## Board of Directors

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| **Subject:** | Report of the Quality Committee | **Date:** 18/03/2020 | |
| **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**

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| 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** | |
| | **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** | **x** |

**Overall Level of Assurance**

| | Significant | Sufficient | Limited | None |
|---|---|---|---|---|
| | | | | |

| **Risks/Issues** | |
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| **Financial** | No financial risks identified |
| **Patient Impact** | Assurance received with regards to the Safety and Quality of Care through the Reports presented with the exception of Dementia screening |
| **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 18/03/2020. The meeting was quorate. The minutes of the meeting held on 15/01/2020 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 Board of Directors is asked to note:**

- The content of the report
- The positive outcome of the deep dive carried out into the increase in Pressure Ulcer through quarter three
- The positive assurance received in relation to the ongoing work in relation to the mortality outlier status for fractured neck of femur
- The requirement to provide a regular report on services deemed to require additional support to maintain clinical and/or financial sustainability and viability
- The plan to ensure timely and effective assurance is provided to Quality Committee to provide the necessary assurance on the safety and quality of care provided during this challenging period.

**1. Medicines Optimisation Strategy**

1.1 Quality Committee received the Medicines Optimisation Strategy 2020/25. The Strategy is taking a different approach from previous iterations as it is taking a more inclusive view of the wider health community within the Integrated Care System (ICS). The five key strategies objectives are; placing patients at the centre of care with medicines; collaborative working with partners within the wider health community; optimising the use of digital technology (including ePMA); placing patient safety at the heart of medicines usage; and ensuring a competent workforce to deliver the medicines optimisation agenda.

1.2 Quality Committee accepted the Strategy with the caveat that a few minor amendments are made and a year on year progress plan is agreed. Quality Committee agree to review the Strategy in 18 months.

**2. Advancing Quality Programme Report**

2.1 Quality Committee accepted the regular report of progress within the Advancing Quality Programme.

2.2 The following actions were agreed as embedded and the blue form approved:
1920.2.03a – Focus on safety culture in operating theatres and other areas where interventional procedures are undertaken
1920.5.17 – The provider should commence temperature checks in the rooms where medicines are stored
1930.5.20 – The provider should ensure that patients are brought to the Radiology Department with their medical notes

2.3 Quality Committee agreed to a review of the Advancing Quality Committee to ensure it reflects current improvement requirements and captures any actions that will be identified in the 2020 CQC Inspection Report.

**3. External Accreditation/Regulation Report**

3.1 Quality Committee accepted the report. This report replaces the previous CQC regular report and encompasses a wider range of external accreditation processes such as JAG, Laboratory and Screening programme accreditations and the process around the Getting It Right First Time (GIRFT) visits.

**4. Fragile Services Report (Haematology)**

4.1 Quality Committee accepted the report. The Board of Directors are aware of the current challenges facing the Haematology Service at Sherwood Forest Hospitals NHS Foundation Trust (SFH).

4.2 Immediate action has been taken to ensure the safety of the current service and understand the significant challenges facing the staff in both the clinical and pathology elements. The Medical Director is leading discussions with Haematology colleagues from Nottingham University Hospitals (NUH) with a view to the provision of support; however the NUH service is also facing significant pressure.

4.3 SFH will commission a review of the service, which will encompass laboratory and clinical haematology services; however the original timescale may well be altered due to the current COVID-19 situation.

4.4 A Head of Service has been appointed who will provide external support and leadership to the current clinical teams, whilst SFH and NUH colleagues work together to develop a joint recruitment strategy.

4.5 Closer working relationships are being forged to consider the longer-term strategy. It is anticipated that SFH will always require an acute (hot) laboratory service but there may be opportunities to consolidate future pathology service provision and future outpatient provision.

4.6 Quality Committee asked that assurance is provided in relation to any service that are deemed to be fragile, thus a regular report will be presented to subsequent committee meetings.

**5. Deep Dive – Hospital Acquired Pressure Ulcers**

5.1 Quarter three had seen a significantly higher number of Hospital Acquired Pressure Ulcers (HAPU), in particular during December 2019. Consequently a deep dive into the rise in December was commissioned.

5.2 The deep dive indicated that all HAPUs were graded as low harm, with no lapses in care identified. Two PUs were deemed to be avoidable with both patients being in a plaster cast. Work has been undertaken to reduce the risk of PU from a cast with an enhanced training package being launched across the organisation on 23/03/2020 to increase the levels of monitoring and care required for these patients.

5.3 The national guidance on PUs focuses on deep PUs but the Trust has adopted this rigorous process and applied it to category 2 PUs thus ensuring rapid identification and learning before more sever harm is caused.

5.4 The Tissue Viability Team are working proactively with Divisions to embed this model with actions recorded and completed.

**6. Nursing, Midwifery and AHP Board Report**

6.1 Quality Committee accepted the report. It was noted that the Board is to become more strategic with a number of sub-groups reporting in. The membership has been reviewed and will consider the inclusion of additional Allied Health Professionals. The appointment of a governor/patient representative on the group is planned to be in place by the end of the calendar year.

**7. Patient Safety Quality Group Report**

7.1 Quality Committee accepted the report and notes the following items for escalation to the committee:

- The gap analysis that had been conducted following the neonatal critical care review and the business case identifying the subsequent funding requirements to increase staffing levels.
- The request to revise and simplify the training for hospital transfusion
- The intention to conduct a wider analysis of potential harm to patients who have an extended stay within the Emergency Department
- The positive feedback received by the Maternity service from the Healthcare Safety Investigation Branch (HSIB)

- The proposed changes to the Trust-wide Audit process to ensure audits are more meaningful, promoting improvement and changes to practice where required.
- The ongoing work in relation to the mortality outlier status for Fractured Neck of Femur

7.2 Quality Committee agreed to a review of Patient Safety Quality Group to optimise discussion and time spent.

**8. Quality Account update**

8.1 Quality Committee were assured that the Quality Account was on track to meet the required timescales.

**9. PLACE Inspection Report**

9.1 Quality Committee received the report. Following recent PLACE Audits Quality Committee were informed that SFH had scored exceptionally well across all domains.

**10. Board Assurance Framework (BAF) Report**

10.1 Quality Committee accepted the report and agreed the following amendments to the BAF:

- PR1: catastrophic failure in standards of safety and care – the Likelihood score to be amended to 5 increasing the overall risk rating to 20
- PR2 – Demand that overwhelms capacity – the Likelihood score to be amended to 5 and the Consequence score to remain at 4 increasing the overall risk rating to 20

10.2 There were no amendments to PR5 – Fundamental loss of stakeholder confidence. Quality Committee noted this risk would no longer be under the remit of the committee following the introduction of the new version of the BAF from May 2020.

**11. Plan to maintain assurance to Quality Committee during current period**

11.1 A plan will be developed within the next week to agree the assurance mechanism to Quality Committee on the maintenance of the safety and quality of care.