To	The Board
For meeting on:	26 July 2018
Agenda item:	10
Report by:	Jessica Dahlstrom, Head of Governance Sofia Bernsand, Deputy Head of Governance
Report on:	Corporate Report

Introduction

1. The Corporate Report brings together reports of all of NHS Improvement's Board committees. This report summarises the committees' activity since the last meeting of the Board, which took place on 24 May 2018.

Technology and Data Assurance Committee meeting – 6 June 2018

2. Systemwide digital governance: The Committee noted that, as part of the new joint working between NHS England and NHS Improvement, this was the last meeting of the Technology and Data Assurance Committee, and that it would be important to put in place robust governance arrangements for this area of work going forward. A decision on future executive arrangements and non-executive board oversight would be for the joint boards to make, but Committee members provided thoughts and comments.

3. Architecture and standards strategy: A discussion took place on the national architecture and standards strategy and the role of the regions in enabling data sharing between primary, secondary and other care providers. The need for a more coordinated approach to procurement focused on measuring the value of investments for the system rather individual organisations was highlighted.

4. Update on Personalised Health and Care 2020: An update was provided on the five key workstreams encompassed in the Personalised Health and Care 2020 (PHC2020) programme. The components of PHC2020 most relevant for NHS England and NHS Improvement were discussed in detail.

5. Update on the joint work on Integrated NHSI / NHSE systems and business: The Committee received a presentation which provided an overview of the change programme and the model for NHS England and NHS Improvement working as a single joint entity. The importance of alignment on key principles was emphasised and it was noted that alongside other priorities, automation and self service was a key area for focus.

6. TDAC independent member visit: The Independent Members presented their findings from a day of presentations which they had attended on Friday 25 May 2018. 8The Independent Members praised the work delivered by NHS Improvement's enterprise architecture and emphasised the importance of this role in the context of joint working. They also praised the Model Hospital product which had improved significantly and was a valuable resource.

7. Full minutes of the meeting are attached as Confidential Annex A.

Quality Committee meeting – 20 June 2018

8. Patient story: The Committee watched a video describing the end of life care received by a teenage cancer patient. The Committee reflected on the positive and coordinated care which had been given in this case which was inspiring. The importance of sharing positive stories was highlighted. The concept of appreciative enquiry was discussed and it was noted that this was a technique focused on extracting learning from high performance by staff.

9. Quality Dashboard and update from regions: A detailed discussion took place on the key findings set out in the Quality Dashboard, which is included as a separate Board paper. The Committee also considered four reports from the regions setting out, for each region, current quality trends and issues.

10. Mortality oversight: The Committee considered a report which set out mortality rates for acute trusts. The assurance process applied to the outliers was outlined. An explanation was provided of the statistical or coding issues which could cause providers to become outliers. NHS Improvement should provide more support, or organise peer support, to enable providers to submit their data accurately. The importance of ensuring mortality data was taken seriously and issues were understood and addressed was highlighted.

11. Full minutes of the meeting are attached as Annex B.

Audit and Risk Assurance Committee meeting – 3 July 2018

12. Draft new strategic risk register: The Committee considered the draft new strategic risk register and commended the work that had taken place to develop the new register. It was noted that the draft register reflected the new agreed approach to identifying and categorising risks and included risks relating to joint working with NHS England and NHS Improvement's organisional design. The importance of ensuring that there is no gap in risk ownership during the transition period between the old and the new register was emphasised. The Committee also requested that any common risks for both NHS England and NHS Improvement be jointly reviewed by both organisations.

13. Internal audit progress report: The Committee considered the completion of the 2017/18 internal audit plan and progress made against the 2018/19 plan. It was noted that the 2017/18 plan had now been completed and that sufficient work had

been undertaken throughout the year for the Head of Internal Audit to be able to provide an annual audit opinion. The Committee considered the 2018/19 plan and the importance of revising the plan to ensure it reflected changes in priorities arising from the joint working programme with NHS England and changes to the operating model was highlighted. The Committee agreed that a revised plan would be submitted to the Committee for approval at its next meeting.

14. Internal audit reports: The Committee received internal audit reports on the Healthcare Safety Investigation Branch, Cyber security / identity access management and partnerships.

15. Consolidated NHS Provider Accounts 2017/18: The Committee noted that for the first time (following a direction Secretary of State of Health and Social Care) NHS Improvement had prepared consolidated NHS provider accounts for both NHS trusts and NHS foundation trusts. The consolidated provider accounts had been audited by the National Audit Office (NAO) and would be laid before Parliament. The consolidated NHS foundation trust accounts had been prepared as a separate document with no commentary, consolidated annual governance statement or an audit opinion. These would not be laid before Parliament. The Committee noted the enormous effort that had gone into producing these accounts. The Committee reviewed the audit completion report, including the draft letters of representation and audit certificates and approved the consolidated 2017/18 NHS provider accounts and the consolidated 2017/18 NHS foundation trust accounts.

16. Head of Internal Audit annual audit opinion report: The Committee considered the annual assurance report which provided moderate assurance that NHS Improvement had adequate and effective systems of control, governance and risk management in place for the reporting year 2017/18.

17. Monitor's and NHS Trust Development Authority's 2017/18 Annual Report and Accounts and audit completion reports: The Committee considered a report, which summarised changes made to Monitor's and NHS Trust Development Authority's (NHS TDA) final 2017/18 annual reports and accounts (the Accounts) since they were considered by the Board at its meeting in May. The NAO provided an update on the audit completion reports for Monitor and NHS TDA and noted the challenges arising from Monitor and NHS TDA being managed as one entity. The Committee considered the audit completion reports, including the draft letters of representation and audit certificates for both entities and approved the Accounts.

18. Draft minutes of the meeting are attached as Confidential Annex C.

Recommendation

19. The Board is asked to note recent committee activity.

NHS Improvement

MINUTES OF A MEETING OF THE QUALITY COMMITTEE HELD ON THURSDAY 20 JUNE 2018 AT 14.00pm AT WELLINGTON HOUSE, 133-155 WATERLOO ROAD, LONDON SE18UG

Present:
Sarah Harkness, Non-Executive Director (Chair)
Jonathan Broad, Patient and Public Voice Member
Vincent Connolly, Regional Medical Director (North)
Lord Ara Darzi, Non-Executive Director
Siobhan Heafield, Regional Nurse – Professional Leadership, Midlands and East
Kathy McLean, Executive Medical Director and Chief Operating Officer
Mark Radford, Director of Nursing Improvement
Oliver Shanley, Joint Regional Chief Nurse (London)
Nigel Sturrock, Regional Medical Director (Midlands and East)
Imogen Voysey, Patient and Public Voice Member
Richard Wilson, Director of Quality and Intelligence & Insight
Alice Webster, Regional Director of Nursing (South)

In attendance:
Jessica Dahlstrom, Head of Governance
Sherree Fagge, Head of Nursing End of Life Care

1. Welcome and apologies (oral item)

1.1. Apologies for absence had been received from Maggie Boyd (Director of Clinical Quality, Midlands and East), Sue Doheny (Director of Quality and Clinical Leadership), Celia Ingham-Clark (Interim National Director of Patient Safety) and Ruth May (Executive Director of Nursing).

1.2. There were no declarations of interest.

2. Patient story

2.1. The Committee watched a video describing the end of life care received by a teenage cancer patient. The Committee reflected on the positive and coordinated care which had been given in this case which was inspiring. The importance of sharing positive stories was highlighted. The concept of appreciative enquiry was discussed and it was noted that this was a technique focused on extracting learning from high performance by staff.

2.2. It was noted that end of life care was the fastest growing pathway of care and the importance of getting it right was highlighted. End of life care should be

viewed as enabling healthier dying. The importance of empowering patients and ensuring their needs were heard and fully understood was emphasised.

3. End of life care deep dive (QC/18/15)

3.1. The Head of Nursing End of Life Care introduced the paper. The Committee noted that any apparent irregularities in the data were caused by the differences in trust-level and site-level reporting. The history of the end of life collaborate was outlined and the improvements achieved by some of the trusts participating were considered.

3.2. The Committee noted that a support offer had been developed for trusts. There was a focus on sharing of best practice and connecting trusts with each other. Key themes had been identified and the work programme was closely aligned with hospice care providers so that the work could be coordinated. An intensive support programme had been created for trusts currently rated 'Inadequate' in this area by the Care Quality Commission (CQC). The Committee noted that the team was also increasingly working jointly with NHS England on end of life care.

3.3. A discussion took place with regard to preferred place of care and preferred place of death. The patient pathway for end of life care would need to be re-examined and the role of ambulance service providers was important in this regard. The importance of identifying patients likely to die in the next 90 days was highlighted and the Committee noted that system coordination was crucial to ensure that all care providers were aware of patients' wishes.

3.4. The interaction with care homes and the skills and confidence of care home staff was considered. Training and development would help in this regard. A discussion took place on the number of trusts who were rated 'Requires Improvement' in this area and Committee members commented that it was important to provide support to all of these trusts in addition to those rather Inadequate. The link to board leadership and culture was discussed.

3.5. Consideration was given to using the advanced care planning tools which were now in place to secure improvements in the delivery of end of life care. Digital and/or patient held records could be helpful in achieving this. A discussion also took place on the expectations of society in relation to death and the fact that many people now expected to die in hospital. The communications around dying at home and the services which could be made available to patients at home were important in this respect. The pressures on NHS staff were noted and the importance of making time for improvement alongside the day to day workload was highlighted. The Committee requested that an update be brought to committee in twelve months as it was important to keep the pressure up in this key area.

4. Minutes and matters arising from the meeting held on 26 April 2018 (QC/18/11)

4.1. The minutes for the meeting held on 26 April 2018 were approved and matters arising were noted. The first three open actions related to matters which were now on the forward plan for the Committee and could therefore be closed. The Committee would receive a further update on E. Coli rates and Infection Prevention and Control at its next meeting. It was agreed that both actions relating to the Winter Review could be closed and the Committee would be sent the final version of the Winter Review. In relation to the action regarding the difficulty of obtaining a CQC rating of Outstanding for safety, it was noted that the criteria for an Outstanding rating should be revisited to allow space for learning and improvement and this would be discussed with the CQC. The action in relation to Patient Safety Checklists remained outstanding.

5. Quality Dashboard (QC/18/12)

5.1. The Director of Quality and Intelligence & Insight introduced the key findings set out in the Quality Dashboard including changes that had occurred as a result of CQC inspections. The Committee noted that the reduction in VTE assessments appeared to have stopped but close monitoring was required.

5.2. Consideration was given to data on Infection Prevention and Control and Mortality. It was noted that this had been a high mortality winter which was considered to be partly as a result of the volume of patients treated in hospital during this winter period. The importance of continuing to review winter mortality data and learning from it was highlighted.

5.3. A discussion took place on higher than expected variation in out of area placement data. Mixed sex accommodation data was considered and the Committee discussed the approach taken to 'flu vaccination rates for NHS staff.

5.4. Work was progressing on creating more mental health indicators and new indicators were expected to be available for the next meeting.

ACTION: RW

5.5. It was noted that there may be a data quality issue in relation to end of life care as in many cases the place of death was not recorded, and therefore it was not possible to comment on the percentage of patients who had died in the place that they wished to die. A query was raised in relation to data on hip fracture rates and this would be investigated by the Director of Quality and Intelligence & Insight to report back at the next meeting.

ACTION: RW

5.6. A discussion took place on length of stay and readmission rates which would need to be monitored closely. Staff sickness rates were considered and the difficulties associated with comparisons with other sectors were noted. Committee members noted that a more detailed breakdown of data for any

particular indicator could be made available on request. The Committee expressed its thanks for a very useful report.

6. Update from the regions (QC/18/13)

6.1. The Committee considered four reports from the regions setting out, for each region, current quality trends and issues. In relation to the South, an update was provided on a C. Difficile reporting issue in the region. Work was ongoing with NHS England and commissioners to rectify this. The region thanked the NHS Improvement recruitment and retention programme which had been helpful in aligning workforce plans across the region. The issue of providers competing for staff was highlighted.

6.2. An update was provided on key issues in the London region, including an overview of a number of warning notices which had been received by providers in the region. Issues with the interface between the emergency departments and mental health services were outlined. It was noted that this was a broader issue nationally and that recommissioning of services may be required in some cases. The Committee also noted that work was ongoing to develop better soft intelligence and early warning indicators to ensure trusts which required support were identified early. The Committee discussed the importance of trusts in London getting the basics right to ensure more providers being rated CQC Outstanding in the region.

6.3. In relation to the Midlands and East region, the Committee discussed the occurrence of Never Events in relation to connecting patients to air rather than oxygen supply. There were processes in place to prevent this from happening but these were not sufficiently effective. An update was also provided on Infection Prevention and Control and C. Difficile specifically. New initiatives to improve performance in this area would be put in place in the coming months. The learnings from implementing a new IT system were also discussed.

6.4. An update was provided on key developments in the North region including positive changes to CQC ratings. The region was taking an approach of partnering Outstanding or Good trusts with other providers in the region to share learning. A discussion took place on where reports on Serious Untoward Incidents were discussed and published and how learning from these reports was shared. Some of the cultural challenges could be overcome by sharing areas of good practice as well as Serious Untoward Incidents.

6.5. The Committee welcomed the presentation of information in the London and South region reports in particular and requested that this template would be used going forward.

7. Mortality oversight (QC/18/14)

7.1. The Director of Quality and Intelligence & Insight introduced this report, which set out mortality rates for acute trusts. The Committee noted that all outliers in

the data were followed up by NHS Improvement and mortality data was regarded as a smoke alarm which could be indicative of wider issues. There were two mortality statistics considered in the report and the differences between these statistics were explained.

7.2. End of life care and learning from deaths had been considered separately by the Committee, and this report was focused on an analysis of the statistical data. The assurance process applied to the outliers was outlined and Committee members noted there were a number of questions which NHS Improvement asked of outlier trusts including evidence of board understanding and challenge, a robust improvement plan, evidence of provision of safe good quality care, a clear governance structure and offer of NHS Improvement support.

7.3. An explanation was provided of the statistical or coding issues which could cause providers to become outliers. NHS Improvement should provide more support, or organise peer support, to enable providers to submit their data accurately. The importance of ensuring mortality data was taken seriously and issues were understood and addressed was highlighted.

8. Any other business

8.1. Committee members noted that this was the Committee Chair's last meeting, and thanked her for setting up the Committee and leading it with great success.

Close