Board of Directors

Subject:	Report of the Quality Committee	**Date:** 06/06/19	
Prepared By:	Elaine Jeffers, Deputy Director of Governance & Quality Improvement		
Approved By:	Barbara Brady, Chair of Quality Committee		
Presented By:	Barbara Brady, 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 promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x			x	x

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
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 15/05/19. The meeting was quorate. The minutes of the meeting held on 20/03/19 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 made by the Dermatology Team against their action plan following a Quality Summit
- The successful implementation of NICE Guidance
- Quality Committee's formal endorsement in the procurement and installation of the Birth Right Plus tool.
- The robust process in place for Nurse Revalidation

1. Action from the Quality Committee meeting 20/03/19

- At its meeting on 20 March 2019, the Committee had requested further assurance in relation to the CCG's control mechanisms against the BAF risk 'demand overwhelms capacity'. This covers three risks: Primary Care, Sherwood Forest Hospitals Trust and other organisations' ability to treat patients.
- The Committee were particularly concerned in relation to the Primary Care risk and sought deeper assurance on the controls in place to manage this.
- The Committee were directed to an excerpt from the CCG's risk register, which had been circulated with the action tracker. The Committee were advised that this was the only assurance the Trust could provide on the management of that risk.
- The Committee acknowledged that a review of the BAF is taking place in May and further consideration was needed as to the risks the Quality Committee were assuring itself on.
- Quality Committee is trying to mitigate an ongoing risk that it cannot control therefore the action should be around working with external colleagues on how they are controlling the risk. The Committee hoped that once the Integrated Care Partnership (ICP) develops further, risks may become more aligned.

2. Dermatology – Progress against the Dermatology Quality Summit Action Plan

2.1 In line with the process of monitoring actions following a Quality Summit specialties are required to present an update to the Quality Summit at the six-month post summit mark. Dale Travis attended Quality Committee to present progress against the Quality Summit Action Plan, on behalf of the Dermatology Team.

2.2 The Committee were reminded that the Quality Summit had been convened to address concerns in relation to potential clinical risk within the Dermatology Service following two NEVER events related to:

- Wrong site surgery;
- Delay in patients receiving results (Cancer Pathway);
- Suspicion of cancer discussed at the Dermatology MDT but not upgraded to the 62-day Cancer Pathway.

2.3 DT provided an update for the Committee on progress against each action arising from the Summit's findings.

2.4 Concern was raised regarding the 35% increase in referrals in 2017/18 against the reduction in the conversion rate. This is multifactorial and includes a reduction in service provision across primary and secondary care and an increase in inappropriate referrals. Quality Committee were advised that the Trust was in discussion with the CCG regarding cancer referrals against conversion rates in general.

2.5 It was recognised that the Trust was doing all it could to improve quality internally but that there was an interdependency and pressure on the referrals coming in.

3. 360 Assurance

3.1 In line with the Quality Committee Work Plan, the 360 Assurance Internal Audit Plan for 2019/20 was presented to the Committee. The plan provides a schedule of audits including those relating to clinical areas due to take place across the Trust through the coming year.

3.2 In context, commissioned 360 reports are discussed at Audit Committee but where it is felt the audit relates to a clinical area Quality Committee should be aware.

3.3 Should the Committee identify an additional area where a 'deeper dive' was needed there was capacity for this to be escalated to the Audit Committee for review and inclusion in the Plan.

3.4 The Committee noted the content of the Internal Audit Plan for 2019/20.

4. Clinical Effectiveness Annual Forward Plan/Progress

4.1 Quality Committee received and were assured by the Clinical Effectiveness Annual Report for 2018/2019. Quality Committee were assured that Clinical Audits and Effectiveness was monitored by Patient Safety Quality Group (PSQG) and through Divisional Performance Reviews.
4.2 The Committee agreed there had been huge progress in clinical auditing, that reporting was now in a stable place and delivering better quality.
4.3 AH advised that during their last visit the Care Quality Commission (CQC) commented that reporting should be linked to the direction of travel the Trust wants to take, using audits to review some of the issues. Whilst the Trust is not quite there yet overall the function has significantly improved from three years ago with closer alignment to strategic priorities.

5. NICE Guidance Annual Report

5.1 Quality Committee received and were assured by the NICE Guidance Annual Report. The report outlines the work undertaken by the Trust in 2018/19 for delivering NICE Guidance.
5.2 During this period 222 publications were issued by NICE, with 139 assessed as relevant to the Trust. As of 31 March 2019 42 guidance assessments were in progress, 21 published in 2017/18 and 21 in progress from 2018/19.
5.3 The Committee recognised the amount of work undertaken which was previously not demonstrable and now one of the Trust's success stories.
5.4 Quality Committee were assured the guidance is provided to the most appropriate speciality, assessed, tracked and progress tracked.
5.5 It was explained that when under Special Measures implementation of NICE is a key recommendation, once a Trust comes out of Special Measures it remains good practice to follow their guidance however the speciality needs to assess whether the guidance is appropriate and deliverable.
5.6 The Committee agreed that all future reporting should be aligned with the new strategy.

6. Advancing Quality Programme (AQP) (Regular) Report

6.1 The Committee received and were assured by the Advancing Quality Programme report.
6.2 Quality Committee agreed the two 'red' actions presented at the 20 March Committee meeting had now provided sufficient evidence to demonstrate adequate progress and as such be re-rated as 'amber'.
6.3 The Committee reviewed the evidence for blue forms 2.2, 5.02, 5.06, 5.15 and 5.28. On consideration of the Blue Form(s) presented at the meeting, the Committee were content that they had received enough evidence for assurance.
6.4 Quality Committee received an update on the AQP planning process for 2019/20, it was noted that actions completed would be removed and those that did not hit trajectory in 2018/19 would roll over to 2019/20 and returned to red. It was noted that action 5.05 had been taken as far as it could by the Trust and turned to grey.
6.5 Further detail is included within the separate AQP Report to the June Board of Director meeting.

7. Care Quality Commission/External Regulation (Regular) Report

7.1 Quality Committee received and were assured by the regular CQC and External Regulation report.
7.2 The Committee were informed very little had changed since the report presented in March 2019. The Trust's next engagement meeting will be held on 23 May following a further change of Relationship Manager (Julie Scott) who had recently visited Kings Mill Hospital.

7.3 It is proposed to revisit the unannounced 'dummy run' Provider Information Request (PIR)

exercise in quarter two 2019/20.

7.4 The Biliary Tract Mortality Outlier response outcome had not yet been received from the CQC Outlier team. It was hoped this would be confirmed at the forthcoming CQC Engagement meeting.

8. Maternity Closures (Assurance) Report

8.1 Quality Committee received and were assured by the report.

8.2 The Committee were advised that a Quality Summit for Maternity Services was held at the end of April where the Women and Children's Division presented four reports, including a summary of the Sherwood Birthing Unit closures during 2018/2019.

8.3 Over the period April 2018 to March 2019 the Unit closed on 25 occasions, 11 when there were no local birthing units able to take patients due to their own acuity and dependency, on 14 occasions 28 women were affected, 19 in labour and 9 for assessment only. A mini RCA was conducted for all cases with the trust Head of Midwifery writing personally to the families affected offering an apology.

8.4 The report provided gave context around the rationale for the closures highlighting that 20% of the midwifery workforce are currently unavailable for work due to sickness, redeployment, maternity leave and additional sickness following maternity leave.

8.5 Whilst significantly challenging for the Department, further actions to reduce risk have been made and the escalation policy followed on all occasions.

8.6 Quality Committee were advised that a number of national strategies for maternity 'on call' were being reviewed to see whether they could be adopted locally.

8.7 One preferred solution, which would not affect closures but significantly support the system for monitoring impact is the installation of 'Birth Rate Plus', an acuity tool that identifies peaks and troughs, which would allow the Division to identify risk and any early triggers. This was prioritised by the Division as a key IT investment; however, this was not approved in the business case round due to the prioritisation of an alternate digital system. Quality Committee heard a meeting is scheduled with the Chief Executive later this month to look at IT priorities and was agreed that this be escalated due to the risk factor relating to Maternity closures.

9. Nurse Revalidation (Regular) Report

9.1 Quality Committee received and were assured by the Nursing Revalidation Annual Report for 2018/2019.

9.2 The Committee were reminded that it is a requirement for all Registered Nurses and Midwives to renew their registration with the Nursing and Midwifery Council every three years through Revalidation.

9.3 A robust process is in place whereby when Revalidation is due, Registered Nurses receive an email notification.

9.4 In the period April 2018 to March 2019, 425 Registered Nurses Revalidated, 42 of which held a bank only contract.

9.5 Quality Committee agreed that the Nursing and Medical Revalidation reports should remain on the Quality Committee Work Plan.

10. Quality Account 2018/19

10.1 Quality Committee received a verbal update on progress since the approval of the draft Quality Account at the Extra-Ordinary Quality Committee on 2 May 2019.

10.2 A presentation had taken place to Health Watch with their statement awaited.

10.3 A review meeting is scheduled with Price Waterhouse Coopers (PWC) on 17 May 2019. The document is now locked with only one version accessible by the Deputy Director of Governance and Quality Improvement for amendments.

10.4 Final review and updates will take place on 20 May 2019 with the final Quality Account submitted to PWC, Audit Committee and the extraordinary meeting of the Board of Directors

for final sign off on 23 May 2019.

11. Board Assurance Framework (BAF) (Regular) Report

11.1 Quality Committee noted that plans were in place to review the BAF through a Board workshop at the end of May 2019.

11.2 **PR1: Catastrophic failure in standards of safety & care**
The Committee discussed PR1. The Committee were assured that previous versions of the BAF were archived as a point of reference if required. The Committee discussed risk PR1, rated 12 and agreed the risk rating remain unchanged.

11.3 **PR2: Demand that overwhelms capacity**
The Committee discussed risk PR2, rated 16 and agreed the risk rating remain unchanged.

11.4 **PR5: Fundamental Loss of Stakeholder Confidence**
The Committee discussed PR5, rated 10 and agreed the rating remain unchanged.

12. Quality Committee – Terms of Reference (Regular) Review

12.1 At the meeting held on 20 March 2019, Quality Committee noted that there may be a cross-over of responsibility with the newly established People, Culture and Organisational Development Committee therefore any update to the Quality Committee Terms of Reference should take this into account.
12.2 Quality Committee were advised the People, Culture and Organisational Development Committee have now agreed and signed off their Terms of Reference therefore a review of both needs to take place to ensure they are aligned.
12.3 A final draft of he amended Terms of Reference to be presented to the Quality Committee on 17 July 2019.

13. Quality Committee Workplan (Regular) Review

13.1 Quality Committee received the Work Plan as presented to the Board in April 2019. It was noted that the items shaded in grey were for the Committee's information to give assurance around the reporting route.
13.2 The Revalidation of Allied Health Professionals, Occupational Therapists, Physiotherapists and other related roles were represented as it did not currently fit within the Nursing or Medical reports. Following presentation of the Nursing Revalidation report this item will now be added to the Committee Work Plan.
13.3 Quality Committee discussed the issue of the staff satisfaction survey and recognised whilst aspects of the survey, particularly around the quality of care delivery and the perception of staff, should be reviewed by the Quality Committee, members agreed the analysis and review of the survey would be within the remit of the People, Culture and Organisational Development; however a level of assurance was required by the Quality Committee in order to demonstrate progress made. It was agreed that this should be done through the PSQG and reported back through the PSQG regular reporting.

Elaine Jeffers
Deputy Director of Governance and Quality Improvement
May 2019.