

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>7.11.19</b>	<b>Agenda item</b>	<b>Bo.11.19.12</b>

## A report from the Chair of the Quality Committee

<b>Presented by</b>	Laura Stroud, Non-Executive Director
<b>Author</b>	Tanya Claridge, Director of Governance and Corporate Affairs
<b>Lead Directors</b>	Bryan Gill, Chief Medical Officer; Karen Dawber, Chief Nurse
<b>Purpose of the paper</b>	This paper is to provide the Board of Directors with an overview of the work of the Quality Committee in September and October 2019.
<b>Key control</b>	This paper is a key control for the strategic objectives to provide outstanding care for patients and to be a continually learning organisation
<b>Action required</b>	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:

Readmissions – The Committee were advised that a programme of audit work is underway to understand whether there are any related clinical implications and a summary of findings to date were provided to the Committee.

C Difficile – The Committee noted that an increase in Trust attributed cases has been reported due to the changes to the reporting algorithm from April 2020, the Committee were assured that a robust review for each case is undertaken with lessons learned and action plans agreed with the relevant Clinical Business Unit.

The Committee were both assured and reassured by data available for July and August 2019, when industrial action was taking place within the Trust, despite this action, the data demonstrated sustained performance and improvement in relation to quality indicators.

##### 1.2 Governance: Quality Oversight System

The Quality Committee considered the recent industrial action and the importance of being sighted on any impact over what could be a prolonged period of action. The important role of the Quality of Care Panel meetings was noted during this time. The Committee received assurances that the Trust would risk assess the situation as necessary.

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### 1.3 Risk: Haematology

The Committee were informed that the Haematology Service has been the subject of a Trust level Quality Summit since September 2018. A comprehensive action plan is in place and a full report on progress was presented to the meeting in September. The Committee were assured of the executive level support and regulation of the action plan, and were sighted on the risks associated with long term service delivery within the current service delivery model.

### 1.4 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.

### 1.5 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: Patient Safety and Health and Safety Management and Compliance Incident Report

The Committee received the Patient Safety and Health and Safety Management and Compliance Incident Report and was assured that the report demonstrated the effectiveness of the controls in place to ensure a consistent and high quality approach to the management of incidents in the Trust.

### 1.7 Key Control: Nurse Staffing Data Publication

The Committee received and noted the report, and were assured by the approaches being taken to understand risks related to staffing and the steps being taken to mitigate them.

### 1.8 Risk: IRMER Regulations

The Committee were informed of a recent short-notice CQC inspection of IRMER guidance (radiological safety guidance). As a result an Improvement Notice was received and further information and an action plan will be submitted to the December Quality Committee, following discussion at the Health and Safety Committee. The Improvement Notice concerns quality, Regulation 6, procedures, protocols and quality assurance programmes. A risk assessment has been undertaken which does not score at 12 or above on the care group risk register. A detailed action plan has been compiled and signed off to address areas of non-compliance and this has been shared with the CQC. The Committee requested a further update at its meeting in December.

### 1.9 Key Control: Infection Prevention and Control Report

The Committee received the routine report and was assured by the significant progress being made by the Trust in relation to the prevention and control of infection.

## 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: Maternity Report – Quarter 2 – 2019/2020

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The Committee received the Maternity Report – Quarter 2 and noted the challenges and the complexities in the care but were assured by the work being undertaken and the report was noted by the Committee. The Committee were assured in relation to ongoing compliance with the Maternity Incentive Scheme.

### **2.3 Key Control: Mortality Review Improvement Programme/Learning from Death Update (Quarter 2 2019/20)**

The Committee approved the report and were assured by the progress being made in relation to the mortality review programme to date.

### **2.4 Key Control: NHSE Public Health Screening Reports**

The Committee noted that as part of the contract held with NHS England for screening services this suite of annual reports highlight the key achievements and developments in each service over the year. The Trust provides screening services in collaboration with partner Trusts, in antenatal and new-born screening, bowel cancer screening, breast screening and cervical cancer screening. The reports were approved by the Committee.

### **2.5 Key Control: Clinical Effectiveness Quarterly Report**

The Committee reviewed the content of the report and agreed that the appropriate risks had been identified in relation to the implementation of external recommendations and the management of the national audit programme, and that these are being managed appropriately. The Committee also agreed that the assurance in relation to effective implementation of recommendations and the management of the national audit programme is of the appropriate nature and strength.

## **3. Are our services responsive?**

### **3.1 Key Control: Palliative Care Annual Report**

The Palliative Care Annual Report was received by the Committee, which identified areas of good practice and areas where challenges and opportunities for change and improvement had been identified. The Committee were assured in relation to the outcomes identified within the report.

### **3.2 Key Control: Learning Disability (LD) Benchmarking Audit and Workplan**

The Committee noted the progress being made, as described in this paper and were assured that, whilst further work needs to be undertaken in relation to training for staff on learning disabilities, this will enhance the identification and flagging of patients with a learning disability and ensure that reasonable adjustments are considered and made when they attend hospital.

### **3.3 Key Control: Mental Capacity Act, Deprivation of Liberty Standards and Liberty Protection Standards (LPS)**

The Committee received an update in relation to forthcoming changes in legislation, and acknowledged that further engagement in district wide discussions is required in ensuring that as the understanding around the LPS becomes clearer the Trust is able to adequately and appropriately plan for the changes. The Committee were assured that this engagement and development work will be monitored by the Safeguarding Adults team and reported to the Integrated Safeguarding Committee.

## **4. Are our services caring?**

### **4.1 Risk: Patient Experience Survey Outcome**

The Committee received a detailed presentation and update from the Chief Nurse, and members of the Chief Nurse Team. The Committee were assured that proportionate and appropriate controls and improvement plans were in place to support Trust-wide improvement.

### **4.2 Key Control: Patient Experience Q1 2019/20**

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The Committee received the report and noted areas of risk and the effectiveness of the associated mitigation in relation to the management of the complaints programme, compliance with the Accessible Information Standard and the initiatives in place across the Trust designed to improve patient experience and respond to the aspirations within the patient experience strategy.

## **5. Are our services well led?**

### **5.1 Governance: Leadership Walk-round Quality Update/Engagement Walkround Quarterly Update**

The Committee were assured that the revised approach to leadership walkarounds had resulted in a more comprehensive and monitored programme

### **5.2 Key Control: Our Quality Plan**

In March the progress with 'Our Quality Plan 2018/19' was discussed by the Quality Committee in the context of the organisational restructure and its timeframe was extended to September 2019, as proposed by the Chief Medical Officer and Chief Nurse, to enable a period of engagement and review. As a result the Director of Governance and Corporate Affairs commissioned a review of the progress to date to provide assurance in relation to the continued focus on and improvements being made associated with the delivery which was received by the Committee in July 2019. The Committee, in October 2019 approved the revised Quality Plan, which has been submitted to the Board of Directors for approval.

### **5.3 Governance: Quality Data Framework**

The Committee were assured by the approach taken and the enhanced governance in place across the Trust in relation to the quality of data that is produced, and how it is used. The Committee welcomed the rigour evident within the framework, and the impact this level of scrutiny would have on effective decision making and analysis.

### **5.4 Key Control: Freedom to Speak Up Quarter 1 report**

The Committee received the Quarter 1 report from the Freedom to speak up programme and were assured that the principles of the national programme are being adhered to by the Trust and that action is being taken as appropriate to address issues and risks identified.

### **5.5 Governance: Care Group Governance**

The Committee received and noted the Care Group Governance structure.

## **6. Committee Governance**

### **6.1 Committee Annual Report**

The Committee received and approved its annual report 2018/19.

### **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.

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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
<b>NHS Improvement:</b> Risk assessment framework, quality governance framework, code of governance , annual reporting manual
<b>Care Quality Commission Domain:</b> <i>Safe, caring, effective, responsive, well led</i>
<b>Care Quality Commission Fundamental Standard:</b>
<b>Other (please state):</b>

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