

Meeting Title	Quality Academy		
Date	30 June 2021	Agenda item	QA.6.21.7

## QUALITY OVERSIGHT AND ASSURANCE EXCEPTION PROFILE MAY 2021

Presented by	LeeAnne Elliott, Deputy Chief Medical Officer		
Author	Sarah Branigan, Quality Governance & Datix Manager		
Lead Director	Judith Connor, Associate Director of Quality		
Purpose of the paper	The purpose of this presentation is to provide the Quality Academy with assurance in relation to the Quality Oversight System.		
Key control	This presentation is a key control for the Board Assurance Framework		
Action required	To note		
Previously discussed at/informed by	All elements of this presentation are discussed at the weekly Quality of Care Panel		
Previously approved at:	<b>Academy/Group</b>	<b>Date</b>	
	N/A	N/A	

### Key Options, Issues and Risks

This new model for Quality Oversight was introduced during COVID to ensure continuing assurance for Patient Safety during the pandemic. It sets out a whole range of safety indicators to ensure that quality of patient care is monitored and managed appropriately. This information, in the same format is presented to the Quality of Care Panel on a weekly basis.

### Analysis

Incidents: Theme around delay in critical medications identified in May. Discussion at various forums; IPMG/QuOC/Medicines Nursing & Midwifery Forum/Medicines Safety Forum. Quality Improvement to look at undertaking project with new Junior Doctor intake.

Regulators: Reporting and responding to external agencies.

1 CAS Alert received in May, which requires a response through the CAS process:

NatPSA/2021/002/NHSPS - Urgent assessment/treatment following ingestion of super strong magnets. Vicky Cox and Liz Jones in AED have been identified to respond by 19.08.2021.

NatPSA/2020/006/NHSPS – Inhalation - Non compliant – Risk Assessment completed.

NatPSA/2021/001/MHRA – BD giving sets – work still ongoing.

4 incidents reported to the HSE under RIDDOR.

1 incident reported under SHOT.

1 screening incident reported to Public Health England.

CQC monthly engagement meeting held on 25<sup>th</sup> May, presentation by Chief Operating Officer on Covid-19 summary and operational overview. Next meeting 23<sup>rd</sup> June.

Inquests: Remote hearings for Inquests continue. 1 Inquest heard in May related to AED.

4 further Inquests listed for June/July/August/September.

Regulation 28 received for Inquest heard in March related Orthopaedic/Vascular/Plastics. Work to formulate response ongoing.

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**Claims:** In May the Trust formally responded to 6 Clinical Claims making admissions; there were no Claims settled.

**Patient Experience:** There were 32 complaints, 163 PALS issues and 47 compliments received in May. 51 complaints and 183 PALS issues were responded to.

**Learning:** Maternity Unit compiled an SBAR to highlight recommendations and learning from an HSIB report around a Neonatal death. (Appendix 1)

Three external updates received which have been considered at Quality of Care meetings during the reporting period:

1. Court of Protection Rules – Covid-19 vaccination not in best interests of patient (Appendix 2)  
Learning from this ruling is that regardless of whether a patient is assessed as not having capacity the wishes and feelings previously expressed should be taken into account when considering Best Interest decisions albeit that this should be regarded a case specific.

2. New GMC Guidance – decision making and consent (Appendix 3)  
The guidance update reflects the changes to medical practice, the law around consent, the healthcare environment and the doctor-patient relationship which have occurred since the original guidance was published in 2008.

3. HSE prosecution of Scottish healthcare provider in respect of their failure to protect the safety of a patient in their care which resulted in a fine.  
NHS Ayrshire & Arran Health Board Case details (Appendix 4)  
The Safeguarding Team is reviewing the information to identifying whether there are any actions that need to be taken by the Trust.

#### Recommendation

The Quality Academy is asked to

- Note the comprehensive report attached
- Be assured that quality oversight is has been maintained during the Covid period
- Consider the new approach to providing assurance which will link into the work of the Quality Academy and its three pillars, Assurance, Learning 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 (*)					

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Explanation of variance from Board of Directors Agreed General risk appetite (G)	
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Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal/regulatory implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

<b>Regulation, Legislation and Compliance relevance</b>
<b>NHS Improvement: (please tick those that are relevant)</b> <input type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input checked="" type="checkbox"/> Code of Governance <input checked="" type="checkbox"/> Annual Reporting Manual
<b>Care Quality Commission Domain: Effective</b>
<b>Care Quality Commission Fundamental Standard: Good Governance</b>
<b>NHS Improvement Effective Use of Resources: Clinical Support Services</b>
<b>Other (please state):</b>

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>1</b>	<b>PURPOSE/ AIM</b>
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The presentation provides a summary of quality governance, risk management, learning and improvement discussions and actions escalated through current Quality Oversight System processes.

<b>2</b>	<b>BACKGROUND/CONTEXT</b>
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Key issues to be considered are:

Incidents that have been graded as moderate and above reported in May 2021.

Serious Incidents that have been declared 17<sup>th</sup> May to 13<sup>th</sup> June 2021.

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Incidents reported to external agencies.

Complaints received and closed during May 2021.

Trust response to National Patient Safety Alerts.

Mortality Data.

<b>3</b>	<b>PROPOSAL</b>
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Not applicable

<b>4</b>	<b>BENCHMARKING IMPLICATIONS</b>
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Not applicable

<b>5</b>	<b>RISK ASSESSMENT</b>
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Not applicable

<b>6</b>	<b>RECOMMENDATIONS</b>
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For Academy to receive information and note actions taken.

<b>7</b>	<b>Appendices</b>
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Appendix 1: SBAR – Neonatal Death

Appendix 2: Court of Protection Rules – Covid-19 vaccination not in best interests of patient

Appendix 3: New GMC Guidance – decision making and consent

Appendix 4: Hospital Prosecution (Case Details)