North West Anglia NHS Foundation Trust

COUNCIL OF GOVERNORS SUBCOMMITEE ASSURANCE REPORT

Presented for:	Information/Escalation
Committee Name:	Quality Assurance Committee
Presented by:	Dr Christine Hill (Dr Mark Sanderson, Committee Chair on annual leave).
Date of Committee Meeting:	26 July 2022

Items received by the committee for assurance:

Agenda Item		Level of Assurance	Board Action Required? (double click to select)
2.2	Mortality report	Reasonable	☐
	Quality report	Reasonable	☐
	DIPC report	Reasonable	☐
	Maternity report	Reasonable	☐

POINTS OF ESCALATION	1) A potential enforcement notice from the CQC has been received following a completed H&SE investigation regarding an incident in September 2021 on Bay Tree Ward at Hinchingbrooke when a patient was injured after falling from a window. Immediate actions taken by the Trust after the incident included ensuring all windows were secure and no other patients were at risk of harm. Evidence provided to the HSE included staffing levels at the time of the incident, window risk assessments for all sites, clinical and non-clinical policies in relation to safety and security incidents and management of patients with post-operative delirium. 2) A patient developed hospital-acquired MRSA bacteraemia at PCH. A post infection review noted that there were lapses in care of a wound which is thought this was the portal of entry for MRSA into the bloodstream. The patient has since died and this will now be investigated as a serious incident. 3) The national standards of healthcare cleanliness 2021 (NHS England) replaced the national specifications for cleanliness in the NHS (2007). The 2021 cleaning standards are mandatory and were to be adopted by 4 May 2022. The new standards have been implemented on the Hinchingbrooke and Stamford sites by Mitie, however, there will be a delay in implementation on the PCH site whilst Medirest employ more staff to fulfil the new standards. This is likely to be by the end of September 2022. 4) An antibiotic prescribing audit done as part of our annual audit schedule was disappointing, and many clinical areas were not in line with guidance. This problem is exacerbated by a lack of pharmacists in the Trust.

	5) The committee discussed a CQC improvement notice Issued under the Health and Safety at Work Act 1974 and the Ionising Radiation (Medical Exposure) Regulations 2017 ('IR(ME)R'). A focussed inspection by the CQC was carried out on 27 May 2022 as a result of a notification by the Trust that that 21 patients had received an underdose of radiotherapy to superficial skin lesions between June 2021, when a new radiotherapy machine replaced an old machine, and May 2022 when the error was noticed. The notice outlined a breach under Regulation 6(1)b for a failure to adequately document the commissioning process of new equipment installation; and under Regulation 15(1)a(i) for the inadequate assessment of the dose of ionising radiation delivered to the patient. The Trust is required to (i) establish an effective quality assurance programme for written procedures and protocols; (ii) establish a system for recording analyses of events involving or potentially involving accidental or unintended exposures proportionate to the radiological risk posed by the practice and (iii) put in place any measures necessary to improve inadequate or defective performance of equipment. The committee noted the contents of the CQC report and that an action plan was due to be submitted by the Trust to the CQC. The committee asked for updates on progress until these actions are in fully place.
KEY ISSUES	1) Mortality report: • The overall Trust HSMR remains within the 'as expected' range, but the HSMR for PCH remains statistically significant. • The issue regarding identification of Dr Foster data has now been resolved, allowing deep dives into mortality coding data to continue. A deep dive into 'pneumonia' coding has been completed and further audits into respiratory diagnoses are planned. The focus on coding reviews is on accuracy, correctly identifying comorbidities, recording palliative care and avoiding the use of '?' when doctors make a diagnosis (this presents problems for the coder). • The external clinical coding review has commenced. • A joint clinician and clinical coding validation trial for deaths in June for wards A3 and B14 at PCH has commenced. 2) ED and inpatient area boarding/cohorting was down from 270 to 250 patients in June: 166 patients received corridor care for 1-3 hours, 43 patients for 3-6 hours, 26 patients for 6-10 hours, eight patients for 10-12 hours and seven patients received corridor care for more than 12 hours. The longest period of corridor care was 36 hours for one patient. 3) Maternity – the committee received a report on a regional visit of maternity services to provide assurance against the 7 immediate and essential actions from the first Ockenden report. Findings were that work in areas are ongoing and making progress and many areas of good practice were identified. 4) There were 248 new cases of Covid in June 2022, compared to 174 new cases in May 2022.
BOARD ASSURANCE FRAMEWORK & RISKS	No changes to the risk rating for those risks aligned to the QAC.
CELEBRATING OUTSTANDING PRACTICE & INNOVATION	NICU and SCBU awarded UNICEF BFI (Neonatal Standards) Stage 1 Accreditation and Bliss Baby Charter Bronze Accreditation.

LEVELS OF ASSURANCE

Level	Description of Level of Assurance
Substantial Assurance	The report highlighted a sound system of control, designed to address the relevant risks with controls being consistently applied. Highly unlikely to impair the achievement of both system and strategic objectives.
Reasonable Assurance	The report did not highlight any material weaknesses in the system of internal control that would present material risks to the achievement of both system and strategic objectives.
Partial Assurance	The report highlighted some material weaknesses in the system of internal control that would present material risks to the achievement of system objectives. May also impair achievement of strategic objectives.
Limited Assurance	The report highlighted significant material weaknesses in the system of internal control that would present material risks to the achievement of both system and strategic objectives.