this type of incident, and explicitly the identification of recommendations and learning was proportionate and appropriate.

1.4 Key Control: Patient Safety and Health and Safety Management and Compliance Incident Report

The Committee received a report which is designed to profile the totality of patient safety and health and safety management and compliance incidents, themes and trends, actions and learning. The Committee uses the report to support its understanding, assurance and its influence on the quality and safety of the services provided by the Trust. This paper is designed to provide assurance to the Committee that such incidents are recognised, managed appropriately and contextualised effectively within the Trust. The Committee reviewed the detail, analysis and subsequent actions being taken described in the report and decided that, in totality, they provided assurance that actual and latent risks related to patient safety, and those related to compliance with health and safety legislation have been appropriately identified and mitigated across the Trust.

1.5 Key Control: Safe Staffing

The Committee receives a report relating to safe staffing every month, this report is also received by the Workforce Committee. The Committee was alerted to areas of potential risks and decided that it was assured that appropriate mitigation was in place to manage risk associated with staffing.

1.6 Key Control: Safer Procedures

The Committee received, as planned, further assurance in relation to the work to assure the Trust's response to the implementation of National Safety Standards for Interventional Procedures (NatSSIPs). The Committee were assured that the work being undertaken was appropriate and proportionate and that there was significant internally generated assurance, which was strengthened by the involvement of Internal Audit in the scoping and assessment exercise undertaken. The Committee noted that Audit Yorkshire will be performing an audit in relation to compliance with the National Standards and the associated NPSA alert later in 2019/20.

1.7 Key Control: Infection Prevention and Control Report

The Committee received assurance associated with one the key controls it uses when agreeing the level of assurance described in the Board Assurance Framework (in terms of the Trust's effective delivery of its Strategic Objective to provide outstanding care for patients). The Committee were assured, for a number of reasons, in relation to the outstanding work of the Infection Prevention Control team and clinical staff across the Trust. Evidence considered included

- the rapid identification and effective management of an outbreak of Carbapenemase-producing Enterobacteriaceae (CPE) on a ward,

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- the rigour that has been applied to the assessment and mitigation associated with the any infection prevention and control risks associated with the issues with ventilation being managed by the Trust.
- In relation to hip and knee surgery, the Trust has not reported a single hip or knee infection in over 300 cases.

1.8 Key Control: Security Management Standards For Providers

The Committee were assured that the work being undertaken to ensure full compliance with the standards was appropriate and proportionate and being monitored by the Health and Safety Committee.

2. Are our services effective?

2.1 Key Control: Information Governance

The Committee reviewed the content of the Information Governance report and the Senior Information Risk Owner's (SIRO) report and decided that it was assured that information governance was being effectively managed in the Trust and that actual and latent risks were being managed appropriately. The Board of Directors had delegated responsibility for the sign-off of the Data Security and Protection Toolkit to the Quality Committee. The Committee considered the report and associated assurance statements, including its review and approval at the Information Governance Sub-Committee and evidence and approved the submission of the Data Security and Protection Toolkit.

2.2 Key Control: High Priority Audit Programme 2019/20

The Committee received and approved the Trust's High Priority Audit Programme for 2019/20, it again noted the challenges faced by the Trust in relation to the effective delivery of the National Audit Programme, and the mechanisms being designed to mitigate the risk to its delivery.

2.3 Single Stroke Service Collaboration Project – March 2019

The Committee were updated in relation to the progress being made in relation to the single stroke service collaboration project and received and noted a paper which had been presented to Airedale NHS Foundation Trust and the Clinical Commissioning Group.

3. Are our services responsive?

3.1 Key Control: National Audit of Care at End of Life

The Committee received an update to a previous area under consideration as planned, and noted that the national report remains unpublished, the early notification of findings have been discussed at the End of Life Care Operational Meeting and the Patients First Sub-Committee. The Committee were informed that once published the governance associated with the Trust's response will be managed through established systems used by the Clinical Audit and Effectiveness Committee.

4. Are our services caring?

4.1 Key Control: National Maternity Services Survey

The Committee received a summary of the results of the seventh annual national maternity survey, this was a specific agenda item requested from the Committee following the receipt of the Patient Experience report at the Committee in February. The additional assurance was requested as the Committee were concerned that there was a potential that behind the overall positive messages in the report received there was data showing some clear opportunities for change and improvement. The additional evidence provided, particularly in relation to the time delays in relation to the survey publication and the work that has been undertaken by the service, resulted in the Committee being assured that the outcomes for the service are average, but that it is working to continuously improve the experience of the women and the families it cares

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for.

5. Are our services well led?

5.1 Governance: Quality Account

The Committee received an update in and noted the progress with the development of the 2018/19 Quality Account at its meeting in both March and April, as defined in the associated work programme.

5.2 Key Control: Combined Learning report

The Committee received the report (which covered Quarters 2 and 3 2018/19 due to the abridged Committee meeting in December 2018) which describes the Trust level outputs from its knowledge management framework which is in place to support learning from 'precursor events' (which can be complaints, incidents, claims, inquests, mortality reviews, tacit knowledge and experience of staff etc.). The Committee was assured that the design of the system was enabling system wide learning and was assured that effective action was being taken to ensure learning from precursor incidents.

5.3 Clinical Services Strategy and Quality Plan

The Committee reviewed the Quality Plan 2018/19 in the context of the Clinical Services Strategy 2017-2022 and the work of the Committee. The Committee agreed that the Quality Plan was still relevant and valid for the organisation and that it should not be seen as extant and should be subject to formal review and evaluation at the May Committee meeting and any revisions to be made considered in relation to the new organisational structure.

5.4 Quality Management System

The Committee received a paper which described the Quality Oversight System in use in the Trust, and recognised that the systematic approach to quality management was key to the work of the Committee in its assuring role. As such the Committee requested that the paper was attached as an Appendix to this report to provide information to the rest of the Board of Directors.

5.5 Risk Management Strategy

The Committee were informed that the Trust's Risk Management Strategy (2017-2020) was originally ratified by the Board of Directors in November 2017. The outcome of a table top review undertaken in 2018, reported to the Integrated Governance and Risk Committee in November 2018 identified that in principle the strategy was being implemented effectively, but would require refinement once the Board and Board Committee review was completed in January 2019. In addition the Committee were informed of the outcome of the Audit Yorkshire review of the implementation of the Risk Management Strategy. This review was undertaken using Terms of Reference required by the Chair of the Audit and Assurance Committee. The Audit and Assurance Committee received this report, detailing significant assurance, at its February meeting. As a result the findings of the internal audit report minor revisions were made to the Risk Management Strategy to address the recommendations, and also to reflect the new organisational structure. The Committee considered the strategy specifically in the context of its assuring role in relation to the effective management of strategic risk.

5.6 Governance: Sub-Committee reports

The Committee was assured in respect of the work being undertaken by its sub-committees and other committees which support the assurance associated with the achievement of the strategic objectives. It received and approved the revised Terms of Reference of the Health, Safety and Resilience Sub-Committee.

5.7 Executive Leadership Walkarounds

The Committee was informed that the Trust has revised its approach to Executive Leadership Walkarounds, and that a development session was held with the Board of Directors at its meeting in April to support the changes being made. The Committee was assured that the general performance of the programme was

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satisfactory and that the Corporate Affairs team are actively working with the Assurance team to ensure that issues identified during the walkarounds are addressed in a timely way and that feedback to all involved is effective.

Recommendation

The Board of Directors is requested to note the work of the Quality Committee in scrutinising the Foundation Trust's arrangements for the management and development of safety, effectiveness and patient experience. It is also asked to note the assurance level and statement agreed by the Committee which is provided on the Board Assurance Framework.

Strategic Objective 1: To provide outstanding care for patients

Confidence: There is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are established. The Quality Committee recognises the improvements that have been made and undertook a formal review of achievements and performance during 2018/19 at the April meeting to confirm this assurance level.

Strategic Objective 4: to be a continually learning organisation

Confidence: Evidence continues to be presented to Committees and Board which demonstrates the significant progress made, recognising that there are further opportunities for change and improvement. The Quality Committee undertook a full review of achievements and performance during 2018/19 in April 2019. As a result they recommended that this should no longer be a strategic objective of the organisation, but referenced in a revised vision or mission statement and the effectiveness of the key controls monitored through other relevant strategic objectives.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Risk Implications	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	▪	
Quality implications	▪	
Resource implications	▪	
Legal/regulatory implications	▪	
Diversity and Inclusion implications		▪

Regulation, Legislation and Compliance relevance
NHS Improvement: Risk assessment framework, quality governance framework, code of governance , annual reporting manual
Care Quality Commission Domain: Safe, caring, effective, responsive, well led

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Care Quality Commission Fundamental Standard:
Other (please state):

Relevance to other Board of Director's Committee:					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
▪	▪				