Minutes of the Quality Governance Assurance Committee held on the:

Date **Wednesday 21 October 2015**

Venue **Boardroom, G099, Building 12**

Time **2.00pm to 4.00pm**

	Name	**Role**
Present:	Dr J Anderson **(JA) Chair**	Non-Executive Director
	R Edwards **(RE)**	Non-Executive Director
	S Hickman **(SH)** (representing M Arthur)	Compliance Manager
	D Loughton **(DL)**	Chief Executive
	G Nuttall **(GN)**	Chief Operating Officer
	Dr J Odum **(JO)**	Medical Director
	Dr J Parkes **(JP)**	Non-Executive Director
	J Vanes **(JV)** (Observer)	Chairman of the Trust
Attendees	Dr H Sullivan **(HS)**	Consultant Obstetrician and Gynaecologist
Apologies:	C Etches **(CE)**	Chief Nursing Officer
	M Arthur **(MA)**	Head of Governance & Legal Services

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1	**Apologies for absence** Apologies were noted. **Declarations of Interest**	
1A	There were no Declarations of Interest.	
2	**Minutes of Previous Meeting** RE asked if the minutes could read RE and not RB. JA asked if there were any further developments on The Intensive Support Team coming to the Trust to review the Urology Department. GN replied that the Intensive Support Team would not be coming into the Trust due to a backlog of work within their team. However, GN reported that the Intensive Support Team have been into UHNM and the TDA have asked that the UHNM report be shared with this Trust because the TDA feel the recommendations to UHNM will be the same as to our needs. GN confirmed that she received the report last week but to date had not had chance to review. DL asked if the TDA had resolved the issue regarding the breeches that this Trust receives from Dudley. GN stated that it is proposed there is going to be a national change, commencing at the beginning of November, if a referral is sent after 42 days and the patient breeches this will count against the sending Trust, however if a referral is sent before 42 days to this Trust and the patient breeches it will count against this Trust. This gives a 20 day turnaround. GN did stress that the paperwork still needs to be ratified. GN confirmed that the Trust is still 1 Urologist down. The meeting discussed overseas recruitment. **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 23 September 2015 were approved as a correct record.**	
3	**Matters arising from the Minutes** The matters arising from the Minutes were updated on the action log sheet and closed.	
4	**Regular Reports**	
4.1	**Integrated Quality & Performance Report – G Nuttall** GN presented the performance section of the report. Due to the performance section of the report being discussed in Finance & Performance Committee earlier in the day, JA agreed for GN to highlight key points. GN reported in September there had been 62 on the day cancelled operations, the main	

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	reason being issues within Ophthalmology (5 due to non-consent and 15 due to a water leak in the Theatre). GN informed the meeting that the 5 cancelled due to non-consent was due to a never-event. An RCA and investigation is currently being undertaken. The Emergency Department saw an increase in September with an additional 190 attendances compared with the same period last year. In October to date, there has been an additional 327 attendances in the first 14 days of the month; this is an increase of 6.7% increase compared to last year. Ambulance handover also saw deterioration in September for both 30 – 60 minutes (36 patients) and over 60 minute (6 patients) breach targets. There were no patients who breached the 12 hour target. GN informed the meeting that cancer was discussed in-depth at the Finance & Performance meeting earlier. For September the Trust is predicting a possible failure of the 62 Day Screening and 62 Day Referral to Treatment. Final cancer data is uploaded nationally 6 weeks after month end. With 62 Day Screening there were 4 patients who breached (3 x complex cases and 1 x tertiary). GN assured the meeting that there were no issues regarding diagnostic waits. GN reported to the meeting that there had been an increase in the Trust sickness rate in September. The absence rate was 4.57% which is 1.31% above the Trust target of 3.24%; this is 0.26% higher than the sickness rate for the same period last year. JP queried the figure on the “Care on a Postnatal Ward” and asked why it had been a substantial drop from August (92%) to September’s figure of (84%). GN advised that she could not answer that but would look into the issue and feedback. The meeting discussed the Maternity FFT recommendation rates and DL feels that the impact has been due to Stafford patients being moved to this Trust. JA raised concerns regarding the staff turnover at this Trust. Currently the Trust turnover is 12.22% (which is below the Trust target of 13.2%). However, the Trust is above the national average of 8.99%. JP asked for clarification regarding the safeguard raised against West Park alleging neglect, the case is now closed with the outcome undetermined / inconclusive. DL replied that sometimes you do not always have enough evidence to say yes or no. JP suggested that a better explanation may be needed for future reports. RE queried the number of radiation incidents and asked how we compare with the national benchmark. JO replied that there is no national benchmark and a challenge has been put into Medical Physics department on how do we benchmark and what assurances can be offered to ensure that this Trust is as safe as or safer than other organisations. The department replied that all incidents are reported and the number of incidents is no higher than any other Trust. RE queried the WHO checklist benchmarking of 98% which seems to fluctuate. RE asked if a note could be put against target.	

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	RE sought clarification on the HSMR "*we are in the process of investigating a data quality issue that is likely to affect negatively the HSMR".* JO suggested that negatively be replaced with adversely. JO reported that the figure is adversely until corrected by Coding. RE asked what speciality level were the predicted fines for in September. GN replied Orthopaedic, General Surgery and Oral Surgery. GN assured the meeting that a recovery plan was in place. RE asked why the "Delayed Transfers of Care – Excluding Social Care Delays" had been noted. GN replied that the Trust was highlighting the delay via Social Care and this was to show the Board the breakdown. JA mentioned that the Trust had received 23 complaints during September in comparison to 42 received in the same period. During September there were 31 complaints closed, of these 10 were responded to within 25 days, 9 complaints took between 26 to 35 working days to investigate (2 with consent to breach, 7 without consent to breach) and 12 complaints took longer than 35 working days (5 with consent to breach, 7 without consent to breach). JA informed the meeting that plans are in place to have replies by as a flat 30 days. The meeting noted that the Safety Thermometer was 95.59% in September and this is a significant improvement in month and the lowest since November 2014. There has also been a reduction in patients with any harm from a fall and a reduction in new VTE's. JA commented that there is a high rate of c section rates and an increase in 3rd & 4th degree tears. In September there were 4 full term babies admitted to the neo-natal. **Resolved: Report was accepted**	
4.2	**Board Assurance Framework / Trust Risk Register – S Hickman** SH presented the BAF and TRR report to the meeting. **Board Assurance Framework (BAF):-** There were no new risks and 3 red risks for September. **Risk SR8** – that there is a failure to deliver recurrent CIPs, **Risk SR9 –** that financial balance (and surplus) is not achieved and **Risk SR12** – that the retention and development costs of staff are unaffordable. There were no risks closed. The following risks were reassigned: **Risk SR5 –** if competition causes a significant shift in activity – reporting committee is now Trust Management Committee. **Risk SR8** – that there is a failure to deliver recurrent CIPs – the Chief Operating Officer is now responsible for this risk.	

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	Risk SR12 – that the retention and development costs of staff are unaffordable – the Director of Human Resources and Organisational Development is now responsible for this risk. SH reported that: **Risk 937 –** had been downgraded **Risk 535** – had been updated with positive control **Risk 535 –** had been updated with positive assurance **Risk 3644 –** had been a new positive assurance The meeting discussed the BAF report and GN assured the meeting that this report was discussed at Finance & Performance earlier although no decisions were agreed (other than SR8 above) **Trust Risk Register (TRR):-** There are 3 new risks: **Risk 4243** – NIPE Standards of Hip Screening for New-born Babies **Risk 4113 –** Inability to achieve the Division's CIP target (Division 1) **Risk 4287** – Cardiac arrest bleep holders are not receiving all cardiac arrest calls There are no red risks. RE asked if "System bugs in Safehands causing delays to bed allocation" on TRR **risk 2719** had been sorted yet. GN replied that it is not as significant as it was; a revised work plan was now in place which reduced the severity of the risk. JA queried **risk 3051** outliers within the service. JA asked if there was any evidence that outliers caused additional mortality / morbidity and is Safehands effective in identifying and what allocation and when do the medical staff see the outliers and what is the seniority. JA mentioned that outliers have always been an issue. JO replied that there is no evidence of mortality or morbidity with outliers. The patients who are outliers are the safer patients and not in acute stage of illness. All outliers are reviewed first thing in the morning (daily) by a Junior Doctor and a Consultant. There are twinned arrangements for all wards, so if there is an issue outside of the ward round a Doctor can be contacted from another ward. The impact on the Trust is terrible, reducing elective patients. GN explained how an outlier can increase the length of stay. Safehands does identify the correct patients who can be outlied. Ward rounds are monitored and reviewed by the 12.30pm bed meeting. The meeting discussed the effect of outliers on the patients and Trust. The meeting assured JA that the patients are well looked after. DL reiterated that the practice was safe but it was not acceptable. RE queried **risk 535** and asked for clarification on "MRSA screening data not automatically fed due to lack of HL7 feed Oct 15". GN replied that she could not answer the question and this could have been updated by CE. RE asked if **risk 3486** could be removed. The meeting agreed to this.	

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	RE sought assurance that **risk 3644** the "refurbishment of Mortuary body store and viewing room due mid-April" was completed. GN confirmed that it was. RE asked if "failure to make an improvement in compliance gaps will impact the Trust's registration status with CQC" should read "compliance gaps with CQC standards" would be clearer. This was agreed. RE asked if dates or origin and dates of escalation could be added to the TRR. SH to escalate this to MA. JA raised concerns regarding **risk 4243** "The Orthopaedic Consultants currently job share between New Cross Hospital and Birmingham Children's Hospital. It is not unusual within the summer months for the consultants to have 2 consecutive weeks annual leave and this leave 4 weeks without consultant presence at the hip clinic". The Trust currently only offers 24 slots per month to review babies. Helen Sullivan offered assurances that all babies are examined and scans are given to the high risk babies. GN replied that before she accepted this risk, she contacted the Directorate to ask what plans were in place. Lewis Grant had offered assurances that there was an action plan in place and the risk was being monitored at Directorate level. JA queried **risk 4287** and asked why the Cardiac Arrest bleep holders are not receiving all cardiac arrest calls. JO replied that following investigations it was discovered that the signal sent is inconsistent and the reason for this is unknown. Tests have been undertaken to ascertain the problem and JO reported that IT and Switchboard do not know what the problem is. A digital bleep system will be installed within the next few weeks. **Resolved: Report was accepted.**	SH
5	**Sub Group Reports**	
5.1 5.2	**Patient Safety Improvement Group minutes – September** The meeting accepted the minutes **Chairman's Report** **1. New procedure approved** Renal Guard Surgical Application - approved for the use in cardiothoracic surgery to assist in the reduction of acute kidney injury in patients undergoing surgery. **2. Ward performance** Themes emerging vary in each Division as follows: Div. 1 – Falls and documentation - Staffing breaches (general surgery) Div. 2 – Documentation - Signature, dates and times, intervention charts for pressure ulcer prevention - Staffing breaches - Late observations - Infection prevention – C. Difficle cases	

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	3. Safety Checklists Both divisions disappointingly have reduced compliance and the recurrent theme is around Obstetrics and Emergency Department. Both divisions have been invited to the October 2015 meeting to provide assurance around sustained improvement. **4. Discharge Audit** The annual audit demonstrated some good compliance to policy, but discharge checklist compliance is very poor. A new discharge checklist was launched in August 2015 which is thought to be less onerous to complete therefore higher compliance is expected. **5. Learning Lessons** It was suggested from a general discussion, that involvement of Junior Doctors in complaint and incident investigations and governance meetings could be beneficial. In addition it would support their development as they progress to a consultant role. **6. Resuscitation report** There was evidence of significant improvement in adult DNAR compliance (paediatric DNR 100%). It was disappointing to note the checking of paediatric resuscitation trollies reduced to 55% (previously 74%). It was agreed that this is unacceptable and operational areas of the organisation were charged with immediate improvements. **Resolved: Report was accepted.**	
5.3 **5.4**	**Quality Standards Action Group Minutes – September** The meeting accepted the minutes. **Chairman's Report–** **4.1 <u>Guidance in relation to the Abortion Act – Update report:</u>** The Abortion Act of 1967 requires the abortion certificate HSA1 to be completed and signed by two doctors "who have each reached their opinion in good faith before the abortion is performed." The Act also requires form HSA4 to be completed accurately in full and returned to the CMO within 14 days of the procedure. Audits at RWT have demonstrated a 100% compliance with completion of form HSA1 and incomplete compliance with completion and returning of form HSA4. A new process for ensuring completion and returned of form HSA4 has been put in place and the most recent audit relating to this was conducted between 1st March 2015 – 31st August 2015. Sixteen cases were identified. There was a 100% return of HSA4 to CMO. However 12 of 16 forms were posted within 14 days. Summary: The risk will remain as Amber on the O&G risk register. QSAG suggests electronic submission of the form with documentation of returned and completion made in the clinical record. Thirdly, a re-audit and presentation will be requested for January 2016.	

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	4.2 <u>Quality Review Visit Ward A14 report:</u> An internal "CQC style" visit was undertaken of Ward A14, the clinical lead being Dr Halahakoon. Subsequently the caring domain was rated outstanding. The safe and responsive domains were rated as good. The effective and well-lead domains were rated as "requires improvement". In each domain there were areas of good practice noted, but also areas for improvement. Their particular note and concern were instances of poor documentation by medical staff in the clinical record, failure to sign and note the time of the entry made, and failure to use the identification stamp when required. Incomplete documentation was noted on treatment sheets including allergy boxes not completed and medicines information being legible. There were also issues with nursing documentation. Communication between medical and nursing staff was felt to be poor in some instances, possibly related to the number and timings of Ward rounds undertaken on the ward. There were also issues with continuity of care and handover in the Upper GI Surgical Team. An action plan has been formulated to address these issues and a further report to update QSAG on these actions is required in November 2015. **4.3 <u>Final CQC Report:</u>** Following the Trust's CQC inspection in June 2015 an action plan has been drawn up to address all the recommendations made by the CQC in their final report. Progress against each of the actions was presented and continues at pace. The necessity to have all of the actions completed at the earliest opportunity was discussed and it was agreed the action report would be reviewed on a monthly basis at QSAG. **4.4 <u>Clwyd Hart Report – update from June 2015</u>** Paul Archer, Interim Patient Experience Manager presented the report. Good progress continues to be made with implementation of the improvement action plan. Specific points of discussion/recommendation at QSAG were as follows: The process by which complaints were investigated requires review to ensure all aspects are covered within appropriate timescales and depending on the complexity of the complaint it may be necessary to (appropriately) extend the timescales of response to the complainant, but keeping the complainant fully informed of progress. It was agreed at the internal Baker Tilly Audit into the complaints process should continue. This will report to the Audit Committee in due course. **4.5 <u>Freedom to speak up (Sir Francis QC) report:</u>** Good progress has been made with implementing the recommendations from the Freedom to Speak Up Report. A further report was requested to be presented to QSAG in 2 months' time to provide a further update.	

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	4.6 <u>IG Communication Plan:</u> Given the increased numbers of incidents relating to Information Governance and/or confidentially breeches a communication plan has been developed to advise and inform all Trust staff of their responsibilities and requirements on how best to ensure compliance with IG requirements. Communication will be delivered and disseminated across the organisation and the report was received for assurance. **Resolved: Report was accepted.**	
6 **6.1**	**Routine Reporting / Themed Review Items** **Third & Fourth Degree Tears – Dr Helen Sullivan** JA advised HS the purpose of this Committee asking for this paper. HS then presented the paper on Obstetric anal sphincter injury (third and fourth degree tears). HS reported that this is one of their Key Performance Indicators (KPI's). HS advised the meeting that obstetric anal sphincter injury can be prevented and the biggest factor is a first baby. HS advised that the larger number of tears were due to inspecting the perineum properly after delivery. The largest risk was in primigravida. Warm compression was being trialled as this had been shown in other studies to reduce risk. Making Caesarean section routine was the only way to reduce tears. HS offered the following assurances to the Committee: reviewed monthly at Intrapartum Care Group and departmental Governance Meeting as part of maternity dashboard and key performance indicators. Two large audits have been conducted over the last three years and neither were showing any significant problems, Midwifery Led Unit (MLU) now review all cases and when a spike occurs a detailed review is undertaken for example in the MLU in August 2015. JO asked if any of the cases were unavoidable and HS responded by saying 99% of all cases are unavoidable. JA asked HS about the admission of term babies for level 3 NNU care. HS replied that a high number reported, partly due to support given in transfer from labour ward to neonatal unit, which is often stopped on arrival. JA suggested that better descriptors are required for board interpretation**.** JA thanked HS for a good report. **Resolved: Report was accepted.**	
7	**Issues of Significance for Audit Committee –** The meeting agreed to raise to the Audit Committee that a good report had been received from Obstetrics'.	

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	Issues of Significance for Trust Board – **Integrated Quality and Performance Report (for September)** • Continued rise in ED attendances over September and even more in October has impacted on wait times. • Continued failure to meet targets for 62 day screening and 62 day to first treatment in Cancer care. 82% of tertiary referrals received after 42 days and 41% after 62 days. This has a significant impact on timely care. Capacity issues in Urology continue. • High staff turnover (12.2%) and high sickness absence (Av. 9.5days) continues to impact on service needs. • Fewer complaints received in month, but timescales for response with and without consent continues to be of concern • Safety thermometer above target—first time since November 2014 (improvement) • Falls below target for last 3 months (improvement) • Continued delays in transfers of care largely due to waiting for domiciliary packages and delay in SC assessments. • Actions in place to address shortfall in timely production of discharge summaries—some improvement in month. **Board Assurance Frame work and Trust Risk Register** • BAF risks are now all assigned to a named executive. 3 of 10 are red. Little movement on the risk profile and all risks details not fully populated. High concern re SR1--workforce plan- in relation to nurse and doctor shortages. (This is a national problem). • Continued concern over ability to achieve CIPs. Div. 1 risk escalated to TRR. • TRR has three new risks in addition to the 7 new last month. • 4243 Plans in place to increase capacity for neonatal hip ultrasound. • 4287 Cardiac arrest bleep holders to be issued with digital bleeps to ensure no missed calls. • 3051 discussed in detail. No evidence that outliers receive less effective or less timely care, but does result in some delay to discharge and volumes impact on bed availability for elective admissions. • Many risks profiled in IQ&P report. **Patient Safety Improvement Group (September 2015)** • At least two areas of non-compliance in use of safe surgical checklists. Both divisions presented themselves to the October meeting for assurance purposes. • Disappointing results of audit on Paediatric Resuscitation Trolley checks (55% of 20). This has been addressed. • VitalPAC upgrade in progress. • Concern re documentation highlighted by ward monitoring performance. **Quality Standards Action Group (September)** • Internal CQC style visit to Ward 14 highlighted difficulties in communication due to the number of consultant ward rounds and their timing. Effective handover strongly recommended. One area rated outstanding-- Caring. • Progress on action plan since CQC's visit—discussed monthly. • Updates on patient experience and complaints together with an internal audit	

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	investigation continues. • Communication plan to address breaches in Information governance in place. **Third & Fourth Degree Tears** • Report on Obstetric anal sphincter injury discussed with Dr H Sullivan • Detection greater because of increased observation after birth. • Trial of warm compression to at risk perineum's to be trialled. Need to discuss with commissioners whether this is a useful metric to report on IQ&P monthly report. • Admission of term babies for level 3 NNU care also discussed. High number reported partly due to support given in transfer from labour ward to neonatal unit which is often stopped on arrival. Better descriptors required for board interpretation.	
8	**Evaluation of Meeting – ALL** This item was not discussed.	
9	**Any Other Business – ALL** There was no other business to discuss.	
10	**Date and time of Next Meeting**: Wednesday 25 November 2015, 2.00pm to 4.00pm, Boardroom, G099, Building 12 **Please note the new time of this meeting.**	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.2	RE asked if dates or origin and dates of escalation could be added to the TRR. SH to escalate this to MA.	SH	21.10.15	25.11.15	
4.2	RE mentioned that following the mini CQC inspection one issue raised was if there were a number of Consultants per ward the co-ordinating of ward rounds was difficult. This was then raised at QSAG and will be monitored by QSAG. MA to update **TRR 3705**.	MA	23.09.15	~~21.10.15~~ 25.11.15	SH asked if this related to A14 QRV. RE confirmed it was. SH replied that this review will go to QSAG in November and the Division meeting. SH to follow up with Divisions 1 and 2.
4.1	There was an increase in falls per 1,000 occupied bed days in June of 6.94. All RCA's are completed on harm caused falls. CE to invite NHS England to review falls within the Trust.	CE	22.07.15	~~23.09.15~~ ~~21.10.15~~ 25.11.15	The meeting agreed to bring this item forward. The Trust is still waiting for the review. In CE's absence it was agreed to bring forward to the next meeting.
4.1 – Feb 15	CE raised concerns that we are still breaching around consent in regards to complaints. CE will be meeting with Carol Bott to discuss complaints and the changes not having a positive impact. CE agreed to update the meeting on any progress made	CE	18.02.15	~~25.03.15~~ ~~22.04.15~~ ~~27.05.15~~	GN informed the meeting that this was discussed at the last QSAG meeting and QSAG have asked for additional work to be done on the report and re-present again. B/F – April 2015 RE reported that QSAG have asked for additional work to be undertaken. MA advised the meeting that in Carol Bott's absence Paul Archer is covering / supporting the work within the Patient Experience team. PA advised the

					meeting of the current situation and after discussion it was agreed that the report / update should go to QSAG for assurance. The assurance should then be escalated to this meeting.
				~~24.06.15~~	CE reported that Carol Bott is back from sickness and CE has spoken to Paul Archer in regards to where we are at with the league tables for Directorates. Work is on-going which includes a dashboard to come to here and Trust Board.
				21.10.15	JO informed the meeting that this item was discussed within QSAG and the management of the complaint process. JO reported that Paul Archer had done some good work and had a good grip on the role. This item is being brought back to QSAG.

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
9	JV asked CEm to organise a meeting with himself, MA, Adrian Sargeant and Roger Dunshea to discuss committee cycle	CEm	23.09.15	21.10.15	Arranged for 9 November 2015
4.2	MA asked if the Directors were still happy to receive the risks and circulate to their teams or did they want Sukhbinder Khunkhuna to circulate direct to their teams and be sent to the Directors for final sign off. After discussion it was agreed that MA would e-mail the Directors and ask for their opinion	MA	23.09.15	21.10.15	SH confirmed that this had been completed
4.1	JA queried medication incidents as this report had no incidents causing serious harm but the QSAG report indicated that there was 1 with harm. CE agreed to investigate.	CE	22.07.15	~~23.09.15~~ 21.10.15	Bring forward to the next meeting. JO replied that this issue should be resolved following the instillation of the Medicine Safety Group. JO confirmed that there will be a better process in place. Close
4.1 – June 15	JA queried the number of unexpected term babies to Neonatal unit, in May there were 3 unexpected admissions. This was discussed in-depth and It was agreed to provide brief detail for each full term baby admitted to the neonatal unit unexpectedly to enable this meeting to note any trend or concern regarding care. **CE agreed to do the action.**	CE	24.06.15	~~22.07.15~~ 21.10.15	CE confirmed that the Directorate will come and present to the October QGAC. CE has received a letter regarding 3rd& 4th degree tears. National Midwifery guidelines have been reviewed and the Trust will now be adhering to them. Dr Sullivan is attending the meeting on the 21 October, agreed to close

4.2	JA queried **TRR risk 3431** and why it stated CAUSE. JA asked if New or Old could be identified by each risk. MA to action.	MA	23.09.15	~~21.10.15~~ 25.11.15	GN reported to the meeting that this had not yet been actioned. SH agreed to make the necessary changes. Actioned – to be closed
4.2	JA queried **TRR risk 3431** and why it stated CAUSE. GN to remove CAUSE.	GN	23.09.15	~~21.10.15~~ 25.11.15	GN reported to the meeting that this had not yet been actioned. SH agreed to make the necessary changes. Actioned – to be closed