Clinical Governance Committee meeting minutes

PURPOSE:
To inform the Trust Board about the matters discussed at the Clinical Governance Committee (CGC) on 11 September 2012

MAIN ISSUES:
The key items from the CGC are as follows:

CGC0903 - The Committee reviewed the Kings Fund Report, ‘Preparing for the Francis report’ and a review of the structure of the CGC requested for report back in November.
CGC0904 - A presentation was given by the Surgery Directorate on how they assure quality of care within the Directorate.
CGC0905 - Three case studies describing the use of the Clinical Psychology Service trialed on Radnor Ward was presented for the Patient Story.
CGC0906 - Progress of the National Outpatient Survey Action Plans 2011 and the work undertaken was noted.
CGC0907 - An update on the Effective use of NICE Quality Standards was noted.
CGC0908 - The Quality Indicator report for July was presented.
CGC0910 - Areas of good practice and progress were noted in the End of Life Care Strategy annual report.
CGC0911 - Dr Fosters Trust mortality report – an update was given from August 2012 and the progress made was noted.
CGC0912 - Quality Strategy 2012 – 2015 and the Quality Account priorities action plan 2012 - 2013 was approved.
CGC0913 - The Safety Plan update was noted.
CGC0914 - The Risk Annual Report was noted.
CGC0915 - Risk Report Card Q1 2012/13 was noted.
CGC0916 - SII/CR Q1 2012/13 Compliance Report was noted.

ACTION REQUIRED BY THE BOARD:
To note the minutes and action taken to provide assurance.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:
Minutes of the Clinical Governance Committee

AUTHOR: Lydia Brown
TITLE: Non-Executive Director/Clinical Governance Committee Chair
DATE: September 2012
Minutes of the Clinical Governance Committee
held on 11th September 2012
in The Boardroom, Salisbury District Hospital

Present: Lydia Brown (Chair) Maggie Cherry
Tracey Nutter Claire Gorzanski
Sally Tomlin Stephen Long
Christine Blanshard

In attendance: Lisa Dye (Note taker) Louise Dennington (CGC0904)
Daryl Connolly (CGC0905) Katherine Jenkins (CGC0905)
Mandy Cripps (CGC0904)

Apologies: Nigel Atkinson Peter Hill
John Stokoe

Welcome

Minutes of previous meeting (10th July 2012)
The minutes were accepted by the Committee as a true record of the meeting.

It was noted that the ToR would now be amended to reflect Peter Hill as Interim Chief Executive and no COO attendance.

CGC0901–Matters arising / Actions Tracker

CGC0704 -Patient Story - Review or Literature
TN to forward documents to the Committee.

CGC0712 - Dementia Strategy Update
Scores will be available at the November CGC

CGC0902 - Review of Reporting to the CGC (N. Atkinson)
LB clarified the purpose of the review and noted that it links to the Kings Fund report, ‘Preparing for the Francis report’, see CGC0902

CGC0903 - The Kings Fund – ‘Preparing for the Francis report’ How to assure quality in the NHS - July 12 (C. Blanshard, T. Nutter)

The report was written to help providers consider whether our system of quality assurance is effective and whether we need to do any further work to improve it before the Francis enquiry into the serious failings of care at Mid Staffordshire NHS Foundation Trust is published in the autumn.

How does SFT currently assure quality?
A key part of the assurance process is the Salisbury Organisational Trigger Tool (SOTT) which was developed by Tracey Nutter and has been in use within the Trust for over 2 years. Tracey has commissioned an evaluation of the tool by Professor Peter Griffiths, University of Southampton. Katrina Glaister is the local project manager who is working with a range of staff to ascertain the degree to which it has been embedded in their area, their understanding of its role and relevance so that it can be changed and strengthened in the light of the Francis Report.

The Kings Fund Report
The report recognises the importance of supporting frontline clinicians to identify and tackle poor quality care and of boards to change the organisational culture in the NHS. Internal assurance is the first line of three lines of defence. Regulators will be heavily criticised for not recognising and acting quickly enough into serious failures of care. The report also highlights the burden of external systems on providers which hamper the delivery of high quality care because efforts are concentrated on providing evidence for external reviews. There is some evidence that public reporting of data on benchmark quality has an effect on reputation and individuals.

4 key principles should be in place in the design of an effective quality assurance system. The evaluation of the SOTT will help SFT establish whether these principles are embedded within the organisation. The questions for SFT to answer in preparation are:

1. The system should be patient centred – do we listen to and respond to the experiences and concerns of patients, their families and carers. **Do we hear and act upon them?**

2. The system should engage staff - are staff able to raise concerns about quality and safety, are they heard and acted upon. **Are we doing enough to monitor staff experience and other indicators of staff engagement and respond and act upon it where appropriate?**

3. The system should promote good governance and effective leadership within the Trust and not be at the expense of external review preparation. **Do we think we have an effective governance system in place that promotes learning and improvement?**

4. The system should ensure that roles and responsibilities are clear so all those who work in the Trust need to be clear about their role and responsibility from Board to ward. **Do we consider roles and responsibilities within SFT for quality assurance are clear and understood?**

The Committee agreed that the Trust listens and responds to experiences with the processes that are in place.

Feedback from the CMB noted there is a patient focus, although there is a reactive approach to creating extra bed capacity. Also, good systems of communication are in place for listening to staff but that feedback on changes implemented could be improved. It was noted the Raising Concerns Policy is currently under review.

The Committee considered that the governance systems that are in place to be robust. Corporate memory/learning could be improved.

It was agreed the Quality Strategy (see CGC0912) sets out specific roles and responsibilities for delivering a quality agenda.

It was noted that some Job Descriptions may need updating with regards to values, escalating issues, patient care and safety. A review of all Job Descriptions is currently being completed by HR.
The Committee queried whether awareness of quality of patient care across the whole patient journey is always considered. TN said there is good practice and learning from the safeguarding agenda, and the NICE quality standards look at the interfaces and divide across the community services for older people.

The Committee agreed that overall there are good practices in place at Salisbury but the Trust should not be complacent. The Committee agreed that the CGC would need to provide assurance for the four key areas.

**ACTIONS:**

- The Committee requested feedback on the review of the SOTT at the July 2013 Clinical Governance Committee.

- The Committee requested for a sub-group is to be organised to review the CGC structure in light of the Francis report and a report back to the November CGC.

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**CGC0904 - Directorate Quality Report - Surgery (M. Cripps, L. Dennington)**

The Surgery directorate management team attended to present Quality in their directorate and how they provide assurance.

**Structure and Processes**

- Directorate DMT monthly meetings
- Speciality Clinical Governance meetings
- Key Quality Indicators
- Executive Quality and Safety Walks
  - Diabetic eye screening
  - Radnor Ward
  - Vascular Unit
- Performance monitored via 3:3 and Stocktakes
- Risk Register
- Organisational Trigger Tools
- Directorate Dashboard - Urology and Theatres
- Real time feedback & patient surveys

**National Audits, NICE Guidelines, Technical Appraisals, Interventional Procedure Guidelines**

- NICE Review against Guidance x 5
- Tech Appraisal 229 - Retinal Vein Occlusion
- National Review - RCS Emergency Surgery
- New procedures x 3.
- National Confidential Enquiries - NCE
  - Caring to the End
  - An Age Old problem
  - Perioperative care; Knowing the Risk
  - Adding Insult to Injury

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TN

LB/TN/

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CB/CG
Service Improvement
- Aortic Aneurysm Screening Wilts and Dorset
- NHS Innovation Single Stop Surgery
- NHS Elect Urology Service Review
- Ophthalmology Service Review
- Diabetic Eye Screening
  - Management structure
  - Establishment
  - Database
- One Stop Sentinel Lymph Node Biopsy Breast
- Radnor Psychological follow up clinic
- Theatre Management System

Challenges
- Capacity issues Ophthalmology and Urology
- Theatre efficiency
- Bed capacity
- Medical Photography

No Questions were asked.

The Committee thanked the Surgery team for their presentation.

**CGC0905 - Patient Story (Dr K. Jenkins, D. Connolly)**
KJ and DC described the use of the Clinical Psychology Service that had been trialed on Radnor Ward with the aim of reducing post traumatic stress for patients, relatives and staff members.

The Committee thanked Kate and Daryl for their presentation.

Mandy Cripps confirmed that there are some funding issues and currently Clinical Psychology services are part funded in the community.

The Committee agreed it would make more sense for such support to be offered earlier for patients rather than only in the community where the impact of no intervention is greater.

The Committee agreed on the effectiveness of the service for both patients and staff.
ASSURING A QUALITY PATIENT EXPERIENCE

Analysis of the results of the 2011 national outpatient survey were presented to the Clinical Governance Committee last November (2011) when it was noted that clinical areas would be asked to work with the directorate management teams to develop action plans for improvement where required, supported by the Patient and Public Involvement team.

The action plans from Medical Surgical, Dermatology, Rheumatology, Gynaecology and Respiratory Out Patients Departments were presented. Most of the teams felt that there was little they could implement that was going to make a radical change to their results, they have, however, tried hard to create action plans that have been appropriate.

Each areas action plan is attached and was updated at the beginning of August this year 2012.

The Committee noted the work undertaken.

ASSURING CLINICAL EFFECTIVENESS

CGC0907 - Effective use of NICE Quality Standards update (C. Blanshard)
The NHS Outcomes Framework 12/13 provides a framework and accountability mechanism between the DH and the NCB and acts as a catalyst for improving outcomes and tackling health inequalities across the whole health community.

NICE Quality Standards are a set of specific, concise statements and associated measures covering the treatment and prevention of diseases and conditions.

The NCB supported by NICE is developing a COF. The first set of 44 COF indicators were revealed in August which cover recovery from stroke, tackling diabetes and improving maternal health. A selection of final indicators will be considered by the NCB in October 2012 for inclusion in 2013/14 COF in time for the next round of contract negotiations.

Nineteen Quality Standards have been published to date. SFT’s compliance with these are:

- Six non compliant low risk.
- Four baseline assessments are in progress and close to completion.
- Four baseline assessments for standards published before February 2012 have not started but plans are in place.
- Baseline assessments for the four most recent Quality Standards have not been started yet.
- One is not applicable to SFT.

Measurement either as submissions to national datasets or through local indicators seems robust. The greatest challenge is to ensure an integrated approach across organisational boundaries to baseline assessment and improvement work.

The Committee noted the update.
Four SIIs were commissioned.

Six cases of C Difficile occurred in July 12 all on separate wards. This represents a peak similar to the same month at SFT and in other Trusts in the South West in 2011. RCA’s were undertaken in all six cases but no links or patterns were identified and antibiotics were prescribed appropriately. Further work needs to be done to establish the effect of the high use of proton pump inhibitors in the community and C Difficile.

The crude mortality rate has fallen again in July 12. The SHMI adjusted for palliative care for January to December 2011 is 95 which is ‘as expected’.

GTT remains below target over the last four months at a time when escalation beds remained open.

Hip fracture patients being operated on within 36 hours has showed an improvement following a dip in June 12.

There were four falls resulting in a fracture. An aggregated review of nine fractures in quarter one 12/13 showed a change in the type of falls to the more independent patients who slip or fall during recovery or the rehabilitation stage. Improvements in documentation of preventative action, written information and communication with families and intentional rounding for patients at high/extreme risk of falls are all in progress.

There were no non clinical same sex accommodation breaches.

Patient real time feedback shows more work is needed to ensure patients know about what is planned for their care and treatment plan. A document called ‘your plan for your care’ is due to be presented to CMB in September to help improve this important aspect of care.

The Committee queried feedback from the RTF.MC confirmed that unless patient wishes to remain anonymous feedback is given to the wards immediately. Volunteers are also trained to guide any patients on raising a concern.

The Committee noted the report.

CGC0909 - Major Issues Sheet (C. Blanshard)

The Major Issues report was presented noting:

- PIP breast implants final report of the expert group published by the DH.
- The Kings Fund published ‘Preparing for the Francis report’.
- The NHS Chief Executive’s annual report 11/12 was published.
- The criminal records and barring system is scaled back by the government to more proportionate levels.
- Report on the effect of the NHS Constitution published by the DH.
- New family and friends question announced. Work started at regional and local level to plan for implementation.
- Wessex LETB functioning in shadow form.
• GMC have issued further guidance on medical revalidation.
• Wiltshire CCG concentrate on authorisation and QIPP.
• Local review of governance and management arrangements of health and safety started.
• Progress of local action in response to HS&E improvement notices. A paper is due to Trust Board in October.
• Trust receives excellent rating for cleanliness, food, privacy and dignity following a PEAT inspection.
• Trust is committed to engage with staff as part of the South West pay and terms of conditions consortium.
• National cancer patient survey results published with over 90% of patients rating their care at SDH as excellent or very good.
• National audit of laparoscopic theatres achieved a maximum score and gold rating.

The Committee noted the report.

CGC0910 - End of Life Care Strategy annual report (C. Blanshard)
A background and SFT results from the National Care of they Dying audit 2011 and a local care of the dying audit in March 2012 are set out.

Areas of good practice and progress include the introduction of ADASTRA, initiatives in some specialties with advanced care planning, a very successful ward based education programme, a new robust rapid discharge process, a change to bereavement suite signage and raising public awareness of dying.

Future priorities:
• Comprehensive use of ADASTRA.
• Better advanced care planning which is documented and shared across organisations.
• Collaborative work with the PCT/CCG on end of life care.
• Continuing training and education programme.
• Roll out of the rapid discharge process as the norm.
• Joint working with the dementia strategy steering group.

CB confirmed that GP’s use a different computer system to SDH. SDH does have access to both but the systems do not talk to each other.

The Committee noted the report.

CGC0911 - Dr Foster report - August 2012 (C. Blanshard)
Mortality:
Between April 2011 to March 2012 HSMR was 95 or 104 when rebased but still within the expected range. SFT’s SHMI for the period January to December 2011 was 101 ‘within expected range’ and when adjusted for palliative care is 95 the same as our HSMR. 31% of deaths were coded as palliative care deaths during January to December 2011 probably because of the Hospice on site. The SHMI trend for all activity over the last three years shows a consistent pattern of within expected range.

Between January to December 2011 the SHMI and HSMR funnel plot indicates SFT within expected range and when benchmarked against other Trusts. During the
same period the relative risk of death from secondary malignancies and congestive heart failure were above expected. The mortality steering group lead has reviewed all 31 deaths in the secondary malignancy group and found none of the deaths were avoidable; all the patients except for two died within 24 hours of admission and had shared care with the hospital palliative care team which is good practice. However it does raise the question of whether these patients could have received palliative care at home. A review of the congestive heart failure deaths is underway.

Performance summary June 2011 to May 2012 indicates a single death from ECT. A case review was undertaken and indicated the patient died from bronchopneumonia and had not had ECT.

**Patient Safety:**
Pressure ulcers remain higher than expected. Coding does not differentiate between hospital and non hospital acquired ulcers. Work is being taken forward to enable accurate recording and therefore coding. The introduction of the Safety Thermometer is showing that many Trusts under report nationally. It will be interesting to see how we compare against other organisations’ safety thermometer data which we will be able to benchmark ourselves against this year.

Post-operative haemorrhage or haematoma is showing above expected. Most of these patients were plastics patients who returned to theatre for the evacuation of a haematoma as a proactive measure rather than managing the situation conservatively. A case review showed that the haematoma rate against the total number of procedures within the plastics department is low at 0.37%. The cases were reviewed in detail and found to be a particularly complex subset of patients who required tissue transfer as part of their reconstruction. In this group a haematoma rate of 5% is comparable to studies published in the literature.

Post-operative respiratory failure is showing above the national average. The Consultant Nurse and an Intensivist have partially completed a review of these cases.

Accidental puncture or lacerations continue to show as higher than expected but the numbers have decreased from 144 in the February 12 report to 118 in the current report. Coding changes in respect of colorectal and cataract surgery are starting to have an impact. There has been a decrease in the relative risk when compared to the previous three months.

Obstetric trauma coding issues remain ongoing. The Trust has feedback concerns to Imperial College around the codes and methodology without any impact on the way trauma is reported. The Maternity Services local dashboard shows 3rd and 4th degree tears as 2.9% year to date against a national goal of less than 5%. This is monitored by the Clinical Risk Group.

**Service line indicators:**
Knee replacement readmissions were above the national average. These cases were reviewed in 2011. It was considered 25% of the re-admissions might have been avoided if the patient had had greater support on discharge. A telephone contact, visit or OPD with an orthopaedic therapist has been put in place to reduce this number.
The Committee noted the report.


The strategy sets out the definition of high quality care along with the objectives, goals, structures, processes, capabilities, culture and measurement to make the strategy a reality.

It’s aim is to ensure a robust quality governance framework is in place to provide assurance that the Trust is compliant with essential levels of quality and safety and is continuously striving for quality improvement.

The quality priorities in the Quality Account are the key drivers for quality improvement and improved patient outcomes as a year on year plan.

SL noted that the Values & Beliefs were written in 2005. TN confirmed they are included the review of strategy being completed by Jenny Hair.

The Committee approved the Quality Strategy

The Committee noted the priorities action plan.

## ASSURING PATIENT SAFETY

**CGC0913 - Safety Plan Update. (T. Nutter)**

The Safety work stream was established in December 2007 as part of the Organisational Development Strategy and was developed to incorporate the Patient Safety First Campaign during 2008. The objectives of the programme and associated measures have now been further enhanced through participation in the SHA wide quality and safety project which was launched in October 2009.

TN reported that the Safety Steering Group has now been disbanded and presented the new reporting. Gill Cobham has taken over from Lorna Wilkinson as Programme Lead

All interventions are making progress and we continue to receive very positive feedback from the SHA faculty. The Committee is asked to note the following:

- The work continues reporting on >60 datasets monthly to the SHA extranet. This allows us to track progress over time.
- The Critical Care work stream is well established and sustaining changes to practice.
- The perioperative work stream continues to have some challenges around aspects of the Surgical Site Infection bundle such as glucose control which is being unpicked. Compliance with all sections of the WHO checklist continues to improve.
- The Medicines Management Group is currently facing staffing difficulties and have requested to suspend data collection.
- The General Ward Group have challenges around escalation following EWSS trigger (CCOT leading on), achieving reliability across all ward areas with the SKIN bundle. Work on the Catheter Care bundle has begun It is important to note that this is the heaviest work stream in terms of
interventions and clinical areas to cover and there have been positive achievements in use of Safety Briefings, completed observations, calls to outreach etc

As part of the national CQUIN the Trust must has implemented the Safety Thermometer from April 2012. We have had some IT issues which have been reported back to the NHS Information Centre.

Key Next Steps:
- Work is ongoing in all work streams
- The Urinary Catheter Care bundle to be implemented
- Focused work is required in those wards struggling with the SKIN bundle
- Details around each intervention are described in the report
- Safety Thermometer data collection monthly

It was noted that some wards are receiving additional training from the Critical Care Outreach team around recognition of deterioration and escalation to the outreach team.

ST further noted that the Critical Care Outreach Team now have 2 non-medical prescribers who can now prescribe when called to a patient.

It was noted that the results of the intentional rounding pilot were good, and there will be full implementation across the Trust.

The Committee noted the report and the work being done.

**CGC0914 Risk Annual Report 2011/12 (T. Nutter)**
This Risk Management Annual Report provides detailed evidence around each of the strategic goals for Risk Management, and how they are being achieved within the organisation.

Key Items to note are:
- Progress against the strategic goals as set out in the Risk Management Strategy (2011)
- Progress against the Annual Risk Management Plan 2011/12 (Appendix 1)
- Mid Year progress report against the Annual Risk Management Plan 2012/13 (Appendix 2)
- Annual Report Card 2011/12

LB queried the progress on the Healthcare Records Committee and note there are some areas that use different forms.
CG confirmed that the HC records committee are clear on not agreeing to all new papers as it is always considered where else this information is covered (other forms or IT systems)

TN confirmed that if an incident arose it would be highlighted to the Committee. Although there is nothing stopping the CGC from asking for KPI’s on HC records. TN further confirmed that audits of nursing documentation are completed annually.

It was noted that there should be an Annual Healthcare Records report to the CGC.
The Committee noted the achievements in the report and management plan.

**ACTION:**
- The Committee requested for updates to be sent to the CMB and reported to the CGC via the minutes.

**CGC0915 Risk Report Card Q1 2012/13 (T. Nutter)**

The Risk Report Card Q1 was presented noting:
- 823 incidents reported over the quarter
- No incidents categorised as catastrophic
- 12 incidents categorised as major
- 3 major incidents due to fractures within the quarter
- No Never Events within the quarter
- 2 new Clinical Reviews commissioned within the quarter
- 5 new Serious Incident Inquiries commissioned within the quarter
- 1 Local Review commissioned within the quarter

The Committee noted the report.

**CGC0916 - SII/CR Q1 2012/13 Compliance Report (T. Nutter)**

Updates since May 2012 CMB to outstanding recommendations:
- SII87 (PCI death): Recommendations (c) and (g) updated
- CR76A (Gynae cancer referral to MDT) Recommendations 1-3 completed
- CR76C (Gynae cancer referral to MDT) Recommendations 1-4 completed
- CR76D (Gynae cancer referral to MDT) All recommendations completed
- SII 94 (Grade IV Pressure Ulcer) Recommendations 1-3 completed
- SII 98 (Grade III Pressure Ulcer) Recommendations 1-3 and 6 completed
- SII 103 (Grade III Pressure Ulcer) Recommendations 1-3 and 6 completed
- SII 90 (C-diff deaths) Recommendations 10, 11, 13 completed
- SII 95 (Grade IV Pressure Ulcer) Recommendations 1-2 completed
- CR 82 (Deterioration post endoscopy) Recommendations b-d completed
- CR86 (Equipment Failure) Recommendation b completed
- SII 101 (MRSA Outbreak) Recommendation 1, 2, 5 and 6 completed

Reviews with outstanding recommendations:
- SII87 (PCI death)
- CR76A (Gynae cancer referral to MDT)
- CR76C (Gynae cancer referral to MDT)
- CR 78 (Misdiagnosis of Cancer)
- CR 79 (ED Trauma Management)
- SII 94 (Grade IV Pressure Ulcer)
- SII 98 (Grade III Pressure Ulcer)
- SII 103 (Grade III Pressure Ulcer)
- CR 73 (Child transfer to PICU with Burn)
- SII 90 (C-diff deaths)
- CR 81 (Patient management with liver disease)
- SII 95 (Grade IV Pressure Ulcer)
- CR 80 (Delayed review of Oncology patient)
- CR 82 (Deterioration post endoscopy)
- CR 85 (Pre-operative diagnostics)
- CR86 (Equipment Failure)
- SII 101 (MRSA Outbreak)

Reviews with recommendations added to Department/Directorate Risk Register
- Nil

New Recommendations since May 2012 CMB
- SII 94 (Surgery) Grade IV Pressure Ulcer
- SII 98 (Surgery) Grade III Pressure Ulcer
- SII 103 (Surgery/Medicine) Grade III Pressure Ulcer
- CR 73 (CS&FS) Child transfer to PICU with Burn
- SII 95 (Surgery) Grade IV Pressure Ulcer
- CR 80 (Medicine) Delayed review of Oncology patient
- CR 82 (Surgery) Deterioration post endoscopy
- CR 85 (Surgery) Pre-operative diagnostics
- CR86 (Surgery) Equipment Failure
- SII 101 (MSK) MRSA Outbreak

Serious Incident Inquiry/Clinical Review for Closure
- CR76D (Gynae cancer referral to MDT)

The Committee reviewed the summary
No areas were identified as requiring further clarity or focus.

PAPERS FOR NOTING

CGC0917 - Clinical Risk Group Minutes (Jun& Jul)
The Committee noted the minutes with no exceptions raised or queries.

CGC0918 - Infection Control Committee Minutes (Jul)
The Committee noted the minutes with no exceptions raised or queries.

CGC0919 - CMB Minutes (Jun & Jul)
The Committee noted the minutes with no exceptions raised or queries.

CGC0920 - Children & Young People’s Quality & Safety Board (May)
The Committee noted the minutes with no exception raised or queries.

ANY OTHER BUSINESS

Enhancing the Healing Environment
TN reported on a Seminar she had attended about the use of light and design to stimulate the senses in a particular way that will help provide the right environment for patients. TN noted she would be making a capital bid for a pilot project on Redlynch and Pitton.

ACTION:
- The Committee requested feedback on progress.

Date of next meeting:
Tuesday 13th November 2012 12noon – 2.30pm Boardroom, SDH

TN

ALL