The Royal Wolverhampton NHS Trust

CHAIRMAN'S SUMMARY REPORT
Quality Governance Assurance Committee May 2018
4 June 2018

Agenda Item No: 12.5

The Royal Wolverhampton NHS
NHS Trust

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:	May 2018	
Action Required by receiving committee/group:	√ For Information □ Decision □ 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	**Advise** **<u>New committee structure</u>** Detailed minutes from QSIG and COG continue to give insight into the depth and detail of the discussions at these committees, in addition to the respective chairs' reports. In future CLIP will report to COG. **<u>QGAC agreed an objective for 2018/19</u>:** That the Trust will have developed during the year metrics which will enable the Board to be assured that it can adequately assess the performance of all the divisions, including in particular the new Community and Primary Division 3. Previous Community metrics have been removed from IQPR and the VI metrics, while welcomed, will need further refinement. QGAC will take an interest during the year in the ideas for metrics the new management team in Division 3 will be developing. **<u>PALS Safeguarding report</u>** This report to CLIP provided an update on complaints processed through the formal statutory complaint process which did not meet the Section 42 criteria to be considered as a Safeguarding investigation, and which no longer appears in the IQPR. This information will in	

	future be included in the Patient Experience Report to the Board. The report presented data from April 2017 to March 2018. The Trust received 31 complaints which did not meet the Safeguarding criteria, approximately 8% of complaints received during this period. Of these, 16 related to general care of the patient - pressure ulcers. Other themes included communication, patient discharge, information, resources and clinical treatment. A meeting with the safeguarding team was proposed to review training / learning requirements particularly around improving communication with nursing homes and patient discharge. **Themed reviews** QGAC expects to receive a report on Emergency C-sections in July, and on Cancer waiting times in June. **Assurance** **Organ Donation Six Monthly Report to COG** For the financial year 2017/18, the Trust achieved 100% referral rate for potential organ donors (DBD/DCD) – a total of 9 patients. Seven of these patients proceeded to become actual organ donors, which is a significant improvement over previous recent years. The improvement is due to a change in leadership and team working and also a revised organ donation structure. **Hospital Transfusion Group Report to COG** Generally, performance relating to transfusion matters is very good across the organisation. Of note, there were 11 Serious Hazards Of Transfusion (SHOT) reportable incidents reported between 1st October 2017 – 31st March 2018, three of which were in obstetrics (low grade) including two anti-D treatments given to the wrong and/or inappropriate patients. Mandatory Training compliance for transfusion is currently at 90.4%. Notably, whilst all staff have access to the national e-learning package a more “user friendly” bespoke local e-learning training package has been developed, which may facilitate improved compliance figures. **QRV A5 Trauma and Orthopaedics** Generally positive report to QSIG on this, with all domains scoring good apart from safety which requires improvement, and response from A5 Wards Sister gave examples of improvements made or in hand since the visit. Detailed and pertinent discussion at QSIG.

Report: National Reporting and Learning System (NRLS): how to understand your patient safety incident reporting

This report from NRLS compared RWT's data from April 2016 to September 2016 with data from the same period in 2017. The board can take assurance from the fact that there is no evidence of potential under-reporting of incidents as a whole, there was no significant change in reporting levels per 1000 bed days, and reporting is now more timely. Governance will be looking at whether incidents classified as low and no harm are correct, whether the spread of reporting indicates any areas not that may not be reporting, and will monitor themes.

Legal Report

The paper to CLIP covered the reporting period April 2017 to March 2018. Compared with 2016/17 there has been a decrease in the number of clinical negligence claims received and an increase in the number of claims closed with no financial settlement. There was an increase in total damages and costs between 2016/2017 (£1,095,801) and 2017/2018 (£7,384,973), but this was due to historic high value claims being settled. There was a significant decrease in the number of personal injury claims received and an increase in the number of claims closed where the trust had denied liability and the claimant had not pursued any action, resulting in the period for making a claim expiring. There were 2 matters which were subject to adverse decisions by the H M Senior Coroner during this financial year.

Partial Assurance

IQPR: Cancer waiting times

While other indicators showed improvement in April, cancer waiting times showed a drop, particularly 2 week breast symptomatic, down to 42.37%. This was partly due to local factors raising demand by 30%, but it also seems that nationally pressure is increasing. The Cancer Intensive Support team is visiting the trust w/c 4 June to look at pathways. Simon Evans gave a presentation to F&P on a cancer dashboard to track performance more closely, and will do so for QGAC in June.

SUI Report discussed at QSIG

Divisions to review outstanding SUI actions with a view to rationalising what needs to be done or to close; and to carry out theming of actions for commonality. Small group set up to discuss the detail, and feed back to QSIG. The issue of overdue actions from other items e.g. external reviews, Health and Safety etc were highlighted for the attention of both Divisions.

Quality Review Visit D7

QSIG received a report of a revisit in December 2017 following an earlier visit in February where there were 3 domains scored as requiring improvement. The revisit confirmed that improvements had been made, but 2 domains were still scored as requiring improvement. It also revealed multiple issues from different staff disciplines including documentation completion, use of stamps and the absence of standard ward rounds due to multiple specialty outliers on the ward. The issue of the knowledge, skills and training of D7 (Gynae) ward staff to manage multiple specialty patients was highlighted and consideration of training needs and support was to be given.

NatSips Audit reports to QSIG

Reports were received from Care of the Elderly (CoE) and Urology OPD. CoE reported positive assurance on safety and needed to take forward actions around the consent and patient information leaflets for elective Lumbar Puncture. Urology OPD reported positive results but audit sample size was small, therefore was asked to provide re-audit results in 6 month.

Trauma Governance Group - report to COG

Whilst there has been an improvement in compliance against the performance standards with respect to Trauma governance, two specific areas require a focus of attention, as follows:

Patients with an ISS (injury severity score) greater than 15 to be seen by a Consultant within 5 minutes of arrival in ED. At present only 3.7% of such patients are assessed within this timeframe, compared with the Trauma Unit average of 14%. Improved triage and utilisation of a “Trauma documentation booklet” will improve compliance.

Time to CT scan for head injury patients should be less than one hour. However, the Trust scores 33.3% compliance against the Trauma Unit average of 60%. The protocol for Trauma CT scans has now been agreed with the CD of Radiology and following this protocol, should enhance compliance. The Trauma Governance Lead will meet with the CD and Clinical Lead of the Emergency Services to discuss both of the above.

VTE Prevention & Treatment - report to COG

Compliance for VTE prevention and treatment assessments for patients admitted to the Trust is set at a minimum of 95%. Historically, the Trust reported compliance data for patients who received their VTE assessment at any stage following their admission. From April 2018 it has been agreed to report compliance against only those assessments made within 24 hours of admission. The Trust is to ensure assessments are undertaken across all admission portals/areas to maximum effect, including the use of the Maternity

	Badger system to enable electronic capture of ED assessments in Maternity. In addition, the VTE assessments have been extended to include 16-18 year olds. Previously, the cohort only included the patients 18 years of age or older. The impact of this new change is uncertain. **<u>Never Events Report</u>** CLIP discussed the summary report covering all never events recorded from January 2017 to March 2018. The majority of causative omissions identified were human factors/human errors and CLIP considered what other aspects, e.g. of the environment contributed to the human errors. **No assurance** **<u>Health & Safety Steering Group (6 monthly) Report</u>** COG was informed of a number of areas across the Trust where there are gaps/areas of concern with a major or moderate level of risk, due to non-compliance with regulations. The departments identified will be managed through Divisional processes in the first instance.
Risks Identified: **Include Risk Grade (categorisation matrix/Datix number)**	