NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	17 July 2018
Paper number	D2

Quality Governance Committee Assurance Report

For approval:		For assurance:	x	To note:	

Accountable Director	Bill Tunnicliffe Non-Executive Director		
Presented by	Bill Tunnicliffe Non-Executive Director	**Author**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners	x	Invest and realise the full potential of our staff to provide compassionate and personalised care	
Ensure the Trust is financially viable and makes the best use of resources for our patients		Develop and sustain our business			

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance		Quality of Care	x
Finance and use of resources		Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Not applicable		

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	P1.1 P1.2 P1.3

Please see the individual summaries in the report

Level of assurance and trend							
Significant assurance *High level of confidence in delivery of existing mechanisms/objectives*	☐	**Moderate assurance** *General confidence in delivery of existing mechanisms /objectives*	☐	**Limited assurance** *Some confidence in delivery of existing mechanisms /objectives*	☐	**No assurance** *No confidence in delivery*	☐

Recommendations	The board is requested to • Approve the change in risk rating from 16 to 12 for board assurance risk 1.2 • Receive this report for assurance.

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Executive Summary

Never events: the Committee received an update in relation to the action plans associated with the misplaced naso gastric tube and the removal of the incorrect tooth never events. The Chief Nurse expressed concern that the development of the naso gastric tube policy has been too slow. She is personally pursuing this. She stated that the learning was essential and this had taken place. The Chief Medical Officer stated that one recommendation will remain red due to the lack of stroke consultants in post and the inability to provide seven day working. I have requested a regular report on never events and serious incidents to be presented to the Committee.

Surgical services review: The Divisional Medical Director for Surgery, Mr Paul Rajjayaban attended the meeting together with colleagues to explain the actions taken since the receipt of the Review undertaken by Mr Tim Graham. There was obvious commitment to the actions identified and currently being undertaken. It was acknowledged that the findings within the recent CQC report were disappointing but the Division stated that getting the fundamentals right (e.g. hand washing) was imperative. We also discussed the vision and the working of the Division. It was acknowledged that the Review had provided a catalyst for change for example 7 day working. The Division will be asked to report again to the Committee as part of the routine divisional reporting to QGC.

CQC report: The Committee received the CQC report which was published in early June. The action plan should be submitted to the CQC by the end of June. We also received a list of 'Must Do's and Should Do's'. These actions are also be mapped to the Quality Improvement Strategy. The Committee received a demonstration of a tool being used to monitor the actions being undertaken. We will receive an updated report at our July meeting.

Clinical Governance Group (CGG): The Committee received a report outlining the key performance indicators mapped against the key plans underpinning the Quality Improvement Strategy. **Limited assurance** overall**. Moderate assurance** for Patient Experience.

Complaints and PALS annual report: The Committee approved this report for presentation to the Trust Board and the report is later on the agenda. There has been a concerted effort within the Trust to improve performance within this area. The Committee heard that a key area of going forward is ensuring learning is embedded within the Trust. The Committee has requested review of PALS resource. **Moderate assurance**

Monthly Mortality Performance Report: The Chief Medical Officer reported that both the HSMR and SHMI were not outliers at values of 104.82 and 104.53. The review into the pneumonia high HMSR has revealed that there are significant coding problems and practice has changed to ensure that this does not re-occur. The elevated weekend HSMR is being investigated. He will be writing to Dr Foster to request a review of the sepsis HSMR as the Trust is no longer an outlier. There is an increasing number of mortality reviews being undertaken but learning from mortality reviews remains patchy across the divisions. **Limited assurance**

Safeguarding Annual Report: The Committee approved this report for presentation to the Trust Board with the additional of further information in relation to training. Progress has been made in many areas, in particular the liaison with external agencies. **Limited assurance**

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HealthWatch Care in the Corridor: The Chief Nurse presented the report. She has met with the Chief Officer of HealthWatch and the Committee will receive the action plan associated with the report at our meeting in July. The Committee acknowledged the work undertaken by HealthWatch in undertaking the survey and producing the report.

Breast Screening incident update: This paper related to the national screening programme's alert that some women had not had their appropriate screening. Within Herefordshire and Worcestershire, this affected 4000 women. The Committee received assurance in relation to the process and numbers being screened. We will receive an updated report at a later meeting. **Moderate assurance**

Safety Alerts: The Chief Nurse and Chief Medical Officer are reviewing the process for managing alerts. This will be bought back to the next meeting. **Limited assurance**

Risk Management Strategy & Handbook: The Committee approved the document for submission to Trust Board.

Board Assurance Framework: We received proposed changes to the BAF risks 1.1, 1.2, 1.3 and 2.1. We are recommending the following:

Risk 1.1 *The Trust fails to deliver safe, high quality compassionate patient care to our patients*

- KPI - Change to the metric in respect of national audit reports (links to the Clinical Effectiveness Plan agreed by the QGC earlier this year)
- Rationale - Removal of the sentence in respect of complaints process needing review
- Control – addition of divisional governance leads
- Gaps in control – addition of divisional governance leads and their role
- Gaps in assurance – role of governance leads.

Risk 1.2 *The Trust fails to deliver safe, high quality compassionate patient care to our patients*

- Reduction in risk score to 12 from 16 (reduction in severity from 4 to 3). The rationale for this proposal is the following:
  - Six improvement collaborate projects in place
  - Risk management strategy and handbook revised
  - Divisional quality improvement plans in place
- Gaps in assurance include
  - clear plans for earned autonomy
  - CGG terms of reference – revision
  - Clear framework for trained staff in QI methodology

Risk 1.3 *There is a risk that patient safety and performance may be adversely affected due to weaknesses in systems and processes*

- Insertion of the policy on Diagnostic Tests - Including the Requesting Process and Review with Acknowledgement
- Completion of actions – 6 out of 10 level 2 actions have been completed. There is a more detailed report relating to this audit in the private part of the agenda.

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Risk 2.1 *The Trust is unable to design healthcare around the needs of our patients, with our partners*

- Additional mitigating actions in place

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Mandatory Training update: The Committee received an update on mandatory training compliance from the Director of People and Culture. **Limited assurance**

Received for information

- **QGC work plan**

Items discussed at the May QGC meeting:

- **Infection prevention and control**: The Committee received a very informative presentation by the lead microbiologist and the associate Chief Nurse. The presentation covered the key metrics associated with infection control including a 12% reduction in year of cases of e coli bacteraemia. Hand hygiene audits are to be increased. The three year objectives for IPC are linked to the Trust Quality Improvement Strategy and the Patient Safety Plan. Work is needed on carbapenem prescribing and catheter care. The Trust does not have a dedicated continence care team.
- **Safeguarding Q4 report**: Concern was expressed in relation to the number of medical staff undertaking training in this area. A dedicated trainer is now in place.
- **Patient Carer and Community Engagement**: Complaints performance will now be reported quarterly as performance has improved. I will be visiting the Bereavement Office to better understand the ways of working.
- **Clinical Audit - Better Outcomes for Patients (BOPP)**: this report will be presented to the Audit and Assurance Committee at its July meeting.
- Other items discussed:
    - Monthly mortality report
    - Final draft – Quality Account
    - Clinical Governance Group
    - Medicines Optimisation
    - Transfusion group

Background

This report is the regular report to Trust Board from the QGC. It covers the meetings held in May and June 2018.

Recommendations

The board is requested

- To receive this report for assurance.