

# Chair's Report QGAC 3 March 2020



Agenda Item No: 7.3

**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.*

<b>Name of Committee/Group:</b>	Quality Governance Assurance Committee	
<b>Report From:</b>	Rosi Edwards - Chairperson	
<b>Date:</b>	February 2020	
<b>Action Required by receiving committee/group:</b>	<input checked="" type="checkbox"/> For Information <input type="checkbox"/> Decision <input type="checkbox"/> Other	
<b>Aims of Committee:</b> Bullet point aims of the reporting committee (from Terms of Reference)	To review and oversee the management of risk across the Trust.	
<b>Drivers:</b> 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.	
<b>Main Discussion/Action Points:</b> Bullet point the main areas of discussion held at the committee/group meeting which need to be highlighted	<p><b>QGAC Chair's report February 2020</b></p> <p><b>Advice</b></p> <p><b>Shrewsbury and Telford:</b> QGAC considered the outcome of the Risk Summit and the potential risk to services at RWT presented by the difficulties being experienced at Shrewsbury and Telford, in particular the impact should a proportion of emergency cases be diverted to RWT. The possibilities of creating additional capacity at RWT and the limitations on doing so (primarily staffing) were also discussed. More up-to-date information should be available by the time of the board.</p> <p><b>Information Governance:</b> QGAC confirmed its readiness to approve RWT's submission on Information Governance at its March meeting, should the Board agree to devolve responsibility to QGAC in order to meet the IG deadline.</p> <p><b>TRR:</b> QGAC considered the updates to the risks and again questioned whether some risks should still be on the TRR.</p> <p><b>BAF:</b> QGAC considered the two risks allocated to it, SR12, Mortality and SR13, Cancer.</p> <p><b>SR12:</b> QGAC noted the steady reduction in the SHMI. Following the discussion at the previous meeting on when it would be appropriate to reduce the rating, and noting that the SHMI score was only one aspect of a large programme of work, and taking into account the second Silverman Report and Mr Silverman's presentation to the February</p>	

Board, QGAC decided to reduce the score from 16 to 12.

**SR13:** QGAC noted the positive updates and were assured by the COO that the drop in January's performance (not reflected in the updates but appearing in the IQPR for January) reflected seasonal patient choice not to attend for test/treatment and that the improved performance had resumed in February. In January and February RWT had assisted Walsall with breast referrals (70 referrals) and was now booking within standard again.

QGAC also considered 5 red risks not on the TRR or linked to the BAF and agreed that they should continue to be monitored at divisional level, while querying whether some of the ratings were appropriate.

**Learning from Deaths Report:** QGAC received this report and were pleased by the progress. It noted the further reduction in the SHMI and the further reductions projected by PwC.

**Learning from Experience (previously CLIP)** this sub group reports to COG. There will be a critical review of its Terms of Reference to determine if it is still required, and if there is a still need to have a specific sub-group for the purpose of ensuring learning is gained from incidents and reviews, how it should be constituted.

#### **Assure**

**Serious Untoward Incident Actions Audit:** QGAC noted the report presented to QSIG and considered that this gave assurance that actions were being monitored and that the outcome was good. An audit is conducted every six months, it is a two-fold audit, a sample is taken across the three Divisions and then Governance look at the action plans developed from SU's to see whether or not there is evidence available for those marked as complete and also if the evidence provides assurance that the action has been completed.

There was a 92% return rate which is positive and of the evidence returned 82% showed full compliance (completion of the actual action). This is an improvement on previous audits completed.

It was reported that the areas where it was difficult to get the evidence to demonstrate completion were in the outbreaks, slips/trips and falls etc. Previously there has been less scrutiny of these action plans. These are being monitored at ESERG and Governance is confident that smarter action plans will make it easier demonstrate compliance with this audit.

**New procedure: punch biopsy:** QGAC noted QSIG's approval of a procedure to improve patient experience in Dermatology. This procedure is part of the fast-track clinic where the Consultant will see the patient and then the Nurses, who have their own list, will pick up any fast-track patients so the biopsies can be done on the day.

QSIG was assured that the Clinical Specialist Nurses in Dermatology have completed their level of competencies with the Dermatology Consultants. Each nurse has observed over 50 and performed 433. Each Clinical Nurse Specialist will undergo a robust training programme, the same as the Clinical Fellows.

This new procedure will reduce waiting times and Waiting List Initiatives (WLIS's) and it will allow the Consultants to focus on other aspects of the service. The Nurses are also part of the breaking bad news process and if a biopsy is benign the Nurse can discharge the patients with the agreement of the Consultant.

**Quality Review Visit - Division 3 Dental Services – Pendeford Health Centre** QGAC noted the report to QSIG of this review in October 2019 which found Safe, Responsive and Well-led to be all Good, and Effective and Caring to be Outstanding

Members of the Assessment Team followed the patient's journey from assessment to treatment and found it to be excellent. Patients received a personal service and there was good documented evidence of Information Governance and Infection Prevention. All of the processes were in place and there had been a stress risk assessment completed. Excellent safeguarding knowledge, information available on how to raise a safeguarding if required. All staff spoken to knew of the processes to follow. A number of children were in attendance throughout the day and the families were very emotionally positive about the service received.

#### **Partial assurance**

##### **ED Performance: 12 hour breaches**

QGAC considered the recent 12 hour breaches and the assurance obtained via discussion at QSIG to clarify the process for management of 12 hour breaches. QSIG was assured that each breach is reviewed by the Emergency Department for potential harm and the outcome reported to the Commissioners following Division 2 sign off. The 14 x12 hour breaches in January were due to bed capacity and were clustered around one or two days at times of high demand.

**IQPR: Sepsis:** QGAC was told the drop in performance from 100% to 75% in ED for screening (amber) and from 100% to 65% for intravenous antibiotics within an hour (red) was due to the very high demand in ED in January and that performance has gone up again in February.

**IQPR data:** for late observations and sepsis the Trust continues to rely on prevalence data. The Trust continues to work with the software suppliers to resolve the reporting issues but would not expect to move away from prevalence data for 6 months until the reporting system on Vitals can be demonstrated to be working properly.

	<p><b>104 day harm review report:</b> QGAC considered the assurance QSIG obtained through the 104 day harm review report when November and December harm reviews were reported. Themes of avoidable delays included delays for robotic surgery, ultrasound and CT scans, very late tertiary referrals, equipment failures, cancer pathway tracking. Themes of unavoidable delays included complex care needs, co-morbidities, anesthetic reviews and emergency admissions within the cancer pathways.</p> <p>Actions identified to address themes:</p> <ul style="list-style-type: none"> <li>- A mandatory training package relating to Cancer pathway tracking is being developed for all staff involved in the Cancer Pathway.</li> <li>- Actions from the report relating to Histopathology delays and for the Cancer Board are being taken forward by the Clinical Lead for Cancer.</li> </ul> <p><b>No assurance</b></p> <p><b>Histopathology result delays</b>                  QGAC were informed of significant delays (up to 3 months) in the availability of Histopathology results. This prevented the completion of harm assessments in some cases and was impacting on MDTs and cancer treatment. It was anticipated that a new Consultant appointment would assist this position.</p> <p><b>Black Country Pathology Service performance</b>                  QGAC discussed this in the light of histopathology delays (above). It was explained that BCPS still does not have enough Histopathologists and that the workload has gone up by 15-20%. The merging of the separate services to form BCPS has coincided with pathology new-build and the taking on of the HPV contract. It was not possible to give QGAC assurance of when the service could be expected to recover in terms of turn-round times.</p> <p><b>Matters for Audit Committee</b></p> <p>There were none</p>
<p><b>Risks Identified:</b></p> <p><b>Include Risk Grade (categorisation matrix/Datix number)</b></p>	