Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Report of the Quality Committee	**Date:** 19/09/18	
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 19/09/18. The meeting was quorate. The minutes of the meeting held on 18/07/18 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:

- Progress to date on the priorities aligned to the 2017/18 Quality Account
- The inclusion of the 37 ‘Should Do’ actions from the 2018 CQC report as Campaign 5 within the AQP
- The approval of the evidence submitted via the ‘Blue Form’ for Campaign 3: Action 3.4 – Mortality
- Positive Report from 360 Assurance, Internal Audit re ‘Transfer of Handover’
- No requirement to report to ‘Each Baby Counts’ for over 12 months
- The work undertaken to achieve the Induction of Labour Standard has been submitted for

an HSJ Award

- The commitment of the Trust to participate in the national 'Always Events' programme, initially looking to improve compliance with 'Hello, my name is….' and adding in 'Positive Patient Identification'.
- The Cancer Clinical Psychology team have been shortlisted for a Macmillan Excellence Award
- The shortage of 1litre bags of Normal Saline, the necessity to accept an un-licenced product from the United States and the lack of assurance for Quality Committee around the forward planning and tracking for ongoing medicines shortages by Pharmacy
- Assurance received on the actions being taken to address the recently identified NEVER Event for the retained guidewire
- No amendments required for the Principle Risks assigned to the Quality Committee

1. Quality Account Report (annual progress report)

1.1 Quality Committee received the annual update of progress on the 2017/18 Quality Account.
1.2 The delivery of the priorities aligned to the Quality Account are monitored through the Advancing Quality programme and are on track to deliver within required timescales.
1.3 Planning for the 2018/19 Quality Account will commence from November 2018 in order to ensure that maximum time is allocated to define and agree the Quality Priorities for the forthcoming year.

2. Advancing Quality Programme Report

2.1 Quality Committee received the regular progress report for the Advancing Quality Programme and acknowledged progress to date
2.2 Quality Committee agreed the proposal to reinstate the 'Blue Form' methodology of providing assurance that actions within the AQP had been achieved and were embedded within business as usual processes across the organisation
2.3 Quality Committee accepted the evidence presented in relation to Campaign 3: Action 3.4 - Mortality and agreed it provided sufficient evidence that the action was now embedded and sustained across the organisation
2.4 Quality Committee accepted the CQC 37 'Should Do' actions as Campaign 5 of the Quality Strategy (AQP Improvement Programme)

3. 360 Assurance Follow up Report –'Transfer of Handover'

3.1 Quality Committee were assured by the 360 Internal Audit Report for 'Transfer of Handover'.
3.2 Despite the positive outcome further work is being undertaken to continue to strengthen handover processes. This includes the move to host the handover documentation within Nervecentre to provide a more robust audit trail
3.3 A 'deep dive' into the quality of the accountability handover and has been commissioned to provide additional opportunities for learning and improvement
3.4 Progress on the follow-up actions will be presented to Quality Committee in January 2019

4. Patient Safety Quality Group Report (PSQG) (monthly – August/September 2018)

4.1 PSQG received the exception report from the Women and Children's Division reporting that it had been over 12 months since a baby had met the criteria for reporting to 'Each Baby Counts'.
4.2 The Trust has been an outlier for the Induction of Labour (IOL) on the Maternity Dashboard and national benchmarking for several years. Following significant work this standard has now been achieved, with a subsequent reduction in length of stay, improved patient

experience and improved quality and safety of care. The work undertaken has been submitted for an HSJ Award.

4.3 The Antenatal and Newborn Screening Assurance visit took place on 18/09/18. Initial feedback has been received identifying no areas of immediate concern. A full report will be presented to Quality Committee in November

4.4 The Emergency and Urgent care Division reported an improvement in their FFT response rate achieving 12% which is 1% above the national average. This is in recognition of the work undertaken, although more needs to be done to consistently improve

4.5 The Diagnostic and Outpatient Division presented the initial outcomes of the CQC Radiology Reporting visit carried out during the summer. The report highlights the variation in reporting times, however there are currently no national standards available. The Division have developed internal standards and will monitor them through their governance forum and through the exception reporting to PSQG.

4.6 Following the identification of poor performance relating to Positive Patient Identification several recommendations for improvement have been made by the Patient Safety Quality Group. This includes raising awareness of the importance of ensuring the correct patient is identified at all stages as part of the work the trust has committed to with the national 'Always Events' programme.

4.7 Significant progress has been made at the Water Safety Group with the most recent water sampling results for July returning very low levels of Legionella species (non-pathological)

4.8 Quality Committee received assurance of the actions taken to address the recent Pseudomonas cases within the Intensive Critical Care Unit. The outcome of the investigations were reported to the September PSQG meeting confirming that the strain found within the environment differed to that identified within the affected patients. Three patients have since died, two of whom were known to be infected. A Structured Judgement Review (SJR Mortality Review) is being conducted for each to determine whether any contributory factors were present

4.9 The Cancer Clinical Psychology team have been shortlisted for a Macmillan Excellence Award

4.10 The Medicines Optimisation Report highlighted the need to carry out a deep dive into the management of controlled drugs within Theatres. Although no specific concerns had been raised there were opportunities to improve.

4.11 The National Shortage of 1litre bags of Normal Saline was escalated to PSQG. Quality Committee were not assured that adequate actions had been taken by pharmacy to escalate the issue with the Medical Director or take appropriate action with regards to the quality assurance processes required. Baxter (fluid supplier) had sourced an un-licenced product replacement from the United States, however Quality Committee were not assured that there were robust monitoring and tracking processes in place

4.12 Further concern was raised by Quality Committee relating to the processes Pharmacy have in place to horizon scan forthcoming shortages of medicines and to adequately plan for the shortfall with robust contingencies in place.

4.13 Quality Committee have asked Steve May, Chief Pharmacist to attend the November Quality Committee to provide an assurance report

4.14 A 360 Assurance Audit into the management of patients with mental health needs within the Trust commenced on 17/09/18. The outcome will be reported through PSQG and Quality Committee in due course

4.15 A 360 Assurance Audit is currently underway for Duty of Candour. The outcome will be reported through PSQG and Quality Committee in due course

4.16 Quality committee were assured that the recently identified NEVER Event relating to the retained guidewire in Acute Medicine is being appropriately investigated

5. Care Quality Commission (CQC) Report (bi-monthly)

5.1 Quality committee received the regular CQC report highlighting:

- The actions required following the 2018 CQC Inspection (see AQP Report)

- Initial plans to prepare the Trust for the 2019 Inspection
- The continued analysis of the CQC Insight Intelligence Tool
- The intent to de-register Ashfield Health Village as a Sherwood Forest Hospitals NHS Foundation Trust site

6. The Engagement and Involvement Strategy

6.1 Quality Committee received the update on the development of an Engagement and Involvement Strategy for the Trust.
6.2 Agreement was reached to widen the scope of the Strategy in an attempt to link into the numerous user groups in the community. There was recognition that we should optimise the opportunities to engage wider through the Integrated Care System working and also think in a more creative way about whom, how and when to involve and engage with.
6.3 To support the further development of the Strategy a self-assessment against the NHS Improvement Patient Experience Improvement Framework is underway. The Framework enables organisations to carry out a diagnostic to establish how far patient experience is embedded into its leadership, cultural and operational processes
6.4 A revised Strategy will be presented to the October meeting of the Board of Directors

7. Board Assurance Framework Principle Risks

7.1 Quality Committee reviewed the following principle risks:
- PR1: Catastrophic failure in standards of safety and care – no amendments required
- PR2: Demand that overwhelms capacity – no amendments required
- PR3: Critical shortage of workforce capacity and capability – no amendments required
- PR5: Fundamental loss of stakeholder confidence – no amendments required