Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors – 29th June 2017

Subject:	Report of the Quality Committee	**Date:** 22/06/2017	
Prepared By:	Paul Moore – Director of Governance & Quality Improvement		
Approved By:	Mr Tim Reddish –Chair Quality Committee		
Presented By:	Mr Tim Reddish –Chair Quality Committee		
Purpose			
This paper summarises the proceedings of the Quality Committee meeting held on 21st June 2017, and highlights those matters identified by the Committee for reporting to the Board of Directors.		**Decision**	
		Approval	
		Assurance	**X**

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**
X	**X**	**X**	**X**	**X**

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 **X**	Negative reports
Risks/Issues				

Financial	
Patient Impact	
Staff Impact	
Services	
Reputational	

Committees/groups where this item has been presented before

N/A

Executive Summary

The Quality Committee met on 21st June 2017. This paper summarises the proceedings and draws the Board's attention to any matters and assurances identified by the Committee for reporting to the Board of Directors.

Patient Safety & Quality Board Report

The Committee received and reviewed the report of the Patient Safety & Quality Board (meetings held on 3rd May and 7th June 2017. Those matters drawn to the Committee's attention included:

(i) The PSQB has kept under review the outputs of divisional governance. The Quality Committee were briefed on those areas where divisions have been tasked to improve, namely: (i) extending the scope of mandatory audits to increase sample size and compliance; (ii) clarification (where indicated) on the extent to which NICE guidance is

implemented at divisional level; and (iii) addressing local clinical policies and procedures that have passed the review date. The Committee were satisfied with the explanations given and the action described to strengthen control in these areas.

(ii) The Committee were briefed on the output of a local Quality Summit held with the Division of Surgery on 16th June 2017. An internal Quality Summit is a device used by the Executive to examine more closely the effectiveness of divisional governance and support learning and improvement. The Quality Summit explored: (i) concerns associated with recent serious incidents; (ii) the timeliness and quality of divisional governance reporting; and (iii) arrangements to support the urology cancer multi-disciplinary meeting. The Executive advised that the Quality Summit had a strong developmental and supportive emphasis, and was found to be constructive, informative and insightful by members of the Divisional management team. Actions were agreed at the Quality Summit and are being developed into a plan by Division. The Quality Committee welcomed the opportunity to consider the issues and learning from the Quality Summit at the next meeting of the Committee;

(iii) The PSQB drew the Committee's attention to insufficient compliance with the requirement to assess the risk of venous thrombo-embolism (VTE). The Executive outlined its intention to: (i) review and assure that patient's without evidence of VTE risk assessment received thromboprophylaxis appropriate to their care; and (ii) to agree improvement trajectories with divisions for the remainder of 2017/18.

Board Assurance Framework (BAF)

(i) The Quality Committee reviewed the BAF. At the request of the Board Risk Committee, the Quality Committee with input from the Chief Nurse and Medical Director considered the target risk rating and agreed an amendment as follows: acceptable risk tolerance (Target Risk) of 8 (Severity=4 X Likelihood=2).

(ii) The Quality Committee also considered the extent to which its annual cycle of business is driven by the risks outlined in the BAF, and concluded that the Annual Work Plan shall be developed further to capture and programme a review of assurances in respect of managing elective and non-elective demand.

Advancing Quality at Sherwood Forest

(i) The Committee sought and received an update on the progress of developing and implementing the Advancing Quality Programme (formerly known to the Board as the Quality Improvement Plan). The Committee were advised of progress to date, and informed of the potential risks associated with the roll out of Nerve Centre.

(ii) The Discharge and Mental Health & Learning Disability Programmes have been reviewed by the Chief Nurse and will be signed off in the next two weeks; and the specific measures of success for each programme shall be confirmed at the next meeting of the Advancing Quality Board.

(iii) The Quality Committee welcomed the update but expressed some dissatisfaction that elements of the plan continue to be developed and require sign off at the end of quarter 1. Reasons were given by the Executive and reassurance provided that action in these areas has been progressing was accepted by the Committee.

Annual Complaints Report

(i) The Committee reviewed a report setting out the experience of care for service users in 2016/17. The report covered complaints, concerns and compliments received.

(ii) Complaints increased by 4% in 2016/17 (n=378). 94% of complaints were investigated and responded to within 25 working days. 95% the complaint responses addressed the concerns and were closed. 5% (n=19) of complaints were re-opened at the complainants request. 2.4% (n=9) of complaints were referred by the complainant to the Parliamentary Health Service Ombudsman – to date 5 cases have either not been

upheld or a decision taken by the PHSO not to investigate; four cases are under consideration by the PHSO.

(iii) The Divisions of Surgery, Medicine and Urgent Care account for the majority of complaints received (82%); this distribution of complaints is expected given that a large proportion of direct patient care is handled through these divisions.

(iv) Service users have identified the following problems in their complaints (please note complaints often highlight multiple problems):

1	Appointment - Cancelled/Delayed	77.78%
2	Communication - Admin	64.81%
3	Waiting Time - for outpatient appointment	34.66%
4	Waiting Time - for results	31.22%
5	Waiting time - for surgery	24.87%
6	Communication - doctor	23.02%
7	Attitude - doctor	18.78%
8	Communication - Nurse/Midwife	13.23%

(v) The Trust received 1801 compliments during 2016/17, an 84% increase on the same period in 2015/16.

(vi) The Quality Committee received details of the actions taken to learn and improve following complaints.

Central Alert System

(i) The Quality Committee sought and received assurance that there are no alerts overdue for implementation.

Ward Accreditation

(i) The Quality Committee reviewed the outcomes of ward accreditation, a process of assessment at ward level to evaluate the standard and control of care at ward level. There are four outcomes: gold, silver, bronze and white. 30 Wards have been reviewed and the results are as follows:

	Num	%
Gold	0	0
Silver	17	56.67
Bronze	12	40.00
White	1	3.33

Escalation to Board of Directors

(i) There are no specific matters requiring escalation to the Board of Directors.

Paul Moore
Director of Governance & Quality Improvement
On behalf of the Chair of the Quality Committee