NHS
The Royal Wolverhampton
NHS Trust

Minutes of the Quality Governance Assurance Committee
5 November 2018

Agenda Item No: 12.6

Minutes of the Quality Governance Assurance Committee

held on the:

Date **Wednesday 19 September 2018**

Venue **Room 6, WMI**

Time **2.00pm to 4.00pm**

	Name	**Role**
Present:	R Edwards **(RE)** - Chair	Non-Executive Director
	P Archer **(PA)**	Patient Safety & Shared Learning Associate
	M Arthur **(MA)**	Head of Governance & Legal Services
	A M Cannaby **(AMC)**	Chief Nursing Officer
	G Nuttall **(GN)**	Chief Operating Officer
	J Small **(JS)**	Non-Executive Director
Attendees:	K Wilshere **(KW) –** via Skype	Company Secretary
Apologies:	D Loughton	Chief Executive
	Dr J Odum	Medical Director

Item No		Action
1	**Apologies for absence** Apologies were noted.	
1a	**Declarations of Interest** There were no Declarations of Interest.	
2	**Minutes of Previous Meeting - Quality Governance Assurance Committee:** **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 25 July 2018 were approved as a correct record.**	
3	**Matters arising from the Minutes** The action log was updated accordingly.	
4	**Regular Reports**	
4.1	**Integrated Quality & Performance Report – August – AM Cannaby & G Nuttall** AMC advised the meeting that a lot of reports were waiting for exempts. There has been a change in the clinical way that is reported to the Executives, concerning the actions to reduce the delays in completing reports into Serious Incidents, AMC said that changes in the way of reporting meant there was no longer any bottlenecks at the Executive level. At Divisional level there are approximately 6 or 7 that have breached; work is on-going to ensure that investigations have been done. Some of the cases are complex and the CCG are aware of the issues. Plans are in place to close everything by the end of September. AMC informed the meeting that she feels half will be closed the others will be closed within a further 2 to 3 weeks. Incidents that are being added to the SUI Register now are being picked up in a timely way. AMC advised the meeting that there are two main issues, the first being August holidays and secondly there is still an issue around people wanting to do RCA's and how this can be added into job plans, how to encourage staff to do that etc. There is a list of SUI's and these are being monitored weekly, CCG are involved in everything and AMC is hopeful that over the next 4 to 6 weeks these are resolved. RE asked how other Trusts encourage staff to do RCA's. AMC replied that some Trusts put RCAs into job plans where they are built into admin time, some offer financial incentives. AMC was pleased to report that there is a slight improvement in the VTE Risk Assessments. VTE's were set at 95% by the end of March. AMC confirmed that a lot of work has been undertaken on AMU on closing VTE assessments off. AMC mentioned that there is an issue with BadgerNet, which is the new Maternity system. The meeting was informed that the VTE's are being completed however; they are not flowing through the electronic system. The Trust IT department have been trying to rectify the issues. There is also an issue within ED and Stroke unit because they are on different systems.	

Item No		Action
	Plans are in place to ensure the data is captured until the IT issues are resolved and these may include capturing the data on paper and then add to the system. On SEU some of the Specialist Nurses are starting to do some of the VTE's. AMC mentioned that there were five C-Diff cases in August, three of these were on Ward C19. RCA's conducted indicate that the strain was environmental and AMC assured the committee that a deep clean process was being undertaken. Ward C19 was moved 2 weeks ago and was deep cleaned. AMC advised the meeting that a lot of work had been undertaken in regards to recruitment. Over the next couple of months qualified nurses and HCA's will commence work within the Trust. This will leave approximately 150 / 160 vacancies across the Trust. There are no vacancies within maternity, Neo-natal have vacancies but these can be filled by Midwives. Clair Hobbs, Head of Nursing for Division 1 has reported only 5 vacancies within Surgery Division. Unfortunately recruitment within the Stroke Unit was not as successful, 3 nurses did not arrive and a couple of nurses are leaving the Unit. There is an acute problem on Ward C16 for a number of reasons. Division 2 (Medicine) requires a lot of work; however, AMC did assure the meeting that recruitment is going in the right direction. JS asked where the staff are coming from. AMC advised that a number are newly qualified. There is zero tolerance of unfilled HCA positions. This is helped by potential recruits hearing through word of mouth that the Trust is an excellent place to work. AMC does not think that full recruitment will be resolved until next summer. Clinical Fellowship work has commenced; AMC thought it would particularly attract recruits internationally. The meeting discussed the Trust mortality and were advised by AMC that there are currently 400 SJR1's outstanding and these are to be reviewed. There are approximately 50 SJR2's outstanding, however as the SJR1's are being completed these may then be escalated to SJR2's and will then cause these to increase. AMC advised that these will need to be monitored carefully. AMC reported to the meeting that following the visit of an external visitor on Monday, the Board were advised that Sepsis is not on the Trust dashboard, this has now been corrected. AMC explained the Sepsis Six to the meeting which is used in the Emergency Department and the acute inpatient departments. It is known that within the Emergency Department the delivery of the antibiotic care within the first hour is not happening. GN, Sepsis lead Consultants and some nurses have developed a business case for two new nurses (band 6 & 7) to concentrate on making sure things are actioned as they should along the Sepsis pathway. A new Vitalpac solution is being tested that has components in it which contain a Sepsis package so information can be collected electronically. The CQUINs need to be met by the end of March. AMC is hopefully that the jobs will be advertised within the week. GN delivered the performance part of the report by exception as the report was discussed in-depth at the Finance & Performance meeting earlier in the day. The meeting noted that in August performance within urgent care was improved and the Trust is now in the top 30 nationally for the improvement, even though it is still below the Trust target of 95%. GN advised the meeting of the two patients who breached the 12 hour target during August. These were two males with mental health issues, one was transferred to London and one was found a bed locally. There is a national crisis for male mental health beds and this is due to high demand and less beds. The CCG have requested a meeting with the Mental Health Trust – Black Country Partnership and this Trust to see if assessment processes can be speeded up. GN advised that following a meeting in Birmingham last week the main issue is staffing due to the inability to recruit nurses in particular.	

Item No		Action
	GN brought to the attention of the meeting and suggested a discussion should be held at Trust Board in regards to ambulance conveyances. GN reported that there is a 6% difference in figures between August 2018 and August 2017. GN advised the meeting that following a CQC visit Russells Hall, Dudley have been asked to review the provision of their Emergency Department overnight. Shrewsbury & Telford are making a recommendation to their Trust Board to close one or both or neither of their two Emergency Departments at night. The potential closures of these three Emergency Departments will have a significant effect on Sandwell (Russell's Hall), Wolverhampton and Queen Elizabeth, Birmingham. Should Shrewsbury & Telford close that will have a massive impact on this Trust. GN assured the meeting that this is being factored into the Trust winter planning. The CCG are aware of the potential risk to the Trust and this was raised at the Delivery Board. GN to review the risk registers and once a decision has been on Shrewsbury & Telford this will need to be monitored carefully. It was agreed to discuss further at Trust Board. GN reported to the meeting that cancer performance had not improved and GN does not think it will for a further six months. The meeting was assured that there are lots of actions and pathways in place to resolve the issue. GN advised that there is current a 6 to 10% increase on referrals into the two week wait. The target figure of 105 patients treated has had to be increased to 118 patients to keep up with the demand and start to reduce the backlog on the 62 day pathway. Issues within the Cancer specialities include capacity and staffing challenges. Additional support is being provided by the Cancer Alliance who are meeting with the Trust cancer leads to discuss the pathways. Administrative staff have been increased within the Cancer Team to help track the patients and this has been funded in the short term by Cancer Alliance. Urology are currently treating more patients than ever, unfortunately even so a lot of the patients treated are in breach. RE asked if any links had been identified between the cancer delays and Trust mortality. AMC advised that harm reviews had been completed for June when no harms had been identified and were underway for July. It was found that additional support is required for the Clinicians. AMC to meet with GN outside of the meeting to discuss further. AMC said that there had been one alert for cancer, concerning cardio-thoracic regarding lung resection in 2016 and the team had completed the review on this. The meeting discussed cancer targets / mortality further and were assured that this is being monitored and the Directorates have undertaken mortality reviews of each death. RE commented on the Friends & Family Test and noted that there was a far better response rate in recent months and the Trust was within 0.4% of the all England rate. AMC replied that a lot of work has been undertaken. AMC explained to the meeting what processes are in place now to encourage people to respond. JS mentioned that the dashboard works much better and alerts you to any issues and can scan and look at issues. **Resolved: Report was accepted**	

4.2	**Board Assurance Framework Key Issues – K Wilshere (via Skype)** KW advised the meeting via Skype that: There was 1 new Red risk, no new risks closed and 3 existing red risks: **SR1** – Workforce – Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff. **SR8** – That there is a failure to deliver recurrent CIPs. **SR9** – That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus. New risk **SR12** - Mortality: deaths are occurring that could and/or should have been prevented and/or that the trust death rate does not accurately reflect the clinical care at the trust. This had been reviewed and agreed by the Medical Director. It was agreed that it should go to Trust Board as it is, that further work was needed on it to make sure that it fully reflected all the actions in the action plan, which was being further developed and worked on. RE commented that controls C7, 8, 9 10 include evidence which should be under the section "positive assurances". This risk will be monitored at QGAC. Updates completed to **SR1; SR6b, SR9** and **SR11** are under review for updates. KW advised the meeting that he is in the process of reformatting the BAF to make it clearer and also to ensure that controls and evidence were correctly described and allocated. The meeting agreed that this was an improvement.	
4.3	**Trust Risk Register Key Issues – M Arthur** MA advised that there are 32 risks on the Trust Risk Register. **3 new risks:** **5012 -** External/temporary pacing boxes (COO) **4547 -** Emergency Department with potential safeguarding issues (COO) **5097 - I**mplementing the new Agenda for Change pay deal (CFO) All of the above are populated and amber graded. **4 risks removed:** **4849 -** CT reporting (COO) **4862 - I**ncrease in demand for Neonatal cots at level 1, 2, 3. (COO) – this risk has been merged into a new risk and is currently awaiting Divisional sign off. **4962** - NNU Staffing - Neonatal Workforce (COO) **4841** - Risk of CPE becoming endemic in clinical areas (CNO) **5 red risks:** **2080** - Risk to quality of patient care: reduced manpower (COO) – there has been positive assurance and actions added to this risk – the grade remains the same. **4661** - Lack of robust system for review and communication of test results (MD) – there are three new actions added to this risk. There have not been many updates on the controls but when the policy is audited this should be amended. There have been no incidents that MA is aware of. **4472** - Delays in Cubicle Assessment and Triage (COO) – this has had positive assurance,	

	actions and monitoring controls added in. **4113** - Division 1 failure to achieve CIP target (COO) – further actions have been added, no assurance reported on this month and remains red. **4903** - Risk of non-compliance with Thoracic Service Specification (COO) – there has been updates around assurance and actions. All of the above have been updated. MA commented that there has not been enough movement with the red risks to warrant changing the grade. GN feels that **4903** can have the grade reviewed and managed at a Directorate level. This can be re-escalated if there are any changes. **5045** – Sepsis: the description was too long and has now been reduced to two paragraphs. A business case has been developed for 2 sepsis nurses and AMC confirmed it had been approved. " **4734** – mortality: MA advised that JO had recommended that this risk is to be reviewed in light of the new BAF risk." **1713** – JS asked about the update to Audit Committee due in September. RE advised that an update on the Internal Audit results will be given at Audit Committee on Monday 24 September which she would be attending. This risk should be updated after that and she will also be able to report back verbally at the next meeting on the view taken by Audit Committee." **4528** – patients' notes: JS asked what progress had been made as this risk had been unchanged for a long time. GN to chase for an update. **4706** – RE asked how the actions under "what else we can do" would improve the position in Theatres. GN confirmed that action is being undertaken and not reflected in the risk. Estates are planning to undertake further work within Theatres that is linked to this risk. The risk needs to be updated. **5012** – JS asked if this was an internal or supplier issue and if it is what are the Trust doing to alert suppliers. AMC advised that there has been an issue around training which has been resolved; an issue around wires and this has been resolved. Maintenance has also been resolved. AMC contacted Kelly Emmerson (Healthcare Governance Manager – Division 2) to ask if this risk could be de-escalated, Kelly advised that she would take back to the Division for approval. MA to forward the risk update to QGAC members, AMC advised the meeting that she is meeting with the three Healthcare Governance Managers monthly to review the TRR and update as and when.	**GN** **GN** **MA**
5	**Sub Group Reports**	
5.1	**Chairman's Report – Quality & Safety Intelligence Group (QSIG) – July 2018 – A M Cannaby** **<u>e-PMA</u>** – A bid for hardware to aid implementation is being placed with NHS Improvement. This will enable timely user access. **<u>Future RCA process and 48 hour report</u>** – Discussions with CCG continue around reporting SUIs in line with National framework, the requirement for a 48/72 hr report as and when requested only. Trust to determine the necessary internal process to facilitate RCA production and this will be taken forward in consultation with CCG.	

	VTE – Work underway (outside QSIG) to review arrangements and recorded targets for VTE (4 and 24 hour). **External review** – all divisions have been challenged to oversee the progress of actions following external reviews. These were reported to be on agendas for upcoming Divisional Governance meetings - some pending closure. **Mortality review** – All Divisions challenged to monitor improvements on Mortality review returns. **Leadership Walkabout Report** – review planned. **Quality Review visits** – Community and VI practices carry out local peer reviews and self-assessment respectively. Future plan is to integrate Community visits with the Trust QRV programme and move away from self-assessment in VI practices to improve independent assurance. **Division 1 reported highlights -:** Spike in medication incidents to be presented/reviewed at Divisional Governance to understand issues and report back. Sustained late observation compliance (no red wards) – for past 3 months 100% WHO compliance reported in June 18 Decreased Documentation audit compliance to be monitored by Division Compliance concerns with VTE within 24hrs – an improvement plan to be developed. **Division 2 reported highlights-:** Decrease in medication incidents and zero medication errors in June 18 Significant reduction in overdue SUI action with work ongoing **Division 3 reported highlights-:** Reported concern over backlog of non-urgent imaging studies unreported. Progress made reduced 7332 May 2017 to less than 3673 in June 2018. To reduce IG incidents within Community plans are in place to obtain electronic devices for Community staff. Awaiting CQC report following visit to 4 practices in July **Resolved: Report was accepted.**	
5.2	**Quality & Safety Intelligence Group minutes – July 2018** The meeting accepted the minutes from the July meeting.	
5.3	**Chairman's Report – Quality & Safety Intelligence Group (QSIG) – August 2018 – A M Cannaby** **QRV annual evaluation report** – A comprehensive evaluation of QRVs undertaken between April 17 to March 18 reported that Caring had three 'outstanding' and no 'requires improvement' ratings. Safe domain had the most ratings of 'requires improvement' and all areas revisited have shown an improvement. Concerns were discussed about the number of red actions overdue follow QRV. These were to be escalated for local action and for Divisional monitoring.	

	RCA delays in completion – The meeting discussed delays in RCAs being completed to timescale and noted the following issue: • not all staff trained to undertake an RCA will agree to undertake/lead an RCA. • Often same staff frequently asked to lead RCAs • Acknowledged that conducting an RCA investigating was time consuming and not incorporated in job plans. The issue of identifying adequate staff and time to complete RCA was to be considered by Divisions. A central role to support the RCA process is being but will still require Divisional RCA investigators. **Evaluation of new meeting structure –** As part of the 3 month evaluation of the new meeting structure, it was requested to obtain Divisional input/feedback. A short survey from Divisional QSIG members (9 issued 5 returned) was discussed and it was agreed that three months was too early to evaluate the meeting. It was acknowledged that the reports from the 3 divisions and the information provided to the QSIG meeting, was good. The divisions would seek to reduce duplication of information it produced for QSIG and TMC. **SUI outstanding actions** – Improvements made across all Divisions in reducing the number of overdue SUI actions. **Mortality returns** – Targeted work continues across Divisions to improve and increase mortality review returns. **Audit plans** – Audit plans are slightly behind schedule at Q1 but are subject to routine and ongoing review and monitoring. **104 Day Harm Review** – the meeting received a report on the new process for reviewing patients waiting 104 days or more for their first Cancer treatment. The process involved the review by the Cancer Clinical lead of all patients that have gone over the 104 day wait, the review is liaised with Clinicians and the MDT leads in determining whether harm has been caused. A monthly meeting is chaired by the Chief nurse along with Cancer lead specialists (nursing and medical), CCG, Governance (and GP to join shortly) to discuss decisions on harm that is then reported to QSIG. Currently the 104 Day Harm Review was mandatory and it was agreed that the report would come to QSIG for the next couple of months and then review. **Divisional Dashboard reports** – Division 1 reported a high amber risk to be taken to Division in September. This related to the Sonography Service being compromised due to high sickness levels and vacancy. The risk is to be approved and considered for the risk register/TRR. Division 1 – Investigation into increased medication incidents confirmed there are no concerns, no harm was associated with these incidents and it is indicative of positive reporting. RE re Division 2 - The Acute Stroke Unit (ASU) have encountered nurses leaving to work in other parts of the organisation together with recruited nurses withdrawing just prior to commencement of post. A collective staffing action plan is developed and includes daily staffing meeting, social media campaign, Matron support, increase in volunteers and nurse bank. A local task and finish group will review the skills mix for Stroke Services and Rehabilitation.	

	Division 3 – to target reducing the number of incidents that remain open on datix. **Resolved: Report was accepted.**	
5.4	**Quality & Safety Intelligence Group minutes – August 2018** The meeting accepted the minutes from the August meeting. RE referred to the QRV Community 6 month report, item 6.2 and asked when Skyguard had been introduced. AMC offered to find out more and inform the meeting.	**AMC**
5.5	**Chairman's Report – Compliance Oversight Group (COG) – July 2018 – G Nuttall** **<u>SUMMARY OF SIGNIFICANT ISSUES</u>** 1. **<u>VTE</u>** The meeting was advised that there was a dip in weekly VTE performance since April 2018. The Trust is required to report on VTE within 4 hours and then a second within 24 hours. Any assessment after 24 hours does not count toward the performance metric. There are challenges with additional areas to count (CDU) and also with IT – Vital Pac. Options to improve the assessment were discussed, including not moving patients from the emergency portals. RCA process was confirmed for all patients who had no VTE, to identify if any harm. Agreed for RR and GN to meet to discuss patient moves from AMU in the first instance. 2. **<u>INFECTION & PREVENTION CONTROL – 6 MONTH REPORT</u>** Six month annual report was presented for 2018/19. The Trust is currently (July 2018) below the internal C Diff target. Challenge in meeting MSSA and MRSA bacteraemia and MRSA acquisition. Deep clean programme has commenced. Business Case to support CPE testing to be presented to TMC (note – approved in July 2018). 3. **<u>NICE IMPLEMENTATION GROUP</u>** Noted that NICE policy OP56 is now a standard operating procedure. Currently a gap between Primary Care teams and NICE guidance assessment, which is being worked on. Good progress being made by the NICE group. 4. **<u>PLEURAL SERVICES GROUP</u>** Six monthly report by AS, stating one of the best reports since 2013. No SUI's and 2 Datix. Policy CP60 is due for review in January 2019. Overall, service running well with good progress being made. 5. **<u>NATIONAL EMERGENCY LAPAROTOMY AUDIT</u>** Fifth year of collecting data, report covered December 2015 – November 2016. Trust mortality was 9.6%, just less than the national average. Work required in using a pre-operative risk protection score. **Resolved: Report was accepted.**	

5.6	**Compliance Oversight Group minutes – July 2018** The meeting accepted the minutes from the July meeting.	
5.7	**Chairman's Report – Compliance Oversight Group (COG) – August 2018 – AM Cannaby** **1. Pressure Ulcer & Tissue Viability Update** Good progress has been achieved regarding avoidable pressure injuries. Adult Community Services has not reported an avoidable Stage 4 PU since September 2017, and no avoidable Stage 3 incidents since April 2018. There has also been a significant reduction in pressure injury incidents per 1000 bed days this financial year. The new categorisation of pressure ulcers was described and from October 2018, the Trust will be reporting pressure ulcers, according to the pressure ulcer consensus. Notably, the terms "avoidable" and "unavoidable" must not be used, and "omissions in care" will continue to be identified. There have been 3 retained dressing incidents which have been investigated, and similar learning outcomes were noted for each incident. A cavity wound care log tool has now been introduced to mitigate against the possibility of not identifying cavity dressings, and this issue has been escalated to QSIG with the recommendation that audits of compliance are undertaken routinely. **2. Point of Care Testing/V.1. Practices** The Roche Coaguchek point of care testing equipment is currently giving falsely lower results for INR's >4.5 than when samples are analysed in the Lab. A risk assessment has been undertaken, and any community POCT results >4.5 are now being checked in the Lab. An "All User" e-mail has been sent out to this effect, and Roche diagnostics are investigating the cause for the issue. Some of the V.I. Practices are not compliant with the Trust's POCT policy, and these are working towards partial compliance by December 2018. The issue is with the governance arrangements at the V.I. practices for example: no internal quality control; no external quality assurance; no training / competency records etc. POCT testing in mainly glucose, urinalysis, pregnancy testing and one INR meter. **3. Information Governance Report** The Trust is now using the new Data Protection & Security Toolkit (DPST) and work is currently ongoing to establish the leads for the new requirements. In addition, there is an ongoing discussion with NHS Digital as to whether there should be a separate submission for each V.I. Practice and a separate one for RWT. The total number of I.G. incidents continues to rise, with 307 incidents reported during 2017/18. However, the number of STEIS reportable incidents has fallen with only 12 being reported in 2017/18. Four incidents graded as Level 2 or greater were reported to the ICO. The themes of the incidents are unchanged. The number of FOI's has increased, as has the complexity of the information requested. This has contributed to a reduction in compliance against the response times. There are resource issues within the team to be able to respond and monitor effectively. FOI log in will move to Datix within the next few months, which should provide some improvement. It was noted despite the deterioration in compliance, no complaints had been made to the ICO.	

	4. RWT Cervical Screening Programme - July 2017 - June 2018 In April 2018 there was a screening quality assurance visit to RWT, which was largely positive, although a number of recommendations were made. **Issues of note were as follows:** a) Laboratory turnaround time to report cytology smears have fallen significantly at 5 days from 93.7% Quarter 2 2017/18 to 11.7% Quarter 1 2018/19. This is due to an increase in activity. However, at 10 days the 98% turnaround time requirement has been delivered. b) DNA rates for RWT Colposcopy follow up appointments range from 19% to 24.7% (standard< 15%). c) Between January - July 2018, six of eleven Colposcopists attended 50% or more MOT's. The standard is that all Colposcopists should attend a minimum of 50% of MOT's. This latter item has been escalated to QSIG and through the Gynaecology Directorate for action. **5. Better Births Report 2016 - National Maternity Review** The Trust is committed and engaged with the STP LMS workstream. The main issue presented to COG is in ensuring that continuity of care by Community Midwives is improved, and this remains a focus of attention. **6. Morecambe Bay Report** An update on the RWT organisational gap analysis against the recommendations made in the Morecambe Bay report was presented. All actions are in place and it was noted that the Morecambe Bay report has been superseded by the Better Births report (which is ongoing), and on this basis it was agreed to formally close further reporting against the Morecambe Bay report. **Resolved: Report was accepted.**	
5.8	**Compliance Oversight Group minutes – August 2018** The meeting accepted the minutes from the August meeting.	
6	**<u>Assurance Reporting / Themed Reviews</u>** **6.1 Mortality – A M Cannaby** AMC presented a paper in regards to Standardised Mortality Rates Summary of Trust position. AMC advised the meeting that there is a small operational group, chaired by JO, that meets on a Monday afternoon, there is also a Mortality group, incorporating the Doctors, chaired by Dr Viswanath and this is a monthly meeting. AMC acknowledged to the meeting that there is a backlog of the SJR 1's and this currently stands at approximately 400, however this figure changes daily. There is also approximately 52 SJR2's to be undertaken. AMC noted that staff have to attend training to complete an SJR2 but over the last few months things have been slowly increasing. The meeting was informed that individuals will be paid extra to do this additional work to get clear the backlog of both the SJR 1's and 2's. AMC explained to the meeting the role of the Governance department and how they co-ordinate the SJR's. The learning from the process of an SJR2 is	

	being discussed amongst a lot of Trusts. Every death is reviewed within this Trust, however some Trusts only do a selection / randomly. AMC through this Trust's approach was best and that the Medical Examiner role would speed up the reviews. She referred to the requirements of LeDeR (Learning Disabilities Mortality Review) report and would circulate it to the Committee. It was noted that Mortality is discussed at the Executive Director Group and Compliance Oversight Group. At the monthly Quality & Safety Intelligence Group each Division reports their progress against Mortality. Both COG and QSIG chairs' reports and minutes are then discussed at this meeting and then at Trust Board. AMC considered that there is a decent Governance process in place, but that mortality issues need to be more prominent at board level. AMC discussed with the meeting the coding process within the Trust. When it is audited, the coding matches the patient records. The issues raised by Dr Viswanath and Jo Cotterill (Acting Head of Clinical Coding & Data Quality) when they audit the records, are that the clinician has recorded the presenting problem rather than the diagnosis of the cause. There is a need for more education for consultants on what needs to be written in what circumstances, and a need to find the best way to do this. The meeting discussed the needs of the ageing population of Wolverhampton. It was acknowledged that the Trust has a good palliative care team and evidence that the Trust does really well in this. AMC said the trust intends to expand the palliative care team and look at increased provision of End of Life Care within the Community. AMC assured the meeting that Mortality is the main agenda item for discussion at the Executives Wednesday meeting. **6.2 Committee Self-Assessment for Effectiveness – R Edwards** RE presented the above questionnaire to the meeting. After a brief discussion RE asked CE to circulate to the committee for discussion at the next meeting. RE will circulate a note of her reflections on the self-assessment.	**AMC** **CE** **RE**
7	**Issues of Significance for the Trust Board** **Advise** Evaluation of new meeting structure New format for BAF QGAC review of effectiveness **Assurance** SUI outstanding actions Division 1 – Investigation into increased medication incidents Pleural Services Group: **Partial assurance** Mortality - new BAF risk and mortality report: IQPR Cancer waiting times 104 Day Harm Review Pressure Ulcer and Tissue Viability Update to August COG	

	VTE performance: QGAC discussed the issue raised at COG concerning the dip in weekly VTE performance since April 2018 Point of Care Testing (POCT) VI practices RWT Cervical Screening Programme - July 2017>June 2018 National Emergency Laparotomy Audit reported to COG on fifth year of collecting data, (December 2015 – November 2016). Infection and Prevention Control Report NICE implementation Report QRV annual evaluation report Delays in completion of RCAs Sonography Service **Issues for Audit Committee** QGAC identified none at this meeting.	
8	**Evaluation of Meeting – ALL** Good long discussion on Mortality.	
9	**Any Other Business – ALL** There was no other business to discuss.	
10	**<u>Date and time of Next Meeting</u>:** Wednesday 24 October 2018, 2pm to 4pm, Room 6, WMI **Please note the change of venue**	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.3 / 19.09.18	**4528** – JS asked if the datix had been updated as it has been on for a long time. GN to chase for an update.	GN	19.09.18	24.10.18	
4.3 / 19.09.18	**4706** – RE asked what else we can do with the Theatres. GN confirmed that action is being undertaken and not reflected in the risk. Estates are planning to undertake further work within Theatres that is linked to this risk. The risk needs to be updated.	GN	19.09.18	24.10.18	
4.3 / 19.09.18	**5012** – JS asked if this was an internal or supplier issue and if it is what are the Trust doing to alert suppliers. AMC advised that there has been an issue around training which has been resolved; an issue around wires and this has been resolved. Maintenance has also been resolved. AMC contacted Kelly Emmerson (Healthcare Governance Manager – Division 2) to ask if this risk could be de-escalated, Kelly advised that she would take back to the Division for approval. MA to forward the risk update to QGAC members,	MA	19.09.18	24.10.18	
5.4 / 19.09.18	RE referred to the QRV Community 6 month report, item 6.2 and asked when Skyguard had been introduced. AMC offered to find out more and inform the meeting.	AMC	19.09.18	24.10.18	
6.1 / 19.09.18	AMC referred to the requirements of LeDeR (Learning Disabilities Mortality Review) report and would circulate it to the Committee.	AMC	19.09.18	24.10.18	

6.2 / 19.09.18	**6.2 Committee Self-Assessment for Effectiveness – R Edwards** RE presented the above questionnaire to the meeting. After a brief discussion RE asked CE to circulate to the committee for discussion at the next meeting. RE will circulate a note of her reflections on the self-assessment.	CE RE	19.09.18 19.09.18	24.10.18 24.10.18	Completed
4.1 / 25.07.18	GN confirmed that she has received the report from the Intensive Support Team and will share with everyone.	GN	25.07.18	~~19.09.18~~ 24.10.18	GN confirmed that the report has been submitted to Finance & Performance and will share with this meeting. Bring forward.
4.2 / 30.05.18	**4862 –** Neonatal cots – RE asked if the business case for additional staff had been approved at the April TMC, GN confirmed that it had and the department are out to recruitment. RE asked for the action regarding comment commencing *There are ongoing incidents relating to the lack of clinical equipment etc*, GN agreed to review this.	GN	30.05.18	~~20.06.18~~ ~~25.07.18~~ ~~19.09.18~~	GN reported that 4862 is going to be amalgamated with risk 4962. GN said that when she asked about "ongoing incidents relating to the lack of clinical equipment etc" no-one knew of any. RE asked that, in order to close this out, the originators of the risk be formally asked for the reasons behind this previous negative assurance, whether there had been any incidents, and what action had been taken. Bring forward to July meeting. GN confirmed that she did chase for an update on this risk however did not receive a reply and therefore this risk was not updated – bring forward to September. GN confirmed that Division1 have updated their risks

				24.10.18	and no incidents have been raised. Bring forward to October meeting.
5.2 / 25.04.18	**1713** – JS asked GN about the business case for recording electronic tool to assist with job planning. GN replied that an update paper went to the Executives, GN to add a revised date to this risk.	GN	25.04.18	~~30.05.18~~ 20.06.18 ~~25.07.18~~ ~~19.09.18~~ 24.10.18	GN reported that she had had a conversation with Brian McKaig regarding conducting a complete review of the job planning risk. Brian McKaig will be reporting to the Audit Committee in August. Bring forward to the next meeting. GN confirmed that she had spoken to Brian McKaig who agreed to update the risk; however, this will now be done in readiness for the Audit Committee in August. Bring forward to the next meeting. GN confirmed that this risk is not yet been updated but is being prepared for Audit Committee – bring forward to September meeting. GN confirmed that this will be discussed at the Audit Committee on Monday and will be updated verbally. Agreed to leave open until October meeting.

Closed Agenda Items – To be removed at the next meeting

ITEM	Action to be taken raised from the meeting	Lead	Carried forward from	Committee Review date	Update
4.2 / 25.07.18	**4903** – JS asked for an update on this risk regarding awaiting decision of NHSE, the cost on thoracic work. GN replied that there is still no decision from NHSE and suggested that the risk is downgraded and be reviewed.	GN	25.07.18	19.09.18	GN confirmed that she did e-mail following the meeting and it is now a Directorate risk. JS mentioned on the TRR there is an action around an MDT meeting involving Walsall & Worcester looking at aligning programmes but does not conclude. GN confirmed that it is not yet concluded. Agreed to close this action.
9.1 / 25.07.18	**Review of how the pilot committee structure is working – M Arthur** MA updated the Committee on a meeting which had taken place between herself, AMC and JO to evaluate how the new meeting structures have been going. The new format helps the groups to focus on quality and safety in detail with the Divisions. There has been an helpful information transfer between COG and QSIG. The highlight report is an evolving report and the dashboard data is the previous month. There is still room for development within the reports. The meeting discussed the feedback and it was suggested that a questionnaire is sent to the Divisions trios for their opinion and views. This was agreed.	MA	25.07.18	19.09.18	PA confirmed that questionnaires had been circulated to the trios. Of those sent out five have been returned. General opinion was it was too early to do a full evaluation. However, they thought that the process was good and there was an opportunity to have frank and robust conversations. QSIG asked if the next questionnaire could be left longer before reissued. Agreed to close

4.2 / 20.06.18	MA mentioned risk **4734** – Mortality risk (MD) – there is no positive or negative assurance but there is on-going work into the investigations of alerts that have been received. Risk to be populated. DH advised that JO is developing an action plan which will help to populate the risk. Following discussion it was agreed to review this risk and reviewed due to the risk of the reputation to the Trust.	JO	20.06.18	~~25.07.18~~ 19.09.18	MA mentioned about the development of the dashboard on mortality, however, the risk has not been updated. JO confirmed that this risk would stay on the TRR as well as appearing on the BAF as a reputational risk. The meeting suggested that the risk could go on the BAF and the detailed separate actions be monitored there - the workforce risk was a useful example. It would then be monitored at QGAC. JO to ask Jane McKiernan to update the risk – bring forward to September. On the agenda - close
8.2 / 30.05.18	**Committee Self-Assessment of Effectiveness** RE presented a QGAC Effectiveness checklist to the committee. After agreement it was agreed for CE to circulate and with the closing date of 4 weeks after this.	CE	30.05.18	~~20.06.18~~ ~~25.07.18~~ 19.09.18	CE confirmed that the closing date is the 11 July – bring forward to the July meeting. CE confirmed that she is waiting for a couple of more responses and will bring to the September meeting. On the agenda – Closed
4.2 / 20.06.18	**4661** - Lack of robust system for review and communication of test results (MD) – this risk needs to be updated with results if available.	JO	20.06.18	~~25.07.18~~ 19.09.18	MA confirmed that this risk had not been updated. JO informed the meeting that the Directorates are now using the I system for filing of the pathology reports (for Outpatients only). After a brief update and assurance from JO that he would obtain feedback it was agreed to bring this action forward to September. This action was updated during 4.2 of the September minutes and agreed to close.