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United Lincolnshire Hospitals
NHS Trust

Report to:	Trust Board
Title of report:	Committee Assurance Report to Board
Date of meeting:	31st October 2017
Chairperson:	Penny Owston
Author:	Bernadine Gallen
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	**Learning from deaths – assured process in place to progress the guidance** **SO1** The policy has been developed and published on the internet. A briefing paper has been produced to inform the board on their responsibilities which will be presented in November 2017. The key areas the Trust need to improve are in sharing learning and engaging with families. The Trust is also investigating the role of the medical examiner and a business case will be produced.
	Adverse Incident Report – assured new SI process is being designed however less assured with the grading of harms **SO2** NRLS data indicates that reporting culture per 1000 bed days at ULHT is 31.26 against national average 40.4. In addition reporting culture per 1000 bed days for moderate harm at ULHT is 7.94 against national average 2.1. New SI process being developed with learning forums – proposal has been approved by CMB and will be returned to CMB on the 16th November with the detail. **Action:** Gain greater clarity of grading for November meeting **Action:** All Never Event reports to be presented to meeting
	Patient Experience – assured processes are in place **SO1** The overdue complaints were reviewed (6 with Executives for sign off) and clinicians were contacted however it was felt they were not prioritising the completion of these complaints. DoN will write to the Clinicians and if still not completed they will be escalated to the Chief Executive **Action:** Discuss with Medical Director to ensure non-compliance with responding to complaints is incorporated in their appraisal **Action:** To review how many have been bounced back to clarify if they are increasing or decreasing.
	Deep dive –Pilgrim – not assured remodelling will be completed due to staffing **SO1**

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	A presentation on the current position and improvements at Pilgrim was delivered. There has been improvements in relation to strengthening their senior staffing levels and governance processes. There are two GI bleed rotas with an aim of having one Trust rota. The senior team have now left and it is business as usual as there are senior staff appointed to key roles.
	Deep dive – IPC – not assured against the hygiene code **SO1** A presentation was delivered on our current position with IPC. There is one cohesive plan for IPC. There are 6 work streams identified. **Actions:** Not assured with compliance against hygiene code and a gap analysis with mitigation to be completed by November 2017.
	Deteriorating patient – not assured with poor documentation **SO1** There are currently persistent themes due to lack of adequate documentation so an evidence base log does not exist. **Action:** To request Jan to input issue with documentation in his briefing
Non assurance received by the Committee	**Mortality –not assured with documentation** **SO1** There is a discrepancy at Lincoln between the number of patients the Palliative Care team have documented they have seen compared to the number coded in Dr Foster. A selection of notes will be audited to assess if it is a documentation issue or a coding issue **Action:** report on the audit to be presented in December to QGC
	Pressure Ulcers – not assured due to the increase in cat 3 /4 **SO1** There are 2 wards that have a higher incidence of category 3 / 4 pressure ulcers. Nursing documentation is also currently being reviewed. **Action:** Matrons for the identified wards to complete a deep dive. **Action:** Deputy Chief Nurse to be invited to November QGC to produce the documentation strategy.
	Safeguarding – not assured staff are aligning their training to practice **SO1** MCA training is 3 yearly and incorporated within core training however when new guidance is implemented staff are not automatically updated . There is also an issue with the theory practice gap and to overcome these issue the SG team are providing clinical supervision for ward staff however the SG team are limited due to their staffing levels. The community teams are working with ULHT to review their priorities. The potential to have one Safeguarding Team is being discussed. **Action:** SG to review how to ensure staff are updated with latest guidance between their MCA training
	Duty of Candour – not assured of data collection **SO2** The Trust is currently 59% compliant with verbal apology. The Deputy Chief Executive is requesting the evidence to be available. **Action:** To enquire how the DoC compliance data is collated

	Risk Register – Assured working as intended and committee is altering their processes to align. 2 new risk were added to the risk register • Inability to offer OT/excess hours at Pilgrim theatres – this risk was not a true reflection as excess hours / OT can be signed off by a Director. To return to the author to ensure correct risk is documented. • Scrubber in theatres – further clarification is required to ensure the scrubbers are allocated to the priority areas. One risk to be closed • The committee agreed to close the risk There will be a deep dive on the following for November • ePrescribing • Non Invasive Ventilation
Issues where assurance remains outstanding for escalation to the Board	• IPC – non-compliance against the hygiene code • Documentation – consistent lack of adequate documentation and evidence base log does not exist
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, non-executive Director					√							
Kate Truscott, non-executive Director							√			√		
Neill Hepburn, Medical Director					√	√	√	√	√			
Michelle Rhodes, Director of Nursing					√	√	√	√	√	√		
Mala Rao						√	√	√	√	√		
Jan Sobieraj							√		√	√		

Chris Gibson									√	√		
Non-voting members												
Jennie Negus, Deputy Chief Nurse					√	√	√	√	√			
Bernadine Gallen, Quality & Safety Manager					√	√	√	√	√	√		
Karen Sleigh, Head of 2021 (agenda item)					√		√	√	√			
LECCG Representative					√	√	√		√	√		
Simon Priestley							√					
Charles Barstead								√				