The Royal Wolverhampton NHS Trust

# Approved Minutes of the QGAC Committee of 20 February 2019

## 1 April 2019

Agenda Item No: 12.10

# Minutes of the Quality Governance Assurance Committee

## held on the:

**Date** **Wednesday 20 February 2019**

**Venue** **Room F127, Building 12**

**Time** **2.00pm to 4.00pm**

| | **Name** | **Role** |
|---|---|---|
| **Present:** | R Edwards **(RE)** - Chair | Non-Executive Director |
| | M Arthur **(MA)** | Head of Governance |
| | A M Cannaby **(AMC)** | Chief Nursing Officer |
| | M Martin **(MM)** | Non-Executive Director |
| | G Nuttall **(GN)** | Chief Operating Officer |
| | Dr J Odum **(JO)** | Medical Director |
| | | |
| **Attendees:** | F Pickford **(FP)** | Head of Safeguarding |
| | M Bains (**MB)** | Shadowing the minute taker |
| | | |
| **Apologies:** | D Loughton | Chief Executive |
| | V Whatley | Deputy Chief Nursing Officer |

**NB: The meeting was not quorate after 3.30pm due to M Martin leaving.**

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| 1 | **Apologies for absence**<br><br>Apologies were noted. | |
| 1a | **Declarations of Interest**<br><br>There were no Declarations of Interest. | |
| 2 | **Minutes of Previous Meeting - Quality Governance Assurance Committee:**<br><br>The following changes were noted:<br><br>Meeting date was 23 January and not September<br>Grammatical errors x 4 were made to the January minutes prior to circulation to the Trust Board.<br><br>**RESOLVED: Minutes of the Quality Governance Assurance Committee held on 23 January 2019 were approved as a correct record.** | |
| 3 | **Matters arising from the Minutes**<br><br>The action log was updated accordingly. | |
| 4 | **Regular Reports** | |
| 4.1 | **Integrated Quality & Performance Report – January – A M Cannaby / G Nuttall**<br><br>AMC presented the Quality report to the meeting.<br><br>The meeting noted that a while lot of work is going into VTE assessment the Trust is struggling to reach the 95% target. AMC advised that she has had a conversation with Maternity and Midwifery. They were still including a lot of day procedures and are having a full VTE assessment which is affecting the numbers.<br><br>AMC mentioned the late patient moves and noted that 79% of the data are from AMU. This area works 24 hours a day and patients are expected to flow through continually. AMC has reviewed the good flow practice and there is nothing that she can find around the flow management that is showing bad practice. There were 79 patients that moved ward to ward and AMC mentioned that she has not had chance to review the data but would do. RE queried why AMU was being documented if it was not necessary. AMC agreed to review the data and report back to the meeting.<br><br>Complaints have increased in two Directorates (Elderly Medicine and Obstetrics & Gynaecology wards). AMC advised the meeting that the Matron for Elderly Medicine was off this week and AMC would update the Trust Board on Matron's return. AMC mentioned that there have been issues around surveys and patient feedback in Obstetrics. AMC has looked into these and informed the meeting that there were six, in brief detail these were discussed with the meeting. AMC stressed that all of the six complaints were from different areas and | **AMC**<br><br>**AMC** |

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| | sought assurance from Tracy Palmer, Head of Midwifery, that these complaints were all being addressed. AMC mentioned that there is a Midwifery Patient Experience 2017 report that had been embargoed until the end of January and unfortunately the results were not very good. However an internal survey has been conducted where the information and response has been much more positive, this survey will be conducted again. The Trust is mindful of patients not being satisfied with the service. Reports for the MLU are very good and as an organisation we are turning women away from surrounding areas who wish to give birth here.<br><br>GN presented the Performance report to the meeting.<br><br>There is a slight deterioration in referral to treatment time (90%) in January and this was due to patient choice extending pathways and capacity issues at sub-speciality level. GN advised that the BBC Healthtracker for January had this Trust at 39th (best performing) out of 134.<br><br>January saw an improvement in Diagnostics with a lot of hard work going back into recovering the Diagnostic position. There has been an increase in referrals from Cardiology for CT and MRI scans. GN assured the meeting that February is looking better. Endoscopy which was being outsourced has now recovered and is back within trajectory for six weeks diagnostics. An internal business case is being developed to open an additional room at Cannock for Endoscopy clinics.<br><br>The Emergency Department saw one 12 hour breach and this was a complex case waiting for a PICU bed. GN and JO gave a brief update and assured the meeting that a full RCA is being undertaken. JO assured the meeting that both the Paediatric and Adult teams worked with the child and also support from Birmingham Children's Hospital.<br><br>Ambulance handover in January saw a deterioration for both 30-60 minutes and the >60 minute target compared with the previous year is an improvement. The BBC Healthtracker shows this Trust to be 26th out of 134. GN mentioned that between 5 to 8 ambulances per day are transferring stroke patients. The increase is also due to the diverts taken from Telford and Russell's Hall Hospital.<br><br>GN informed the meeting that the Trust is challenged on the cancer performance. There is still a lot of work on-going and there are significant increases in two week waits predominately in breast, however, this is a national problem and other organisations are failing the two week wait. The Trust has capacity for 380 referrals per month for breast and in January there is over 500 and that trend is continuing and currently the Trust does not have the capacity. A separate meeting will be arranged involving the Breast Team, Pathology, Radiology and all of the other associated teams that are involved with breast care. RE asked if the proportion of cancer diagnoses had gone down with the increasing number of referrals or stayed the same. GN said it had stayed broadly the same, indicating that the increased referrals were appropriate. GN mentioned that Dr S Grummet did a video that has been shared with all local GP's and will be repeated. Dr Grummet attends GP events to discuss referrals. An in-depth action plan is in place and the Intensive Support Team is still offering support and doing in-depth modelling with demand and capacity with all cancer pathways. Revised trajectories have been submitted for next year's performance. GN commented that following various reviews and advice the Trust is going in the right direction.<br><br>RE queried why on "the % of patients who presented with sepsis to the emergency departments – the target is 90%, the chart indicates red on 45.9% and amber on 52%. AMC will review.<br><br>RE asked about the graph which indicates SJR: Divisional Allocation (No) v Completed | **AMC** |

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| | (September 2018 to December 2018) and asked if the graph needed to be reviewed as the bars from Division 2 Allocated are too high following the change in criteria. The meeting discussed the report in-depth and AMC advised that the contents of the report need to be changed. AMC asked MA to liaise with Lesley Burrows to update the graph and include the new criteria.<br><br>RE asked about the Healthcare Assistants as the matrix says the Trust is down on Healthcare Assistant care hours per patient day; however the graph indicates that the Trust is using more to cover wards. Following confirmation, AMC informed the meeting that the national indicate is three to turn it green. The Trust sometimes uses Healthcare Assistants to do enhance care and supplement, however there are some roles that are not being filled due to sickness and when it is aggregated the Trust is 2.8 rather than 3. AMC gave assurance to the meeting that the figures are correct.<br><br>**Resolved: Report was accepted** | **MA** |
| **4.2** | **Board Assurance Framework Key Issues**<br><br>MM mentioned that nothing has changed on the submitted report and asked about the process of how it is done. MM noted that the report is submitted to Trust Board every two months but it comes to the other relevant committees every meeting and asked why a live document would stay the same from one Trust Board meeting to the next Board. RE confirmed the when she compared this month's report to last months the only changes were that the corrections in red had been accepted into the report and were now black. MA informed the meeting that historically the BAF was due to Trust Board quarterly however due to issues this has not happened. MM feels that the report should be updated more regularly. GN agrees that the BAF should be updated monthly and confirmed that Keith Wilshere sits with the Executives on a monthly basis to update said report, however that has not happened this month. AMC offered to speak to Keith Wilshere. The meeting agreed that the report is much better in the new format and a lot of hard work has gone into the new format.<br><br>JO confirmed that **SR12** has not been updated, however JO to update the meeting further under section 6.2 of the agenda. MM asked JO Stan Silverman's report was available to review, JO replied that the report will be read at the private section of the Trust Board.<br><br>**Trust Risk Register – M Arthur**<br><br>MM noted that the description on the summary sheet for risk **4113** is incorrect. GN advised the meeting that the risk has been updated. MA to change to **Trust wide CIP Target.**<br><br>MA presented the above and advised the meeting of the following:<br><br>**2 new risks:**<br><br>**5082 -** Neonatal Workforce and Activity (COO) – MA advised that from the risk being escalated and the report being produced this risk has been downgraded to a nine. Therefore this risk has been reduced following a review of staffing, changing of posts etc. This risk is now on the local register.<br><br>**5088** - Fragility of SaTH service (COO)<br><br>**0 risks removed** | **AMC**<br><br>**MA** |

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| | **5 red risks:**<br><br>**2080** - Risk to quality of patient care: reduced manpower (COO)<br><br>**4661** - Lack of robust system for review and communication of test results (MD) – new updated submitted with positive and negative assurance. A new action has been added for local SOPs development. JO advised the meeting that TD Web cannot be closed down yet as Histopathology results cannot be viewed fully on ICE. There are many routes by which results can be communicated, apart from TD Web. He said that it will be a number of weeks before ICE allows histopathogy results to be viewed fully and it can then become the sole viewing platform. Each Directorate has been required to draw up their own SOPs to ensure their processes sign off the viewing and filing of results.<br><br>**4472** - Delays in Cubicle Assessment and Triage (COO).<br><br>**4113** - Division 1 failure to achieve CIP target (COO)<br><br>**5088** - Fragility of SaTH service (COO) – this is a new risk and MA confirmed that it is up to date and populated.<br><br>**Resolved: Reports were accepted** | |
| **4.3** | **National Reporting & Learning System (NRLS) – M Arthur**<br><br>MA presented the above report and informed the meeting that there is no evidence suggesting potential underreporting within the Trust and no significant change with our incident reporting rate for occupied bed days.<br><br>However, speed of reporting to NRLS the Trust is still seven days slower than the national average, which the Trust was already aware of. An action is noted to explore resources to conduct Quality Assurance checks for no harm incidents. Our no harm incident reporting has increased, which is suggestive of a healthy reporting organisation. The level of reported incidents causing severe harm and death is very slightly higher; however, this indicates transparency and more scrutiny around moderate and above.<br><br>Themes of incidents are reviewed and that is done via the IGR reports to Divisions and the CLIP group.<br><br>One issue noted was the transport delays / failure and MA advised the meeting that Division 2 have identified a risk around the discharge delays on their risk register. A large amount of work has been undertaken with Social Care to address the issue. It has also been picked up at the last CLIP meeting.<br><br>Communication issues are being looked at closely, with a deep dive review to gain a better understanding of what they are, for example to ascertain if they relate to verbal or written communications.<br><br>Actions to take forward include harm incidents and uploading issues to NRLS quicker.<br><br>One item which impacts on the report is how staff feel and receive feedback after the incident, this is slightly improving (from 60% receiving feedback in 2017 to 63% in 2018). How to make sure staff receive feedback was discussed further and JO mentioned that this is a recurrent theme. | |

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| | **Resolved: Reports were accepted** | |
| **5** | **Sub Group Reports** | |
| **5.1** | **Chairman's Report – Quality & Safety Intelligence Group (QSIG) – January 2019 – A M Cannaby**<br><br>The key points noted from the QSIG Chair's report are:<br><br>• **CP50 Compliance** (Policy for the management of risks associated with Pathology and Radiology Clinical Diagnostic and Screening tests).<br>• Plans to stop the use of TD Web for new results were still under discussion and consideration. Further update will be pursued re local SOPs and TD Wed issues**.**<br><br>**Resolved: Report was accepted.** | |
| **5.2** | **Quality & Safety Intelligence Group minutes – January 2019**<br><br>The meeting accepted the minutes from the January 2019 meeting. | |
| **5.3** | **Chairman's Report – Compliance Oversight Group (COG) – January 2019 – Dr J Odum**<br><br>The key points noted from the COG Chair's report are:<br><br>• VTE Group Report<br>• IP Group Report<br>• Clinical Audit Group Report<br>• Safeguarding Group report<br><br>**Resolved: Report was accepted.** | |
| **5.4** | **Compliance Oversight Group minutes – January 2019**<br><br>The meeting accepted the minutes from the November meeting. | |
| **6** | **<u>Assurance Reporting / Themed Reviews</u>** | |
| **6.1** | **Safeguarding Update – F Pickford**<br><br>FP presented the above report which covered quarter 3 (October to December 2018).<br><br>The meeting was informed that the report shows each area as requested by the CCG assurance framework and is completed on a quarterly basis.<br><br>**Standard 1 – Safeguarding Governance**<br>RWT have attended all requested partnership monitoring and safeguarding 1:1 meetings with CCG during quarter 3. Actions noted for quarter 4 include the roll out of Child Protection Information Service across the organisation. This is currently in place within Emergency Department, Cannock and will be expanded in to the Children's area and Maternity. | |

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| | **Standard 2 – Safety**<br>There has been a large recruitment drive within the Safeguarding Department however to date the Professional Lead / Named Doctor for Adults is still vacant. Actions for quarter 4 include a review of PREVENT training package in line with the national requirement has been completed today. Recruitment for the Named Doctor and the update to the RWT Safeguarding Children Policy have been written and submitted to the Policy Group.<br><br>**Standard 3 – Training**<br>There has been a huge training drive around the different levels in terms of Safeguarding. The report indicates the compliance and non-compliance. Training was amended in October 2018 to identify changes in national legislation. Target for compliance by the end of March is 95%. FP confirmed that staff are booking onto the training and communication has been sent out encouraging staff to attend the training.<br><br>**Standard 4 – Safeguarding Team Supervision**<br>There is one outstanding due to this person being a new starter.<br><br>FP briefly presented the data collated for the CCG and advised that this is good.<br><br>FP said that regarding safeguarding incidents raised against the Trust, those that do not qualify as safeguarding incidents when investigated go through the Complaints Team so that issues raised can be looked into. If they do qualify there is a safeguarding inquiry. The Trust is recognised as being good at doing RCA's and recording on Datix.<br><br>**Standard 7 – Audit**<br>FP's report gave an update on the action plan following CQC inspections, and in view of a pending CQC visit. The third MCA / DoLS audit report in January 2019 covering 16 clinical areas showed a continuing 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. FP agreed the audit should have been included as an appendix to the report and agreed to send it to QGAC.<br><br>All organisations have been asked to review volunteers training following the Lampard recommendations.<br><br>RE asked about the Safeguarding Children e-learning and the low percentage of completion. FP confirmed that the hours of training required was changed, there is now two hours e-learning and test and the rest of the training to be completed by March 2020. The aim is to achieve 95%. After a brief discussion it was agreed to add expected and achieved target to the training database.<br><br>AMC mentioned that the CQC action plan had dates which had passed and needed to be updated.<br><br>MM commented that it was a good report.<br><br>GN mentioned that the Volunteers Policy needs to be updated; AMC recommended that GN forward the said policy to Alison Dowling copying to Deputy Chief Nursing Officer. | **FP**<br><br>**GN** |

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| | **Resolved: Report was accepted.** | |
| **6.2** | **Mortality Update Report – Dr J Odum**<br><br>JO presented the above report.<br><br>The meeting was informed that the quality agenda there is a significant amount of work that has been completed. For example the Medical Examiner role has been established and it is working progress and the feedback from relatives and the Council around the Registrar who is registering the deaths in the office.<br><br>Various audits are taking place within the Emergency Department in regards to patients presenting with sepsis and Pneumonia has been completed. Sepsis audit indicated gaps through the pathway.<br><br>There have been appointments to Palliative Care Team, Sepsis Teams and Nursing.<br><br>The statistics will take a while to come down due to the data being fed via NHS Digital.<br><br>JO assured the meeting that some of the recommendations from the external report will be implemented and added to the action plan.<br><br>RE asked if the external report indicated why the Trust is an extraordinary outlier. JO replied that this was discussed at the Directors meeting and advised that Sultan Mahmud is reviewing the information.<br><br>**Resolved: Report was accepted.** | |
| **6.3** | **Terms of Reference – Review and Agree – Chair**<br><br>Due to the meeting overrunning, it was agreed that MA and RE would make updates to the Terms of Reference, circulate and agree virtually.<br><br>**Resolved: Terms of Reference to be agreed virtually.** | |
| **6.4** | **QGAC Meeting Schedule – M Arthur**<br><br>Due to the meeting overrunning, it was agreed that the meeting schedule would be circulated and agreed virtually.<br><br>**Resolved: QGAC Meeting Schedule to be agreed virtually.** | |
| **7** | **Issues of Significance for the Trust Board**<br><br>**Advise**<br><br>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.<br><br>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. | |

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| | **Assurance**<br><br>**Infection Prevention Group Report to COG**<br>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.<br><br>**National Reporting and Learning System (NRLS)**<br>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, 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.<br><br>**Partial Assurance**<br><br>**Issue: VTE Assessment**<br>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.<br><br>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.<br><br>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.<br><br>RE asked for a report on what KPMG's concerns about RWT's VTE assessment process were, what we have done about them so far and what we still need to do. AMC agreed, and would try to get something to the March QGAC, though it might not be until the April QGAC.<br><br>**Issue: reporting of high risk/abnormal test results**<br>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)<br><br>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.<br><br>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 | |

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| | for local SOPs for results reporting with mandatory reviewing of compliance by Directorate and consultant.<br><br>**Mortality**<br>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.<br><br>**Clinical Audit Group Report**<br>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.<br>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.<br><br>**Safeguarding Group Report to COG - issue: MCA/DoLS awareness**<br>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.<br><br>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.<br><br>**No assurance**<br>None identified.<br><br>**Matters for Audit Committee**<br><br>**VTE Audit by External Auditors.**<br><br>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.<br><br>No new matters identified for Audit. | |
| **8** | **Evaluation of Meeting – ALL**<br><br>Informative with good discussions | |

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| 9 | **Any Other Business – ALL**<br><br>There was no other business to discuss. | |
| 10 | **Date and time of Next Meeting:**<br><br>Wednesday 20 March 2019, 2pm, Room F127, Building 12<br><br>**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 |
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| 4.1 – 20.02.19 | AMC mentioned the late patient moves and noted that 79% of the data are from AMU and feels that this area works 24 hours a day and patient flow through. AMC has reviewed the good flow practice and there is nothing that she can find around the flow management that is showing bad practice. There were 79 patients that moved ward to ward and AMC mentioned that she has not had chance to review the data but would do. RE queried why AMU was being documented if it was not necessary. AMC agreed to review the data and report back to the meeting. | AMC | 20.02.19 | 20.03.19 | |
| 4.1 – 20.02.19 | Complaints have increased in two Directorates (Elderly Medicine and Obstetrics & Gynaecology wards). AMC advised the meeting that the Matron for Elderly Medicine was off this week and AMC would update the Trust Board on Matron's return. | AMC | 20.02.19 | 20.03.19 | |
| 4.1 – 20.02.19 | RE queried why on "the % of patients who presented with sepsis to the emergency departments – the target is 90%, the chart indicates red on 45.9% and amber on 52%. AMC will review | AMC | 20.02.19 | 20.03.19 | |
| 4.1 – 20.02.19 | RE asked about the graph which indicates SJR: Divisional Allocation (No) v Completed (September 2018 to December 2018) and asked if the graph needed to be reviewed as the bars from Division 2 Allocated are too high following the change in criteria. The | MA | 20.02.19 | 20.03.19 | Email response to SJR Allocation - 22.02.19.msg |

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| | meeting discussed the report in-depth and AMC advised that the contents of the report need to be changed. AMC asked MA to liaise with Lesley Burrows to update the graph and include the new criteria. | | | | |
| 4.2 – 20.02.19 | AMC offered to speak to Keith Wilshere in regards to the **Board Assurance Framework report** | AMC | 20.02.19 | 20.03.19 | |
| 4.2 – 20.02.19 | **Trust Risk Register – M Arthur**<br><br>MM noted that the description on the summary sheet for risk **4113** is incorrect. GN advised the meeting that the risk has been updated. MA to change to **Trust wide CIP Target.** | MA | 20.02.19 | 20.03.19 | |
| 6.1 – 20.02.19 | GN mentioned that the Volunteers Policy needs to be updated; AMC recommended that GN forwards said policy to Alison Dowling copying to Deputy Chief Nursing Officer. | GN | 20.02.19 | 20.03.19 | |
| 7 | **Matters for Audit Committee**<br><br>VTE Audit by External Auditors<br><br>MM reported that Audit Committee 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. RE and MM, both on Audit, stressed the importance of RWT being able to demonstrate that it identified all patients who required VTE | ~~RE~~<br><br>MM / RD | ~~23.01.19~~<br><br>20.02.19 | ~~20.02.19~~<br><br>**May 2019** | MM confirmed that this was raised at the Audit Committee and acknowledged that KPMG were the ones to make recommendations to improve the process, they were then going to see what work they could do between now and the year end to see if those were being implemented sufficiently to give a clear opinion when we come to the Quality Report. VTE is being reviewed again. Lengthy discussions took place and assurance was given that work is on-going to try to improve VTE's.<br><br>RE asked if it would be possible to have a report on what KPMG have found and where the Trust is |

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| | assessment, and that they received the assessment at the appropriate times. RE to seek an agenda item on this for the 12 February Audit meeting. | JO | 20.02.19 | 20.03.19 | currently. MM replied that Roger Dunshea to ask for this report.<br><br>JO to ask Kevin Stringer why VTE was selected again for audit. |
| 4.2 / 2301.19 | **Risks 5112 / 5116**<br><br>MM mentioned that she did a walkabout on ICCU in October and the Nurse in Charge was excited about the new staff recruited and how education had developed a two month programme to train the new staff (combination of ward and classroom). MM advised the meeting that she is surprised to see the risk. GN reported that the business case was had not been agreed when MM did the walkabout. The meeting discussed these two risks and it was agreed that GN would review | GN | ~~23.01.19~~ | ~~20.02.19~~<br><br>20.03.19 | GN confirmed that risk **5112** has had some updates, around evidence that it is not working (page 41 of the TRR). Dates have been updated but the risk has not been updated but it has been reviewed. GN confirmed that she will ask the Directorate / Division to review the risk. The meeting discussed the risk and issues in recruiting to ICCU<br><br>Bring forward to March. |
| 4.1 / 23.01.19 | RE asked about the emergency C-section rates which require auditing to determine if the indicators are appropriate. RE noted that the previous QSIG minutes mentioned that the Commissioners have concerns and the Directorate. RE requested the audit results are brought to this meeting, this was agreed. VW to advise the date. | VW | 23.01.19 | 20.02.19<br><br>20.03.19 | E-mail with update from Vanessa Whatley –<br><br>The audit summary report to be presented at CQRM in February and QGAC in March. |
| 4.1 / 21.11.18 | GN agreed to review the TRR and consideration to the BAF (Cancer) | GN | 21.11.18 | ~~23.01.19~~<br><br>20.02.19 | GN advised the meeting that she is currently in the process of completing this action and will update at the next meeting.<br><br>GN to email RE/KW/MM with views to agree reasoning<br><br>GN confirmed that she has started this work but will |

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| | | | | 20.03.19 | circulate prior to her leave. |
| 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~~<br><br>~~21.11.18~~<br><br>~~23.01.19~~<br><br>20.02.19<br><br><br><br><br>20.03.19 | GN advised that this risk had still not been updated – GN to chase for an update and bring forward to the November meeting.<br><br>To be discussed under TRR – leave action open<br><br>Risk not updated – agreed to bring forward to next meeting.<br><br>GN asked JO if he would be happy to review the risk for Clinical Web Portal and asked if he feels that this is still a risk. JO agreed to this. JO explained the process of web portal<br><br>MA to see if any datix has been raised. |
| | | JO<br><br>MA | | | |

**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 |
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| 9 | MA advised the meeting that herself and AMC had met to discuss the reporting schedule for this meeting and it will be brought back for discussion along with the Terms of Reference for consideration. | CE | 23.01.19 | 20.02.19 | On the agenda – Completed |
| 6 | RE advised that in the future there will be a verbal or report under this section to discuss Mortality. This will be presented by either RE or AMC. | CE | 23.01.19 | 20.02.19 | On the agenda - Completed |
| 4.1 / 23.01.19 | RE asked if the figures within the Rapid Intervention Team could be reviewed for the number of patients sent to ED. The figure currently states 8.4%; RE asked how 8.4% was calculated. GN agreed to review. | GN | 23.01.19 | 20.02.19 | AMC advised that following a meeting yesterday someone from the Rapid Intervention Team discussed two schemes. The first will see them going into A7 and A8 to try and pull patients from that environment. Data is being collected. A short amount of time is being held in Emergency Department and discussions are on-going to see if time can be spend in there to see if they can help.<br><br>GN reported that Dr Stuart Hutchinson had recently had an article published in the British Society of Geriatrics and GN to share this.<br><br>CLOSE |
| 4.1 / 21.11.18 | RE asked for a brief description on what the Trust is measuring in regards to HIV tests offered | GN | 21.11.18 | ~~23.01.19~~ | GN explained that this is for patients who come to the Trust if they need a HIV test and this is the data that should be recorded. GN confirmed that she has been asked why the figures are so low, GN has been assured that the figures will be in the 70's for the last quarter but currently she is not receiving appropriate assurance. Meeting discussed this briefly and it was |

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| | | | | 20.02.19 | agreed that this should be marked as green. GN asked that this action is brought forward to the next meeting while she seeks assurance.<br><br>Completed - close |
| 4.1 / 24.10.18 | RE sought clarification under the item of Urgent Care on page 14, line 6, in regards to *Trolley waits in ED not longer than 12 hours,* after a brief discussion it was agreed to remove the word **not.** | GN<br><br>CE | 24.10.18 | ~~21.11.18~~<br><br>~~23.01.19~~<br><br>20.02.19 | Meeting noted that the word ***not*** was still in the risk. CE to speak to GN<br><br>RE reported that NOT is still on both November and December IQPR. GN confirmed that she had not changed the IQPR and item to be brought back to February meeting.<br><br>Changes have been made following reviews – close |
| 4.2 / 24.10.18 | **4903** - Risk of non-compliance with Thoracic Service Specification (COO) – GN advised that this should not have been graded at 4 x 5 = 20 red risk. MA to ask the Healthcare Governance Manager to review this risk. | MA | 24.10.18 | 21.11.18<br><br>~~23.01.19~~<br><br>20.02.19 | Updated on section 3 of the minutes.<br><br>GN confirmed that this has been updated. MA confirmed that the risk has not been downgraded even though an update has been received. After a brief discussion GN asked MA to check. GN confirmed the grade change on the 19 January.<br><br>Reviews made and agreed to close<br><br>Email updated - "The Divisional Management Team have discussed Risk 4903 – Risk of non-compliance with Thoracic Service Specification this morning and I can confirm that this risk has now been downgraded from a red risk to a high amber risk (risk score 12) as a high amber this will remain on the TRR" |