

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	9/1/20	<b>Agenda item</b>	Bo.01.20.11

## A report from the Chair of the Quality Committee

Presented by	Laura Stroud, Non-Executive Director		
Author	Laura Stroud, Non-Executive Director Tanya Claridge, Director of Governance and Corporate Affairs		
Lead Directors	Bryan Gill, Chief Medical Officer; 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 November 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			
<ul style="list-style-type: none"><li>to provide outstanding care for patients and</li><li>to be a continually learning organisation</li></ul>			
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 and Assurances Received			
	Strategy/governance/risk		Level of assurance
1. Are our Services safe?			
1.1	Strategy: Quality Dashboard		Level 1 operational
	The Quality Dashboard is reviewed at every meeting and specific areas of quality performance considered have been. The Committee was assured that the data in the quality dashboard provides assurance in relation to the Trust’s performance associated with the key quality metrics and that areas of exceptions or potential exceptions had been identified and associated assurance was available within specific reports received by the Committee.		
1.2	Governance: Quality Oversight System		Level 1 operational
	The Quality Committee considered the contemporaneous summary of the work of the Quality Oversight System which is routinely provided. The continued important role of the Quality of Care Panel meetings was noted. The Committee were advised of a potential Never Event in the maternity service, which is currently being investigated as a serious incident, the outcome of which will be considered in light of the national Never Events framework. The Committee agreed to receive further information at the January meeting in the routine Serious Incident report.		
1.2	Key Control: Serious Incident Report		Level 1 operational
	The Committee receives a report detailing serious incidents declared and serious incident investigations completed in the preceding month 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		
1.3	Key Control: Nurse Staffing		Level 1 operational
	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 in specific risk assessments and decided that it was assured that appropriate mitigation was in place to manage risk associated with staffing across the Trust.		

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1.4	<b>Risk: IRMER Regulations</b>	<b>Level 3 Independent</b>
	The Committee were updated in relation to the recent short-notice CQC inspection of compliance with IRMER regulations. The Trust was issued with an improvement notice in August and had implemented a detailed action plan to address the concerns identified in relation Regulation 6, to the development of related policies and procedures. The Committee were informed that the CQC had re-inspected the area of non-compliance on the 16 <sup>th</sup> December and were satisfied that the improvements made were consistent and proportionate and agreed to lift the improvement notice. The Committee were assured in relation to the rigour of the process used to respond to the improvement notice and welcomed the outcome of the inspection process.	
1.5	<b>Risk: Incidents related to unconscious bias</b>	<b>Level 1 Operational</b>
	The Committee had previously requested additional assurance in relation to the approach taken through the Learning Hub in responding to a theme of 'unconscious bias' which had been identified within the Trust's incident profile. The Committee required assurance that the theme had been recognised and was being addressed in a proportionate way throughout the quality and learning management system and assurance framework of the Trust, both centrally and within the Care Groups.	
1.7	<b>Key Control: Infection Prevention and Control report</b>	<b>Level 1 Operational</b>
	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. The Committee noted the performance associated with C Difficile, MRSA bacteraemia and the associated lessons learnt. The Committee received an update on prevalence of CPE, with particular focus on screening gastroenterology emergency admissions. The Committee received assurance in relation to the mitigation associated with the management of an estates risk which could have resulted in a infection prevention and control risk	
1.8	<b>Risk: Update on infectious diseases service</b>	<b>Level 1 Operational</b>
	The Committee noted the update provided in relation to the infectious diseases service and were assured by the mitigation that has been put in place to maintain the service for patients.	
2. Effective		
2.1	<b>Key Control: Clinical Effectiveness Quarterly Report</b>	<b>Level 1 Operational</b>
	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.	
2.2	<b>Risk: National Paediatric Diabetes Audit: Outlier status (16/17)</b>	<b>Level 1 Operational</b>
	The Committee requested a presentation from the Paediatric Diabetes Nurse Specialist team to provide the context to the service and the complex population that it serves, the audit findings, and the response of the team to the audit results as a result of the outlier status in relation to the national audit. The Committee were assured that the approach being taken to address the opportunities for change and approach was aligned to the Trust's approach to sustainable quality improvement, with clear identifiable and measurable improvement trajectories.	
2.3	<b>Risk: 30 day readmissions</b>	<b>Level 1 Operational</b>
	The Committee requested specific assurance in relation to the Trust's 30 day readmissions, the Committee noted the detailed work undertaken to understand our position and was assured that a detailed improvement programme is in place and requested further updates to future Committee meetings.	

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2.4	Risk: Sepsis Update	Level 1 Operational
	The Committee received a report providing assurance in relation to progress against NICE guideline [NG51] and Quality standard [QS161]. The report highlighted and provides an escalation summary of key risks in our systems and processes which impact on assessment and treatment of sepsis, the associated mitigation and progress with work plans to improve compliance with sepsis screening and treatment. The Committee was assured by the content of the paper, and supported the recommendations made.	
3. Are our services responsive?		
3.1	Assurance: Enhanced Care Pilot	Level 1 Operational
	The Chief Nurse requested that the Committee received a presentation summarising the work being done and associated outcomes within the enhanced care pilot, focusing on the responsiveness of care we provide for patients with additional needs. The Committee were informed of the plan to extend this pilot further. The Committee also reflected that Executive paired walk-arounds should focus on 'initiatives' as well as wards and departments.	
3.2	Key Control: Safeguarding Adults Bi-annual report	Level 1 Operational
	The Committee were assured that the content of this bi-annual report provided assurance in relation to the effectiveness of the controls in place to ensure our adult patients are safe and protected from abuse.	
3.3	Key Control: Safeguarding Children Bi-annual report	Level 1 Operational
	The Committee were assured that the content of this bi-annual report provided assurance in relation to the effectiveness of the controls in place to ensure infants, children and young people receiving care from our services are safe and protected from abuse.	
3.4	Risk: In-patient survey and updated action plan	Level 1 Operational
	The Committee received a presentation describing the progress being made with (and a description of the associated initiatives) the national inpatient survey action plan. The Committee were assured that the actions being taken were, and the assurance presented in relation to their effectiveness was proportionate and consistent with the response agreed by the Committee following the publication of the results of the survey.	
Are our services caring?		
4.1	Key Control: Patient Experience Q2 2019/20	Level 1 Operational
	The Committee received the report and noted areas of risk and were assured by 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. The Committee were informed that a Quality Improvement Collaborative commenced during Quarter 3, focusing on key areas of delivery of the strategy.	
4. Are our services well led?		
5.1	Assurance: Royal College of Anaesthetists Assurance Visit	Level 3 Independent
	The Chief Medical Director requested that the Committee receive a presentation summarising the outcome of a peer review designed to standardise good practice and drive improvement and is recognised by the CQC as an official information source. The Committee were informed about the rigour of the assessment process, and were assured that the 12 of the 128 standards which were unmet and the 4 standards met with recommendations, were areas that the team were already aware of and working on and had plans to address by March 2020. The Committee were impressed with the findings in relation to leadership, culture, in particular in relation to engagement	
5.2	Assurance Bradford Accreditation Scheme	Level 1 Operational
	The Chief Nurse requested that the Committee receive an update in relation to the Bradford Accreditation Scheme. The Committee were informed that in order to support the strategic objective to provide 'outstanding care for patients' the scheme was being redeveloped to ensure the outcomes reflected outstanding practice, rather than good care.	

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5.3	<b>Key Control: Learning from precursor events</b>	<b>Level 1 Operational</b>
	The Committee received its routine report in relation to learning from precursor events. The Committee noted the report and contextualised it in relation to assurance related to the effective operation of the quality oversight system	
5.4	<b>Key Control: CQC Compliance</b>	<b>Level 1 Operational</b>
	The Committee received a summary of the preparation for and the initial informal outcomes of the CQC inspections of the Trust in November and December 2019. The Committee were assured by the reported rigour applied to the pre-inspection preparation and noted the timescales for publication of the report.	
5.5	<b>Key Control: Freedom to speak up (Q2 report)</b>	<b>Level 1 Operational</b>
	The Committee noted the contents of the report and the concerns that have been raised at the Trust during Q2 2019/20 and decided that it was assured that the Trust has effective systems and process to identify and respond to FTSU concerns.	
5.6	<b>Key Control: Clinical audit and effectiveness sub-committee</b>	<b>Level 1 Operational</b>
	The Clinical Audit and Effectiveness Sub-Committee, as set out in its Terms of Reference, has a responsibility to provide assurance to the Quality Committee, which is a sub-committee of the Board of Directors, that services provided by the Trust are grounded in evidence based effective clinical practice. The Committee decided that the Clinical Audit and Effectiveness Committee had delivered its objectives, as described in its Terms of Reference, and agreed the proposed changes to strengthen its performance.	
5.7	<b>Key Control: Draft Patient and public engagement strategy</b>	<b>Level 1 Operational</b>
	In noting that building and sustaining effective relationships with people who use our services, our members, our local community and the wider population of Bradford takes time, effort and commitment. The Quality Committee approved the draft strategy and agreed to receive a detailed implementation plan at its January meeting for approval. The Committee also agreed that it would identify the key assurance milestones it requires, and that these would be added to its work-plan following approval of the implementation plan in January.	
5.8	<b>Risk: EPRR</b>	<b>Level 2 Oversight</b>
	The Committee were informed of an escalation from the Audit and Assurance Committee, which having scrutinised the assurance provided to the Quality Committee in relation to the EPRR core standards, decided that further assurance was required to support the Trust's reported position. The Committee agreed to receive additional assurance at its meeting in January, before a further review at the Audit and Assurance Committee in February, and prior to the formal and final submission to Board in March 2020.	
<b>Committee Governance</b>		
6.1	<b>Risk appetite</b>	
	As requested by the Board of Directors the Committee reviewed the risk appetite statement in relation to strategic objectives one and four (to provide outstanding care for patients and to be a continually learning organisation). The revised statement is attached at Appendix 1 of this report.	
<b>Recommendation</b>		
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.		

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients		g				

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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)
▪	▪				