Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**27 September 2017**		

Title of Report:	**Clinical Governance Committee Update Report**
Status:	**For Information**
Sponsor:	**Jeremy Boss, Non-Executive Director**
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Appendices:	**None**

Purpose

To update Board of Directors on the activity of the Clinical Governance Committee held on 17th July 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

Inquests – Regulation 28 Actions: Women & Children's Baby King

The Head of Division, Women and Children's provided an overview of the Inquest into the death of an infant (Baby King) which had concluded in January 2017 with HM Coroner for Avon issuing a Regulation 28 report outlining actions to be taken for the management of women who may be progressing to a Vaginal Birth After a previous Caesarean Section (VBAC).

The Head of Division, Women and Children's advised that the Trust had undertaken a comprehensive investigation, devised a detailed action plan following the inquest and receipt of the Regulation 28 report, and had implemented the following changes:

Changes to Trust processes in relation to action one

- All women who have had a previous Caesarean birth are reviewed in the antenatal clinic by an Obstetrician at 28 weeks of pregnancy. A discussion regarding the risk of VBAC is undertaken, documented and a birth care plan made, then documented by the Obstetrician.
- Capture of the discussion regarding risks and relevant information is detailed on sticker 1 which is placed in the maternal handheld health record at the 28 week appointment with the Obstetrician;
- If the lady chooses VBAC, a capture of the birth plan is on a second sticker at the 28 week appointment by the Obstetrician;
- If the woman chooses an elective Caesarean section it would be booked in accordance with the revised Caesarean Birth Guideline and documented by the Obstetrician on sticker 1.

Changes in Trust processes relation to action two

- The learning following the inquest was taken to a variety of forums to provide a focus on documenting risk, decision making and care plans and to ensure wide dissemination of information. This included: Perinatal morbidity and mortality

meeting, maternity governance meeting, divisional governance meeting and PROMPT (Practical Obstetric Multi-Professional Training). The documentation of a plan regarding date and time of category 3 Caesarean section and record if any deviation from the plan was agreed;
- When a decision to perform a category 3 Caesarean section was planned the doctor making the decision must order this on millennium, the order must include planned date and time of Caesarean/whether the patient would be an inpatient or outpatient prior to the Caesarean/care plan until Caesarean section;
- Audit of compliance of action 2 would be undertaken.

The Head of Division, Women and Children's advised that the compliance audit of all emergency caesarean births would take place on a quarterly basis, with results of the first audit due to be available in late August. The Committee noted that these would be reported through the Operational Governance Committee.

The Committee acknowledged the processes put in place following receipt of the Regulation 28 report and resolved to provide the Board of Directors with significant assurance in respect of this aspect. However, there was a lack of evidence that the changes introduced had been embedded, as the compliance audit had not yet been completed, and the Committee requested an update in March 2018.

Inquests – Regulation 28 Actions: Medical Falls

The Head of Nursing, Medicine provided an overview of an Inquest held in April 2017 into the death of a patient, who was of high risk of falls, and who was commenced on anticoagulant/anti platelet medication following a clinical suspicion they were suffering from acute coronary syndrome. Following a series of falls, a CT scan showed that the patient had sustained bi-lateral frontal brain contusions. Due to the risk of further cerebral bleeding which outweighed the risk of venous thromboembolism, the patient's anticoagulants/anti platelet medication was stopped. The patient died of a pulmonary embolus 21 days later.

HM Coroner for Avon wrote to the Trust as a Paragraph 37 Letter, and concluded that they were concerned that the patient had not had adequate supervision, as they had suffered a number of falls whilst under the care of the Trust. The Coroner sought evidence that measures around observations described during the inquest were being taken forward. The Trust had responded outlining the ongoing falls prevention work and new enhanced care bundle that was being developed.

The Coroner had confirmed that he would not be issuing a Regulation 28 Report following receipt of the Trust's response.

Falls

The Head of Nursing, Medicine presented an update on the Trust's falls prevention programme highlighting that this was one of the Trust's top patient safety priorities for 2017/18 with the Falls Steering Group recognising the need to review the Trust's work plan and current interventions in place for falls prevention.

In March 2017, the Falls Steering Group led a Trust wide improvement programme for falls prevention in all adult inpatient areas whose aim was to provide assurance that the falls prevention pathway was robust and that staff had access to the most

appropriate interventions to prevent, wherever possible, patients falling and experiencing harm from the fall.

A falls immersion event for all Senior Sisters/Charge Nurses and Matrons was held on 3rd May 2017 followed by a period of engagement to allow ward teams to embed the programme improvements in preparation for a go live on 19th June 2017. Data had shown that on average over the previous year, the number of patients at the hospital who had suffered a fall was 105 per month, with 82% of these patients being over the age of 65 years. The aim of the programme was to reduce the total number of inpatient falls between the go live on 19th June 2017 and the end of March 2018 by 10%.

The revised improvement programme included a number of interventions, with outcome measures established, which would be monitored through the Falls Steering Group who report into the Patient Safety Steering Group.

The Committee resolved to provide the Board of Directors with significant assurance relating to the programme of work implemented, noting that since the go live event there had already been a decrease in the number of falls, but sought evidence against the outcome measures at their meeting in March 2018.

Assessing Capacity and Consent Follow Up

The Consultant Urologist presented the Assessing Capacity and Consent follow up report which provided an overview of the audit carried out on consent for planned procedures and use of the Mental Capacity Act (MCA) 2005 for adults with learning disabilities. The audit had been undertaken as there was uncertainty whether people with a learning disability were being properly consented and capacity assessed when they were coming to the Trust for planned procedures and the necessary legal processes that needed to be followed.

A random sample of case notes for twenty patients with learning disabilities were audited for the period July – December 2015. The Committee noted that the Trust was non-compliant in two areas.

Standard	Compliance
There is evidence of mental capacity assessment (form) or discussion in medical notes	60%
Evidence that support has been given to make the decision and reasonable adjustments have been made	70%
Evidence of if patient lacks capacity that a best interest's decision has been made and who was involved in the process	30%
Evidence of correct consent form 4 used for patients who lack capacity to consent.	37%
Consent form completed by clinician	75%

Results from the audit had been discussed and disseminated at the Surgical and Medical Sisters meetings, Clinical Reference Group and to the Surgical Division via Safety Surgery meetings with refresher training also planned.

The Committee noted that a number of recommendations had been proposed as a result of the audit which would be overseen by a Task and Finish Group.

The Consultant Urologist advised that a re-audit was due to commence shortly which would include data split by speciality, to determine which were most frequently affected and whether the patient required advocacy.

The Committee supported the programme of work to be undertaken by the Task and Finish Group and resolved to provide the Board of Directors with partial assurance, requesting to review again once the results of the re-audit were known.

Major Trauma Outcomes
The Clinical Lead for Major Trauma presented the Major Trauma Outcomes report and highlighted that Elderly Trauma was a growth area for the organisation with 498 cases seen during 2016, making the Trust was one of the largest trauma units in the Severn Trauma Network.

Mortality data outlined that during 2013/14, the Trust had 1.2 additional survivors out of every 100 patients. In 2015/16 this fell to 1.2 additional deaths out of every 100 patients, making the Trust one of the worse performing in the Severn Network from a mortality point of view. As a result of the deterioration, a case note review of all trauma deaths was initiated with thirty one sets of notes reviewed which identified themes that the patients were age >80, used anticoagulants and had suffered rib fractures. The review also identified that for four of the deaths, steps could have been taken which would have reduced the likelihood of the patient's deaths.

Since then, in 2017 there have been several trauma deaths where actions could have been taken to reduce the likelihood of death. It had been recommended that the Trust cohorts all elderly major trauma patients onto one ward, cared for by Orthogeriatrics with Orthopaedic/General Surgical and ward specialist input where appropriate, to help improve trauma mortality rates.

The Medical Director advised that he, and the Chief Operating Officer, had recognised that governance arrangements for Major Trauma could be strengthened and that they were currently reviewing the most appropriate reporting route. The Committee resolved to provide the Board of Directors with partial assurance in relation to Major Trauma outcomes and asked to review again once the governance reporting route had been determined.

Emergency Department CQC Improvement Plan
The Clinical Lead for Emergency Medicine and Matron, Emergency Directorate provided an update of the Care Quality Commission (CQC) improvement plan for the Emergency Department following their inspection in March 2016 where Urgent and Emergency Services were rated as "requires improvement". The Committee noted the following compliance against the CQC recommendation raised:

1. Monitoring of time taken to triage patients who self-presented in the Emergency Department – self presenters were now reported on the Business Objects system and monitored weekly with feedback provided through staff briefings. Staff were

reminded of the need to report through daily briefings;
2. Recording of care and treatment provided including records of pain assessments and early warning scores – NEWS documentation had been revised, with compliance audits undertaken by the Quality Improvement Centre, and a nursing safety checklist had been introduced;
3. Nurse staffing levels – staffing levels had been reviewed with fourteen new staff recruited following a proactive recruitment drive;
4. Mandatory training compliance – compliance of training for both medical and nursing staff was reviewed monthly by the Clinical Lead and Matron with non-compliance taken up with individual staff members;
5. Safe medicines storage and resuscitation equipment checking – checklists for resuscitation and refrigerator temperature checks were undertaken daily;

The Director of Nursing and Midwifery advised that an unannounced mock inspection of the Emergency Department was undertaken on 16th June 2017 to test whether the actions identified had been effective in addressing the concerns raised by the CQC. Findings from the mock inspection would be discussed with the Clinical Lead and Matron for the Emergency Department on 21st July 2017.

The Committee resolved to provide the Board of Directors with significant assurance with minor improvements and requested to review the outcome of the mock inspection in November.

QIPP Management Framework

The Chief Operating Officer presented the QIPP Management Framework report highlighting that KPMG had undertaken an internal audit of the Trust's QIPP process in February 2017 which gave an assurance rating of significant assurance with minor improvement opportunities. One of the recommendations identified the need to develop a new QIPP roles and responsibilities framework which would detail the Trusts approach to QIPP delivery and the processes used by the Trust at corporate and Divisional levels. The framework should also document the processes used to identify and assess quality impacts of QIPP schemes, ensuring that these are appropriately mitigated and on-going monitoring was in-place through the Trust's Quality Board.

The Director of Nursing and Midwifery and Medical Director advised that the Divisions found the current process for sign off of QIPP Quality Impact Assessments (QIAs) onerous and that Quality Board had not yet seen finalised QIAs for 2017/18.

The Committee resolved to provide the Board of Directors with partial assurance as the current process for QIPP was unproven and requested to review at their next meeting.

Microbiology Accreditation for C.diff and Norovirus

The Laboratory Manager, Cellular Pathology presented the Microbiology Accreditation for C.diff and Norovirus report and advised that the Trust had recently applied for United Kingdom Accreditation Services (UKAS) accreditation for the recently introduced Cephid machine, which provided rapid-turnaround C.diff and Norovirus testing capabilities in Pathology. Quality assurance mechanisms were in place to ensure the validity of the results to inform operational decision making and the

purpose of accreditation was to ensure the testing was compliant with ISO15189 Laboratory regulatory standards.

Following advice from UKAS, the Trust had applied for an extension to service of the currently accredited RUH Blood Science Laboratory. In support of this, a gap analysis had been undertaken against ISO15189 standards and action plans were in place to address identified gaps. Following submission of our UKAS application, the Trust was due to be inspected between September and December 2017 with any recommendations identified notified to the Trust within twelve weeks of inspection. The Trust would have six months to implement these.

The Committee noted the Microbiology accreditation process undertaken for C.diff and Norovirus and sought a further update once the results had been received.

Mortality Review Processes
The Medical Director presented the Process for Mortality Reviews highlighting that these were part of Divisional Governance arrangements which were supported by a whole hospital oversight of mortality rates provided by the Clinical Outcomes Group.

Guidance published in March had stated that mortality governance should be a key priority for Trust Boards. A Mortality Surveillance Group had been established who had met to review and agree which deaths would be reviewed. A stock take of current mortality review processes was in place with all deaths reviewed in the Surgical and Women and Children's Division, with Medicine currently only reviewing selected deaths. Clinicians were due to be trained in the use of the Structured Judgement Tool and a Learning from Deaths policy was being developed with a view to present the first tranche of mortality data to the Board of Directors in October 2017, and on a quarterly basis thereafter.

The Clinical Outcomes Group receive a monthly report from Dr Foster that includes mortality data for the whole Trust. As well as mortality rates, the report cites specific diagnosis or procedure codes that have a high risk of mortality. Where required, the Clinical Outcomes Group instruct deeper analysis of specific diagnosis or procedure groups that appear to have a high mortality.

The Clinical Outcomes Group had examined the contradictory evidence of the high HSMR and normal SHMI at the Trust. The difference in the rate of coding of specialist palliative care (a determinant of the expected risk of mortality using HSMR but not SHMI) at the RUH by comparison with national average was likely to be a significant reason for the difference in mortality rates.

The Committee noted the process for Mortality Reviews and progress made towards meeting the milestones from the National Learning from Deaths guidance. The Committee requested that a further update be provided once the mortality design process had been finalised.

Internal Audit Assurance Report: Delayed Transfers of Care
The Chief Operating Officer presented the Delayed Transfers of Care (DTOC) internal audit report advising that a rating of significant assurance with minor improvements

had been given. The recommendation outlined that the correct methodology for calculating DTOC bed days should be defined. This had been rectified and in place by April 2017, through data collected via the patient administration system, Millennium.

Board Assurance Framework (BAF)
The Interim Board of Directors' Secretary presented the BAF outlining that it was due to refreshed shortly and asked the Committee to review amendments to risks three and eight which were approved.

The Committee reviewed the following Prevention of Never Events, providing the documented levels of assurance:

- Prevention of Never Event: Misplaced Naso or Oro-gastric Tubes – the Committee gave a significant level of assurance and asked to review in three years.

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 significant assurance provided in respect of the processes put in place following receipt of the Regulation 28 report relating to Baby King with a request to receive a further update in March 2018 to review results of the compliance audit to ensure the changes introduced had been embedded;
b) the learning from the incident where a patient died as a result of a fall;
c) the significant assurance provided relating to implementation of the Trust wide fall improvement programme, with evidence sought against the outcome measures at their meeting in March 2018;
d) the partial assurance provided in respect of the Assessing Capacity and Consent with the request to receive a further update once the results of the re-audit were known;
e) the partial assurance provided in relation to Major Trauma outcomes with the request to review again once the governance reporting route had been finalised;
f) the significant assurance with minor improvements and the request to review the outcome of the mock inspection at the November Committee;.
g) the partial assurance provided on as the Trust's QIPP Management Framework with a request to review again at the next meeting as the current process for sign off of QIPP Quality Impact Assessments (QIAs) was unproven;
h) the Microbiology accreditation process undertaken for C.diff and Norovirus and the request for a further update once the accreditation results had been received;
i) the process for Mortality Reviews and progress made towards meeting the milestones from the National Learning from Deaths guidance. The Committee requested a further update once the mortality design process had been finalised;
j) the significant assurance with minor improvements relating for the Delayed Transfers of Care (DTOC) internal audit report.

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 18th September 2017 would review the following:

- Prevention of Never Event: Mis-selection of High Strength Midazolam for conscious sedation
- Discharge Services Follow Up
- Safeguarding Children Follow Up
- Safeguarding Adults Follow Up
- Prevention of Never Event: Wrong Implant/Prosthesis
- Prevention of Never Event: Chest or Neck Entrapment in Bedrails
- Pressure Ulcer Prevention Follow Up
- Response to 2016 National Diabetes Inpatient Audit
- 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.