Agenda item: 19/49

Report to:	**Trust Board**
Title of Report:	**Assurance report from Clinical Outcomes and Effectiveness Committee**
Date of meeting:	**25 May 2017**
Recommendation:	**For information and assurance**
Chairperson:	**Jonathan Rennison, Chair**
Purpose	The report summarises the assurances received, approvals, recommendations and decisions made by the Clinical Outcomes and Effectiveness Committee at its meeting on 25 May 2017.
Background	The Committee meets bi monthly and provides assurance to the Board on: • Safe and effective patient care • Prevention, early intervention, recovery and rehabilitation • Ensure that the Trusts responsibility for infection control is effectively fulfilled • Promoting a culture of learning and continuous improvement. • Measure change using clinical outcome measures to monitor the impact of the services provided by the Trust.
Business undertaken	**Terms of Reference** The committee discussed and reviewed the terms of reference and made further recommendations. The committee approved the terms of reference subject to some further changes. **Integrated Performance Report** The IPR for this committee is currently under development and will be further reviewed in format for the next meeting. Executive summary of good areas of performance and areas requiring further improvement:

HSMR: MVdW outlined current performance and that we are now being compared to the 'Shelford Group' which is a group of 11 Trusts that sit within 'lower than expected' range for HSMR.

An overview of the learning from the MRSA bacteraemia was given and the change in blood culture bottles and the new practice. The policy is also being reviewed.

VTE risk assessment was below threshold a review has been undertaken to gain further insight into the actions required to improve overall performance. This has been discussed at the Clinical Advisory Group and a different version of the risk assessment has been developed for stroke patients and some groups of patients who should be excluded, i.e., patients who will be commenced on anticoagulation for acute coronary syndrome. Areas where poor compliance was identified will be targeted by the Divisional Directors.

The IPR was discussed for assurance of actions being undertaken to address areas of performance requiring improvement.

Draft Quality Strategy

The Trust quality priorities have been agreed and the quality transformation group (QTG) set up. External specialist support is being sought to support staff engagement for the development of a strategy. This will be underpinned with the development of the capacity and capability of improvement methodology across the Trust as part of the well-led framework to support continuous learning and a quality focussed culture engaging staff around quality performance. It is proposed to use the IHI as they are able to support and deliver in the timeframes in quarter 2&3.

Clinical Outcomes and Effectiveness Committee risk register

The Committee noted the report and one corporate risk aligned to the committee.

The report was noted by the committee and it noted the further work being undertaken to review this risk. The committee also asked that all risks at 12 and below are reviewed in the work plan twice a year.

Bi-Annual Infection and Prevention Control Report

The Assistant DIPC gave an overview of the report to the committee. Discussion took place on surgical site infection information (SSI) to gain assurance on actions taken. The committee noted the actions taken and asked for further clarification to be included in the narrative in the SSI section and in the Executive summary in respect of the PHE outlier notice. It was noted in the report that it was associated with small numbers although with a decreasing trend in the last three successive years.

The committee were assured of the compliance with the Health & Social Care Act (2008) and the hygiene code. The committee approved submission to the July Board subject to the changes in SSI actions and the Executive summary.

Bi-Annual End of Life Care Report

The committee discussed the work that has seen a significant increase in referrals to the specialist palliative care team and improvements in patients being discharged to their preferred place of death. It was also noted that the number of non-cancer referrals had increased and is now slightly more than cancer referrals. The work to develop end of life volunteers in the Trust and the successful funding from Macmillan and recruitment of an end of life care educator to build upon the work in the Trust.

Quality Account 2016-17

The draft report was discussed and ensuring that the balance in the narrative around improvements achieved and work still to be done is checked, as well as and further proof reading being required. These aspects are underway and it was outlined that we had shared ongoing drafts with partners as part of the timeline for publication on the 30th June 2017.

The committee noted the account and the improvements made and approved the work being undertaken to ensure the report is completed for publication.

Blood Bank Hospital Report

The report was approved by the divisional governance team and reviewed by the Chief Nurse as not all data was completed in time for completion of the wider Trust governance process. The report was taken retrospectively to Quality Safety Group and to this committee.

The committee noted this report and the plan to review workload in the blood transfusion laboratory in response to a new question on workload, also the retrospective governance process taken for CEO sign off due to the tight turnaround required for the Trust to meet its legal requirements with the MHRA.

Reporting groups

The chairs report of the Quality & Safety Group, March and April 2017 was noted and no matters for escalation to the committee.

The Infection & Prevention Control Panel Minutes were brought on this occasion but, will report to Quality & Safety Group in future not the committee.

Risks to refer to risk register	None
Issues to escalate to Board	No escalations to the Board.
For the Board to note	Improvements in end of life care Further review of the Quality Account prior to final publication on June 30th then presentation to the July Board. To develop a timeline for the Quality Strategy over quarter 2 & 3.
Attendance	John Brougham, (JB) Non-Executive Director Tracey Carter, (TC) Chief Nurse & DIPC Rachael Corser, (RC)Deputy Director of Governance & Associate Chief Nurse Mike van der Watt,(MvdW) Medical Director Jane Shentall, (JS) Director of Performance Lisa Emery, (LE) Chief Information Officer Phil Downing, (PD) Head of Nursing Medicine Jo Fearn, (JF) Head of Nursing Women and Children's Steve Barnett, (SB) Chairman Dr Anna Wood, (AW) Deputy Medical Director Ajitha Jayaratnum, (AJ) Deputy Clinical Director Paula King, (PK) Head of Nursing Surgery, Anaesthetics and Cancer Linda Tarry, (LT) Executive Assistant to Chief Nurse (minutes)
In attendance for Specific Items	Michelle Sorely, (MS)Lead Nurse Cancer & Palliative Care Nyarayi Mukombe, (NM) Assistant Director of Infection Prevention and Control