

## Board Report

### Board of Directors (Public)

#### Item 6.2.5

**Subject:** Annual Assurance Report - Quality Committee 2014/15  
**Date of meeting:** 28<sup>th</sup> April 2015  
**Prepared by:** Sue Pemberton Director of Nursing and Quality  
**Presented by:** Sue Pemberton Director of Nursing and Quality

Data Quality Rating	BAF Ref	Impact on BAF Risk Rating?
Bronze	1,2	None

#### 1. Executive Summary

The purpose of this report is to provide assurance to the Board of Directors of the performance of the Quality committee. This Annual Report summarises activity of the Trust's Quality Committee for the financial year 2014 - 2015, and will outline how it has met its Terms of Reference (TOR) and key priorities, as outlined in their terms of reference issue 1.0 approved 27-5-2014. . The purpose of the Quality Committee is laid down in its TOR. In summary, it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, clinical risk management, and workforce. The report identifies the core issues discussed and debated and the assurances received. It also highlights where improvements are required for 15/16 to strengthen the assurance on quality for the Board of Directors.

#### 2. Background

In July 2014, the Governance structure was reviewed and changes made. This followed a review by MIAA who made recommendations that we should review our governance structures to ensure a clear separation between governance and assurance. At this time changes were made to the Corporate Governance Manual and other key policies.

The changes to structure identified two assurance committees:

- Quality Committee
- Integrated Performance Committee

### 3.0 Main Priority and Objective

**The Quality Committee shall provide the Board of Directors with a means of independent and objective review of quality governance:**

To ensure compliance with Monitor's Quality Governance Framework, (QGF) Mersey Internal Audit were appointed to undertake an independent review of the Trusts quality governance arrangements. The review commenced in July 2014 focused on assessing four domains of the Quality Governance Framework. An interim report was presented in November 2014 which recognised this report was a snap shot in time, and also identified that recent changes to the Governance structures were in early implementation phase. Findings from the interim score were calculated as 4, against a Monitor self-assessment process score of 3.5 or less.

The review was completed in December 2014. This included high level observation of the Quality Committee. The Trust achieved a score of 3.5 which is in line with Monitor's assessment process. The Board of Directors were appraised of the findings in a report presented in January 2015. MIAA reports have detailed suggested actions from both the observation of the committee and review of the quality governance arrangements. The main recommendations were that the committee should detail a matters arising item on each agenda and that all items should be accompanied by a paper that is sent out prior to the committee meeting to allow time for members to be appraised of the subject matter and recommendations. In addition the recommendations suggested that the operations board minutes are at the beginning of the quality agenda to ensure they receive the focus they require. The Quality Committee will receive the updated action plan and progress made from the Quality Governance review in July 2015.

### 4.0 Duties and Responsibilities

**The Committee will promote safety and quality in patient care and staff experience and help to identify priorities and risks arising from clinical care and treatment on a continuous basis.**

#### 4.1 Quality Strategy

The Committee had identified the priority areas for consideration:

- **Mortality Ratio** - The committee reviewed the mortality data for December 2014 when the mortality rate was elevated compared to the same time last year. The committee asked for a detailed breakdown of the reasons for this and were given detail in relation to the number of deaths and the reasons for these deaths to provide them with assurance that during this time period there was no element of concern with the deaths listed as many were PPCI patients and palliative care patients. Further assurances have been sought and a more detailed report will be presented to the committee in May following the mortality reviews being completed on these deaths. Whilst good progress has been made with the completion of mortality reviews there has been slippage of late and the committee has asked that this be addressed as a matter of importance.
- **Readmissions** – Information regarding the numbers of readmissions has been presented as part of the quality report with assurance that further work is on-going to understand the reasons for readmissions to other hospitals.
- **VTE assessment and prophylaxis** - The committee have scrutinised VTE data with actions being identified to rectify the evidencing for compliance of prescribed prophylaxis, mechanical and therapeutic treatments for at risk patients of venous thrombolisation
- **Mixed sex accommodation breaches** – These are reported via the quality report and there have been none.

- The committee has received the Quality Strategy, and assurance of the clinical quality priorities
- Quality Impact Assessments – The committee has received detail on the process for quality impact assessments in relation to the cost improvement programme.. The committee will receive a summary of all cost improvement programmes that may impact on quality and the completed quality impact assessment.

## 4.2 Annual Quality Report

The quality report has been completed in accordance with statutory requirements, forming part of our annual report.

## 4.3 External Regulations

In February 2014 the trust received an unannounced inspection of its critical care unit in response to a whistleblowing to the CQC in relation to staffing levels within the unit. The Trust was found to be non-compliant with three of the CQC standards:

- Outcome 13 - Staffing – Non- Compliant – Moderate concern
- Outcome 14 - Supporting Workers – Non-Compliant - Minor concern
- Outcome 16 - Monitoring the quality of service provision – Non- compliant – Minor Concern.

An action plan was put in place with the team in the critical care unit and in October 2014 the Trust was found to fully compliant with all standards.

The CQC intelligent monitoring report has been received by the committee. Whistleblowing events were noted as an elevated risk and both emergency readmissions and a never event as a risk. The Trust was rated as band 4 at that time. The Trust has since been rated at band 6. The committee has received assurance, of the ESQS assessment framework for this reporting period 2014-2015. CQUIN contractual arrangements and quality targets have been reported through the committee performance dashboard with the committee receiving assurance of continued monitoring.

The committee received an update on the trusts PLACE report (external report) and were informed that the trust had achieved above the national average.

The Duty of candour and the Fit and proper person's regulations were introduced by the CQC in November 2014. Details on both these regulations have been reported through to the Board of Directors.

## 4.4 Patient Safety

The Committee have identified the priority areas for consideration:

- **Infection prevention and control** – infection rates have been presented as part of the quality report.
- **Safeguarding** - The committee received the annual report and the external review of safeguarding conducted in August 2014 together with the action plan to address the identified areas for improvement.
- **Safety thermometer** – assurance through the quality report
- **Incident reporting and learning** – assurance through the IICC report.

- **Safe staffing levels** - In relation to staffing levels the Director of nursing has provided assurance that staffing levels are calculated utilising the safer nursing staffing tool and the professional judgement model. It has also been discussed that the Trust, over the winter period in particular, has utilised a high number of bank and agency staff to ensure that staffing levels are maintained within the clinical areas to ensure the safety of patient care is not compromised. Recruitment plans are in place with quarterly recruitment having commenced in 2015. Further discussions have taken place regarding the need to explore overseas recruitment and this is being discussed currently. The committee requested and received further detail in relation to the Catheter labs staffing and theatres.

The Committee received assurance of the work undertaken to manage the risk of a reduction in junior doctors. The Medical Director has taken appropriate action to ensure patient safety is paramount. This risk is monitored on a weekly basis through a steering group chaired by the Medical Director. The committee were informed that there has been two whistleblowing reports to the CQC in relation to the reduction in junior doctors. Following a detailed response of the work undertaken in the Trust mitigate the risk of reduced numbers of junior doctors the CQC have now closed down these issues.

A report detailing the work in progress to address sepsis was received by the committee in March 2015. The committee requested that this report be escalated to the Board of Directors as there are a number of issues that need addressing. This report will be presented to the Board of Directors in May 2015.

An update on falls and the work undertaken to reduce falls across the trust. was also received.

Medications safety – a presentation was received by the committee on the work undertaken to date to implement the national medications safety thermometer. This looked at four high risk medications. This work is in progress and a further update will be received by the committee in July 2015. The committee has also received the numbers of reported medication incidents via the quality report.

#### **4.5 Clinical Effectiveness**

The committee have received assurance through the annual reporting of the progress made in relation to clinical audit and effectiveness processes within the Trust. This included receiving the Clinical Audit and Effectiveness strategy. However there is further work required to satisfy the committee terms of reference that:

- Effective Governance surrounding mortality reviews – one paper was received in September 2014 however the committee needs to receive assurance in relation to the governance and learning outcomes from the mortality review process and this will be received in May 2015.
- Benchmarking data relating to outcomes – this has been discussed at the quality and patient and family experience committee and then with the Operations Board. The Quality Committee now needs to receive assurance of the progress to date with benchmarking data and to understand where improvements need to be made.
- Adherence to best standards e.g. Royal College standards.
- The Medical Director updated the Committee on CUSUM Curves monitoring noting that the Trust routinely monitors individual Consultant performance. Following the recent risk adjustment, two consultants have fallen outside of the desired confidence limit for complex valve and graft procedures. As a result, discussions have taken place with the two consultants concerned and mentorship arrangements put in place. The Committee was informed that a follow up review will take place in 3 months' time.

#### 4.6 Patient and Family Experience

The committee have been provided with assurance against the Patient and Family Experience measures via the quality report. The committee has received the quality strategy which sets out the priorities in relation to Patient and Family Centred Care. The committee has not to date received assurance on compliance with the NHS constitution. This is being addressed and will be received by the committee in May 2015.

#### 4.7 Staff Experience

The committee has received the review of the staff involvement activities that have been undertaken in 2014-15. The committee will receive the draft OD and people strategy in May 2015. The initial results from the national staff survey have been received along with a summary of the staff friends and family results.

#### 4.8 Research and Development

The committee have received assurance on updated developments against the research and development strategy and objectives contained within the strategy document.

#### 5.0. Membership and Attendance

Three nominated Non-Executive Directors, one of whom will be Chair and one Vice Chair. In attendance at all meetings: Director of Nursing and Quality, Medical Director, Director of Strategy and Organisational Development, Director of Research and Informatics

Position - month meeting occurred	Non-Executive Director (Chair)	Non-Executive Director	Non-Executive Director	Director of Strategy and Organisational Development	Director of Nursing and Quality	Medical Director	Director of Research and Informatics
July 2014	√	√	√	√	√	√	√
September 2014	√	√	√	Apologies	√	√	√
November 2014	√	√	√	√	√	√	√
January 2015	√	√	√	√	√	√	√
March 2015	√	√	√	√	√	√	√

The Committee achieved its membership and attendance responsibilities with the Director of Strategy and Organisational Development sending apologies for one meeting.

#### 5. Conclusion

Throughout the past nine months the Quality Committee has received assurance on quality and the identified key priorities of responsibility that are identified in the committee TOR. The committee has met on five occasions with meetings occurring on a bi monthly basis. Review of the recorded minute taking documentation shows an excellent attendance of all committee members.

This annual assurance report review has identified from the minute recording documentation used that the committee has received assurance against the criteria of the TOR however this has not always been received from Operational Board as stated within the terms of reference.

The operational board minutes have been received by the quality committee at each meeting. The operational board has received key issues and any identified risks from the operational Quality and PFEC committee.

## **6. Recommendations**

- The Board of Directors receive assurance that the Quality committee has met its terms of reference noting the areas for improvement  
That the Board approve the updated terms of reference for the Quality committee