Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Report of the Quality Committee	**Date:** 16/05/18	
Prepared By:	Elaine Jeffers, Deputy Director of Governance & Quality Improvement		
Approved By:	Tim Reddish, Chair of Quality Committee		
Presented By:	Tim Reddish, Chair of Quality Committee		
Purpose			
The purpose of this paper summarises the assurances provided to the Quality Committee around the safety and quality of care provided to our patients and those matters agreed by the Committee for reporting to the Board of Directors.		**Approval**	
		Assurance	**x**
		Update	**x**
		Consider	

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
Indicate which strategic objective(s) the report support				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
Indicate the overall level of assurance provided by the report -	External Reports/Audits	Triangulated internal reports **x**	Reports which refer to only one data source, no triangulation	Negative reports

Risks/Issues	
Indicate the risks or issues created or mitigated through the report	
Financial	No financial risks identified
Patient Impact	Assurance received with regards to the Safety and Quality of Care through the Reports presented
Staff Impact	No staff issues identified
Services	No service Delivery risks identified
Reputational	No Trust reputational risks identified

Committees/groups where this item has been presented before

None

Executive Summary

The Quality Committee met on 16/05/18. The meeting was quorate. The minutes of the meeting held on 21/03/18 were accepted as a true record and the Action Tracker updated.

The Board of Directors is asked to accept the content of the Quality Committee Report and the items for note highlighted below:

- The contingency plans in place for Sterile Services (CSSD) both for the immediate and longer-term
- The rapid resolution of the issue raised with regards to the 'not our patient' letters within the Emergency Department
- The significant improvement in case attainment of relevant patients to complete the TARN Data submission
- The actions taken to date to resolve the water safety issues and identification of legionella Species

- The significant achievement in the review of guidelines within the Women and Children's Division
- The request to reconsider the delegation of BAF Principal Risk 3 to the Board of Directors
- The request to reconsider the delegation of BAF Principal Risk 7 to the Audit Committee

1. 360 Assurance (Internal Audit)

1.1 Quality Committee noted and accepted the 360 Assurance 2018/19 Internal Audit Plan and 2019/19-2020/21 Strategic Plan

1.2 Quality Committee noted the 'Medicines Incidents Follow Up' report – confirmation that following 'significant assurance' given this review has been closed.

1.3 Quality Committee noted the Decontamination of Mattresses report – 'significant assurance' given.

2. CSSD Risk update

2.1 Quality Committee were assured by the update provided in relation to the immediate and long-term risk relating to the CSSD Department. The committee satisfied itself that the contingency plan in place to ensure the continued provision of a sterile service was robust and did not present a significant patient safety or business continuity risk.

2.2 Quality Committee were also satisfied that the long-term plan to provide sterile services across partner organisations was the appropriate direction of travel.

3. Claims, Incidents, Patient Experience & Safeguarding (CLIPS) Report (Quarterly)

3.1 Quality Committee accepted the Report. The Report aims to bring together the themes and learning from a number of modalities across the governance agenda. The key themes identified are:

- Treatment and Care (Inappropriate treatment, clinical treatment)
- Delays in Care (delay in treatment)
- Appointments and clinics (delay in appointments)

3.2 Further analysis of these themes is being undertaken and consideration will be given to building them into the Trust Risk Profile

3.3 A discussion was held to clarify the future nature of the report as the report is also presented to the Patient Safety Quality Group (PSQG) where the granular detail is discussed. Consideration will be given as to whether the Report from PSQG will provide sufficient assurance for this agenda item moving forward.

3.4 A 1 page Dashboard is being developed that will support achievement and compliance against the agreed CLIPS metrics

4. Quality Dashboard (Quarterly)

4.1 The Quality Dashboard Report provides an overview of performance based on a consistent set of performance indicators.

4.2 To ensure that the Trust maintains effective control over the quality aspects of the Single Oversight Framework (SOF), a regular Quality dashboard Report is provided to

PSQG.

4.3 Quality Committee accepted the report, however felt that as this report is provided to PSQG it represented further duplication as indicated at item 3.3.

5. Patient Safety Quality Group Report (April & May) (Monthly)

5.1 Quality Committee accepted the PSQG Report for April with the following items for escalation:

- Emergency Department letter – through the Urgent & Emergency Care Divisional Exception Report an issue relating to returned 'not our patient' letters had been raised. Up until 2015 NHS England had provided a redirection service for letters sent to GP Practices for patients either no registered or no longer registered with that practice. The service was terminated in 2015. The Trust has carried out a risk assessment and developed an algorithm in 2016 to manage the consequence of this. It came to light recently that the algorithm had not been applied in the Emergency Department and a number of letters waiting for action had been discovered. Swift action was taken, all letters have been risk assessed and plans followed up where necessary with no patient coming to harm. The algorithm has been reiterated and is now in place. Quality Committee were assured by the actions taken.

- The Major Trauma Group quarterly Report highlighted a mortality outlier alert from the Trauma and Audit Research network (TARN) data between 2015 and 2017. A review had been undertaken where it was discovered that through this reporting period case ascertainment was low at 56-66%. A review of all cases flagged by the alert did not reveal significant management issues with the alert most likely to have been caused by the failure to submit all the data. Quality Committee were assured that appropriate actions have been taken, which is supported by the considerable improvement in data submitted in 2017/18. Case attainment is now performing at >90%. The Major Trauma Group is focussing on the only outstanding issue – Rehabilitation Prescriptions where improvements in documentation of rehabilitation plans are required. Quality Committee noted that the revised Chest Trauma Pathway will go live in June. There are four relevant NICE Guidelines three of which are 100% compliant with 76% compliance on the fourth and an acknowledgement that 100% compliance is not possible.

5.2 Quality Committee accepted the PSQG report for May with the following items for escalation:

- Quality Committee noted the actions that had been taken to provide assurance around water safety across the Trust. Quality Committee noted that the work was being undertaken in conjunction with the NHS Public Health water safety expert, the Trust Estates and Facilities Team, representatives of the PFI provider and sub-contractors. The Medical Director is providing leadership to the Trust water Safety Group until the issues have been fully resolved, however Quality Committee were assured that it was Legionella Species that had been identified, which was not harmful to patients or staff. Quality Committee noted that in addition to the legionella this incident had raised some concerns around robust contract management of outside or sub-contracted companies and this is currently being addressed.
- Quality Committee noted the excellent progress made in the review and update of clinical guidelines within the Women and Childrens Division and thanked the Division and the Governance Support Unit.

6. Advancing Quality Programme (Monthly)

6.1 In preparation for the May meeting of the Advancing Quality Board (AQB), outcome leads and actions owners had been asked to provide a 'Plan on a Page' for each improvement campaign as agreed in the Quality Priorities Strategy 2018/21.

Not all leads had been in a position to provide their plans as the request had coincided with the CQC Core Service Inspection and preparations for the Well-Led element of our full assessment. Meeting the requirements of CQC took precedence over all other quality improvement activities during this period, although it was recognised that there was a considerable amount of work on individual elements of the campaigns underway. Quality Committee were given assurance that the programme would be back on track and progress reported at the July Committee.

7. Serious Incident Summary Report (Monthly)

7.1 Quality Committee accepted the Report as follows:

- The Trust reported 3 serious incident to STEIS for April 2018
- 1 Inquest was held in April with no Regulation 28 (Report to prevent future deaths) issued
- Compliance with Duty of candour remains at 100% for confirmed incidents rated as moderate or above.
- There are currently 26 serious Incidents open on STEIS with 17 currently being considered for closure by the CCG and NHSE.

8. Freedom to Speak Up/Raising Concerns Dashboard Q4 (Quarterly)

8.1 Following the review of committee structures it was agreed that the Freedom to Speak Up/Raising Concerns agenda should be more visible. A quarterly Dashboard indicating themes and contacts has been developed and will be presented to the Quality Committee as part of the annual work programme.

8.2 Quality Committee accepted the Q4 Report and associated Dashboard. It was noted that for the quarter 40% (4/11) issues raised related to behavioural/relationship, bullying/harassment and patient safety/quality. Of the total concerns raised all but one have been resolved presenting an active approach to concerns if raised with the aim to resolve matters in a timely manner. For the majority of concerns raised feedback was given via letter identifying points of learning, outcomes and required actions. Quality Committee acknowledged that it was not always possible to provide direct feedback, particularly if the concern is raised anonymously.

9. Quality Account (Annual)

9.1 Quality Committee had received draft 11 of the Trust Annual Quality Account (2017/18) for comment. It was noted that the format was greatly improved from previous years and that the content flowed well and articulated the journey the hospital has taken over the reporting period. No further comments were made. The Quality Account is due for final sign off at the Audit Committee on 24 May prior to ratification by the Board of Directors on 31 May.

9.2 The Quality Account has been reviewed by the Trust External Auditors to ensure it meets the requirements of NHS Improvement

10. Nursing Revalidation Report

10.1 Quality Committee accepted the report. There were no issues for escalation

11. Medical Revalidation Report (Annual)

11.1 Quality Committee accepted the report. There were no issues for escalation

12. BAF Principal Risks

12.1 The Quality Committee received the new Board Assurance Framework (BAF) and reviewed in detail. The risk scores were agreed. In accordance with the new BAF Non-Executive Directors considered the assurance ratings for each risk.

12.2 PR1 – the Committee were satisfied that the assurance received indicated a positive assurance overall

12.3 PR2 – the Committee felt it had not received assurance in the bundle of papers to make a meaningful judgement on the assurance rating at the meeting. The Committee therefore agreed an interim judgement of 'inconclusive assurance' until such time as the Committee are furnished with assurances on performance, and capacity and demand modelling.

12.4 PR3 - the Committee felt it had not received assurance in the bundle of papers to make a meaningful judgement on the assurance rating at the meeting. Discussion considered the extent to which the Committee is in a position to receive and consider assurances on workforce capacity and capability. The Committee agreed that it would not rate the assurance on this occasion and ask the Board of Directors to consider reassignment of this risk to the purview of the Board itself.

12.5 PR5 - the Committee were satisfied that the assurance received indicated a positive assurance overall

12.6 PR7 - the Committee felt it had not received assurance in the bundle of papers to make a meaningful judgement on the assurance rating at the meeting. Discussion considered the extent to which the Committee is in a position to receive and consider assurances on Emergency Preparedness. The Committee agreed that it would not rate the assurance on this occasion and ask the Board of Directors to consider reassignment of this risk to the purview of the Audit Committee.

12.7 The Committee discussed the need to reconsider the delegation of responsibilities to the Quality Committee. The Chair of Quality Committee agreed to raise this with Chairman of the Board of Directors.