Good Governance because it's time to think again

Quality Committee
Board Assurance Prompt

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What is this guide and who is it for?

This board assurance prompt (BAP) is for chairs and non-executive directors of NHS provider organisations, particularly those on quality committees. It is intended to provide a high-level summary of some of the principal challenges facing quality committees during the COVID-19 pandemic including the restoration and recovery phase. It offers a selection of key assurance questions that quality committees should be asking during the pandemic.

What is a quality committee?

A quality committee is a committee that has been tasked by a board with providing assurance on all aspects of quality and safety of clinical care, including regulatory standards. This remit is often augmented with additional areas such as risk, workforce, research and development, information, performance and communications.

It is chaired by a non-executive director and normally includes additional non-executive directors, the chief nurse/director of nursing and chief medical officer/medical director as a minimum. It should be sufficiently varied in skill and expertise; ideally a non-executive director with clinical experience and expertise should be on the committee.

A quality committee is not a requirement for the NHS in England but is a requirement in Wales although most NHS Trusts have a committee responsible for quality and safety matters.

What is a quality committee during COVID-19?

As per guidance from the NHS England chief executive[1], quality committees are expected to continue during the pandemic but all other committees have been asked to rationalise or prioritise to ensure the non-executive directors and executive management team can focus on the key issues of the organisation during the pandemic.

We recommend that quality committees include other aspects of assurance in their remit during this time, particularly workforce and finance issues as well as some of the other areas mentioned above. An interim integrated assurance committee combining multiple committees may be one way of doing this.

In addition, we also recommend that some items are now dealt with at board level (some finance and operational items) rather than by a board committee so that management time is released. This will prevent overburdening of the quality committee while other committees are suspended or curtailed.

During the reset/recovery period, many NHS trust's may be tempted to revert back to their previous governance structure. This should be avoided, and a review of the governance structures should take place to ensure appropriate arrangement are in place to plan and deliver the plans needed for the reset/recovery phase.

1. Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic, NHS England and NHS Improvement, (28 March 2020)
https://www.england.nhs.uk/coronavirus/publication/reducing-burden-and-releasing-capacity-at-nhs-providers-and-commissioners-to-manage-the-covid-19-pandemic/

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Key challenges for NHS quality committees during COVID-19

The key role for non-executive directors will tend more towards supporting management than scrutiny, which will continue as we move towards the next phase of the pandemic. Scrutiny will still need to continue with a focus on ensuring the right questions are asked and assurance provided.

If non-executives have questions where answers can be delayed, alternative ways for these to be answered should be used, such as actions for executives, 'car parks' or other forums. Along with succinct papers, this will enable committee time to be shortened to cover the agenda.

Despite the suspension/curtailing of board committees, the quality committee should not be expected to do everything and become overburdened. It will now be more crucial than ever for the remaining board committees to interlock and work in tandem, as well as with the board. Non-executives should communicate findings from each other's committees where issues cross responsibility. This will improve triangulation and sound decision making.

Quality committees, just like other committees and the board, will need to prioritise. Although the below is a list of areas that should be covered, organisations should utilise exception reporting so priority is given to those items that are key areas of risk.

CQC Domain	Topic	Risk	Key questions	What does good assurance look like?
Safe	Infection control, including facilities management	Risk of cross infection of COVID and other hospital acquired infections due to availability and priority of PPE and cleanliness of premises and equipment	How are we ensuring staff and patients are protected from cross infection?	Evidence of: • Enhanced cleaning regime with audits • PPE stock levels and fast track (but quality controlled) procurement process • Mortuary capacity arrangements in place for high levels of deaths
	Workforce	Staff shortages due to sickness, and availability Quality of care due to up-to-datedness of skill for retired staff coming back to work Quality of care of COVID patients due to skill of those staff treating COVID patients	How are we ensuring we have safe staffing levels? How are we ensuring staff have the right skills to provide good quality care? How are we ensuring staff can provide care using the new forms of technology?	• Revised safer staffing policy and dashboard showing compliance • Skills matrix with training programme that highlights staff skills fitting patient need • Reintroduction programme for staff who have shielded, off sick • Digital strategy updates that includes staffing skills

		Staff ability to provide care due to a lack of digital skills BAME patients and staff affected disproportionately from COVID leading to additional sickness and staff disenfranchisement	How are we ensuring staff and patients with protected characteristics are protected from the effects of COVID?	
	Testing	Staff shortages and delays in treatment due to issues with pathology	How are we ensuring both our staff and patients are receiving timely testing and results both for COVID and non COVID issues?	• Revised safer staffing policy and dashboard showing compliance • Skills matrix with training programme that highlights staff skills fitting patient need • Reintroduction programme for staff who have shielded, off sick • Digital strategy updates that includes staffing skills
	Health and well-being	Staffing shortages, sickness, breakdowns and early retirements due to poor health and wellbeing support	How are we protecting staff health and well-being?	• A health and well-being plan that includes support in work, outside of work and seeing the impact of this on staffing metrics
	Patient safety	Incidents occur that could have been prevented and are not learned from	How do we know our patients are not coming to unnecessary harm?	• Incident theme reports with lessons learned and immediate actions taken to prevent further harm • Audits to show lessons learnt have been imbedded and showing improvement
Effective	Legal	Decisions are taken in clinical care that are inappropriate leading to litigation, which has an effect on the organisation's indemnity insurance	How do we know clinical decisions being taken are appropriate?	• Audits of clinical treatment provided shows in keeping with guidance • Lack of complaints • Lack of litigation • Assurance from NHSR

	Clinical effectiveness	Clinicians treat outside of clinical guidelines and standards, leading to poor quality care and potential litigation Avoidable patient deaths of both COVID and non-COVID patients	How are we ensuring care is provided within clinical guidelines? How do we know we are not causing avoidable deaths?	• Take up of guidelines • Audits on guideline adherence • Incident reporting • Mortality rates broken down between COVID and non-COVID • Mortality reviews • Incident reporting
Caring	Patient experience	Patients suffer a poor death such as being in pain, not in the place of preference, and lacking emotional support Patient receive do not resuscitate (DNACPR) orders against their wishes or vice versa Families not informed or involved in patient treatment leading to complaints and litigation Fundamental standards of care are not adhered to leading to poor quality care, complaints and litigation	How are we ensuring our patients have a dignified death? How are we ensuring families are involved and informed about patient progress? How do we know fundamental standards of care are being adhered to?	• End of life plans. Audits to show plans are in place and adhered to • DNACPR policy amended in light of COVID • Complaints data • Communications policy • Records audits • Safety thermometer audits. Incident reports • Patient feedback
Responsive	Capacity	Service capacity becomes overstretched so admissions are delayed or diverted Beds are not available for patients' specific needs due to under- or over-availability of COVID beds	How are we ensuring we have enough and the right resources to match demand?	• Demand and capacity modelling for during and post pandemic • Operational plan that fits with demand and capacity modelling for closing and opening up services in order of priority • Performance dashboard that shows peaks and troughs are being managed

	Performance	Patients come to harm due to delays/suspension in non-urgent care Waiting lists grow to a point that it takes much longer than anticipated to regain control on targets in time for commissioners	How are we ensuring patients are not coming to harm while they are waiting for treatment? How are we maintaining a grip on constitutional standards? Are patients that require immediate and urgent treatment being seen?	• Clinical harm reviews on waiting lists that highlight no harms or, if harms highlighted, appointments are booked • Performance reports and dashboards that highlight issues with plans in how they will be addressed • Operational plan for during and post-COVID that gives a trajectory for meeting constitutional standards
	Communication	Stakeholders don't understand the organisation's messaging, causing complaints and reputational damage	How are we communicating with our stakeholders so that they are both informed and consulted in how we are caring for patients?	• Communication strategy and COVID plan that links with the organisation's risk appetite • Lack of complaints
Well-led	Digital and innovation	The organisation is ill-prepared for moving to a more digital way of working leading to lack of efficient and lower quality of care	How we ensure we retain the benefits of innovations brought about during the pandemic? How are we planning to support innovations with the use of digital technology?	• Digital strategy that includes scope for rapid advancement of online appointments, advice and guidance etc, and how staff will be trained to ensure competency in provision • Assessment through QI programme of digital innovations to ensure they are adding value for patients, staff and the trust
	Finance and risk	Financial decisions cannot be justified and lead to post-COVID scrutiny and sanctions Risks related to COVID are not managed appropriately leading to unanticipated consequences	How do we know our COVID related procurement is in line with trust policy? Are we assured that trust procurement policy is aligned with national guidance? How are we managing the risks relating to COVID?	• SFIs/SFOs and scheme of delegation that have appropriate delegated purchasing and decision making powers • Financial report on major purchases that are within the scheme of delegation and SFIs/SFOs • Financial auditing that highlights appropriate practice being adhered to

			How are we ensuring risks not related to COVID are still being managed appropriately?	• BAF, CRR and local risk registers updated to reflect COVID • Actions in place and completed to mitigate risks in a timely fashion

Examples

Workforce

A good example of a staffing plan is Barking, Havering and Redbridge NHS Trust. This may include a calculation of staff reduction scenarios, demand modelling, decision-making tools and redeployment escalation with sub-set divisional plans.

Health and well-being

Many organisations have introduced initiatives to support their staff, such as arranging discounts on top of what is already offered via NHS Discounts, stress rooms and having their own market on premises so staff can shop on-site rather than having to visit the supermarket. NHS Employers have a national tool hub for the health and well-being of staff[2]. Assurance will need to be sought that efforts are not just being explored and enacted but that there is evidence that they are having an impact on staff health and well-being.

Mersey Care NHS Foundation Trust is using a culture of care barometer to measure staff health and well-being.

Tavistock and Portman NHS Foundation Trust and Maudsley Learning have combined to produce a free learning session that deals with the psychological impact of COVID-19[3].

North Middlesex University Hospital NHS Trust has in place ethical panels that meet three times a week. These have non-executive directors as well as management staff to deal with issues such as:

- critical care becoming too full and its criteria for admission such as co-morbidities, underlying issues
- communication with patients, next of kin, and family, such as visiting rights
- survival rates of ICU comparison nationally and internationally
- impact on staff welfare when death rates are high

Clinical effectiveness

Mid and South Essex NHS Foundation Trust have established a clinical advisory group to ensure existing practice and any changes to it are in line with national guidelines.

Communication

University Hospitals of Morecambe Bay NHS Foundation Trust has introduced iPads for patients to communicate with their loved ones via a video conferencing app called Jitsi.

2. Support available for NHS staff, NHS Employers (18 June 2020), https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/support-available-for-nhs-staff#Carers
3. Integrating Care: Depression, Anxiety and Physical Illness, Future Learn (accessed June 2020), https://www.futurelearn.com/courses/integrating-mental-and-physical-health-depression-and-anxiety

Digital and Innovation

A number of trusts have joined the #Nogoingback campaign, which is a platform that enables organisations to share their innovations during COVID-19.

Oxford University Hospitals NHS Foundation Trust has utilised its CEO report to board to highlight how digital transformation has changed the way it provides care and how it benchmarks in areas such as video conferring utilisation.

Key challenges for the NHS quality committees during reset/recovery and post-COVID-19

Post-COVID there should be an impact assessment of the changes made to the organisation in response to the pandemic, such as staff health and well-being, waiting lists, A&E usage, and partnership working.

Non-executive directors will need to readjust the balance during the reset/recovery phase between support and scrutiny of executive management.

CQC Domain	Topic	Risk	Key questions	Examples of good assurance
Safe	Workforce	A large number of staff go on leave or retire post-COVID leading to unsafe staffing levels The organisation loses the volunteers it gained as part of COVID, leading to a poorer patient experience and additional workload on employed staff	How is the organisation ensuring it retains a safe staffing levels post-pandemic? How will the organisation retain the volunteers it gained during COVID?	• Safe staffing plan for post-pandemic that includes plans for annual leave and retention of staff via health and well-being programmes and redeployments. • A volunteer retention programme with professional management in place
Responsive	Estate	The estate of the organisation does not have enough flexibility to deal with patient demand changes, leading to issues of capacity and safety	How is the organisation's estate prepared for the future?	• Estate strategy and plan that shows how the estate can be used flexibly and change with differences in patient demand
Well-led	Risk	The organisation is ill-prepared for a second wave of COVID infections, leading to lack of capacity and safety compromises	What are the organisation's plans for dealing with a future second wave of infections?	• Updated emergency preparedness and business continuity plan that shows how the organisation would prepare for a second wave • CQC inspection preparedness plan

		The organisation does not return to the new normal fast or effectively enough, leading to scrutiny from commissioners and regulators	How is the organisation prepared for a CQC inspection or oversight from commissioners?	• Updated BAF and risk registers that deal with a second wave and potential risks with an inspection with mitigations and actions
	Emergency preparedness and continuity	The organisation does not take learning from COVID in preparing for future outbreaks or emergencies leading to negative impact of future emergencies	How have we updated our plans for future emergencies?	• Updated emergency preparedness and continuity plans which highlights learning from COVID
	Strategy	The organisation does not adjust its strategy in light of COVID, leading to an inappropriate direction	What has changed in our trust strategy in light of COVID?	• Updated organisational and underpinning strategies that take into account changes due to COVID i.e. increased digitalisation
	Finance	The organisation cannot sufficiently reduce its spend from pandemic levels, leading to deficits and therefore rationalisation of services The organisation does not take the opportunities of COVID to inform rationalisation and efficiency savings	How are we planning to return to a financial normality? What efficiencies is the organisation retaining from the COVID pandemic?	• Revised finance plan and trajectories to show return to or improvement on pre-COVID levels • Impact assessment on changes from COVID highlighting those being retained, removed or amended • Capital plans for procurement or retention of technology advancements during COVID

Next Steps

A Quality Committee Matrix will be produced in two to three months' time to take into account the reset/recovery phase so it is clearer what a mature Quality Committee will look like.

Key Actions:

1. Ensure patients and staff are safe
2. Learn the lessons from COVID in respect of the changes it has made to the organisation
3. Plan for reset/recovery as early as possible

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