Minutes of the Quality Governance Assurance Committee

held on the:

Date **Wednesday 20 June 2018**

Venue **Room 1, WMI**

Time **2.00pm to 4.00pm**

	Name	**Role**
Present:	R Edwards **(RE)** - Chair	Non-Executive Director
	M Arthur **(MA)**	Head of Governance & Legal Services
	A M Cannaby **(AMC) (Part)**	Chief Nursing Officer
	D Hickman **(DH)**	Deputy Chief Nursing Officer
	G Nuttall **(GN)**	Chief Operating Officer
	J Small **(JS)**	Non-Executive Director
Attendees:	Simon Evans **(SE)**	Deputy Director of Planning and Performance
Apologies:	D Loughton	Chief Executive
	Dr J Odum	Medical Director

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1	**Apologies for absence** Apologies were noted.	
1a	**Declarations of Interest** There were no Declarations of Interest.	
2	**Minutes of Previous Meeting - Quality Governance Assurance Committee:** **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 30 May 2018 were approved as a correct record.**	
3	**Matters arising from the Minutes** The action log was updated accordingly.	
4	**Regular Reports**	
4.1	**Cancer Dashboard Presentation – Simon Evans** SE presented to the meeting the Cancer Performance Dashboard. The meeting was informed that the dashboard was created to monitor where the Trust is with cancer performance. SE reminded the meeting that cancer is on the Trust Risk Register and the Trust is at an unacceptable level in terms of our cancer performance. This has been recognised and a cancer recovery plan is in place. SE mentioned that there were a lot of complex and different reasons why the cancer performance is in the position it is currently in. SE confirmed that the cancer recovery plan has been agreed and signed off by NHSE and NHSI. The Trust has been visited by an Intensive Support Team (IST) last week to support with cancer improvement. SE explained the dashboard to the meeting and explained that it was still a work in progress. When completed the dashboard will be available on the Information Portal which allows any Manager across the Trust to access the dashboard. The meeting was advised that the Trust has received 10 weeks of cancer referrals in the first 9 weeks of the financial year. RE asked what managers are able to do with this information able to influence waiting times. SE replied that it feeds into the recovery action plan. The Trust is currently working hard on getting tests and reports on tests done as quickly as possible, and also examining the impact of test reports on MDT discussions for individuals. Test results for individuals with an MDT scheduled can be speeded up to ensure they are available for that date and avoid the patient's case having to be postponed to the next MDT slot. SE advised the meeting that the Trust needs to see over 1500 patients every month to keep ahead of ourselves. The meeting was informed that all patients referred to this Trust are offered an initial appointment within 2 weeks, however if the appointment is on day 12 and the patient declines the appointment, a new appointment cannot be made by the 14th day and therefore the patient breaches. SE informed the meeting that the Trust is aiming to offer	

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	patients an initial appointment within 7 days. The Cancer Services department is currently working on Saturdays to reduce the waiting times. Work is on-going with the GP's to reduce the number of referrals to the Trust. Dr Simon Grumett, Trust Cancer Lead, is speaking to those in Primary Care about actions to take prior to the referral. The meeting commented that late referrals were one of the reasons for poor cancer outcomes in the UK, and that while reducing inappropriate referrals was a good thing, we should expect referrals to increase and as a result needed adequate diagnostic capacity. On behalf of the Committee, RE thanked SE for the presentation and assurance. **Integrated Quality & Performance Report – May – AM Cannaby** AMC presented the quality section of the report and advised the meeting that there were some changes to the report and discussions are on-going in regards to further changes within the report. AMC expressed her thanks to the staff that create this report as the data pulled is done manually and not electronically. The meeting noted that late observations had sustained over the last 2 months and both Divisions were below target. Late Patient Moves saw a slight reduction in May, saw some baseline work undertaken over the last month to look at the reasons why patients are moved out of hours. Main issues were capacity, Portering delays and a small percentage around clinical need. AMC is meeting with the Matrons next week to review, once this has been completed AMC and GN will discuss the findings and plan to resolve and put process in place prior to winter. Mortality will be added to the report including avoidable deaths and RCA's for quarter 3 and quarter 4. DH explained how the RCA's are conducted for Mortality and how the new SJR process is completed. AMC informed the meeting that the CCG are keen for Mortality to be included in this report. RE mentioned a dashboard single page report included in a local community trust's IQPR. AM was interested to see this and RE agreed to forward it to her. The meeting discussed Mortality and what will be included in this report AMC advised the meeting that DH is leading a group in regards to Patient Falls; this will be an on-going group. The meeting noted that VTE's had seen a combination of issues, including software issues. AMC is in meetings next week to understand further. DH advised that it was a big piece of work that needed to be unpinned. A spike has been noted in C-diff, MRSA and MSSA. AMC mentioned that some of it will be due to hand washing and some will be environmental. The meeting was assured that cleaning and decanting the wards will now be a priority. The meeting noted a spike within radiation incidents. AMC had been informed by the department that this was due to increased activity, but she questioned how this could affect percentages and is meeting with the department to get clarification. AMC advised the meeting that the target of 95% for mandatory training within Safeguarding was too high and would be reduced. The position for Named Midwife was being advertised. The meeting noted a report in regards to Safer Staffing and AMC explained that it was a	

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	methodology which is used across the UK. Following lengthy discussion AMC asked which graph / report did the meeting wish to see in the report. The meeting agreed to feedback with their views and AMC will feedback to the CCG. GN presented the performance section of the report. GN advised the meeting that the Performance section of the report was discussed in detail at the Finance & Performance earlier in the day. The meeting noted that there was a slight improvement in cancelled operations, which for the second month is in green; GN advised the meeting that she is expecting this to be maintained. RTT is improving in line with the Trust forecast trajectory. The Committee noted an improvement in the total time spent in Emergency Department in May, increased to 90.27% from 84.09% in April. However, there was one 12 hour breach in May for a mental health patient that was transferred to London. The CCG are undertaking an RCA, GN did inform the Committee that male mental health inpatient beds are virtually non-existent nationally. RE asked about Vocare and their performance which has gone down slightly and asked whether their difficulties in staffing their centre at University Hospital of North Staffordshire could impact staffing levels and performance here. GN mentioned that Vocare were still struggling with their staffing levels and breaches occur within Vocare predominately at weekends. Following the presentation at the beginning of the meeting in regards to cancer performance, GN advised the meeting that she does feel that the right things are being undertaken. GN reported that the Trust have been invited to a further meeting with NHSI in July to discuss the actions. **Resolved: Report was accepted**	
4.2	**Board Assurance Framework / Trust Risk Register – M Arthur** MA presented the BAF and TRR papers to the meeting. The meeting was informed that there was very little change on the BAF this month. Only two risks have had updates: **SR1 –** Workforce – attraction, recruitment and retention of staff across the Trust and in particular the future pipeline of nursing and medical staff – business case to be developed to fund an electronic tool which helps to improve staff engagement and communication. **SR6b –** Black Country or Staffordshire STP has an adverse impact on RWT income or services – update to say no change. **BAF Key Issues** 0 new risks. 0 risks closed. 3 red risks: **SR1** - Workforce - Recruitment and Retention of staff across the Trust and in particular the	

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	future pipeline of nursing and medical staff **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus. **Trust Risk Register Key Issues** 1 new risk: **5045** – Sepsis (MD) – MA informed the meeting that this had been populated very heavily and work needs to be undertaken to refine the description of the risk. 1 risk removed: **4767** - Hip Fracture Best Practice Tariff (COO) – this has been downgraded to a 6 and will be managed on local risk registers. 5 red risks: **2080** - Risk to quality of patient care: reduced manpower (COO) – positive assurance added to the risk regarding funding for the skill mix being accrued and work happening on the nursing strategy. **4661** - Lack of robust system for review and communication of test results (MD) – this risk needs to be updated with results if available. **4472** - Delays in Cubicle Assessment and Triage (COO) – there has been update and assurances on this risk. **4113** - Division 1 failure to achieve CIP target (COO) – no changes to the assurances and all of the actions are in date. **4903** - Risk of non-compliance with Thoracic Service Specification (COO) – GN confirmed that the appointment had been made to the position. GN commented that this risk will deescalate when the staff member starts. MA mentioned risk 4734 – Mortality risk (MD) – there is no positive or negative assurance but there is on-going work into the investigations of alerts that have been received. Positive and negative assurances need to be populated. DH advised that JO is developing an action plan which will help to populate the risk. RE noted from QSIG minutes that the SHMI is the worst in the country. The meeting noted that every time a new list was published the RWT position deteriorated. It noted that while much work had been done on determining the reasons for this, it was an uncomfortable position to be in and represented a repetitional risk. RE commented that it was very important for the trust to show that it was adhering to the requirements of the Learning from Deaths Guidelines, and could show how individual cases were being reviewed and assessed. It was agreed that the risk rating needed to be and reviewed due to the repetitional risk to the Trust and that this should be flagged up in the QGAC chair's report. The meeting was told that the next detailed report on Mortality is due in July and asked that this report should come to QGAC. JS commented that the BAF and TRR are a lot clearer and easier to understand.	**JO** **JO**

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	Resolved: Report was accepted	
5	**Sub Group Reports**	
5.1	**Chairman's Report – Quality & Safety Intelligence Group (QSIG) – May 2018 – D Hickman** **COG items for escalation highlighted:** Nothing of significance to raise from COG for month of May 2018 **Divisional Integrated Governance Report and Data Pack** 1. Division 1 / Mortality poor returns noted back to SharePoint. Division advised two component issues, methodology change and also technically upload to SharePoint is difficult. The system is being reviewed via MRG and Directorates are presenting to Divisional Governance in terms of compliance with returns. 2. Division 2 / Falls assessment was noted that medical engagement is the challenge. The clerking proforma to be reviewed to check whether there is a section for relevant points around Falls Prevention by Divisional Medical Director. **SUI Report** It was noted that the following actions within the SUI report relate to corporate policies; For Division 2; work is on-going regarding the Safeguarding Policies (2015). For Division 3; there is a review regarding the Antibiotic Pathway (2016). All areas have been asked to review their actions. Chief Nurse will discuss with Healthcare Governance Manager outside of QSIG. **NatSips Audit reports –** Reports were received from Renal and accepted. **Quality Review Visit D7** C19 Respiratory – deferred to June (Lead unavailable to present) A14 General Surgery Revisit – deferred (Lead unavailable) **Resolved: Report was accepted.**	
5.2	**Quality & Safety Intelligence Group minutes – May 2018** The meeting accepted the minutes from the May meeting.	
5.3	**Chairman's Report – Compliance Oversight Group (COG) – May 2018 – D Hickman** 1. Creating Best Practice Programme work streams have been main-streamed/reduced and will be reviewed for a future way forward. 2. Pressure Ulcer and Tissue Viability Report – A positive reduction in avoidable pressure injuries is reported, with focus needed to address avoidable pressure injuries relating to discharge to Care Homes and complexities within Community Services (including completed CHC assessments)	

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	3. Medicines Management Report – Following the launch of ePMA datix incident monitoring found 10 ePMA related incidents (for April 18). One relates to insulin not being prescribable on ePMA. To mitigate risk systems for insulin management are implemented and audited and the redress of this is prioritised by the medicines Management group. 4. Safeguarding Adults and Children Report – A Wolverhampton CCG Quality visit due in June is expected to assess improvements since 2016 CQC inspection of safeguarding. An outstanding action from the Lampard report relates to vetting and barring processes and an approach to be finalised for the Trust. 5. Clinical Audit report – Positive assurance report on the completion and compliance shown from clinical audit at year end. Work is underway to develop a strategic plan for Clinical Audit for the next 3 years. 6. NCEPOD 'Inspiring Change' Report – A request was made for retrospective Mortality data (including Respiratory pathway) to be reviewed and reported earlier to MRG (in 3 months' time). **Resolved: Report was accepted.**	
5.4	**Compliance Oversight Group minutes – May 2018** The meeting accepted the minutes from the April meeting.	
6	**<u>Assurance Reporting / Themed Reviews</u>** **6.1 – Clinical Audit (Annual) Report** In the absence of JO and Dr Cherukuri, this report was not presented but was read by the Committee. GN assured the meeting that the report had been presented to the sub-committees and challenges are made and answered. There has been good progress over the years. RE commented that the report had been seen by QSIG the previous month and reported to the Board as a positive assurance, and that the report has been following a steady trajectory of refinement and improvement in terms of, e.g., prioritising audits and accounting for audits abandoned JS noted that the proportion of low priority audits had declined, and asked why if an audit is a low priority why do we do them. GN replied it is how the Divisions prioritise them. **6.2 – Health & Safety Assurance Report – M Arthur** MA presented the report and highlighted the following key points to the meeting: **H&S Achievements and developments** • Estates Accreditation – CHAS (Contractors H&S accreditation scheme) • Building new incinerator by end October 2018 • Roll out of segregated offensive waste disposal system by end 2018 • CCTV recording system upgrade in Control room • Infection Prevention achievements e.g. Cdiff under trajectory	

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	Performance 2017/2018 1. 13.8% in reported Health & Safety incidents within sharps, contact injuries, manual handling, violence & aggression. There has also been a 2% reduction in Slip, Trips and Falls. This correlates with decrease in Personal Injury claims. Of the report page 24 shows numbers of incidents per 1000 wte over past 4 years also decreased. 2. Overall decrease in sharps incident reported - 231 in 2016 down to 176 in 2017. Splash injuries and suture needles are still a problem. 3. Increase in RIDDOR reportable incidents in 2017/2018 - increased from 33 to 38 in 2017/2018. Majority of Slip, Trips and Falls saw many occurring over winter. 4. Health & Safety Audit programme (includes review of incidents, risks, Health & Safety training, Observation of MH, sharps, environment, access to Health & Safety / COSHH folder, staff questionnaire, local quarterly inspections). Improved compliance across Division 1 and 2 with follow up work needed in Corporate, Estates and Facilities. 5. Training - Follow up needed to improve numbers – Breakdown and spread of staff will be targeted in 2018 / 2019. 6. No overdue safety alerts – Work to review/audit assurance on closed alerts is planned for 2018 / 2019. 7. Two HSE visits in 2017 / 2018 regarding TB incident and Pathology (routine) – requirements satisfied no actions. 8. In year challenge re staff – work reprioritised, recruitment underway. 9. Lack of first aid trainer to be addressed – May need interim bought in service **Plans for 2018/2019** HSE are prioritising Stress – Reminding of the need for Team and individual stress and action plans. Governance – Health & Safety good to great action plan - (Evaluate safety reps support, clarity of local Health & Safety roles, testing assurance on risk profile, innovate systems) Infection Prevention – develop work streams and projects including sustain Cdiff reduction, device related bacteraemia and a strategy to reduce urinary catheters. Waste – Increase recycling at ward/department level Fire safety – Capital projects in Deansley, Main Theatres and Tugway. Continue RM plan and await outcome of Grenfell Tower Inquiry. GN advised the meeting that the Trust has received the capital funding centrally to replace the cladding. The work needs to be completed by the end of the financial year.	
7	**Issues of Significance for the Audit Committee** There were no issues of significance for the Audit Committee. **Issues of Significance for the Trust Board** **Advise** Division 3 reported for the first time to QSIG. The first Division 3 Governance and Performance Quality meetings have taken place.	

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	QSIG report that Creating Best Practice Programme work streams have been main-streamed/reduced and will be reviewed for a future way forward. Safeguarding Adults and Children Report to QSIG – A Wolverhampton CCG Quality visit due in June is expected to assess improvements since 2016 CQC inspection of safeguarding. An outstanding action from the Lampard report relates to vetting and barring processes and an approach to be finalised for the Trust. QGAC received the Health and Safety Annual Report and were pleased with its coverage and the clear way it presented progress with issues. QGAC considered that the updates to the BAF and TRR were well explained by the covering report and found the maintenance and updating of the TRR helpful and useful. **Assurance** Clinical Audit report – QSIG reported positive assurance on the completion and compliance shown from clinical audit at year end. As at the end of March 2018, the completion rate for audit is 91%. Work is underway to develop a strategic plan for Clinical Audit for the next 3 years. QGAC discussed the report and were pleased with the way the clinical audit process has developed and become increasingly rigorous. **Partial assurance** Cancer waiting times: QGAC received a presentation showing how detailed daily monitoring of key indicators enabled RWT to see whether progress was being made, if not why not, and what needed to be done. Focus is on: early diagnostics; reducing the time to report on diagnostic tests and fitting these in with MDTs for individual patients; early appointment offers to allow scope for patients to vary the date without breaching targets. Monitoring data shows a significant rise in referrals and patients starting on pathways, and an underlying lack of capacity. Pressure Ulcer and Tissue Viability Report – A positive reduction in avoidable pressure injuries was reported to QSIG, with focus needed to address avoidable pressure injuries relating to discharge to Care Homes and complexities within Community Services (including completed CHC assessments) Division 2 / Falls assessment: QSIG noted that medical engagement is the challenge. The clerking proforma to be reviewed by Divisional Medical Director to check whether there is a section for relevant points specifically for medical staff around Falls Prevention. Medicines Management Report – Following the launch of ePMA, datix incident monitoring found 10 ePMA related incidents (for April 18). One relates to insulin not being prescribable on ePMA. To mitigate, risk systems for insulin management are implemented and audited and the redress of this is prioritised by the Medicines Management Group (MMG). Further issue identified was a window of 30 minutes between amending a prescription and revised actions appearing on ePMA. A software amendment reducing this window to 15 seconds has been installed. Mortality: QGAC is due to receive a mortality report, and will wish to be involved in developing the mortality dashboard for reporting to the board and to be assured that reporting covers all the essential items in the national guidance on learning from deaths	

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	Risks identified By COG: ePMA Insulin Management – Monitored via MMG New Risk on TRR: sepsis, 5045: amber risk, reflecting the nationally high risk of sepsis and the priority for all trusts including RWT to reduce deaths from sepsis. Increased risk: Mortality: 4734, p30 of TRR: QGAC noted in QSIG minutes, div 1 report: *JO pointed out we have the highest SHMI in the country which has attracted attention. There is significant view outside the organisation regarding the SHMI and HSMR equals excess mortality / avoidable mortality so we will need to address this way.* QGAC, while sighted on the actions being taken to identify the causes of the high SHMI and to review and investigate deaths questioned whether the reputational risk should increase the risk rating.	
8	**Evaluation of Meeting – ALL** On time, extra presentation which was very helpful from Simon Evans.	
9	**Any Other Business – ALL** AMC advised the meeting that CQC are coming to into 4 of the Trust's practise's on the 5 July.	
10	**Date and time of Next Meeting:** Wednesday 25 July 2018, 2pm to 4pm, F127, Building 12 – **please note change of venue**	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.2 / 20.06.18	**4661** - Lack of robust system for review and communication of test results (MD) – this risk needs to be updated with results if available.	JO	20.06.18	25.07.18	
4.2 / 20.06.18	MA mentioned risk **4734** – Mortality risk (MD) – there is no positive or negative assurance but there is on-going work into the investigations of alerts that have been received. Risk to be populated. DH advised that JO is developing an action plan which will help to populate the risk. Following discussion it was agreed to review this risk and reviewed due to the risk of the reputation to the Trust.	JO	20.06.18	25.07.18	
4.2 / 30.05.18	**4862 –** Neonatal cots – RE asked if the business case for additional staff had been approved at the April TMC, GN confirmed that it had and the department are out to recruitment. RE asked for the action regarding comment commencing *There are ongoing incidents relating to the lack of clinical equipment etc*, GN agreed to review this.	GN	30.05.18	~~20.06.18~~ 25.07.18	GN reported that 4862 is going to be amalgamated with risk 4962. GN said that when she asked about "ongoing incidents relating to the lack of clinical equipment etc" no-one knew of any. RE asked that, in order to close this out, the originators of the risk be formally asked for the reasons behind this previous negative assurance, whether there had been any incidents, and what action had been taken. Bring forward to July meeting.

8.2 / 30.05.18	**Committee Self-Assessment of Effectiveness** RE presented a QGAC Effectiveness checklist to the committee. After agreement it was agreed for CE to circulate and with the closing date of 4 weeks after this.	CE	30.05.18	~~20.06.18~~ 25.07.18	CE confirmed that the closing date is the 11 July – bring forward to the July meeting.
5.2 / 25.04.18	**1713** – JS asked GN about the business case for recording electronic tool to assist with job planning. GN replied that an update paper went to the Executives, GN to add a revised date to this risk.	GN	25.04.18	~~30.05.18~~ 20.06.18 25.07.18	GN reported that she had had a conversation with Brian McKaig regarding conducting a complete review of the job planning risk. Brian McKaig will be reporting to the Audit Committee in August. Bring forward to the next meeting. GN confirmed that she had spoken to Brian McKaig who agreed to update the risk; however, this will now be done in readiness for the Audit Committee in August. Bring forward to the next meeting.
4.1 / 21.03.18	JS and RE expressed concerns about the rise in emergency C-Section rates, which had been increasing since November 2017 when it first went red and now stood at 20.6% compared with target of 14%. CE said that the rate tended to rise and fall over the year and usually ended up at around 20-24%. RE commented that this set of figures was looking more like a trend and JS asked if a report could be presented at either the April or May QGAC meeting with the findings of the review conducted by the Directorate. CE to request the said report.	CE	21.03.18	~~April or May meeting~~ ~~30.05.18~~ **25.07.18**	This action has not been picked up – DH agreed to sort and confirm if the report could be presented in May. Bring forward to May RE confirmed that a report will be presented in July due to data collection.

9 / 21.02.18	MA mentioned that CE and RE were going to discuss at this meeting NED attendance at the PSIG and QSAG meetings, which are due to be renamed in March. Following a brief discussion, it was agreed to defer to the next meeting. CEm to add to the March agenda.	CEm	21.02.18	~~21.03.18~~	CE informed the meeting that herself and RE had spoken. The terms of reference has is for Compliance Oversight Group and Quality & Intelligence Group. It was agreed that after 3 months the meetings would be evaluated to see the impact in terms of QGAC and to make sure that this meeting is assured that the attendees are not missing out on information that is filtering up.
		CE		25.04.18 **25.07.18**	Bring forward – **Review of how the pilot committee structure is working.**
		CEm			CEm to speak to Keith Wilshire re sub groups being on Boardpad. – Completed – add documents to the Reading Room.

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
4.1 / 30.05.18	It was noted that at the early meeting of Finance & Performance, Simon Evans presented a new cancer dashboard that has been developed in house and will help to track the Trust performance. This was discussed at length and it was agreed to invite Simon Evans to the June QGAC to view this dashboard.	CE	30.05.18	20.06.18	Completed - Close
4.2 / 30.05.18	**3069** – Never Events within the Division – JS asked if this risk had been updated to reflect the meeting with the CCG in April. AMC to update.	AMC	30.05.18	20.06.18	Completed - Close
5.3 / 30.05.18	Concerns were raised by the meeting regarding the content of the Health & Steering group report. Following discussion, it was agreed that MA would speak to Margaret Simcock and clarify. MA to also send the Health & Safety Steering Group (6 monthly) report.	MA	30.05.18	20.06.18	 Enc 4.5 HSSG Report COG Apr 18.docx  Email from MA to QGAC members with l Completed - Close
5.2 / 25.04.18	**4962** – RE queried *Evidence that it is working point 2, 102% occupancy in Q2 in Intensive Care (Feb 18),* RE feels that this does not show that it is working at 102% and after a brief discussion it was agreed to move to the column *Any evidence that it is not working*.	GN	25.04.18	~~30.05.18~~ 20.06.18	Bring forward to the next meeting. Close – revised risk – now amalgamated with 4862
5.2 / 25.04.18	**3069 –** JS asked if an update could be added to the *What else can we do?* column following the meeting for assurance. GN agreed to update.	GN	25.04.18	~~30.05.18~~ 20.06.18	Bring forward to the next meeting. Completed - Close