Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**22nd February 2017**		

Title of Report:	**Clinical Governance Committee Update Report**
Status:	**For Information**
Sponsor:	**Jane Scadding, Non-Executive Director**
Author:	**Helen Perkins, Senior Executive Assistant to Chairman, Chief Executive & Medical Director**
Appendices:	**None**

Purpose

To update the Board of Directors on the activity of the Clinical Governance Committee's held on 28th November 2016 and 23rd January 2017.

Background

The Clinical Governance Committee is one of three assurance Committees supporting the Board of Directors in fulfilling its objectives. The Committee is responsible for testing the robustness and effectiveness of the clinical systems and processes operating within the Trust to provide assurance to the Board of Directors.

Business Undertaken

National Institute for Health and Care Excellence (NICE) Compliance

The Clinical Guidance Implementation Manager presented the report advising that she was responsible for monitoring the publication of NICE guidance and disseminating it to the relevant Specialty and Divisional leads who were required to complete a baseline assessment which indicated adherence to the guidance and identified any gaps in practice where NICE recommendations were not met.

Quarterly update reports were submitted to Quality Board and the CCG Clinical Outcomes and Quality Assurance Group which provided a breakdown of adherence to NICE recommendations by guideline type. It also outlined whether there were implementation plans in place to meet NICE recommendations, if any gaps had been identified, as well as any risks to the Trust which had been recorded on the Trust Risk Register. For instances where NICE guidance was not followed this was clearly outlined, reviewed and documented at the relevant Divisional Governance meeting.

The Committee resolved to provide the Board of Directors with high assurance and will review again in three years.

Critical Care: Care Quality Commission (CQC) Improvement Plan

The Matron for Critical Care Services presented the report advising that Critical Care had been rated as "requiring improvement" following the Trust's CQC inspection in March and been asked to review: safe timely discharge, equipment servicing, medicine compliance, cleanliness, incident reporting, policies and procedures and the appointment of a Matron.

The Committee noted that a number of actions had been put into practice which included the safe discharge of patients during daytime hours with a robust system now in place within the Business Intelligence Unit to capture patient data as there is a

CQUIN for Critical Care linked to 30% of discharges within 4 hours of a clinical decision to discharge.

A designated area had been identified on the Unit to Store equipment with a spreadsheet introduced for staff to document where equipment was along with a number of checklists they must adhere too. New digi-lock's had been fitted to the drugs fridge, a lockable storage fridge was now available within the department and new resus trolleys had been ordered that had snap cords on the front.

Nursing staff were aware of the Unit's required cleanliness standards and regular decluttering now occurs. The Unit has also recently had a full deep clean. Staff are encouraged to report incidents/near misses on Datix with any themes reviewed and fed back at staff at Governance meetings. All policies, procedures and Standard Operating Procedures (SOP's) specific to Critical Care were discussed in detail at departmental meetings.

The Committee resolved to provide the Board of Directors with limited assurance and will review again in six months.

Consent Including Patients Without Capacity for Inpatients & Outpatients
The Committee noted that there was an "obtaining consent to examination and treatment" policy in place with four consent forms currently in use at the Trust:

1. Adults with capacity;
2. Parents for children;
3. Procedures not compliant with Anaesthetic;
4. Patients who lack capacity.

Procedures for consenting patients without capacity or with learning difficulties were documented within the Trust policy and outlined that decision making should involve family members, carers and other healthcare professionals. Two Specialist Nurses for Learning Disabilities were available in the Trust to help guide clinicians in this area and the Trust also used an Independent Mental Capacity Advocacy service who provide trained advocates that act in the best interest of the patient.

An annual audit of consent was carried out at the Trust and following a recent audit, two additional mandatory fields had been added to Millennium when listing patients to specifically record whether or not alternatives for management had been discussed and also whether a patient information leaflet had been provided.

Following a review of the use of consenting patients without capacity or with learning difficulties, it had been identified that more time should be spent in Outpatients when the decision to intervene had been made to engage patients, families and carers in capacity/consent discussions rather than waiting to discuss at pre-operative assessments where patients were unable to adequately consider and process the information provided to them with the need to record discussions with patients within medical records.

The Committee resolved to provide the Board of Directors with limited assurance and will review again in six months.

End of Life Care

The Lead Nurse Palliative and End of Life (EOLC) provided an update on the work that had been undertaken on EOLC throughout the Trust. The Committee noted that the Care Quality Commission had reviewed EOLC as a core service for the inspection in March 2016 and given an 'outstanding' overall rating. The Trust was one of eleven acute Trusts to have received a rating of 'outstanding' and the only acute Trust within the South West.

The EOLC work plan was aligned to the themes within the National Ambitions for Palliative and End of Life Care (2015) and work was ongoing against the seven work streams.

The Specialist Palliative Care Team continued to support wards with the principles of the Conversation Project and were in the process of developing a template for Millennium to flag patients who were on an EOL pathway. The Trust had been successful in obtaining a grant application to The Health Foundation which would support further development of the Conversation project model during 2017/18.

The Trust had supported new initiatives including the development of a Continuing Health Care Specialist Nurse/Allied Health Professional role with BaNES CCG and an Enhanced Discharge Service with Wiltshire CCG and Dorothy House Hospice.

The National Care of the Dying Audit highlighted that a member of the Board of Directors should act as a lay person and have an interest in EOLC. Through this report, the Committee requests a Non-Executive Director volunteer to take on this role.

The Committee resolved to provide the Board of Directors with high assurance and will review again in three years.

Safeguarding Adults – PREVENT Follow Up

The Head of Security, Safety and PREVENT provided an update on tier 1 and 2 staff training which was a requirement of the Counter-Terrorism and Security Act 2015. As at the end of December 2016, 95.5% of staff had been trained against a target of 100%, with 36% for tier 2 against a compliance target of 85% over 3 years. The Committee noted that the Head of Security, Safety and PREVENT was confident of achieving the tier 2 target through incorporating PREVENT training into the clinical staff Safeguarding training day and the use of an external provider delivering the training at ward and departmental team meetings, Birthing Centres as well as capturing clinical staff through safeguarding training days.

The Lead Senior Nurse Safeguarding advised that she was confident of the Trust achieving compliance against the safeguarding adults level 1-3 training targets through face to face sessions, via e-learning and departmental/ward training.

The Committee resolved to provide the Board of Directors with moderate assurance in respect of the PREVENT follow up and asked to review again in March 2018. The Committee sought a further update of Safeguarding Adults in September 2017.

Infection Control Follow Up
The Director of Nursing and Midwifery reported that there had been 21 cases of Trust acquired Clostridium difficile (C diff) infection between July and December 2016, 13 fewer cases compared to the same period last year, although the Trust had overshot its trajectory set by NHS England. A number of actions had been put in place to reduce instances of C diff such as the use of sporicidal and disinfectant wipes being trialled across the site for commode cleaning, an alert card being produced to give to patients who had a C diff infection with their GP also receiving a letter advising care when prescribing antibiotics in order to prevent reoccurrence of infection and a C diff workbook being sent out to all wards and departments requiring completion by staff.

During the period July to December 2016, there had been 37 cases of MSSA bacteraemia reported by the Trust. A total of 29 were assigned as community acquired infections with 8 cases Trust acquired.

The total number of E coli bacteraemia cases at the end of December 2016 was 222 (178 community acquired and 44 Trust acquired cases) with the most common source of infection identified as Urinary Tract Infection.

The Committee requested an update at its next meeting on the compliance of training to prevent hospital associated Clostridium difficile.

Discharge Services Follow Up
The Director of Nursing and Midwifery provided an update on the work streams established to support improvement of discharge from the Trust which were monitored through the Urgent Care Board.

<u>Increase the number of patients discharged before midday</u>
In an effort to create early morning flow from the front door, clinical staff were required to highlight a minimum of one patient (silver patients) from their area who would be ready for discharge and their bed space available by 10am the following morning.

<u>Improve effectiveness of Integrated Discharged Service (IDS)</u>
The co-location of the IDS had allowed Social Services from Wiltshire, BaNES and Somerset to work alongside the RUH and community Discharge Liaison Nurse (DLN) teams to improve daily communication and enable collaborative and cross boundary discharge planning. A single referral form into the IDS was now in use on Millennium.

<u>Improve the turnaround time of Medicines to take home</u>
Pharmacy were evaluating whether the use of FP10 prescriptions could be rolled out to the Medical Therapies Unit and Surgical Assessment Unit. The number of wards that had To Take Away (TTA) packs that could be dispensed to patients had been increased to include Charlotte and Pulteney wards.

The Committee noted the work streams update and asked for a further review in six months.

Duty of Candour Follow Up
The Lead for Claims, Inquests and Clinical Risk presented the report advising that during quarter three, 73 incidents that had caused moderate or greater harm were

reported and required implementation of the Duty of Candour (DoC) framework. For the 15 incidents where it was felt that DoC was not applicable, the reporter was asked to include a rationale for their decision on Datix. In 4 instances, it was concluded that the harm had not occurred as a consequence of the care and treatment provided by the Trust. Three incidents related to unplanned returns to theatre and in 2 instances the harm level was found not to have met the DoC threshold; in another it was noted that DoC would be instigated once the outcome of an initial investigation was known. The Lead for Claims, Inquests and Clinical Risk had contacted the Care Quality Commission to seek clarification in relation to "recognised complications" as this had been noted as the justification for not implementing DoC in 5 instances and their response had not provided a definitive answer.

The number of overdue actions had seen a decrease which could be due to actions being closed without the relevant steps being taken. The Lead for Claims, Inquests and Clinical Risk advised that she was undertaking targeted training within the Divisions to ensure that actions were allocated to the correct members of staff to enable appropriate completion.

The Committee were encouraged by the progress made to date on DoC and requested to review again in one year.

Following prior review and discussion at the Operational Governance Committee, the Committee had agreed to review a number of untoward events categorised as Never Events by NHS England as part of their work plan to ensure the appropriate systems and processes were in place to prevent the Never Events occurring, as well as identifying any weaknesses in those systems intended to prevent an occurrence. The following Never Events had been reviewed and a high level of assurance was provided on the processes to ensure their prevention. The processes will be reviewed again in three years:

- Transfusion or transplantation of ABO-incompatible blood components or organs;
- Mis-selection of a strong potassium-containing solution;
- Retained Foreign Object Post-Procedure ;
- Overdose of Insulin Due to Abbreviations or Incorrect Device – incidents related

Review of Clinical & Non Clinical Governance Committee
Following a review of the Clinical and Non Clinical Governance Committees, the Board of Directors' Secretary confirmed that the Committee was performing well and the clinical systems and processes identified for review were appropriate. The effectiveness of the joint Committee and the opportunity for further collaboration had been identified as an area of improvement with a theme-based approach to work planning being drawn up for discussion at the Joint Committee in March 2017.

Doctor Revalidation Internal Audit Report
The Committee noted than an internal audit review of arrangements in place at the Trust for doctor revalidation had been provided significant assurance. The auditors had raised one low priority recommendation relating to the medical appraisal policy which outlined that the Committee was responsible for reviewing the effectiveness of the appraisal and revalidation processes in place and there was currently no evidence

of a review taking place. The Committee agreed that this should be the case and asked the Medical Director to provide a report to a future Committee

External Agency Visits
The Committee reviewed the current external agency visits schedule and requested that the Board of Directors' Secretary provide a report for discussion at the May meeting on the process of external agency visits and how any actions/ recommendations raised are accepted, acted upon and embedded.

Audit Tracker
The Committee agreed to close actions 111 – 114 which related to the Clinical Effectiveness audit.

Key Risks and their impact on the Organisation

No key risks were raised at the Committee.

Key Decisions

The Clinical Governance Committee recommends that the Board of Directors note:

a) the high level of assurance provided on NICE Compliance;
b) the limited level of assurance provided on Critical Care CQC Improvement plan;
c) the limited level of assurance provided on consent including patients without capacity for inpatients and outpatients;
d) the high level of assurance provided on End of Life Care and the National Care of the Dying Audit requirement for a Non-Executive Director to act as a lay person and have an interest in End of Life Care;
e) the moderate level of assurance provided in respect of PREVENT and the request for a further update on Safeguarding Adults in September;
f) the request for an update at the March meeting on the compliance of training to prevent hospital associated Clostridium difficile;
g) the request for an update on the Discharge Project Board work streams in six months;
h) the request for a further Duty of Candour update in one year;
i) the high level of assurance provided regarding the systems and processes in place intended to prevent the occurrence of the following Never Events:
    - Transfusion or transplantation of ABO-incompatible blood components or organs;
    - Mis-selection of a strong potassium-containing solution;
    - Retained Foreign Object Post-Procedure;
    - Overdose of Insulin Due to Abbreviations or Incorrect Device.
j) the significant level of assurance provided by internal audit for doctor revalidation and the Committee's request to review the effectiveness of the appraisal and revalidation processes in place in line with the Medical Appraisal policy;
k) the request to review the process for external agency visits and how any actions/ recommendations raised are accepted, acted upon and embedded;
l) closure of actions 111-114 relating to the Clinical Effectiveness audit.

Exceptions and Challenges

None identified.

Governance and Other Business

The meeting was convened under its revised Terms of Reference.

Future Business

The Committee conducted business in accordance with the 2017/18 work plan. The next meeting of the Clinical Governance Committee, to be held on 27th March 2017 would review the following:

- Anticoagulants including Warfarin;
- Point of Care Testing;
- 52 Week Breaches – assurance across all Divisions;
- Never Event: chest or neck entrapment in bedrails;
- Never Event: Overdose of methotrexate for non-cancer treatment;
- Mortality review process;
- Infection control follow up report - compliance of training to prevent hospital associated Clostridium difficile;
- External Agency Visits;
- Audit Tracker;
- Board Assurance Framework;
- Work Plan, Horizon Scanning and Next Agenda Review.

Recommendations

It is recommended that the Board of Directors note this report.