

Board of Directors

Subject: Quality Committee Update Report
Date: 28th January 2016
Author: Suzanne Banks, Andy Haynes, Paul Moore
Lead Director: Dr Peter Marks

Executive Summary

The Quality Committee took place on 21st January 2016. Following the Committee the following areas have been identified to escalate to Trust Board

- The Quality Improvement Plan (QIP)- There were 11 actions presented to the Quality Committee as completed, of which 10 have been approved
- The Committee sought and received assurance on the current progress regarding SI investigations. The Committee explored with management its concern that the current process is not under sufficient control, given the proportion of investigations overdue for completion and ambiguous presentation of data within the report. The Committee was not satisfied that the assurance demonstrated effective serious incident management and learning. In addition, after taking advice from the Director of Governance, the Committee were not assured that effective arrangements are in place to meet the Trust's statutory Duty of Candour. The Medical Director, Chief Nurse and Director of Governance confirmed their intentions to enhance reporting and improve at pace the timeliness of completion for serious incident investigations and demonstrable compliance with the duty of candour.
- Endoscopy – The Committee looked at the data and had questioned whether we were on track to reduce the surveillance backlog but the Chief Operating Officer advised the Committee Chair and Medical Director that he is confident of delivering this.
- Quality Impact Assessment process was presented to the Committee. It was agreed that the QIA and their risk areas should be held within the Divisions and escalated to the Medical Director and Chief Nurse where there are areas of risk that require additional support

Recommendation

For the Board of Directors to note the issues highlighted from the Quality committee

Relevant Strategic Priorities (please mark in bold)

To consistently deliver a high quality patient experience safely and effectively	To develop extended clinical networks that benefit the patients we serve
To eliminate the variability of access to and outcomes from our acute services	To provide efficient and cost-effective services and deliver better value healthcare
To reduce demand on hospital services and deliver care closer to home	

How has organisational learning been disseminated	Learning identified will be disseminated via the appropriate committee
Links to the BAF and Corporate Risk Register	Board and its Committees are responsible for the systematic review of the trust's control environment
Details of additional risks	

associated with this paper <i>(may include CQC Essential Standards, NHSLA, NHS Constitution)</i>	
Links to NHS Constitution	
Financial Implications/Impact	NA
Legal Implications/Impact	NA
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	Update from the Quality Committee
Monitoring and Review	
Is a QIA required/been completed? If yes provide brief details	NA