NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	9 November 2017
Paper number	D1

Quality Improvement Board Update October 2017

For approval:		For assurance:	√	To note:		For information:	

Accountable Director	Vicky Morris, Chief Nursing Officer
Presented by	Vicky Morris., Chief Nursing Officer
Author	Dilly Wilkinson, Interim Deputy Chief Nursing Officer

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	
	Invest and realise the full potential of our staff to provide compassionate and personalised care	√	Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business	√		

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability	√	Operational Performance	√
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	√

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC	23rd October 2017	Received

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	9 November 2017
Paper number	D1

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R1.1 R1.2 R1.3

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	√	↑
	None		
	Not applicable	√	

Purpose of report	The purpose of this report is to update the Board on the delivery of the Quality Improvement plan and assure on progress.
Summary of key issues	• **Improving patient outcomes** work stream shows improvement in the primary mortality review completion rates since the end of May, VTE assessments, NEWS completion and sepsis screening and treatment in ED at WRH and AGH. • **Operational Improvement** work stream includes the establishment of the frailty unit at AGH and the agreement and implementation of internal professional standards which were developed at 2 process flow workshops with clinical staff. • **Governance** work stream shows improvement against the measure 'national audit with an action plan' currently above trajectory and 100% performance against the fit and proper person test. The interim Director of Governance has undertaken a review of the process which has concluded Significant Assurance. • **Patient, carer and public engagement** work stream has reported a pilot of an app to report Friends and Family Test extended to 5 areas, delivery of the Medicine Division complaints turnaround plan which has reduced the number of outstanding complaints over 6 months and further trajectories have been agreed with each Division to improve performance against complaints finalisation timelines. • **Safe care** work stream has reported an improvement safeguarding training levels through the delivery of additional training, the pharmacy team have implemented twice weekly quality audits with ward level feedback and the delivery of enhanced environmental cleanliness walkabouts. • **Culture & Workforce** work stream has reported the launch of the 4ward programme including the 4 new signature behaviours, appointment to the 'Freedom to Speak up' Guardian and the launch of the 2017 flu campaign. • The dashboard key has been enhanced to include an amber designation as part of the RAG rating. The up and down arrows are against the previous month's performance. • The dashboard shows 19 measures that have improved, 4

	measures that have remained the same and 15 measures that have deteriorated. • The report includes an updated risk register which shows 5 risks of which none are red. All risks have mitigation in place.
Recommendations	The Board is asked to note the update of the Quality Improvement Board.

Enc D1

"Improve, Innovate, Inspire"

Quality Improvement Plan
Programme Update for September 2017

Achievements to date

Improving patient outcomes

Morbidity & Mortality process

- *Total PMR completion rates for deaths since end of May 201[illegible] are at 72.8%, this is due to a combination of the introduction of e-forms and reminder emails when reviews are coming up to or are past their due (30 calendar days) date. For September the % completion within 30 days was 45.80%*

VTE

- *VTE compliance in September (91.52%) is ahead of trajectory (89%)*

NEWS

- *NEWS recording and accuracy are at sustained levels*

PEWS

- *PEWS has transitioned to business as usual on the Paediatric ward at WRH*

Sepsis

- *Sepsis screening (88%) and treatment (91%) results ahead of trajectory (Sep 75%)*
- *Sepsis Nurse Specialist appointed.*

Operational Improvement

- *Frailty project progressing well and is on track to be in place in October*
- *Internal professional standards agreed and launched*
- *No 12 hour breaches since August*
- *EAS recovered in September to 82.24% compared to August 79.77% -Trust wide %*
- *Diagnostic performance in August 4.42% this is ahead of trajectory 4.8%*
- *2 process flow workshops conducted with clinical staff*

Governance

- *National audits with an action plan is ahead of trajectory (Sept performance 84%, against trajectory of 75%).*
- *The Interim Director of Governance has undertaken an audit of the Trust's processes for compliance with the Fit and Proper Persons Test Regulations (FPPT). The purpose of the audit was to identify any gaps in assurance on compliance with the Regulations, lessons learnt and areas for improvement. The audit concluded Significant Assurance. The Audit and Assurance Committee have endorsed the significant assurance for compliance with the Fit and Proper Persons Test Regulations.*

Patient, carer and publi engagement at heart o we do

- *FFT App pilot extended to a further 5 areas in September.*
- *Turnaround plan for medicine introduced 18th Sept 17 and weekly monitoring meetings in place.*
- *Enhancements to the complaints required. First stage relating to action plans introduced.*
- *Trajectories for improvement in complaints response developed for each division.*

Safe Care

- *12 Additional training sessions have been put on in the month of September, resulting in 151 members staff receiving training in safeguarding*

<u>Medicines optimisation</u>

- *Pharmacy quality audit now includes IV fluid storage check*
- *Rapid assessment of expiry dates of IV fluids in ward areas and removal of expired stock*
- *Implemented twice weekly pharmacy quality audits*
- *Implemented agreed communication and escalation process*

<u>Infection Prevention</u>

- *Workshop held with IPC team and microbiologist to realign priorities*
- *Enhanced environmental cleanliness walkabouts*
- *Escalation meeting held with Estates and Facilities company to ensure improvements are made*
- *Rapid improvement week held to develop action plans for remaining quality improvements from quality audit*

Culture & Workforce

- *4Ward Project Launched on Friday 6th October 2017 on all 3 hospital sites headed up by CEO/Chairman and launched to both Patients and Staff Members. 285 staff advocates signed up on the day to help champion the programme going forward.*
- *The 4 New Signature behaviours launched and beginning to be embedded. 4Ward Microsite launched: www.4ward-waht.co.uk in preparation for the first checkpoint on 17th – 27th October.*
- *Successful appointment to Freedom to Speak Up Guardian position following interviews held on 2nd October 2017.*
- *HR Team to support Corporate Nursing Team to attend a Recruitment Fayre being held in Dublin on Saturday 14th October 2017.*
- *Flu Campaign launched on 25th September 2017 as part of Health and Wellbeing CQUIN and over 2000 staff vaccinated within the first week of the campaign.*

KPI Dashboard-September data extracted 11th October 2017

Improving patient outcomes	Operational improvement	Governance	Patient experience & engagement	Safe care	Culture & workforce
PMR completion	Bed Occupancy (G&A WRH)	Daily ward documentation audit compliance	Number of mixed sex accommodation breaches	Have all prescribed medications been administered	Board net leadership score
VTE completion	Bed Occupancy (G&A ALEX)	National audit compliance- audits with a current action plan	Number of bed moves between 2200-0600	Medicines stored within the recommended temp in fridge	Trust pulse score
NEWS calculated correctly	Theatre cancellation	% risks with overdue actions	Complaints response within 25 working days (%)	Resus trolley check compliance	Medical vacancy recruitment requirement
PEWS calculated correctly	% discharges before midday	Compliance with Fit and proper persons process	Number of PALS responses	Cdiff cases	Staff turnover
Sepsis screening in ED	Beds occupied by NEL stranded patients	Improvement training metrics	Trust-wide friends and family score (inpatient)	MRSA cases	
Sepsis treatment in ED	Trust length of stay (Average)		Trust-wide friends and family response rate %	Hand hygiene audit compliance	
Serious incident relating to missed deterioration in patients	Number of patients treated on AEC pathways		% of patients receiving care in ED corridor per month	Trust mandatory training	
19	Emergency access standard			Children's safeguarding compliance	
4	62 day cancer referral to treatment			Adult safeguarding compliance	
15	RTT			Grade 4 avoidable pressure ulcers	

Improvement on performance since last month

Drop in performance from last month

Not meeting trajectory

Within 2% of trajectory

Meeting trajectory

Comparison not available

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Date of meeting	9 November 2017
Paper number	D2

Learning from Deaths

For approval:		For assurance:	√	To note:		For information:	

Accountable Director	Suneil Kapadia Chief Medical Officer
Presented by	Suneil Kapadia Chief Medical Officer
Author	Dr Steve Graystone AMD, Patient Safety

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
QGC	19 October 2017	Received

Worcestershire Acute Hospitals NHS Trust

Date of meeting	9 November 2017
Paper number	D2

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R1.1 R1.3

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	√	→
	None		
	Not applicable		

Purpose of report	To update the Board on avoidable mortality.
Summary of key issues	Members will recall the presentation by Dr James Quinn at the meeting on 14 September on *Learning from Deaths.* The report shows: • A reduction (improvement) in HSMR • An improvement in the rate of completion of primary reviews within 30 days • Progress in transitioning to a medical examiner based model of mortality reviews Major lapses in care considered through the serious incident management process. Divisional reporting of improvement plans to address gaps in care identified through the process remain limited. For this reason only limited assurance can be given that learning and improvement from the mortality review process.
Recommendations	Trust board are requested to receive this report for assurance.

Learning from Deaths Performance Report

1. INTRODUCTION

The purpose of this monthly report is to provide information related to the Trusts Mortality Performance. This is illustrated using several metrics; Crude Mortality Rate, Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-Level Mortality Indicator (SHMI).

This is the second mortality report in the new format, and feedback on the content and detail is welcomed. Some sections are still being developed and these are clearly marked in the report. Further analysis will be included in future months, particularly around areas with current or past alerts.

DEFINITIONS

i. Crude Mortality Rate

A hospital's crude mortality rate is calculated using the number of deaths that occur in a hospital in any given year compared to the number of patients admitted for care in the hospital over the same time frame.

ii. Hospital Standardised Mortality Ratio (HSMR)

Crude mortality rates are useful but they do not facilitate the comparison of performance across different Trusts or groups of Trusts. This is because every hospital has a different case-mix, both in the services that they provide and the characteristics of the local population it serves.
The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than would be expected, and by applying a standardisation methodology facilitates benchmarking across Trusts.
The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

iii. Summary Hospital-Level Mortality Indicator (Quarterly)

SHMI is a hospital-level indicator which reports mortality at trust level across the NHS (acute care trusts only) in England using standard and transparent methodology. This indicator is being produced and published officially by NHS Digital.

See Appendix 1 for a comparison of HSMR and SHMI criteria.

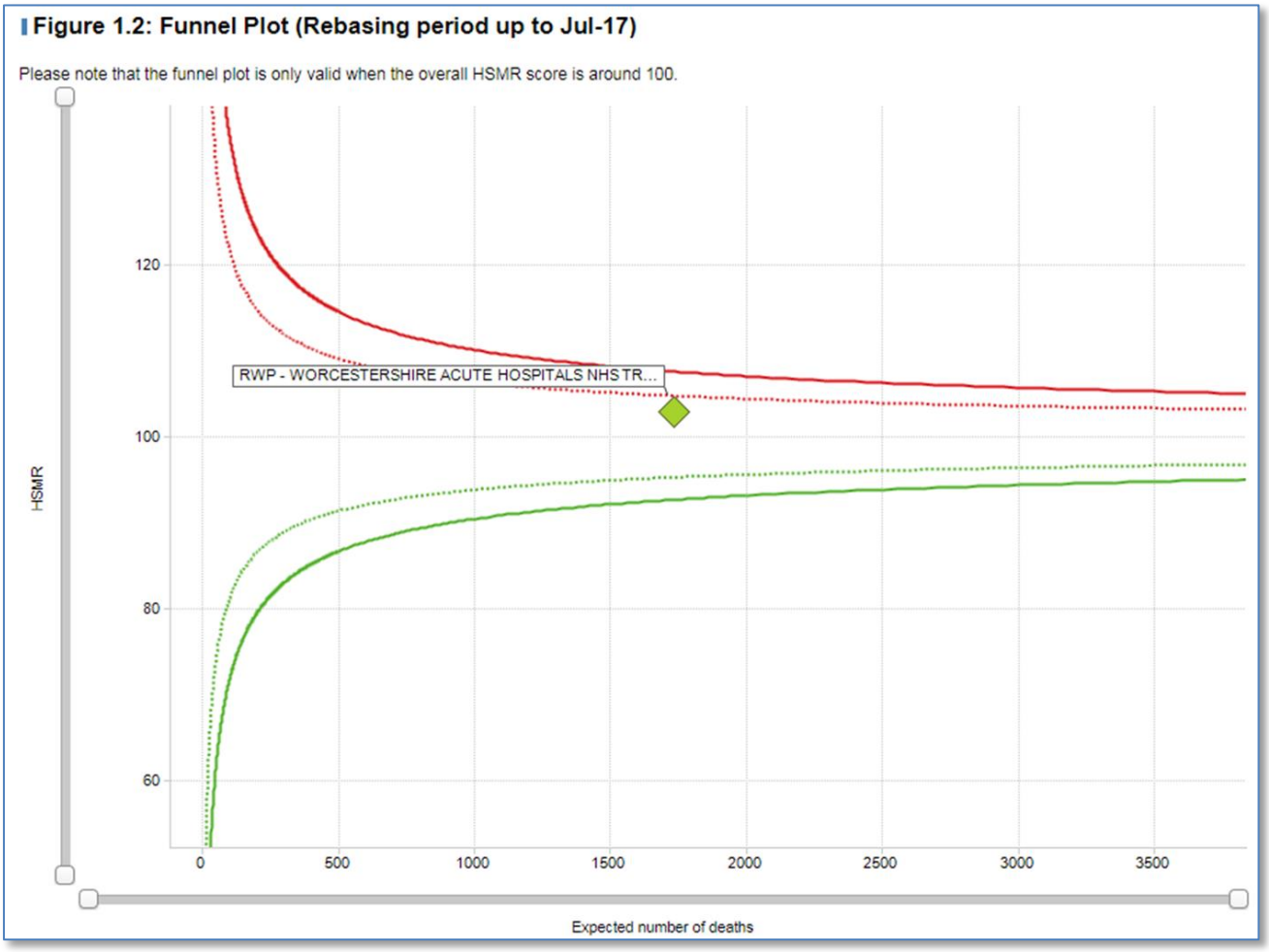
2. TRUST LEVEL MORTALITY

2.1 HSMR

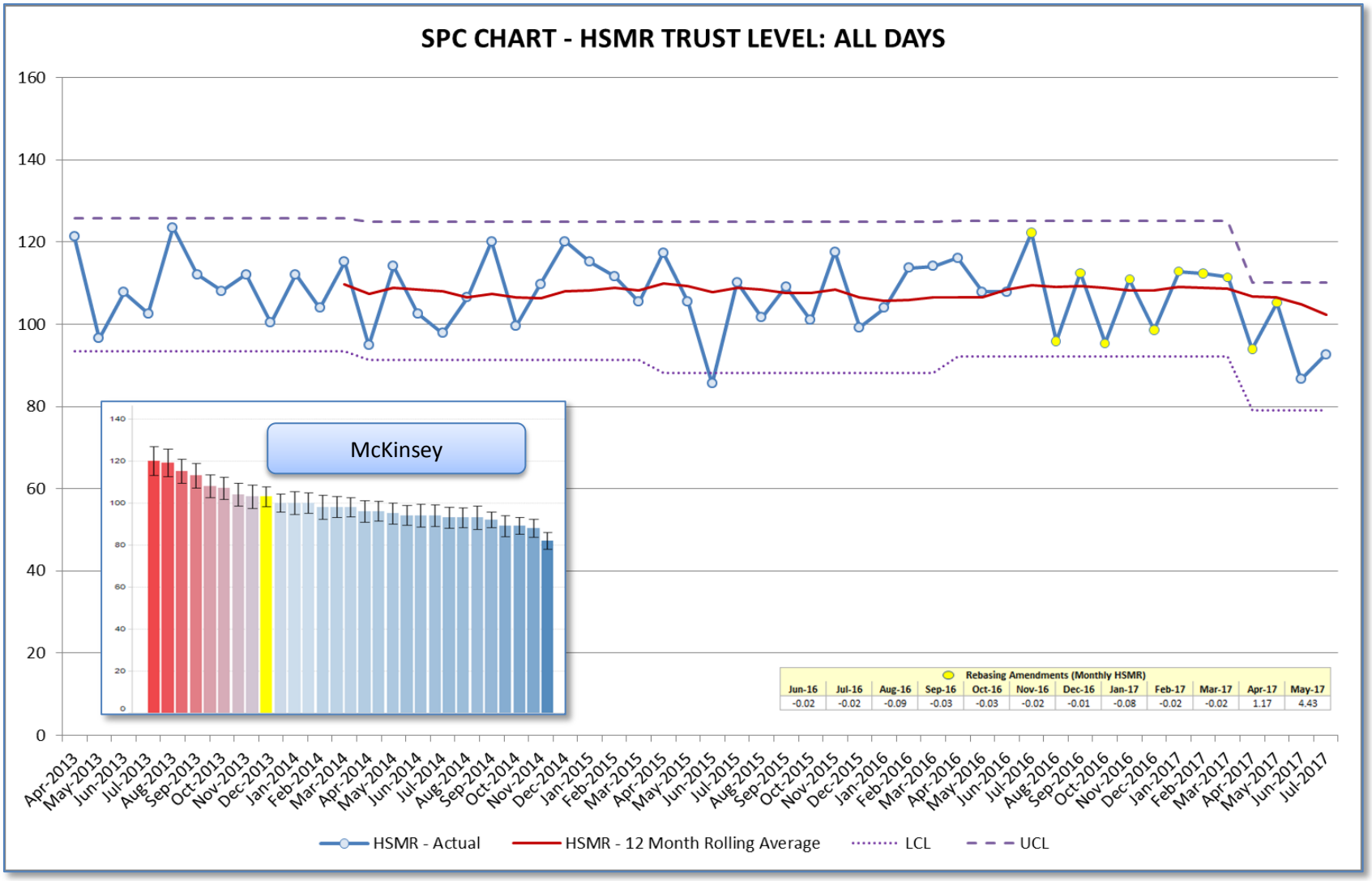
The Data was extracted from HED on the 10/10/2017, and the latest data available was for July 2017.

12 Month Rolling Average	
Aug 2016 to July 2017	102.37
Aug 2015 to July 2016	109.52

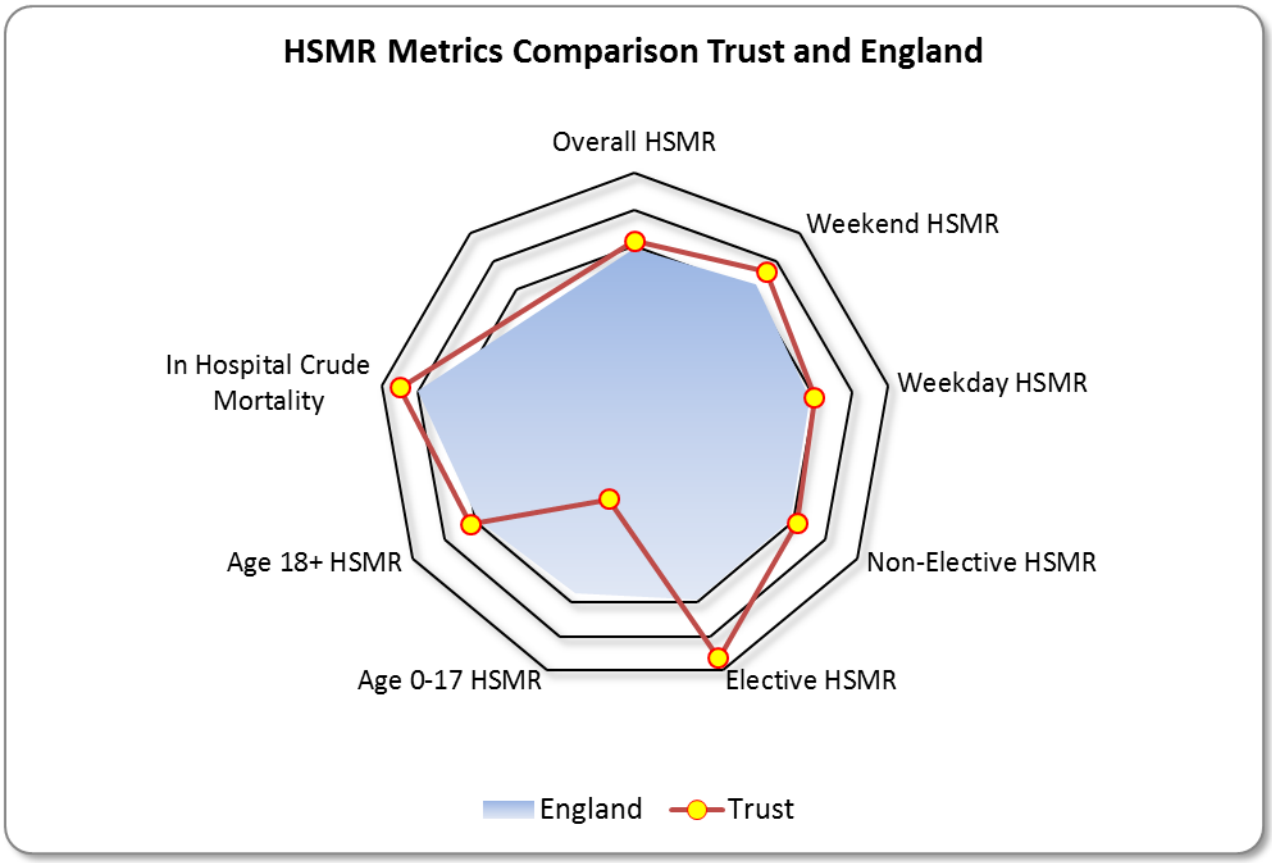
The Trust is not an outlier in respect of its HSMR for the period August 2016 and July 2017 as illustrated by the funnel plot below;

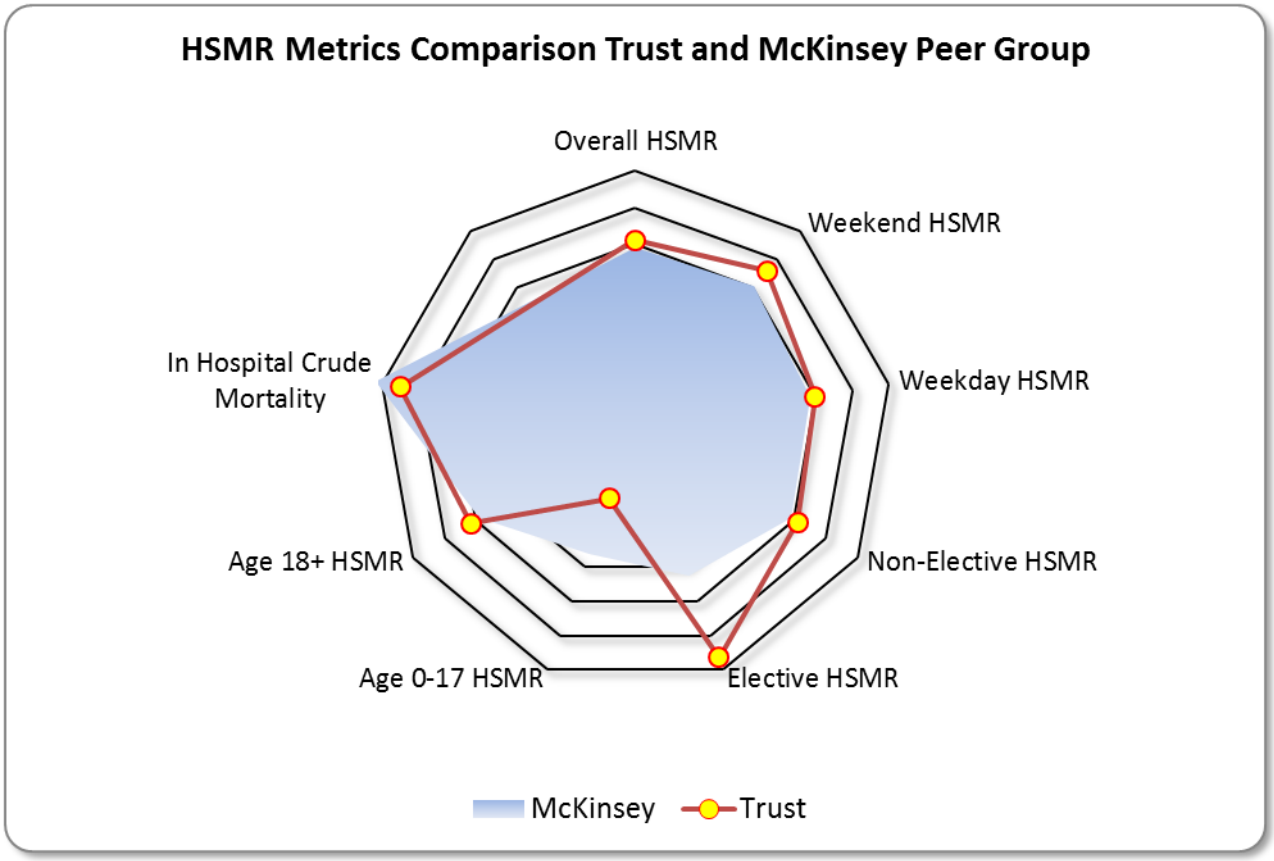


The 3 Diagnostic Groups with the greatest number of mortalities between August 2016 and July 2017 were; Pneumonia, Septicemia and Acute Cerebrovascular Disease. The Trust was not an outlier for any of these Diagnostic Group HSMRs.



**The McKinsey Peer Group is a selection of Acute Trusts with a case-mix and demographic which compare to Worcestershire Acute Hospitals Trust, and is used for benchmarking purposes.*


HSMR Metrics Comparison Trust and England
Overall HSMR
Weekend HSMR
Weekday HSMR
Non-Elective HSMR
Elective HSMR
Age 0-17 HSMR
Age 18+ HSMR
In Hospital Crude Mortality
England
Trust


HSMR Metrics Comparison Trust and McKinsey Peer Group
Overall HSMR
Weekend HSMR
Weekday HSMR
Non-Elective HSMR
Elective HSMR
Age 0-17 HSMR
Age 18+ HSMR
In Hospital Crude Mortality
McKinsey
Trust

SHMI

The Data was extracted from NHS Digital on the 10/10/2017, and the latest data available (published 21st September) was for April 2016 to March 2017.

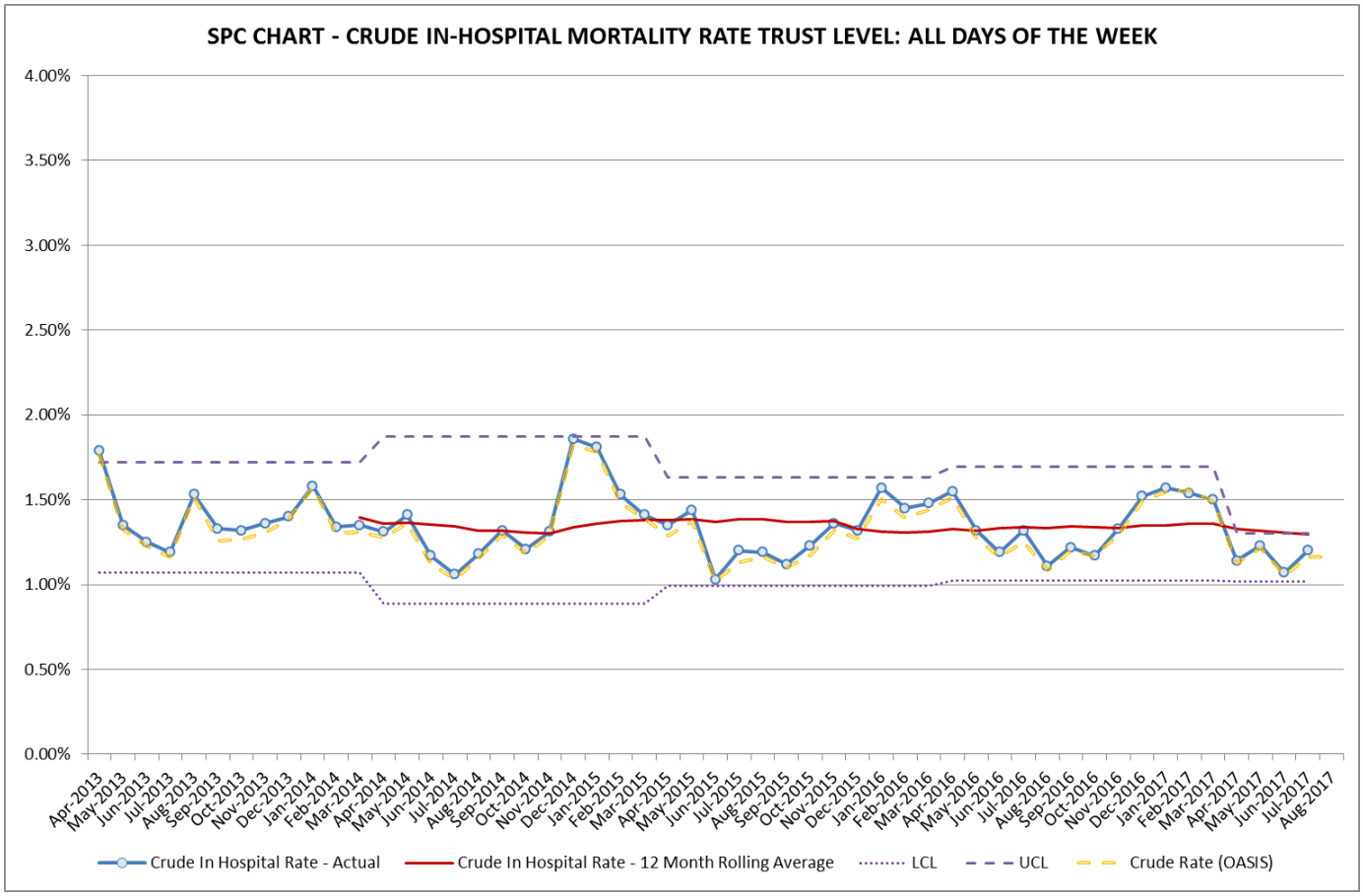
Apr 2016 to March 2017	
SHMI Value	1.0667
SHMI banding	2 – "As Expected"

As the SHMI figures are published quarterly by NHS Digital in depth analysis of these figures for this report will follow the same pattern. The next publication is scheduled for December 2017.

2.2 CRUDE MORTALITY

The Data was extracted from HED on the 10/10/2017, and the latest data available was for May 2017.

In Hospital Crude Mortality		12 Month Rolling Average	
July 2017	1.20%	Aug 2016 to July 2017	1.30%
July 2016	1.32%	Aug 2015 to July 2016	1.34%

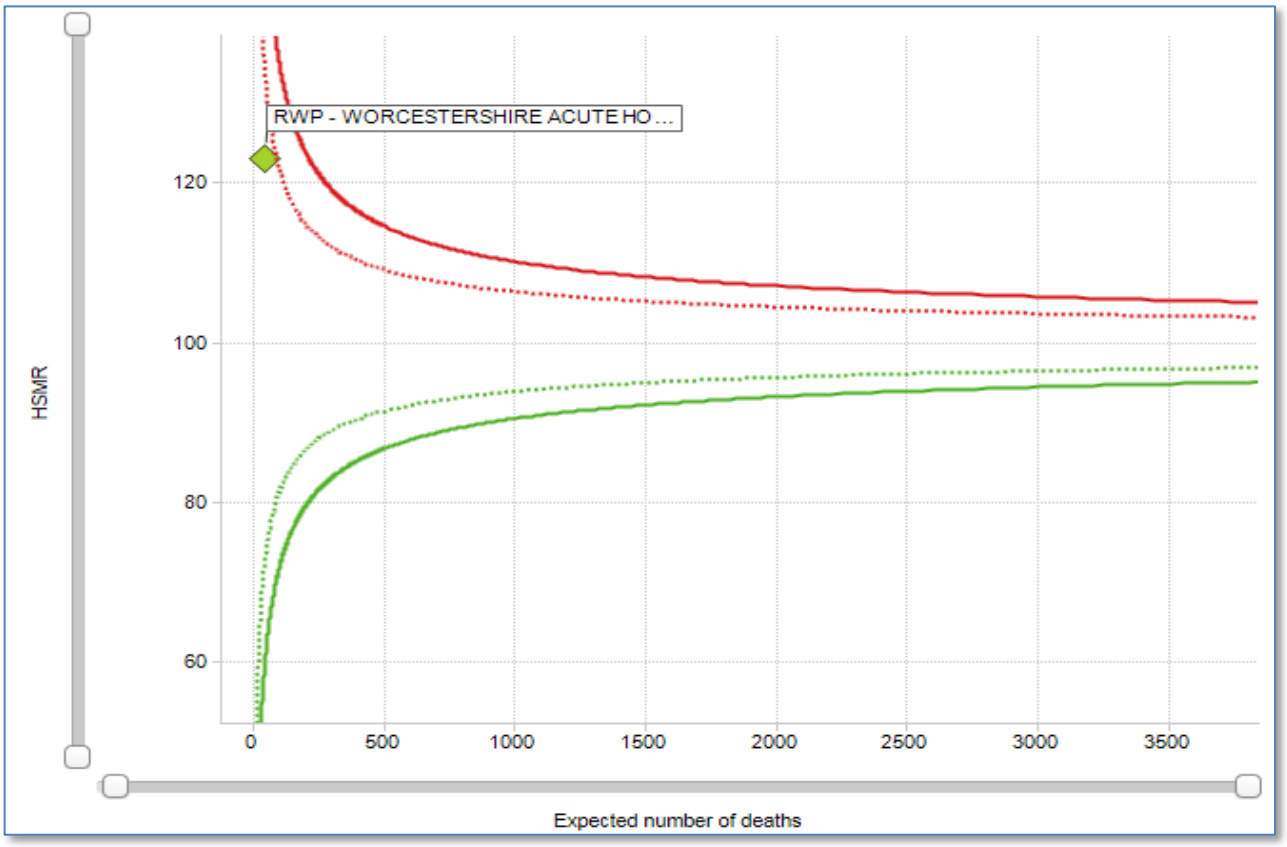


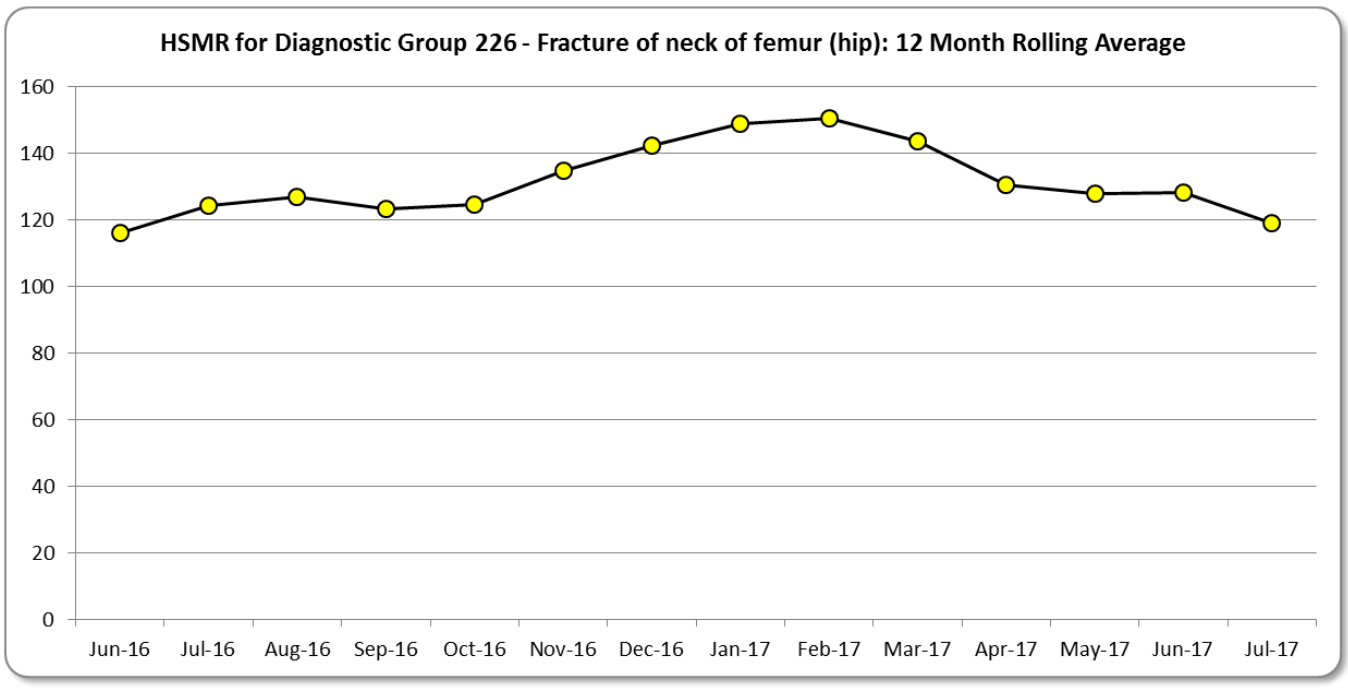
3. DIAGNOSTIC GROUP LEVEL MORTALITY

3.1 HSMR DIAGNOSTIC ANALYSIS

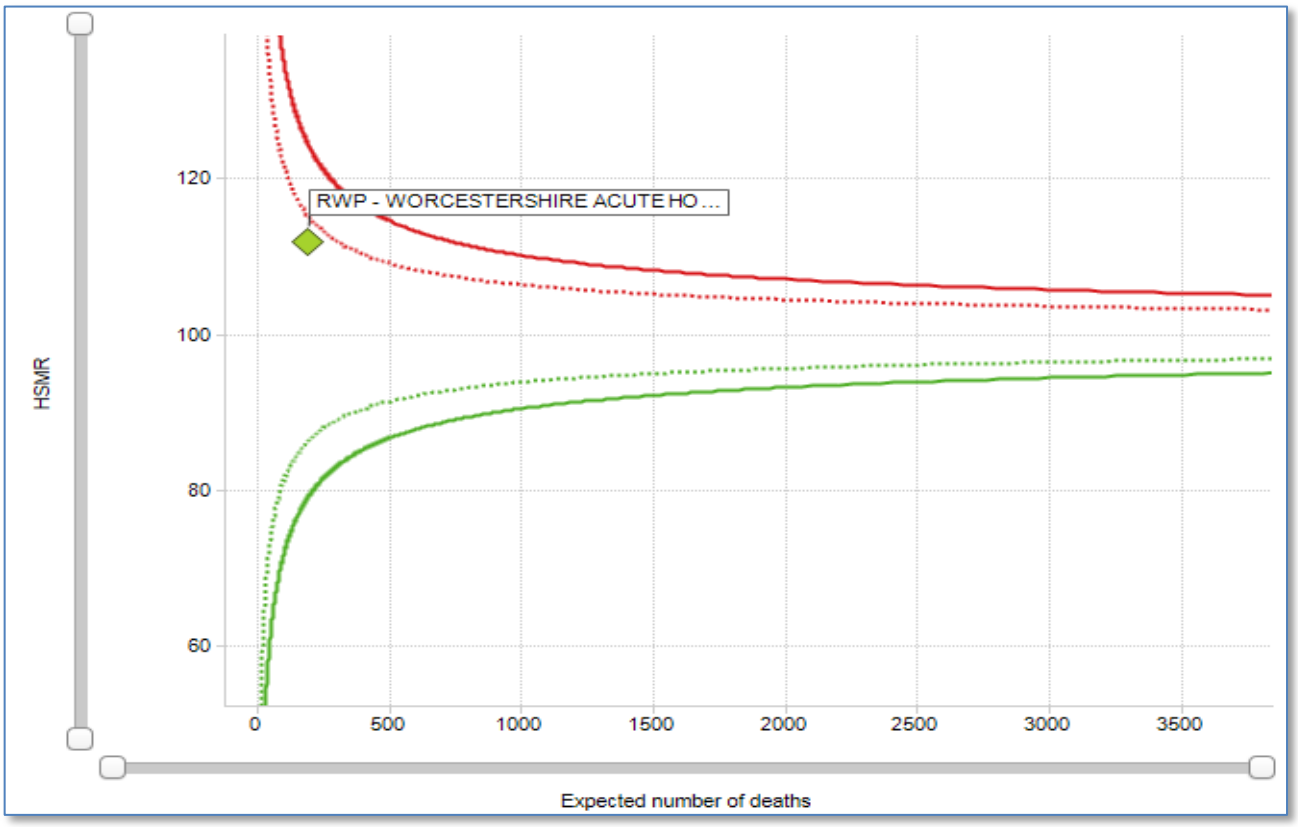
This section provides a comparison of the 12 Month Rolling Average HSMR for two Diagnostic Groups, and the associated Trust position funnel plots.

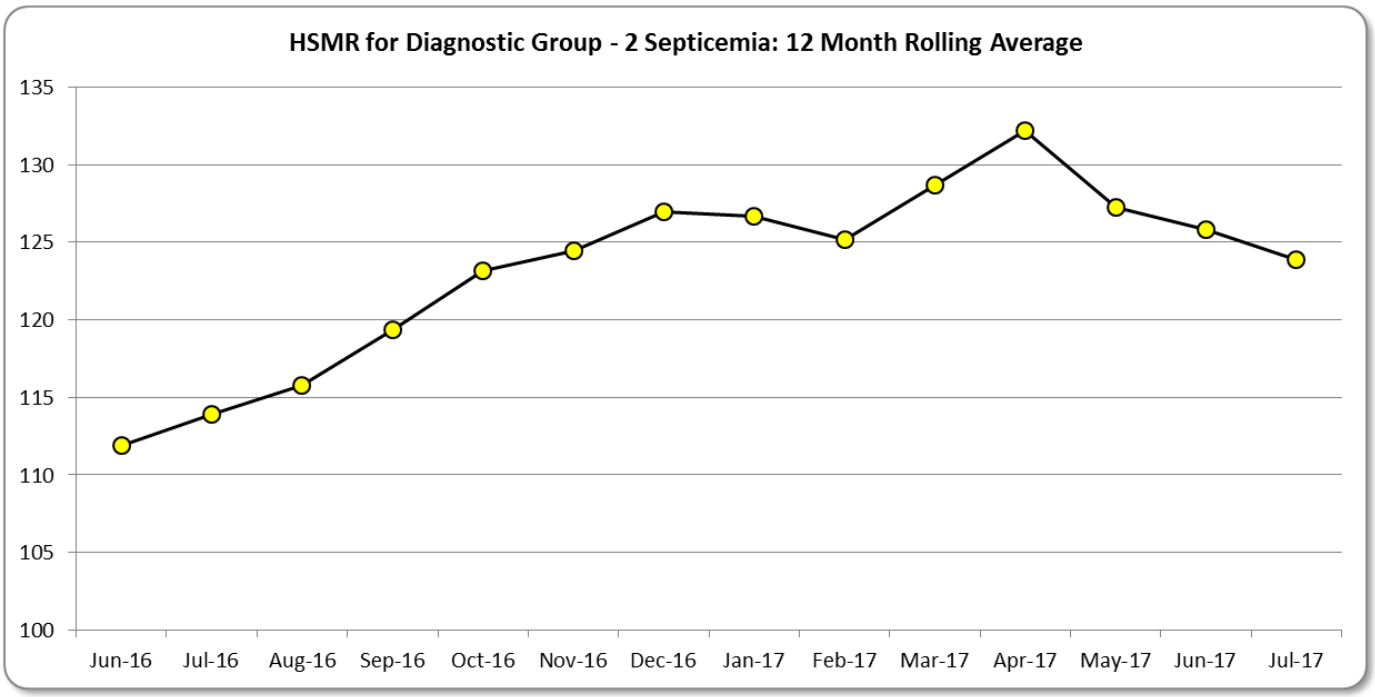
Diagnostic Group 226 – Fracture Neck of Femur





Diagnostic Group 2 - Septicaemia



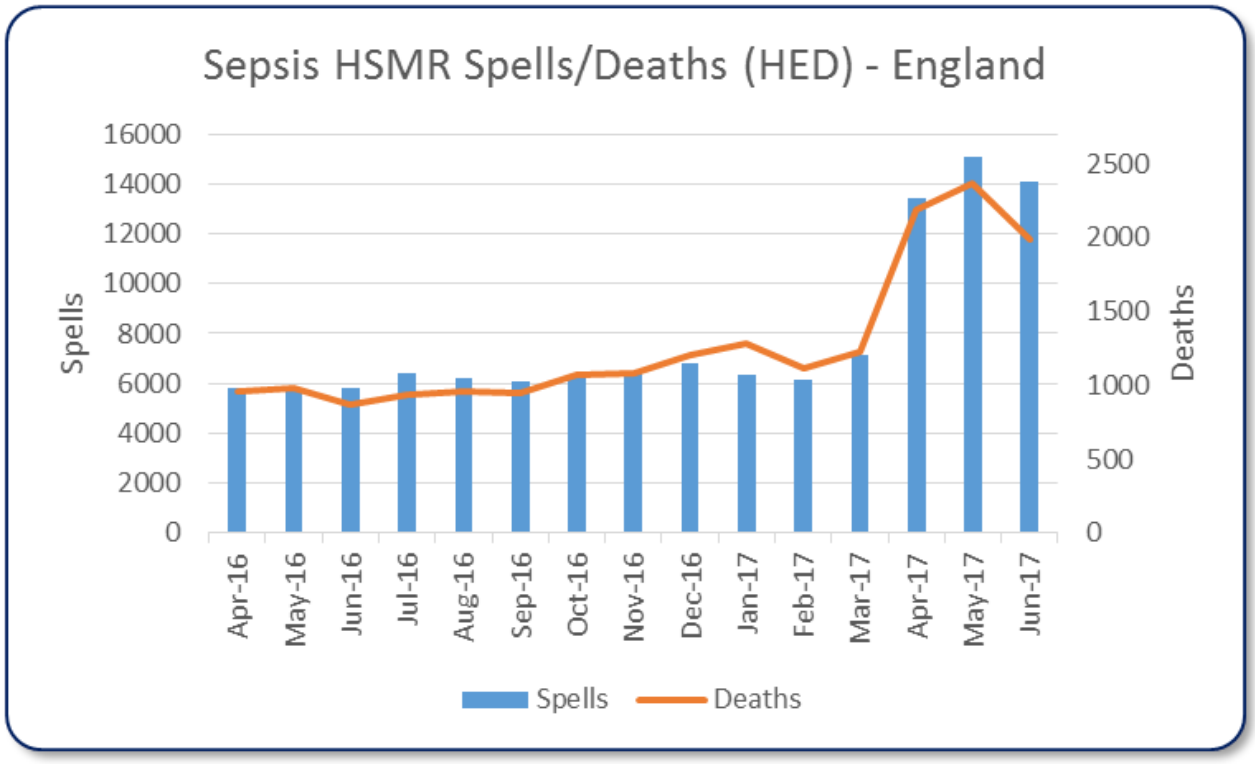


Septicaemia – Further Information

In addition to any local initiatives, two changes have occurred within the NHS nationally which complicate the analysis and interpretation of HSMR changes related to Sepsis;

1. There has been an increased focus on diagnosing and treating sepsis, which may have resulted in a higher diagnosis rate – and hence more patients/admissions being coded with sepsis.
2. New clinical coding guidance[1] was issued for clinical coders on the correct coding of sepsis. This has not in itself caused an increase in the overall diagnosis and coding of sepsis. However, the guidance has meant that, where sepsis has been diagnosed, it will more often be coded as the primary, rather than secondary, diagnosis. Since standardised mortality measures such as HSMR and SHMI are categorised based on primary diagnosis, this has resulted in more activity being categorised as Sepsis/Septicaemia within these analyses.

The impact nationally can be illustrated using HED data, which shows an increase of 127% in the number of spells now coded with a Primary Diagnosis of Septicaemia. The number of deaths allocated to this diagnosis category has also increased significantly, 107%, but not by the same proportion as spells (see below)

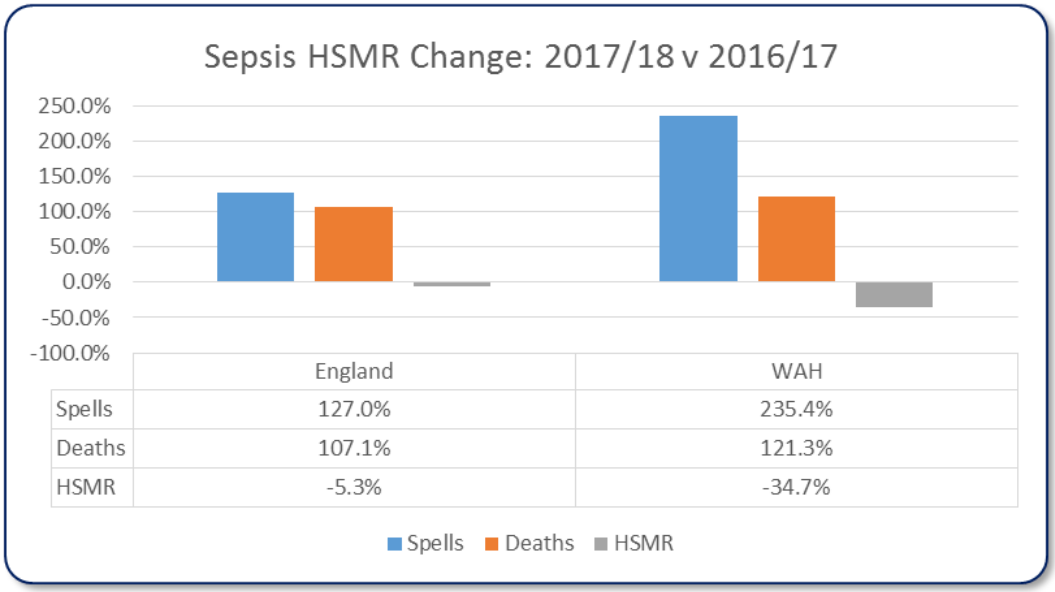


[1] National Clinical Coding Standards ICD-10 5th Edition (2017), section DChS.I.1 on page 42. NHS Digital.

The implications of the national changes mean that the HSMR figures for 2017/18 may currently be understated, and will require a full 12 months using the new guidance to balance out.

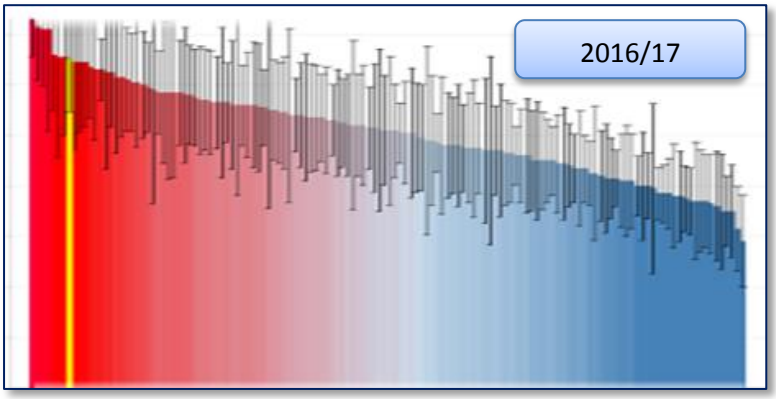
However, there is evidence that the Sepsis HSMR has seen a real reduction at Worcestershire Acute Hospitals NHS Trust;

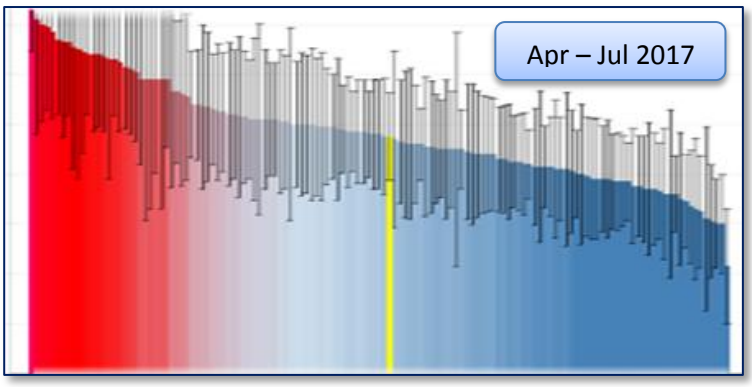
1. The reduction on WAHT's HSMR far exceeds the national reduction.



	England	WAH
Spells	127.0%	235.4%
Deaths	107.1%	121.3%
HSMR	-5.3%	-34.7%

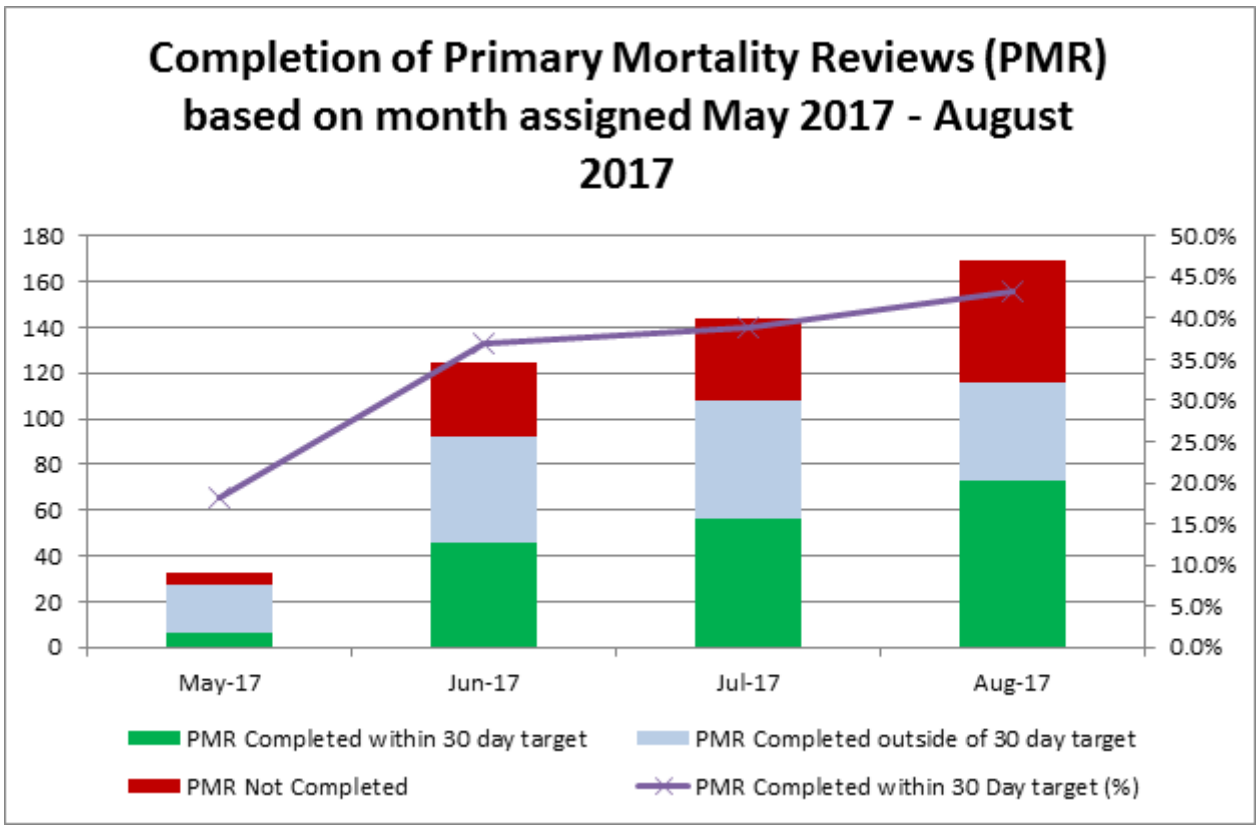
2. The Trust's position in comparison to other Acute Trusts has significantly improved as illustrated in the charts below. Even if the absolute HSMR values are subsequently rebased upwards as the HSMR baseline catches up with the coding changes, the Trust should not be an outlier.





4. MORTALITY REVIEWS

On the 24th May 2017 a new electronic system was implemented to facilitate the collation of Mortality Review Data. A discussion has taken place on the most suitable metric to monitor timely completion of PMRs, and the data below is presented based on the month the PMR was assigned. As such, the data is presented one month in arrears.



5. Structure Judgement Review Update

A transition plan is in place to move from the current process to one compliant with the standards set out by the national quality board.

Progress against this plan is reported to the QIP Board on a monthly basis

All actions are on schedule for transition to a Medical Examiner based process using the Structured Judgement Review (SJR) process. Key activities completed are:

- Mortality lead trained to deliver roll out of SJR to ME's
- Two ME's recruited with plan to train in October and begin reviews in November
- Team trained to undertake mortality reviews in patients with learning disabilities using the LeDeR methodology

Trust policy published and shared with NHSI and CCG's.

Template for capturing outcome of directorate mortality review meetings is being trialled during October with Divisions feeding back utility of document and learning from reviews to MRG end of October.

Suneil Kapadia
CMO

Appendix 1 – Comparison of HSMR and SHMI

Criteria	HSMR (Hospital Standardised Mortality ratio)	SHMI (Summary Hospital-level Mortality Index)
Diagnosis groups used	56 of 259 CCS groups	SHMI (259 CCS grouped to 114 categories)
Percentage of In-Hospital deaths covered	Approx 80% including still-birth	100% excluding still-birth
Includes out-of-hospitals deaths?	N	Y

Standardisation in the model	HSMR	SHMI
Age	Y	Y
Sex	Y	Y
Admission method	Y	Y
Co-mobidity	Charlson score (continuous)	Charlson score in three groups (0, 1-5, >5)
Palliative Care (Z515 diagnosis or treatment specialty 315)	Y	N
Treatment Specialty	N	N
Deprivation	Y	N
Diagnosis sub-group	Y	N
Year of Discharge	Y	N
Rolling-year groups	N	Y
Month of admission	Y	N
Emergency admission in previous 12 months	Y	N
Admission source	Y	N

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NHS Trust

Date of meeting	9 November 2017
Paper number	D3

Quality Governance Committee Report

For approval:	√	For assurance:	√	To note:		For information:	

Accountable Director	Bill Tunnicliffe Non-Executive Director
Presented by	Bill Tunnicliffe Non-Executive Director
Author	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by N/A		
Committee/Group	Date	Outcome

Date of meeting	9 November 2017
Paper number	D3

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R1.1 R1.2 R1.3

Level of assurance and trend			
		√	↑ ↓ →
	Significant		
	Limited	√	→
	None		
	Not applicable		

Purpose of report	This paper provides the Board with the key achievements, issues, and risks discussed at the Quality Governance Committee at the meetings held in September and October.
Summary of key issues	The discussion at QGC is becoming more focussed on providing assurance. The Clinical Governance Group (CGG) provides an excellent report to QGC from which a level of assurance can be gained. This month the Committee members used SQuID as an interactive way to view performance data and I am hoping that this approach will benefit the Committee's work in due course. The Committee heard from two divisions and they outlined their top risks and the mitigations in place. Progress of actions in relation to the section 29a notice were discussed and the lead of VTE attended to present an improved picture with the recording of VTE. Both the Quality Improvement Board report and the report on mortality are on the Board's agenda.
Recommendations	The Board is recommended to: • Review the report and note the progress with the GP letters • Approve the revised terms of reference • Note the report

Date of meeting	9 November 2017
Paper number	D3

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

REPORT FROM THE QUALITY GOVERNANCE COMMITTEE

1 Introduction

This report provides the Board with key quality issues and risks discussed at the QGC meetings held at the meetings held in September and October 2017.

2 Background

The QGC is set up to give assurance to the Trust Board on issues affecting quality of care to patients. The membership consists of three non-executive directors and four executive directors plus a patient forum representative. I am delighted that HealthWatch have recommenced their attendance.

3 Issues discussed

3.1 General

As the Board is aware, I am very concerned with the complaints' performance. I have met with the corporate complaints team which was very illuminating. I am firmly of the view that the root cause of the lack of achievement of the targets is due to the way the divisions manage the complaint, rather than the way the corporate complaints team operate.

I have also visited the T&O ward to triangulate concerns about repeated cancellations relating to elective surgery. I am pleased to report that concerns have been escalated and addressed.

Finally I met with the ward manager and matron on Silver Ward. I was very impressed with the staff including the ward receptionist who had a very good customer focus. I was able to see the safer staffing app working effectively.

3.2 GP letters

The CMO reported that the Trust has dealt with 21000 items of correspondence and there are only 758 items outstanding. Of these, 550 are waiting for further action. Currently there is no evidence of harm. A further 1500 items relate to deceased patients which will be discussed with the CCG. There is now a training programme set up for all clinicians that use Bluespier which will take place over the next 2-3 weeks.

For the future, all items are now cleared within 12 weeks. The draft root cause analysis report shows that much of the problems relate to process and understanding.

QGC will receive a further update in three months.

3.3 SQuID (Safety and Quality Information Dashboard)

QGC were able to review detailed metrics in relation to pressure ulcers. Each case is monitored as not all reporting is consistent with the use of flags. QGC also reviewed VTE assessment after 24 hours and concern was expressed in relation to the performance by the surgical division (27%). The CMO was able assure that this figure will improve when the data collection is consistent (currently audit data are presented).

There was useful insight at the meeting in relation to the role of junior doctors from the trainee representative.

We also reviewed mixed sex accommodation which shows challenges within both critical care areas. This has been picked up with the process flow workshops and also being discussed within the bed meetings. We were pleased that the national sepsis tsar had a positive visit and the report will be bought back to the Committee in due course.

3.4 Women and Children division

The Divisional Director of Nursing attended the September meeting and she set out the governance structure for the division which has been enhanced by the appointment of interim heads of midwifery and nursing.

She outlined five key risks. The lack of a comprehensive electronic maternity information system is the biggest risk. A bid is in for this. She then described the staff 'huddles' now in place for paediatrics which have made a difference to the working of the directorate. This will be considered for roll out in other areas throughout the Trust.

The QGC were appreciative of the report and considered good progress was being made.

Level of assurance: moderate

3.5 Medicine division

The DMD for urgent care and the acting DND attended the October meeting. The top risks were associated with staffing and capacity. They outlined two audits which showed that processes needed to be improved – those relating to NEWS and sepsis screening recording.

QGC considered that the performance relating to serious incident investigation and closure, complaints and mortality reviews has been very poor. Clinical engagement is essential and the division has recognised this and are working with the CMO to improve this.

Level of assurance: limited

3.6 Clinical Governance Group (CGG)

QGC received a detailed report from the Clinical Governance Group (CGG) which had met in the last month. Updates were received in relation to the following:

- Clinical effectiveness
- Quality audit programme
- Safer care work led by DCN (Safety
- Medicines Optimisation
- Resuscitation Audits
- Identifying patients' policy:
- The top three risks for each of the divisions were outlined and the mitigations identified.

Level of assurance: limited

3.7 Section 29A

There was an NHS I led review in September which took place across all three sites. There were approx. 75 people (reviewers, interviewees, support staff etc.) involved in the review, which included colleagues from NHSI, NHSE, HEE, CCG, Healthwatch and internal staff.

The Trust has actioned some of the recommendations such as ensuring that posters are up but there is more work to do for example in relation to drug keys.

Level of assurance: limited

3.8 VTE report

The lead for VTE attended (Miss Rabia Imtiaz). Progress has been made in this area with new forms in place. VTE risk assessment compliance rate for September is 91.5%, (expected trajectory for the month - 90%). However there is wide variation in the compliance rate across the clinical divisions. The monitoring and performance management of the compliance at the divisional and directorate level is vital.

Level of assurance: moderate

3.9 Quality account

The committee received a timeline in relation to the production of the Quality Account. I am pleased to report that the progress of this will be reviewed regularly until the publication of the Quality Account in June.

3.10 Quality impact assessment

Unfortunately, QGC were informed that the process for the development and approval of QIAs is not as robust as it should be. More training will be put in place and QGC will review this area at the end of March.

Level of assurance: limited

3.11 Quality Improvement Board

The Chief Nurse presented the report from the Quality Improvement Board which had considered the Quality Improvement Plan (QIP). The QIP contains six work streams – Improving Patient Outcomes; Operational Improvement; Governance; Patient Experience & Engagement; Safe Care and Culture & Workforce.

A summary of the report is on the agenda for the Board meeting.

3.12 Mortality

The Chief Medical Officer presented the report which has been revised and is much more comprehensive than earlier reports. The report is on the agenda for the Board meeting.

3.13 Harm review

I pleased to report that regular meetings are now taking place with divisions. QGC will receive an update report in January.

3.14 Winter plan

QGC were presented with the latest version of the Winter Plan. An update in respect of this is on the Board agenda. QGC were satisfied that it was a robust plan which dovetailed with other plans for the whole health economy. QGC have requested that the QIAs for the Plan be appended to the final version.

Level of assurance: moderate

3.15 Items approved by the Committee

- BAF Quality risks
- Work plan
- Terms of reference: These are attached for approval by the board. The only amendments are to the membership and the quoracy.

3.16 Items noted by the Committee

- Care in the Corridor Survey Updated actions
- BAF quality risks
- Staff flu vaccination plan

4 Implications

This Committee considers items which are under the framework of the Health and Social Care Act 2012. (Section 29A letter)

5 Recommendations

The Board is recommended to:

- Approve the terms of reference
- Review the report
- Note the report

Compiled by
Kimara Sharpe
Company Secretary

Director
Bill Tunnicliffe
Chairman, QGC

Date of meeting	9 November 2017
Paper number	D3

Terms of Reference

Quality Governance Committee (QGC)

Version: 3.1

Terms of Reference approved by: QGC/Trust Board

Date approved: September 2017

Author: **Company Secretary**

Responsible directorate: CNO/CMO

Review date: March 2018

Date of meeting	9 November 2017
Paper number	D3

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Quality Governance Committee

Terms of Reference

1. Introduction/Authority

The Quality Governance Committee (QGC) is constituted as a standing committee of the Trust's board. Its constitution and terms of reference are set out below, subject to amendment at future Trust board meetings.

The QGC is authorised by the board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the QGC.

The QGC is authorised by the Trust board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

The QGC is authorised to obtain such internal information as is necessary and expedient to fulfil its functions.

2. Membership

Non-Executive Director (Chair)
Two Non-Executive Directors
Chief Executive
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer
Patient Forum Representative

In attendance:
Company Secretary
Deputy CNO (quality)
CCG representative
Associate Director – Information and Performance
Trainee representative

As required:
Other personnel as invited by the Chair

2.1 The Chair of the Group is appointed by the Trust Board.

2.2 Trust employees who serve as members of the QGC do not do so to represent or advocate for their respective department, division or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

3 Arrangements for the conduct of business

3.1 Chairing the meetings
The Non-Executive Director will chair the meetings. In the absence of the Non-Executive Director, the Chair will be another Non-Executive Director.

3.2 Quorum
The Group will be quorate when one third of the members are present including at least two non-executive directors and one clinician, including the Chief Nurse or the Chief Medical Officer or their deputies.

3.3 Frequency of meetings
The Committee will meet monthly.

3.4 Frequency of attendance by members
Members are expected to attend all meetings each year, unless there are exceptional circumstances.

3.5 Declaration of interests
If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the subject consideration has been completed. All declarations of interest will be minuted.

3.6 Urgent matters arising between meetings
If there is a need for an emergency meeting, the Chair will call one in liaison with the CNO/CMO.

3.7 Secretariat support
Secretarial support will be the Company Secretary and a report will be presented to the Trust Board.

4 Authority
The Committee is authorised by the Trust Board.

5 Purpose and Functions
5.1 Purpose
- To be Worcestershire Acute Hospitals NHS Trust own internal quality regulator by;
    - Constructively challenge the organisational strategy
    - Scrutinise Trust management in meeting the agreed strategic objectives
    - Oversee high level clinical performance
    - Be satisfied that services are safe and of high quality
- To enable the Board to obtain assurance that the quality of care is achieving agreed expectations and in line with current good practice and where it is not to that standard, to provide oversight of improvement to achieve the agreed standards.

- To ensure that there are appropriate clinical governance systems with adequate controls in place throughout the Trust in order to:
    - Promote safety and excellence in patient care
    - Ensure the Trust explores opportunities and understands the amount of clinical risk it should accept, tolerate or be exposed to at any point in time (risk appetite)
    - Identify, prioritise and seek assurance on the effective identification and management of risk arising from our clinical business
    - Anticipate and respond to the external environment, paying attention to new (or newly appreciated) opportunities and risks. Looking at what has gone right and wrong in this and other organisations
    - Ensure the effective and efficient use of resources though evidence based clinical practice
    - Ensure that the organisation has an effective learning culture in place

5.2 Duties

In fulfilling the purposes above, the specific duties of the Committee are as follows:

5.2.1 In respect of general governance arrangements:

a. to ensure that all statutory elements of quality governance are adhered to within the Trust;
b. to agree trust-wide clinical governance priorities as contained within the Quality Account and give direction to the clinical governance activities of the Trust's divisions through the Trust Quality Dashboard and exception reports;
c. to approve the Trust's annual Quality Account and the quality aspects of the Annual Governance Statement before submission to the board;
d. to approve the terms of reference and membership of the Clinical Governance Group (CGG) and seek assurance that the expert forums underpinning delivery of quality are appropriate and executing their responsibilities on behalf of QGC
e. to consider matters referred to the QGC by the board or other subcommittees of the Board;
f. to consider matters referred to the QGC by the CGG
g. to receive and approve the annual clinical audit programme ensuring that it is consistent with the audit needs of the Trust;
h. to make recommendations to the Audit and Assurance Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;
i. to receive assurance that its expert forums foster quality governance links with primary care and other stakeholders including patient forum members through receiving of periodical reports as requested

5.2.2 In respect of safety and excellence in patient care, in particular, the QGC is responsible for;

a. assuring the Board that the services provided by Worcestershire Acute Hospitals Trust meet the requirements of the Health and Social Care Act and the CQC's standards.

b. ensuring that internal standards are set and monitored, including (without limitation):
   - commissioning the setting of quality standards and key quality indicators and ensure that a mechanism exists for these standards to be monitored;
   - ensuring that standards outlined in national service frameworks are implemented and monitored;
   - ensuring compliance with the registration criteria of the Care Quality Commission;

c. promoting an organisational climate of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the trust's policy on reporting issues of concern and monitoring the implementation of that policy;

d. assuring that the organisation has controls in place for reviewing patient safety incidents (including near-misses, complaints, and regulation 28 coroner reports (where applicable), mortality reviews)

e. gain assurance from within the Trust that it is looking out to the wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning;

f. assuring that opportunities for improvement in respect of incidents or complaints identified through the national patient survey or locally through PALS, are being taken forward by the organisation;

g. oversight of the system within the trust for obtaining and maintaining any licences relevant to clinical activity in the trust (e.g. licences granted by the Human Tissue Authority or any successor organisation), receiving such reports as the quality governance committee considers necessary;

h. monitoring compliance with the national standards of quality and safety of the Care Quality Commission (CQC), and the quality governance framework or its successor in order to provide relevant assurance to the Board so that the Board may approve the trust's annual governance statement;

i. ensuring that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation;
   - monthly discussion of the strategic clinical risks faced by the trust:
   - six monthly report on the trust's risk management strategy
     - processes to ensure the escalation of risks from directorate and divisional risk registers to the corporate risk register
     - monitoring of the Trust's risk management policy;
     - priorities and actions using the assurance framework;
   - monthly quality exception reports from divisions
   - recommendations from external bodies e.g. the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) or Care Quality Commission (CQC) or Royal Colleges, as well as those made internally e.g. in connection with serious incident reports and adverse incident reports, into practice and has mechanisms to monitor their delivery;
   - implementation of reports or recommendations from National Agencies for Patient Safety (NPSA);
   - escalation to the executive group other sub-committees and/or Trust board any identified unresolved risks arising within the scope of these terms of reference that require executive action or that pose significant

threats to the operation, resources or reputation of the trust;

j. agreeing the annual patient experience plan and monitoring progress;

k. assuring that the Trust has reliable, real time, up-to-date information about what it is like being a patient experiencing care administered by the trust, so as to identify areas for improvement and ensure that these improvements are effected.

5.3.3 In particular, in respect of efficient and effective use of resources through evidence-based clinical practice:

a. to agree the annual quality plan and monitor progress;

b. to receive an annual report from Finance & Performance Committee on the impact on the trust's cost improvement programmes to assure the Board that it's not having a negative impact on quality of care

c. To ensure the Quality Impact Assessments are undertaken on any significant reorganisations (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the committee) and report any concern relating to an adverse impact on quality to the trust board;

To be assured that;

d. care is based on evidence of best practice/national guidance;

e. there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance and guidelines and radiation use and protection regulations (IR(ME)R);

f. the implementation of all new procedures and technologies are embedded according to trust policies;

g. to review the implications of confidential enquiry reports for the trust and to endorse, approve and monitor the internal action plans arising from them;

h. trends in complaints received by the trust are leading to improvement actions in response to adverse trends where appropriate;

i. the development of quality indicators throughout the trust is being undertaken in line with agreed plans;

j. the trust meets the requirements of commissioners and external regulators;

k. any identified gaps in the delivery of effective clinical care are progressed to improve these areas, in all divisions/specialties;

l. the research programme and governance framework is implemented and monitored;

m. there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);

n. where practice is of high quality, that practice is recognised and propagated across the trust and to the wider NHS; and

o. to ensure the trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

6. Relationships and reporting

6.1 The Committee is accountable to the Trust Board. The quality governance committee will report to the Trust Board at each of its meetings in public and where appropriate in private.

6.2 The following sub groups report to the Quality Governance Committee Clinical Governance Group (CGG)

The following expert forums are accountable to the CGG:

- Patient and Carer Experience
- Clinical Effectiveness Committee
- Research and Development
- Trust Infection Prevention and Control
- safeguarding
- Blood Transfusion
- Harm Reduction
- Divisional Governance
- Medical Devices
- Resuscitation and deteriorating patient
- Medicine Optimisation
- Incident Review
- Mortality Review

The Groups listed above will have task and finish groups commissioned to ensure that the expert forums can execute their agreed responsibilities on behalf of QGC.

7 Review of the Terms of Reference

These Terms of reference will be reviewed by March 2018

KS/TOR (corp gov TOR)