

CHAIRMAN'S SUMMARY REPORT of Quality Governance Assurance Committee February 2019 4 March 2019

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Agenda Item No: 12.4

CHAIRMAN'S SUMMARY REPORT

This summary sheet is for completion by the Chair of any committee/group to accompany the minutes required by a trust level committee.

Name of Committee/Group:	Quality Governance Assurance Committee	
Report From:	Rosi Edwards - Chairperson	
Date:	February 2019	
Action Required by receiving committee/group:	<input checked="" type="checkbox"/> For Information <input type="checkbox"/> Decision <input type="checkbox"/> Other	
Aims of Committee: Bullet point aims of the reporting committee (from Terms of Reference)	To review and oversee the management of risk across the Trust.	
Drivers: Are there any links with Care Quality Commission/Health & Safety/NHSLA/Trust Policy/Patient Experience etc.	To receive reports, reviewing and ensuring compliance with national, regional and local standards to ensure high quality service provision and to ensure compliance with regulatory authorities.	
Main Discussion/Action Points: Bullet point the main areas of discussion held at the committee/group meeting which need to be highlighted	<p>Advise</p> <p>The version of the BAF tabled was unchanged from that seen by the board on 4 February. As a result QGAC were not able to provide assurance to the board regarding changes and updates. The process for Executive updating to be reconsidered.</p> <p>Consideration of new BAF/TRR risk regarding cancer waiting times: discussion on wording and whether this should be for BAF or TRR to take place before March QGAC.</p> <p>Assurance</p> <p>Infection Prevention Group Report to COG Increase in CPE cases detected in Wolverhampton through the successful screening programme: COG heard that there had been an increased number in CPEs in Wolverhampton to 34 in 2017-18. To the end of quarter 3 there have been 17 cases detected, all by screening and none through clinical samples, indicating that the screening programme is so far working. There has been no proven or suspected spread of CPEs between patients up to the end of quarter 3, compared with four incidents of this sort during 2017-18.</p> <p>National Reporting and Learning System (NRLS) This report, published late December 2018 and covering October 2017 to March 2018, benchmarks the trust's reporting culture as well as indicating areas for focus to improve internal risk management systems. It found no evidence of potential under-reporting at RWT,</p>	

and no significant change since the previous (Oct 16-March 17) report in reported incidents per 1000 occupied bed days. Frequently-reported incident types: themes fed into existing actions, plus RWT will do a deep dive to find out what the communication incidents actually involve and hence what can be done about them.

Partial Assurance

Issue: VTE Assessment

VTE Group Report to COG said that following improved compliance seen between July – October 2018, monthly VTE assessment rates showed a drop in December 18 to 93.03%. The drop is reported to be (at least in part) attributed to a drop in cohort activity (by 500 patients in Dec 18) for day case electives, chemotherapy and similar patient groups affecting the denominator.

Other changes impacting compliance were: changes to coding of some areas to inpatient activity; increased activity within stroke services; new NICE guidance extended to include patients from the age of 16 (previously 18) included in reports from November.

Monthly exception reports submitted with actions, and plan to increase compliance by 0.5% per month and be back on target March 2019. Targeted work to improve compliance is in progress with Cardiology, ED/CDU, Stroke and Paediatrics.

This topic was also discussed at Audit on 12 February (see below). QGAC have asked for a short report outlining the issues raised by External Audit and the actions taken in response to them, for the March or April meeting.

Issue: reporting of high risk/abnormal test results

QGAC discussed updated red risk 4661 - lack of robust effective system for the communication of high risk or abnormal/unexpected investigation results and the COG report of discussions there on compliance with CP 50 (policy for management of risks associated with pathology and radiology clinical diagnostic and screening tests)

Division 3 had reported that directorates had developed local protocols for requesting acting on and filing of test results in compliance with CP 50. These were overseen by Divisional meeting for assurance.

QGAC were told that there are a number of routes by which test results can be received and viewed, apart from ICE, and including TD Web. Stopping the use of TD Web for new results could not be done until all types of results can be viewed fully on ICE. Hence the requirement for local SOPs for results reporting with mandatory reviewing of compliance by Directorate and consultant.

Mortality

QGAC received a verbal report on progress with the action plan, in particular the impact so far of the medical examiner role (positive from patients and the Registrar of Deaths) and the Silverman Report which is going to the March Board (strengthening the quality improvement

programme, strengthening work on sepsis, improving pathways through ED, and end of life pathways). QGAC asked for the graph on mortality in the IQPR on structured judgment reviews to be amended to align with the text and show the current policy on allocation.

Clinical Audit Group Report

Divisions were below their target for completed audits at Q3, in part this was thought to be due to delay in updating completed audits onto the audit database. Monitoring of audit plans continues and areas of concern escalated to Division (including Haematology, Cardiology and Pharmacy). Assurance given that position will improve by Q4.

The report identified two mandated national audits that were not completed (Surgical audit and Dementia audit) and highlighted issues around decision making on audit participation, escalation and oversight moving forward – to be addressed in next audit planning cycle.

Safeguarding Group Report to COG - issue: MCA/DoLS awareness

While MCA/DoLS training remains positive at 97.6%, the third MCA and DoLS audit has been completed in 16 clinical areas. This showed a continued poor working knowledge from staff around DoLS, particularly in relation to whether a person has to have a mental disorder in order to apply for a DoLS and in relation to who can assess mental capacity.

A range of actions are being taken, including fact sheets for wards; bespoke 1:1 training; support and advice in clinical areas at West park and Cannock and continued weekly reporting of DoLS activity to Chief Nurse.

No assurance

None identified.

Matters for Audit Committee

VTE Audit by External Auditors.

Audit at their December meeting had considered QSIG's request in November for Internal Audit to look at the VTE process. Audit had declined, as there were existing recommendations from External Audit to work through. Chair and NED, both on Audit, stressed the importance of RWT being able to demonstrate that it identified all patients who required VTE assessment, and that they received the assessment at the appropriate times. At Chair's request, this was an agenda item for the 12 February Audit meeting. Audit confirmed that actions arising from External Audit should be worked through, rather than carry out a new internal audit.

No new matters identified for Audit.

Risks Identified:		
Include (categorisation number)	Risk	Grade matrix/Datix