Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Council of Governors		
Date	17.1.19	Agenda item	CGo.1.19.18

A report from the Chair of the Quality Committee
November & December 2018

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 provides an overview of the work of the Quality Committee in November and December 2018.
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 significant improvement on the sepsis indicators following the improvement programme, noting the positive impact of the EPR and the appointment of the sepsis nurse.
- The rates of Catheter Acquired Urinary Tract Infections (CAUTI) and Pressure Ulcers were noted and further assurances relating to both were required. In relation to CAUTI the committee requested receipt of the review of the data submitted through the Infection Prevention and Control Committee, and in relation to pressure ulcers a position statement relating to the effectiveness of actions being taken through the Patient Safety Committee..
- Strong performance has been maintained on a number indicators including VTE assessment, Clostridium difficile, HSMR and MRSA.

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.

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**.** The Committee requested that the workforce committee consider the risk associated with the current lack of regulation of Physician Associates.

The Committee was concerned about a theme within the Never Events reported by the Trust during 2018. All incidents had involved a handover of care mid-procedure. In November the Committee requested a specific paper describing the theme and the proposed approach to addressing the issues. This was received at the December meeting and the Committee decided that the actions described were appropriate and proportionate.

1.4 Risk: Sepsis

The Committee received a presentation in relation to the progress with the sepsis action plan and were assured that the actions currently in progress were effective. The Committee noted the timely and ward level data is now available and being used directly to influence the quality of care.

1.5 Key Control: Safeguarding Children-Bi-annual report

The Committee received the bi-annual Safeguarding Children report and was assured that the structures, processes and associated governance in place in the Trust were appropriate, proportionate and effective. Risks identified related to mandatory training compliance. It also noted that the Local Authority had recently received an inadequate rating in relation to children's safeguarding and looked after children's services. The Committee was informed that a risk assessment of this rating had been completed and there was not assessed to be a significant risk.

1.6 Key Control: Safe-guarding Adults- Bi-annual report

The Committee received the bi-annual Safeguarding Adult report and was assured that the structures, processes and associated governance in place in the Trust were appropriate, proportionate and effective.

1.7 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.

1.8 Risk: JAG Accreditation

The Committee received, for consideration, a paper that had been previously considered at the Finance and Performance Committee. The Committee was asked to consider if it required any further assurance in relation to any risks to the quality of care experienced by patients as a result of the performance concerns identified. The Committee decided that it was assured that appropriate and proportionate mitigation was in place.

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.

2.2 Key Control: Effectiveness Report (Quarter 2)

The Committee received the Quarter 2 Clinical Effectiveness report. It acknowledged the concerns described about the participation of the Trust in the National Audit Programme, but decided that it was assured that risks were being identified and managed in a consistent way and mitigated appropriately. The Committee also decided that it was assured that the appropriate governance is in place to manage the clinical effectiveness programme of work in general, and to effectively escalate actual, emergent and latent risk.

Meeting Title	Council of Governors		
Date	17.1.19	Agenda item	CGo.1.19.18

2.3 Performance: Model Hospital

The Committee received a briefing in relation to the Model Hospital and noted that a Board Development session would be used to define the agreed governance associated with its use across the Board and Board Committee infrastructure.

3. Are our services responsive?

3.1 Key Control: End of Life Care

The Committee received a presentation from the Palliative Care team, subsequent to the receipt of the annual report in September 2018. The Committee were informed of capacity and demand issues within the service, further opportunities for change and improvement. The Committee was also informed of a recent mock inspection into the service which identified that the service was good with some outstanding elements.

1. Are our services caring?

1.1 Key Control: Patient Experience Report (Quarter 2)

The Committee received the Quarter 2 patient experience report. The Committee had previously received a presentation about the new patient experience strategy and noted the achievements in improving the quality and reducing the response time to complaints.

2. Are our services well led?

2.1 Governance: Quality Account

The Committee received an update in the progress with the actions described in the 2017/18 Quality Account relating to Medicines Safety and Patient Experience. The Committee will receive updates on all other areas over the next 3 months.

2.2 Strategy: Learning

Due to the shortened meeting in December the Committee did not receive the learning report. It will receive a joint Q2 and Q3 learning report in March 2019.

2.3 Freedom to Speak Up Quarter 2 report

The Committee received this report and noted the outcome of the review of the National Guardian at Nottinghamshire Healthcare NHS FT, and the fact that this had been cross referenced in the action plan being implemented across the Trust.

2.4 Governance: CQC Compliance Actions: Action plan

The Committee received an update on the progress of the action plan to date. The Committee acknowledged that a further update will be presented to the January Board of Directors' meeting. The Committee decided that it was assured that the appropriate systems and governance is in place to effectively manage the compliance action plan which was developed following the CQC inspections in 2018.

Recommendation

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

Limited Confidence: *Whilst there is confidence that structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are becoming established. The Quality Committee recognises the improvements that have been made, but determined that a longer period*

Meeting Title	Council of Governors		
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of scrutiny was required to ensure sustainability (31st October)
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*

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*
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)
▪	▪				