

Assurance report of the Chair of the Quality Committee for the period ending 10.7.2018

Overview

This Chairs Report outlines the activity undertaken by the Quality Committee held on 10.7.2018. The Trust Board is asked to note the content of the Chairs Report for assurance purposes.

Overall good progress was reported in terms of the implementation of strategic quality and risk escalation measures to underpin and strengthen the Trust's governance and assurance processes and to identify key Quality and Safety risks, reducing gaps in control against key risks and improving compliance with Trust policy.

The Committee was supportive of the Draft R&D Strategy presented as a paper to the meeting, subject to further alignment with the education strategy and the Patient Experience Strategy. It was of concern that this was a late submission to the Committee with no one available from R&D to present the report to the Committee members.

Successful Outcomes and Assurances

The Quality Committee continued to support good progress in demonstrable improvements of the Trust's safety culture through its focus on the key quality and audit measures outlined in this report. Quality of evidence based assurance in support of the figures presented had also improved, in line with the Governance improvement programme which forms one of the Trusts key priorities.

There was significant assurance gained through the presentation of the digital work streams, in particular the introduction of electronic prescribing for HO. This was recognised as a key safety deliverable.

The work completed to date around organisational design demonstrated a positive shift in approach, providing assurance to the Committee in this area. A regular update will be provided at all future meetings. Full provision of data from the Workforce and OD Sub-Committee will be included in this report from the next Committee onwards.

Areas of Concern

- A key area of concern was raised in relation to the large number of risks where the review was overdue, including almost half of the high risks. The Committee requested further monitoring and urgent action by Directorates and Departments to address.
- The Committee was concerned by the numbers of Trust policies which still required review to ensure they were not out of date. A list of all policies and policy owners/responsible Executive owners has been collated and a date for urgent review and update.
- Digital work streams - Concerns were raised in relation to the reliability of clinical pathways monitoring with the likely reduction in MDT supervision of case management, and the need to ensure patients do not fall through the system as MDT control reduces.
- One area to draw to the attention of the Board was the implementation of the Quality & Safety data packs and Quality & Safety meetings within Directorates, details of which are outlined in this report. The Committee was happy that a robust approach to the development and adoption of the data packs was being adopted. However, risks associated with the delay in scheduled Q&S focussed Directorate meetings was a concern for the Committee. The Committee was assured that the Q&S Sub Committee had requested urgent action and an SOP to be produced with timetable for issuing of data packs aligned with recommended timing of Q&S Directorate meetings.
- There was a significant reduction to the inpatient response rate for Friends & Family surveys. The Committee was assured by the action plan to address this, with implementation of electronic hand held devices for accurate and timely data capture and a Trust –wide re-launch in July 2018
- The Committee noted low levels of activity in both radiotherapy and inpatient admissions and requested assurance in relation to sustainability of current plans and associated proposed staffing levels

- Assurance was gained through the achievement of the VTE target on this occasion; however the Committee was not assured that this was going to be sustained due to past record and flux within the staff group. Challenges within the junior medical staff establishment suggest that the use of Physician Associates should be optimised.
- The timescale for completion of the workforce plan is extremely tight due to the delay in finalising the clinical model and responding workforce plans. Assurance was provided from the Executive Lead that the activity required is clear but the timescale remains tight.
- Agency spend is predicted to rise this first quarter but assurance was provided that this is being monitored closely by the Workforce sub-committee.
- Mandatory training is below compliance rate, an action plan is underway and this has also been added to the risk register.

There was confidence that the above actions will see an immediate improvement in the position and that oversight and on-going monitoring can continue to sit with the Committee. There were no issues that the committee considers should be referred to the board for fuller discussion.

Strategic/Significant Operational Objectives

During the period the Committee received and rated assurance against achievement of the following key objectives or milestones as: -

Objective/Milestone	Outcomes	*Assurance	
		Level 1,2 or 3	No → high
To retain & develop our outstanding organisational status through delivery of excellence in quality of care	Substantial progress against CQC requirements by the end of quarter two in preparation for annual CQC inspection during 18/19. Themed CQC relationship meetings from July 18 in place, PIR narratives for completion end July 18.	L3	Significant
To enhance patient safety & risk culture	Q&S data packs produced but not achieved target date launch of 30.6.18 due to required Directorate input to finalise. Directorate Q&S meetings to be established for July 18.	L1&2	Limited
To improve & be recognised as a leader in cancer care through development of clinical outcomes intelligence	Mortality Surveillance annual report achieved. Head & Neck clinical outcomes dashboard first draft produced	L1&2	Significant
To enhance the patient experience and engagement to influence future strategic direction	Patient experience strategy in development for completion end Sept 2018.	L1&2	Limited
To invest in research and innovation to ensure that CCC patients access excellent cancer research wherever they are.	Research strategy July 2018	L1&2	Significant

Exception/Emerging Issues Reporting

- The Q&S data packs launch was not achieved to target. Evidence was presented to support that, whilst the target date had not been met, progress had been significant with the Directorates who are engaged with the new systems and processes to deliver on Q&S and good governance, assurance and risk register escalation. Directorates were redesigning meeting schedules to accommodate the new Q&S focus meetings for July 18. An evaluation questionnaire to assess the impact of the data packs is planned prior to adopting in appropriate corporate areas also. Resource within the Directorates was a concern, which is reflected in an additional piece of work that would aim to support further improvement. The Committee was confident that the risks are being mitigated and that the delay will not have an overall negative impact on the achievement of the objective.
- Development of clinical outcomes dashboards is in progress with SRG input and IM&T have been approached for digitalisation to assist in robust real time refresh of data to support. The Trust Mortality dashboard is in place and under regular scrutiny by the Mortality Surveillance Group
- The Committee received assurance of appropriate Trust serious incident management from a Risk Management Facilitator report, reviewing all serious incidents over the last 3 years.
- The timescale for implementation of the workforce plan was raised as an emerging issue.
- The Associate Director of Quality was in attendance and will attend future Quality Committee meetings of the Board, to strengthen governance processes from floor to Board.

Stewardship

During the period the Committee received and rated assurance against achievement of the following KPIs or target measures as: -

KPI/Target	Outcomes	*Assurance	
		Level 1,2 or 3	No → high
Improvement in VTE Risk Assessment (target 95%) 2018 May June July Aug Sept 96.60%	Q&S Committee do not receive performance data, however this will be in place as a standing agenda item from July 18	L1&2	Limited
Improvement in VTE prophylaxis administration 2018 May June July Aug Sept 100%	Q&S Committee do not receive performance data, however this will be in place as a standing agenda item from July 18	L1&2	Limited
Improvement in sepsis/antibiotics within 1hr 2018 May June July Aug Sept 100%	Sepsis working group formed	L1&2	Limited
Improved compliance against the Trust Audit Tracker actions	NICE Assurance Committee & revised response flowchart controls introduced in Q1 appear to be having an impact	L1&3	Limited
NICE guidance compliance 2018 May June July Aug Sept 82%	Significant progress is being made against NICE guidance compliance Monitoring and Assurance via the NICE Assurance Committee	L1&3	Significant

Clinical Research (subject to approval of the Research Strategy at Board)

KPI/Target	Outcomes	*Assurance	
		Level 1,2 or 3	No → high
Increase participant recruitment to research	Increase patient recruitment from 526 patients in 2018 to 1000 patients in 2020	L1&2	Significant
Diversify the research portfolio to reflect caring and compassionate strengths increasing the qualitative and observational studies	High quality qualitative and observational studies will move from 11% of the portfolio in 2018 to 20% of the research portfolio in 2020	L1&2	Significant
Develop a forward facing research active workforce	By 2021 80% of CCC consultants will be research active from 50% in 2018	L1&2	Significant
Increase the number of studies for which CCC act as Sponsor	By 2021 CCC will act as Sponsor for 10 clinician led studies from 5 in 2018	L1&2	Significant
We will develop IT infrastructure to facilitate patient screening for participation into research	IT systems will be developed for ease of patient screening to assess a patient eligibility to take part in research	L1&2	Significant

Exception/Emerging Issues Reporting

- **Improvement in VTE**

No report in the Q&S sub Committee June 18 cycle of business. May 2018 was first time this year that the Trust exceeded the VTE risk assessment 95% target. The Committee will receive monthly reports in relation to this KPI from July 2018

- **Sepsis Working Group**

The Q&S Committee received the Matrons Infection Control Report and noted that a new part-time member of staff joined the Infection Control Nursing Team at CCC-W to cover the existing long-term vacancy (0.5WTE). This has enabled the team to focus more on sepsis management by convening a working group to identify ongoing work within the Trust and agree priorities and practices across the organisation. Unfortunately the team has managed to meet only once and was not quorate as medical staff and representatives from CCC-L were unable to attend.

- **Improved compliance against the Trust Audit Tracker actions**

The Q&S Committee received a report from the Audit Committee which showed improved compliance against MIAA Quality spot check audits. The Committee noted that following a significant review, the Audit tracker assurance monitoring has been assigned to Clinical Governance Manager (Audit) and audit team. An Audit tracker improvement plan is in place. Audit leads have been provided with standardised action plan template with directive for realistic completion dates and requirement to provide rationale for any actions not achieved within target dates with actions and assurance for completion monitored via an appropriate committee. The Committee noted that the Clinical Governance Manager (Audit) will be in attendance at future Audit Committee meetings of the Board.

- **NICE guidance compliance**

The Committee received a report from the Nice Assurance Committee which showed improved compliance against NICE guidance in June which has been a key Trust priority. The Committee requested additional assurance on action to address areas of non-compliance, noting new processes have been put in place recently to work with key guidance owners to increase compliance

The Committee has requested a higher level of assurance reporting on all identified KPIs until new controls prove to be effective.

Compliance

During the period the Committee received and rated assurance against scheduled reporting on compliance/performance in the following areas of policy, regulation or operational practice as: -

Scheduled reporting from Cycle of Business	*Assurance Rating	Scheduled reporting from Cycle of Business	*Assurance Rating
CQC Report	High	NICE compliance report	Significant
EPRR Annual Report	High	Safeguarding Report	High
Health & Safety Annual Report	High	Open & Honest Care	High
Medicines management report	Significant	Mortality Surveillance Group	High
Harms Review report	High	Drugs & Therapeutics report	High
Sepsis Working Group report	Limited	Clinical Audit report	Limited
NICE Assurance Committee report	Significant	Infection Control report	Significant
Patient Experience Strategy	Limited		
Research strategy	Significant	<ul style="list-style-type: none"> Quarterly reporting against the implementation plan to the Research Governance Committee Reporting to the Quality and Safety Sub-committee Reports to the Research Committee External reporting to National Institute for Health Research in performance in initiating and delivery of research External reports to the North West Coast Clinical Research Network External report to CRUK Experimental Cancer Medicine Centre 	Significant

Exception/Emerging Issues Reporting

- **Patient Experience Strategy** The draft Patient Experience Strategy requires urgent work to complete and meet the required standard. The Committee outlined next steps which included a target date for completion by Sept 2018, following consultation with Matrons and Safeguarding leads. A draft will also be shared with key stakeholders to include the Patient Council and Commissioners. The Committee indicated it would want to see evidence of progress in order to feel assured in this area.
- **Clinical Audit** The Committee received the Clinical Audit Committee report and noted the good work of the Committee. Concerns in relation to the audit tracker assurance monitoring are as described above with mitigation in place.
- **Safeguarding** The Committee received significant assurance in relation to the Safeguarding action plan, noting this is on track for target date delivery, with identified interim safeguarding leads in place, a medical and NED safeguarding lead in place, a safeguarding duty line and recruitment to a permanent Head of Safeguarding and Named Nurse for Safeguarding in progress, following failure to recruit on a previous occasion.

The Safeguarding Committee has now been re-formed with revised Terms of Reference to provide assurance of delivery against the safeguarding agenda. The Annual Safeguarding Report has also been delivered and all safeguarding policies are now in place. However the Committee requested additional assurance regarding DBS checking processes.

The incident reporting system has also been refined to capture safeguarding incidence and provide data to support a new safeguarding reporting dashboard. A safeguarding Trust walk about took place in June to provide front line assurance and identify any gaps in knowledge to target.

However the Committee was concerned in relation to poor compliance with safeguarding training, although slight improvements noted, there were still some staff groups with limited compliance. A training strategy is in place and targeted training to mitigate for this risk.

- **CQC** The Committee received a CQC Insight report action plan and overall update report, noting that the PLACE assessment action plan is in place with planned remedial estates work to include handrails, however current costings from PropCare are in excess of £100k, so alternative suppliers are being reviewed by the Matron.
- **Quality Contract** The Committee identified a gap in assurance in relation to Quality Contract compliance and progress against CQUIN delivery. Both will be reported against in future Q&S Committees for appropriate and immediate escalation of risk.

Risks

During the period the Committee considered the performance in relation to management and mitigation of BAF risks assigned to them and provide the following summary of highlights for the Board to consider as part of their deliberation of risk; -

BAF Risk	Gaps in Control	Comments
1.3 There is a quality strategy approved by the Board and key measurable outcomes reported in the annual quality account.	The quality strategy needs a re-fresh to align with the strategic direction for 2022. This would require a re-fresh of the success outcomes to ensure alignment from floor to Board.	There is a current Quality Strategy in place. The Trust has a planned approach to refresh the Quality Strategy by Q3 2018 in line with strategic direction. Lead assigned to this is the AD of Quality
1.4 The governance committee and flow of information is clear and there is regular reporting from floor to Board.	The frequency is not fit for the purpose of the enhanced strategic aim and needs reviewed	The Q&S Committee Cycle of business frequency and membership has been reviewed to support increased appropriate assurance reporting
1.5 The escalation of risk is defined with trigger points and enhanced processes to address concerns.	Education and training needs need to be established to improve knowledge & skills & embed consistent and sustainable application	Review of the escalation & management of risks delivered Action plan with training & education resources and staffing resources to support within Directorates being finalised end July 2018 following PADR completion. Internal additional training & support established in risk, & incident reporting, external training sourced in key areas eg Safeguarding, data protection
4.3 There are a range of strategies approved by the Board and these are (i) Trust has a workforce & OD strategy, (ii) Communication & engagement strategy, (iii) Education & training strategy and (iv) clinical workforce strategy.	The right workforce is in place with the right skills 3 months ahead of the opening of the new build in Liverpool. There is the right workforce in place for the planned shift of care closer to home for day and outpatient services. We are recognised in the staff survey as an outstanding Trust that invests in innovative workforce solutions, professional development and career progression	Safe staffing data & nurse vacancies data will be a standing agenda item on the Q&S Sub Committee from July 18
10.3 The strategic direction approved by the Trust Board confirms the ambition and plan to be and retain best performing ranking at Trust level and deliver best outcomes throughout its services.	The IPR need to be more forward-looking and comprehensive to provide the necessary assurance that the Trust remains on track to delivery its strategic objective of best in class	IPR being revised and aligned with Q&S data packs information. CQUINs update report to be presented at Q&S Committee from July 18

Risk Escalation**New or Emerging Risks**

- 4.3 Safe staffing & nurse vacancies not currently reported to Q&S Committee and not in Cycle of Business. Reporting will be established from July 2018
- The Committee has requested a review of the Trust management and compliance with safety alerts for assurance

All other risks are being managed within or are achieving progress towards acceptable levels of tolerance and continue to be monitored by the Committee.

Minutes of the meeting provide a full account of the work of the Committee.