Meeting Date	**18 April 2019**	**Agenda Item**	**5.3**
Report Title	**Quality Governance Review**		
Report Author	Jacqui Maunder, Governance Support		
Report Sponsor	Pam Wenger, Director of Corporate Governance/Board Secretary		
Presented by	Pam Wenger, Director of Corporate Governance/Board Secretary		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to update the Forum on plans to review the quality governance arrangements supporting the Quality and Patient Safety Forum, taking into account feedback from the Wales Audit Office (WAO) Structured Assessment 2018 report and feedback from the Health Inspectorate Wales (HIW) report into the Kris Wade inquiry. The report also requests that the Forum approve the updated terms of reference and agrees to review the structure, remit and terms of reference for the supporting sub group structure.		
Key Issues	• To ensure effective governance the Terms of Reference for the Quality & Patient Safety Forum are reviewed annually and presented for approval • Following receipt of a number of external inspection reports in relation SBUHB it is proposed that a review of the quality governance supporting structures in place is undertaken, to include reviewing terms of reference and reporting requirements • the Welsh Government is bringing forward legislation which proposes, to create a new overarching duty of quality on the Welsh Ministers and NHS bodies to exercise their functions in relation to the health service with a view to securing improvement in the quality of services. The Quality and Governance in Health and Care (Wales) Bill is likely to be introduced in late 2019.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☒	☐	☒
Recommendations	Members are asked to: • **NOTE** the report; • **APPROVE** the updated terms of reference for the Quality & Patient Safety Forum;			

	• **AGREE** to review the quality governance supporting structures in place, to include reviewing the terms of reference and reporting requirements.

Quality Governance Review

1. INTRODUCTION

The purpose of this report is to update the Quality & Safety Committee on plans to review the quality governance arrangements supporting the Quality and Patient Safety Forum, taking into account feedback from the Wales Audit Office (WAO) Structured Assessment 2018 report and feedback from the Health Inspectorate Wales (HIW) report into the Kris Wade inquiry. The report also requests that the Committee notes the current draft terms of reference and supports the review described in this report.

2. BACKGROUND

Quality Governance is defined as being 'the combination of structures and processes at and below Board level to lead on Health Board-wide quality performance including:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best practice; and
- identifying and managing risks to quality of care.

2.1 External Inspection Feedback

Following receipt of a number of external inspection reports work has begun to review the terms of reference for the Quality and Patient Safety Forum. The external inspections specifically relate to:

- the Health Inspectorate Wales (HIW) review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled the employment of, and allegations made against former employee Kris Wade[1] and the Special report published on 29 January 2019, and the Health Board's draft improvement plan submitted to Welsh Government. The HIW report identified weaknesses in the quality and safety governance arrangements at the health board.
- The Wales Audit Office (WAO) Structured Assessment 2018[2] Abertawe Bro Morgannwg University Health Board report which made recommendations concerning the Quality & Safety Committee:
    - Rebalancing the work plan, for more systematic coverage of key aspects of quality governance, including closer oversight of the quality strategy and implementation of agreed quality priorities, both of which are due for updating;

[1] HIW) review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled the employment of, and allegations made against former employee Kris Wade http://hiw.org.uk/news/SpecialreviewKrisWade?lang=en

[2] Wales Audit Office (WAO) Structured Assessment 2018[2] Abertawe Bro Morgannwg University Health Board report http://www.audit.wales/publication/abertawe-bro-morgannwg-university-health-board-structured-assessment-2018

- Improving pre-meeting agenda management, to include briefing the Committee Chair and review of papers, to ensure clarity on the purpose of the items presented;
- Providing a stronger risk based approach to scrutiny of issues;
- Ensuring the format of papers is consistent with the new report template and that the content provides clearer identification of risks and assurances. This includes report from the Quality & Safety (Q&S) forum.

2.2. Review of Quality Governance

To enable the Quality & Safety Committee to fulfil its terms of reference, discharge its functions appropriately and assert the level of scrutiny required to gain assurance in relation to the health board's opportunity to deliver safe care, it is proposed that the supporting sub structures reporting to the Quality & Patient Safety forum are reviewed and strengthened as part of the review of the forum's terms of reference.

The draft updated Terms of Reference for the Quality & Patient Safety Forum are presented at **Appendix 1** for reference.

The review will include:

- Reviewing the quality governance sub structure supporting the Quality & Patient Safety forum – see **Appendix 1, sub appendix 1.2.**
- Reviewing the role and remit of each sub group and if there is still a need for such a group or whether there are alternative assurance reporting opportunities
- Reviewing the Terms of reference for each sub group – to include frequency of meetings, role of the Chair, membership (see **Appendix 1, sub appendix 1.3)**, reporting lines and format of reporting
- Shifting the remit of the Learning and Improvement group to focus on sharing learning in accordance with external inspection feedback and considering how this can be undertaken
- Developing the role of the new Clinical Senate and its contribution to quality governance and the setting of quality priorities for 2019-2020.
- Confirming where responsibility for reviewing and ratifying clinical policies should sit – Clinical senate or Q,S&P forum

To assist the sub group leads in reviewing the quality governance sub structure supporting the Quality & Patient Safety forum a questionnaire has been produced to collate information to gain a better understanding of each group's role – see **Appendix 1, sub appendix 1.4**. All leads are requested to complete the questionnaire and email it to Jacqueline.Maunder@Wales.nhs.uk , Interim Head of Compliance by **Friday 3 May 2019.**

2.3Timeline

The time line for undertaking the quality governance review is outlined below:

Date	Meeting/Task	Action
23 April 2019	Quality, Safety and Patient Safety Forum Meeting/Workshop	• Meeting/Workshop to discuss supporting sub structures • Request all leads to complete questionnaire**.**
3 May 2019	Deadline for Sending completed questionnaire in	• All sub group leads to complete questionnaire to support the quality governance review.
21 May 2019	Quality & Patient Safety Forum meeting	• Approve Q&PS Forum TOR • Agree Q&PS Forum quality governance sub structure
20 June 2019	Quality & Safety Committee	• Update on quality governance review and approved TOR and new sub structure
25 June 2019 **23 July 2019** **27 Aug 2019** **27 Sept 2019** **29 Oct 2019** **26 Nov 2019** **17 Dec 2019**	Quality & Patient Safety Forum meetings	• Update report from each supporting sub group
May 2020	Annual review of Q&PS Forum TOR and TOR for sub groups	• Approve Q&PS Forum TOR • Approve Q&PS sub group TOR

3. GOVERNANCE AND RISK ISSUES

The Quality & Patient Safety Forum supports the Quality and Safety Committee to fulfil its purpose to provide:

- evidence based and timely advice to the board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and,
- assurance to the board in relation to the health board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

The Committee through its sub groups monitor the following functions related to quality and patient safety:

- **Compliance with legislation and regulation**: e.g. the Nurse Staffing Levels (Wales) Act, 2016, Putting Things Right (PTR) including redress & clinical negligence, safeguarding & public protection, health and safety, external regulatory frameworks including Health Inspectorate Wales, regulatory notices issued by HM Coroner, recommendations made by the Public Services Ombudsman for Wales (PSOW)
- **Quality planning:** e.g. via the Annual Plan, demonstrating learning and using a quality dashboard based on robust data analysis, through robust public engagement and patient experience, based on understanding population health, principles of equality and diversity, workforce development and wellbeing
- **Quality improvement**: e.g. clinical effectiveness via research, audit, implementation of NICE guidelines professional and service specific standards, learning, education & training, research & development, medicines management, organisation-wide and national sharing of learning
- **Quality assurance**: e.g. improvements using learning generated by internal and external scrutiny, including those undertaken by HIW, Community Health Council (CHC), and other regulatory, speciality, service specific and professional standards, mortality review, evidence based policies and protocols
- **Managing risk** e.g. assessing, understanding and articulating risk via risk registers, infection prevention and control, decontamination, clinical incident reporting and investigation, managing concerns, implementation of patient safety solutions alerts and notices applying learning
- **Duty of Candour -** Regulated professionals are already expected to practice within their Code of Conduct, all of which identify duty of candour as a core requirement. Professional bodies and Royal Colleges actively endorse this and the all Wales 'Procedure for NHS Wales Staff to Raise Concerns Policy' sets clear direction in relation to this matter.

Reviewing the quality governance sub structure supporting the Quality & Patient Safety Forum will strengthen governance and assurance for SBUHB.

It is also important to acknowledge that the Welsh Government is bringing forward legislation which proposes, to create a new overarching duty of quality on the Welsh Ministers and NHS bodies to exercise their functions in relation to the health service with a view to securing improvement in the quality of services. The Bill will include:

- introducing a statutory duty of candour;
- replacing the current Community Health Councils with a new Citizen Voice Body; and
- enabling the appointment of Vice Chairs to NHS Trusts;

The Quality and Governance in Health and Care (Wales) Bill will be formally introduced in year 3 of the Assembly term (i.e. before July 2019) and it will go through a number of stages before it becomes an Act. Once the legislation is enacted all NHS bodies will be required to review and amend their quality governance arrangements to ensure compliance.

4. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the report;
- **APPROVE** the updated terms of reference for the Quality & Patient Safety Forum;
- **AGREE** to review the quality governance supporting structures in place, to include reviewing the terms of reference and reporting requirements.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
This report provides assurance to the board in relation to the health board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.		
Financial Implications		
There are no direct financial implications arising from this report.		
Legal Implications (including equality and diversity assessment)		
NHS Wales Health and Care Standards, Welsh Government, April 2015 http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf . **Welsh Health Circular (WHC/2019/007) Annual Quality Statement 2018/2019 guidance** **The Wellbeing of Future Generations (Wales) Act** **Written Statement - Prosperity for all – the national strategy: The Welsh Government's well-being objectives (2017)**		

https://gov.wales/about/cabinet/cabinetstatements/2017/prosperitforallwellbeingstatement/?lang=en linked to the 7 wellbeing goals within the Future Generations Act and focusses on how services are delivered, as well as what is being delivered.

Social Services and Wellbeing (Wales) Act 2014

Nurse Staffing levels (Wales) Act 2016

The Parliamentary Review of Health and Social care in Wales
https://beta.gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf presented the case for change, and a demand for a new approach to maintain and improve the quality of health and care, as a result of the impact of a growing and changing pattern of need, expectations of services, and the challenge of securing a future workforce.

Putting Things Right guidance, 2013,
http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20%20CLEAN%20VERSION%20%20-%2020140122.pdf This guidance is produced for the NHS in Wales to enable responsible bodies to effectively handle concerns according to the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations").

Framework for Assuring Service User Experience, 2015
http://www.wales.nhs.uk/sitesplus/documents/1064/Healthcare%20Quality%20-%20FINAL%20ENGLISH%20-%2025789_Revised%20Framework%20for%20Assuring%20Service%20User%20Experience_E_WEB.pdf The framework has been updated following Keith Evans' report "Using the Gift of Complaints" and now links with the amended Health and Care Standards which include a standard to promote listening and learning from feedback.

Listening & learning to improve the experience of care, 2015
http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Listening%20and%20Learning%20to%20Improve%20the%20Experience%20of%20Care.pdf Identifies that all patients should be given opportunities to give feedback, without recourse to the concerns process, and more extensive spread of the Framework beyond secondary care is needed. The value of triangulating staff feedback with patient feedback and other relevant information should be exploited as part of the approach to assuring and improving the patient experience.

NHS Wales National Clinical Audit and Outcome Review Plan 2018-19
https://gov.wales/topics/health/publications/health/reports/clinical-audit/?lang=en Clinical audit is one of our main priorities to improve patient care in Wales. Results of these audits provide us with an insight into the quality of care provided and how improvements are being implemented.

Staffing Implications

There are no direct staffing implications arising from this report.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

This report provides assurance to the board in relation to the health board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales balancing short-term needs with the need to safeguard the ability to also meet long-term needs.

Report History	External Inspection Report, Quality, Safety & Risk Committee, 21 February 2019
Appendices	**Appendix 1** 1.1 updated Terms of Reference for the Quality & Patient Safety Forum, 1.2 Quality governance sub structure, 1.3 List of membership and attendees 1.4 Review of Quality Governance questionnaire