Report to:	Trust Board
Title of report:	Committee Assurance Report to Board
Date of meeting:	28th November 2017
Chairperson:	Penny Owston
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Purpose	This report summarises the assurances received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the Committee on behalf of the Board and any matters for escalation for the Board to respond. This assurance committee meets monthly and takes scheduled reports from all Trust operational committees according to an established work programme.
Assurances received by the Committee	**Quality Impact Assessments – assured around the process** The Medical Director and Director of Nursing along with other key roles reviewed the first tranche of schemes put forward by KPMG in relation to quality, patient safety and how these schemes would affect service delivery. They have completed 21 QIAs and of these 4 were not accepted as they required greater intelligence. There are different Risk assessments templates depending on the complexity of the scheme. The process needs strengthening as there were some schemes that had a QIA completed but others did not. The team reviewing the QIAs felt there was a degree of control as they were being reviewed collaboratively by Medical, Nursing and Operational leads. The CCG were unable to attend but the schemes were sent to the CCG. There are also a myriad of risk matrix across the Trust and there needs to be one. The team will be reviewing the second tranche which are the higher risk schemes.
	Medicines – assured licence now in place and there is a plan to increase medical and nursing representation at the MOPs meeting Wholesale and CD drug licence has been approved for the Trust. Top 4 drug error groups remain antimicrobials, opiates, anticoagulants and Insulins in 2017/18. Medical representation has been agreed and Deputy Chief Nurse will get nursing representation to attend MOPS. The meeting will then begin to challenge the issues as there will be appropriate representation.
	Quality & Safety Improvement Plan – assured processes in place but risk for programme 1 and programme 2. Executive team have reviewed and discussed all key milestones. Governance Structure New structure to go to ET in December 2017 to be finalised. The Interim Governance Lead to stay until March 2018. Training Mental health training to be tailored to staff and the trust is in discussion with other Trusts.

	Safety Culture / Staff Charter The staff charter to be launched along with the 2021 roadmap. Executive team to visit wards & departments to discuss.
Non assurance received by the Committee	**Patient Safety – the committee is not assured the extent of the problem for training on all equipment or what it will take to complete the required training. A TNA may need to be completed.** **HSC Court Case** On 15 May 2017 the Trust was found guilty of a breach of Section 3 of the Health and Safety at Work Act 1974. The offence related to the failure to conduct its undertaking in a way such as to ensure, as far as reasonably practicable, that persons not in its employment, who may be affected, were not thereby exposed to risks to their health or safety. The case has identified a need, for focused training on complex equipment with clear reference to the manufacturer's (Instructions for Use) IFU. The Trust must be able to evidence the competency training for specific types of equipment which are complex enough to require focused training, and evidence its systems for maintaining competency, which may include refresher training. The committee identified the absence of evidence for competency against manufacturers IFU for other complex equipment within the Trust with specific reference to areas such as Intensive Care. **WHO** Trust achieve 100% compliance with the WHO audit
	Infection Prevention Control - not assured as there is increased levels of C Diff and blood culture contamination rates but assured there are processes in place to address the issues and increase accountability. There were 6 cases of C. Diff in October 2017 and as a Trust we are likely to go over our trajectory as year to date we are 8 over. There is a fortnightly reduction meeting to review progress. NHSI were on site and they have upgraded the trust from red in June 2017 to amber. They could see lots of improvement and stated the culture was very different. The trust has aligned the action plan to the hygiene code and we are fully compliant with criterion 3/8/10, near compliant with criterion 5 and work is still required on 1/2/4/6/7/9. Increase in blood contamination rates in September to 14% (national is 3%). The increase may be related to the junior doctor changeover. There is an improvement working group. To increase accountability the group is introducing letters for staff who have taken blood cultures and of which they come back as being contaminated.
	Mortality – not assured as we need a fundamental step change to make us good. Medical Director attended a conference at Leicester and West Herts presented how they have fundamentally changed their mortality by undertaking a substantial piece of work to understand patient pathways and ownership by Clinical Directorates. **Action:** Medical Director to present a paper in February 2018 **Comorbidity Audit of patients over 75 with a zero Comorbidity score** 68% (30/44) did not have all comorbidities coded.

	60% (18/30) did not have Charlson index comorbidities coded. Pulmonary and Renal Disease were the top Charlson Index comorbidities missed. **Action:** Quality Governance team to replace completing the SQD in December 2017 and to complete an audit on the comorbidities and discuss with clinicians at the time of the audit the importance of documentation. **Dr Foster Alert-Biliary Tract Disease in-depth review** HSMR for the Dr Foster diagnosis group of "Biliary Tract Disease" was noted to be alerting at Lincoln County Hospital for the period April 2016 to March 2017 (HSMR 240.97). There were 25 patient mortalities compared to the Dr Foster expected 10.37 mortalities. 18 sets of case notes were reviewed for patients at Lincoln County Hospital. Issues identified relate to coding and documentation. **Action:** QGC chair to escalate the disappointment that CHKS did not engage with the Quality Governance team around coding.
	Falls – not assured due to the increase in falls with harm There is an increase in the number of falls with harm **Action:** Thematic analysis to be presented in February 2018.
	Pressure Ulcer Deep Dive – 8A and Shuttleworth – not assured but there are processes in place to stop pressure ulcers from occurring The sisters from 8A and Shuttleworth gave a presentation on the plan on what they are doing to reduce the number of pressure ulcers on their wards. Ward 8A have an action plan in place and the sister and matron have been reinforcing compliance with processes and documentation. Shuttleworth did have an average of 5 pressure ulcers a month from April - August however this has reduced to less than 1 a month. The sister stated she could not hold staff to account unless they have been appropriately trained. And once they have been trained she then will hold them to account. Key areas where the pressure ulcers have occurred is around plaster casts and ensuring processes are in place to prevent these from re occurring.
	Diabetic Ketoacidosis (DKA) – the report does not assure the Trust and the action plan does not address the fundamental problems of DKA The Trust has received the report completed by Leicester University Hospital. There are 37 recommendations and the current action plan the Trust had is not currently fit for purpose. The Medical Director will work with the Diabetic Leads to review the action plan and recommendations to ensure we have a robust process of managing these patients within the Trust. The Nursing Director discussed with the HoN, matrons and sisters DKA and challenged staff to produce a DKA board to increase the profile. **Action:** Medical Director to present the updated action plan in February 2018.
	Risk Register – Assured working as intended and committee is altering their processes to align. 2 new risk were added to the risk register: C. Diff - which was agreed by the committee **The committee was not assured with aseptic facilities in the trust which**

	needs to be addressed – a business case for a new unit is required. Non assurance with standards for aseptic preparation of injectable medicines – there are 2 isolators, one showing significant growth and the other one the magnetic hinges are not working. The fabric of the build also does not comply. There is another risk in the risk register that may need amalgamating with this risk. **Action:** To go onto the risk register as a higher score, to potentially be amalgamated with the other risk that has been on the risk register for 5 years and to add mitigation of what has happened over the previous 5 years. **Action:** A briefing paper to be developed informing the committee of the risks to enable next steps. **Action:** Head of 2021 to incorporate within the January 2018 report where this sits within the capital programme. There will be a thematic deep dive on the following for January 2018. • ID 3763 Documentation and the completeness of this.
Issues where assurance remains outstanding for escalation to the Board	The committee identified the absence of evidence for competency against manufacturers IFU for other complex equipment within the Trust with specific reference to areas such as Intensive Care.
Committee Review of corporate risk register	
Matters identified which Committee recommend are escalated to SRR/BAF	
Committee position on assurance of strategic risk areas that align to committee	
Areas identified to visit in ward walk rounds	

Attendance Summary for rolling 12 month period

Voting Members	J	F	M	A	M	J	J	A	S	O	N	D
Penny Owston,non-executive Director(Chair)					√	√		√	√	√	√	
Paul Grassby, assoc non-executive Director					√						√	
Kate Truscott, non-executive Director							√			√		
Neil Hepburn, Medical Director					√	√	√	√	√		√	
Michelle Rhodes, Director of Nursing					√	√	√	√	√	√	√	
Mala Rao Non Executive Director						√	√	√	√	√	√	
Chris Gibson Non Executive Director									√	√		
Representative LECCG					√	√	√		√	√	√	