CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES

PURPOSE:
To inform the Trust Board about the matters discussed at the Clinical Governance Committee (CGC) on 16 January 2012

MAIN ISSUES:
The key items from the CGC are as follows:
CGC0102 – A presentation was given by the Cancer and Medicine Directorate on how they assure quality of care within the Directorate.
CGC0105 – A patient story was read out about a relative’s concern about the care of a patient on Winterslow ward. The relative felt there was some lack of basic care, lack of communication and a lack of ability to escalate the concerns to somebody in the ward to address the issues. The Trust is currently working on increasing the number of RNs on the ward. Winterlsow will also take part in a service improvement programme.
CGC0106 – The Quality Indicator report for November was presented. CB also briefed the Committee on PIP breast implants and a FOI request from the DH on the Trust’s performance in the last three national stroke audits and the potential for further publicity.
CGC0108 – A bi-annual update on external enquiries and external agency visits report was given and the progress made was noted.
CGC0109 – An update on progress with the Health Records annual work plan was given. The CGC requested future updates go through the CMB and are reported to the CGC via the minutes.
CGC0110 – Dr Fosters Trust mortality report – an update was given from August 2011 and the progress made was noted.
CGC0112 – an update on the Safety Plan was given. It was noted work was ongoing in all areas. TN explained the Safety report to the SHA will cease in March and the Trust will move to a Safety Thermometer which will be reported to the Board regularly. It is planned to continue the work internally and report it to the CGC.
CGC0113 – the Assurance Framework and Risk Register was noted.
CGC0114 – NPSA compliance report was noted
CGC0115 – NRLS report was noted.
CGC0116 – a mid year update report on Safeguarding Adults and Children was given. Internal audit had completed a review and found the Trust is fulfilling its obligation relating to safeguarding. The report was noted.
CGC0117 – a progress report on the Learning Disabilities action plan was given and noted.
CGC0118 – SII90 a report was given on the progress made on the RCA action plan following an increased incidence of C Difficile in July 11. The progress made was noted.
CGC0124 – Public Health Steering Group terms of reference were agreed and a report requested in a year to review progress.

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: Claire Gorzanski
TITLE: Head of Clinical Effectiveness
DATE: January 2012
Minutes of the Clinical Governance Committee  
held on 16th January 2012  
in The Boardroom, Salisbury District Hospital

Present:  Lydia Brown (Chair)  Stephen Long  
Christine Blanshard  Tracey Nutter  
Maggie Cherry  John Stokoe  
Claire Gorzanski  Sally Tomlin  
Peter Hill  Lorna  Lorna Wilkinson  

In attendance:  Helena Bridgman (CGC0102)  
Debbie Butler (CGC0102)  
Lisa Dye (Note taker)  
Ian Harvey (CGC0102)  
Neil Robinson (CGC0102)  

Apologies:  Nigel Atkinson  

Welcome  

Minutes of previous meeting (21st November 2011)  
The minutes were accepted by the Committee as a true record of the meeting.  

CGC0101—Matters arising / Actions Tracker  

CGC1909 – SII/CR Compliance  
Completed  
The report went to the November CMB. It was agreed that during the next Directorate 3:3’s the outstanding recommendations would be discussed, actions agreed and consideration for the risk register as appropriate.  

CGC0411 – NCEPOD Annual Report  
The Committee requested feedback from the Ophthalmology service review at the January CGC. The review date is set for Tuesday 24th January. Update carried over to March CGC.  

CGC0102 – Medicine & Cancer Directorate Quality Presentation (H. Bridgman, D. Butler, I. Harvey, N. Robinson)  
The Medicine and Cancer DMT presented their directorate’s annual quality report.  

Cancer Quality Report  
HB presented the Cancer Quality Report.  
Quality Indicators:  
- Trigger tool - Operational Directorates  
- Improving Cancer Outcomes  
  - Self Assessment  
  - Clinical Lines of Enquiry  
  - Internal validation  
  - External verification  
  - Targeted visits  
  - Quarterly monitoring report – RAG (Red, Amber, Green)
Benchmarking via CQUINS

Patient Safety:
- No red ratings – key areas to monitor
- National Bowel Cancer Awareness Campaign – preparedness
- Electronic MDT data capture
- Prescribing, commissioning, delivery of Systemic Anti Cancer Treatments (SACT)
- Shared care units – patient experience
- Metastatic cancer pathways
- Management of rarer cancers

Risk Management:
- No Serious Incident Inquiries
- 4 Clinical reviews
- Progress on recommendations being made
- 1 Local Review
- No outstanding NPSA alerts
- Risk register – 3 risks scoring >12

Clinical Effectiveness measurements:
- NCAG implementation plan
- Nice Improving Outcomes Guidance
- Clinical Audit
- National Audits – DAHNO, NBOCAP, NOGCA, LUCADA & End of Life Care
- MDT service profiles

**Medicine Quality report**

DB presented the Medicine Quality report.

**Key Directorate Performance Indicators:**
- Non-elective LOS - 6.69 ytd (6.23 Q3) Target 7.78 (10% reduction on 10/11)
- Elective LOS - 3.82 ytd (3.65 Q3) Target 3.48
- DTOCs – shows a downward trend
- Readmissions following non-elective admission - 10.18% ytd (6.6% M9)
  Target 6.04% (25% reduction on 08/09 tbc)

**Key Actions Undertaken:**

DB presented the improvements made in ED, Stroke and Improving Inpatient Flow

The aim has been to embed local leadership of quality/safety/productivity.

IH presented the ward report

**Patient Safety & Quality**
- Key Quality Indicators
- Safety briefings
- Pressure ulcer action plan
- Patient Falls
- Medicines management
- Meal time observations
- Implement intentional rounding
- Peripheral cannula care bundle trial - Pitton
- Neuro-obs chart being developed to trial
- Organisational Trigger Tool to be implemented following feedback from a
Infection Control shows continued improvement with the key areas of Hand Hygiene, BBE, Uniform Policy, Commode cleanliness, Use of VIT, IRAT achieving around 90%.

MSSA, MRSA, C Diff all maintain low levels apart from the known increase in C.diff cases seen in July last year. (See section CGC 0118 for update) Improvements have been maintained with:
- Close liaison with infection control team
- Vigorous monitoring & vigilance
- Audit
- Challenging poor practice
- Reporting at Matrons monitoring
- RCAs involving staff
- Actions from the C Diff “look back” exercise & SII report

IH presented the work ongoing to make improvements on Redlynch and the key activities undertaken:
- Area of concern – complaints, incidents, RTF, KQI
- Discussed with DoN & Deputy DoHR
- Commissioned ward review
- Agreed Terms of Reference
- Report completed
- Leadership, management, ownership, communication
- Action plan developed
- Results discussed with all members of staff
- Address performance issues

NR presented the audits that have taken place in the last year:
Directorate Audit Program in place
- Regular clinical governance meetings
- Each clinical team has a morbidity and mortality meeting – taking turns to present at the Thursday clinical governance meetings for physicians
- Data (ASI/IST) are collected monthly for stroke network and the PCTs (covering all aspects of stroke care - currently coming first within the AGWS region for high standards of care)

National Audits
- National Falls Audit (clinical lead: Dr C. Page)
- Multiple Sclerosis Audit (clinical lead Dr H. Katifi)
- National Audit of Seizures in Hospitals (NASH: clinical lead: Dr J. Lovett)
- Due to start: SSNAP audit of acute stroke management (clinical lead: Dr D. Walters)
- All audit results reported (or due to be) to the CMB – no major problems identified
- NICE guidelines regularly audited – compliant at present in all departments
- Collaboration with the MSK directorate to ensure compliance with the NCEPOD report on the care of elderly people on the orthopaedic wards: an age old problem

LB questioned how long the work on Redlynch took.
IH confirmed it was about a year.
LB thought this to be a good example of what can be achieved.

LW queried whether there were any struggling areas.
DB noted that some teams were not working well as a team.
TN suggested the Organisational Trigger Tool would assist in developing those areas.
NR noted that the changes that have been made to the Clinical Lead structure means that the DMT can get better involved in the workings of those struggling teams and tackle any issues.

The Committee thanked the Medicine and Cancer DMT for their presentation and complimented the amount of work going on.

<table>
<thead>
<tr>
<th>CGC0103 – Executive Safety &amp; Quality Walks Update (L. Wilkinson)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LW reported that the combined walks have due the three months evaluation.</td>
</tr>
<tr>
<td>A tool has been developed to evaluate the walks at every level that is currently being tested with the Quality Leads.</td>
</tr>
<tr>
<td>A report will be presented at the March CGC.</td>
</tr>
<tr>
<td>LW</td>
</tr>
</tbody>
</table>

CGC0104 – CQC Outcome Assurance Report (M. Cherry & T. Nutter)
It is the responsibility of the Clinical Governance Committee to ensure continued compliance of Outcome 1 and 7. The Trust board will be presented with all compliant Outcomes in April 2012.

Outcome 1
MC reported that last years report had been brought up to date.

CG noted that the QRP in November 2011 showed areas from the Adult Inpatient Survey were tending towards worst that expected. The CQC would expect to see an action being taken to improve.
MC confirmed it was included in the report under RTF
PH noted the QRF findings need to be referenced as well.

Outcome 7
TN reported that the action plan shows progress on all actions including:
- Completeness of training MH Capacity and Safeguarding
- Learning Disabilities
- Dementia
- Rapid Tranquilisation policy

CG confirmed there were no areas of concern in the QRP for Outcome 7.

**ACTION:**
- The Committee requested an Action Plan for Outcome 1 to return to the March CGC
- The Committee requested the Action Plan for Outcome 7 is updated and reported back to the March CGC
- The Committee requested the Quality Risk Profile is presented at the March CGC

MC/CB  TN/CM  CG

CGC0105 – Patient Story (M. Cherry)
MC presented a concern that was raised with PPI from a relative of a patient on Winterslow. The relative did not wish to make a formal complaint.
The relative’s Mother, aged 100 years old, was admitted to A&E. The symptoms that she presented were puzzling and she was therefore admitted to Winterslow for further investigation and treatment.

The relative reported:
- The ward were informed of the prescribed medication but had no knowledge of these on discharge a week later. The medication had not been administered.
- No clear communication of the treatment that had been given
- Nursing staff had no clear understanding of what was thought to be the condition they were treating, and the patient notes were unreadable
- A call was requested with the Doctor, and not received six weeks later.
- No room to move patients when they are in obvious discomfort and are disrupting to other patients at night
- Concerns over maintaining her relative’s personal hygiene

TN noted caution as an investigation had not yet been completed and therefore not all sides of the matter are known.
SL queried what process is in place for such stories when they come to light, compared to the formal complaint process.
TN noted that such concerns are investigated. For example, if a concern is raised via the Governors then herself or CB would take ownership of an investigation and request patient notes.

CB questioned that in this story there seems to be no escalation at ward level and concerns have only been raised post discharge.
TN added that patients and relatives can go to Customer Care should they not feel their concerns are being heard on the ward.
TN further added that staffing concerns have been flagged by the CQC, and the Trust is currently working on reviewing skill mix and establishments. Winterslow is also progressing with a service improvement program in 2012.

**ACTION**
- The Chair confirmed a letter of thanks would be written

---

**ASSURING CLINICAL EFFECTIVENESS**

CGC0106 – Quality Indicator Report incl. DSSA (C. Blanshard)
The quality indicator report was presented in a new format with additional data and numerical as well as percentage data.

- 3 MSSA bacteraemias - 2 line related (cannula and catheter) and the 3rd was a patient transferred from another hospital with wound infections. A root cause analysis is underway for all 3 cases.
- *HSMR (*illustrative only) The SHA report a reducing HSMR in July and August 11. Future reports will include both the HSMR and SHMI. Early indicators suggest for this Trust there is little difference between the two measures.
- Re-admissions show an improving picture. A sound process is in place to determine if re-admissions are related to the original admission. A joint audit with the PCT/GP is in progress to ascertain whether non-elective re-admissions could have been avoided if different management had been
undertaken or community or social care had been able to intervene earlier.

- There were 6 non clinical breaches in delivering same sex accommodation, minimal use of escalation beds and only 2 patients who experienced 3 or more ward moves. There were no non-clinical breaches in December.

- Patient real time feedback showed an improved picture. A new indicator is now measured to ask patients whether they know about their care and treatment plan. 12% of patients did not know what was planned when asked about this.

The Committee agreed that the sections in red on the graphs could also show a figure for further clarity.

SL queried the difference between whether patients would know what is planned now and what is planned next. MC confirmed that this was a question that they had struggled to get right but have gone with the phrasing that matches the national patient survey so that the figures can be compared. MC further confirmed that the volunteers are trained on how to complete the survey with patients. LB asked if the volunteers have the opportunity to ask questions outside of the survey to avoid ambiguity in the response. MC confirmed that volunteers do this.

JS queried whether investigations take place when a patient is readmitted more than twice, for example, over an 18 month period. CB confirmed there is no formal process but this can be raised by the GP and reviewed in M&M on a case by case basis. PH confirmed there is no formal process to identify such cases. This would be picked up at ward level.

**PIP Breast Implants**
CB reported that the Trust had contributed to the review of data of all patients that received implants to date and to look at any issues. 1165 patients notes have been reviewed. No PIP implants have been used. No mortalities have occurred in relation to any complications. Over the 10 years reviewed, the expected rate for leakage is 10-13%. SDH has a rate of 21% for all complications (leakage, pain and infection). CB confirmed the audit is out in the public domain and the results will be shared with GP’s.

**FOI request from DOH**
Request to access hospital level data for the three national stroke audits. CB noted caution, although the Trust has done well in these audits they were not designed to be published publically and the data could be misinterpreted. This could be a concerning precedent.

**ACTION**
- The Committee requested for the sections in red on the graphs to be amended to show a figure for further clarity.  

---

**CGC0107 Major Issues Sheet (C. Blanshard)**

---
NHS Outcomes Framework 12/13 published – 60 indicators developed to measure outcomes. Integration, collaboration and aligning with the Public Health Outcomes Framework (yet to be published) and Adult Social Care Outcomes Framework (published) is a key message. 30 of the indicators are currently unknown as they have not yet been published.

A new NCEPOD report – ‘Knowing the Risk’ a review of peri-operative care of high risk surgical patients who died within 30 days of a procedure. There were deficiencies in pre-operative assessment, fluid management, the consent process, intraoperative monitoring and use of critical care facilities. The CMB will commission a clinical lead in January 12 to undertake a gap analysis and action plan.

South West Dementia Partnership peer review inspection took place in November. Initial feedback was very positive. Full report received. The report has been returned for review by the Trust. It has now gone back to the peer review group with some changes to factual inaccuracies for their final review. Once the finalised document has been received it can be made public.

Patient Information Standard – The Trust remains compliant following assessment in November.

TN noted that the Francis Report is due to be published. Following its publication, TN will report to the CGC.

CGC0108 - Bi-annual External Enquiries and External Agency Visits Report July – December 2011 (C. Blanshard)

National Reviews
- Since July 2011, one national review, the annual CQC report on the management of controlled drugs, has been published. The Trust is compliant with the four recommendations.
- One other issue was considered during the reporting period. This was a case of possible deliberate insulin overdose at Stepping Hill Hospital. No immediate local action was deemed necessary and no formal report will be published until police investigations are complete.
- There remain 29 recommendations to complete from five reports in previous reporting periods.

National Confidential Enquiries
- Two reports have been published in November and December 11, reviewing children’s surgery and pre-operative care. These contain 39 recommendations. For children’s surgery, clinical leads have been identified to undertake a gap analysis and action plan. A clinical lead will be commissioned for the second report at the CMB in January 2012.
- The number of recommendations outstanding from previous reports has decreased from 34 to 26, and. leads are being helped to resolve the outstanding issues. However there has been delayed progress with ‘Adding Insult to Injury’. The CGC have requested an update in March 2012. The Critical Care Delivery Group have taken this on to develop an Action Plan. The plan is due to be reported at the CMB and CGC in March 12.

Annual External Agency Visits
There have been three formal visits and one informal visit to the Trust in this reporting period.
Recommendations from six visits in previous reporting periods continue to make progress.

LW noted that page 3 should reference Mental Health Act and Mental Capacity Training not Learning Disabilities.
SL queried the last page reference to the Learning Disabilities Peer Review.
TN confirmed that it has been recognised regionally that there was much to learn from the LD review.

**ACTION:**
- The Committee requested for page three to be amended to reference the Mental Health Training.

---

**CGC0109 – Healthcare Records Committee Update (C. Blanshard)**
A progress report against the annual work plan was tabled. The following achievements have been:
- Introduction of the MAU clerking document
- Quarterly monitoring of complaints related to record keeping and commissioning any necessary actions
- Quarterly monitoring of incidents related to record keeping and any actions arising
- Commissioned and piloted a new blood transfusion monitoring form.
- Ratified skin bundle documentation.
- Agreed to pilot of new maternity (planned caesarean) documentation.
- Participating in the consultation process for medical records innovation

Work in progress:
- Creation of a new GI bleed/pathway document
- Cardiology pathway
- Patient front sheet – single document following registration
- Devising a protocol for destruction of health care records no longer needed
- Annual audit of medical records

The Head of Information Governance is planning to work with the Committee chair to develop robust processes for the management of documents via SharePoint.

It is proposed that the electronic discharge summary working group and the electronic health care record working group will amalgamate with the health care records committee.

**ACTION:**
- The Committee requested for updates to be sent to the CMB and reported to the CGC via the minutes.
CGC0110 – Dr Foster Trust Mortality Report – August 2011 Update (C. Blanshard)
A review of mortality in pneumonia patients with low or no co-morbidities indicated coding issues rather than clinical practice issues, although end of life conversations should have been had were it was evident patients were dying. We have implemented a local agreement to improve coding of co-morbidities.

There is further work to do to differentiate between hospital and community acquired pressure ulcers.

Accidental puncture or lacerations in colorectal and general surgery have been reviewed and identified coding issues. It has been agreed that these will only be coded if it is a full thickness tear.

A local agreement has been reached about posterior lens tears in cataract surgery so that only those patients who have a vitrectomy are coded as having an accidental puncture.

Obstetric trauma coding issues remain ongoing. The Maternity Risk Group have reviewed the patient notes and have found inconsistencies between coding by Dr Foster and SDH. CB wrote to Dr Foster about our concerns. SDH are not the only Trust with that have issues with Dr Foster coding and the results will not be published.

LW queried whether there is assurance that coders can implement these local agreements.

CB reported that firstly agreement is required from surgeons about what is written in the notes so they are clear. Coders will then know the difference and how the notes should be coded.

CG confirmed that the lead coder is undertaking an audit to ensure correct coding.

MC queried EOL care conversation issues.

CG confirmed this is being led by the EOLC Working Group. Pippa Baker (Consultant) is working with Senior Doctors, and the Palliative Care team with ward staff. CG added the National Care of the Dying audit has shown improvements have been made.

The Committee noted the progress made.

CGC0111 – Dementia Peer Review Update (C. Blanshard)
The Dementia Peer Review was completed by the South West Dementia Partnership Peer Review team on 23 November 2011. The trust has received initial feedback on the day of the peer review visit and a draft report The final report is expected in January 2012.

The visit was undertaken to assess the care we provide to people with dementia against the eight quality standards. The assessors observed care on wards and outpatient areas and talked to staff in clinical and non-clinical areas.

The initial feedback from the assessment team was very positive. The team were clearly impressed with the motivation and professionalism of our staff and the way the team were welcomed everywhere they went. They noted in particular the Board and clinician leadership, the positive culture in the organisation, the enthusiasm of
the 55 dementia champions and saw positive interactions with patients at mealtimes and during care provision.

There were some areas for improvement. However, these centred mainly around the creation of a dementia friendly environment. They wanted to ensure we do not lose the excellent ideas being put forward by dementia champions and to ensure we have a sound system of capturing and using these to continue to make changes in the future.

The Committee noted the initial feedback.

**ACTION**
- The Committee requested an update when the full report has been published

### ASSURING PATIENT SAFETY

**CGC0112 – Safety Plan Update (T. Nutter)**

The Safety workstream 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.

The project includes key interventions put forward as part of the national Patient Safety First Campaign. These interventions aim to provide acute Trusts with a focus to begin making evidence based improvements in patient safety. Our overall strategic system level aim is to reduce the inpatient mortality rate and levels of harm associated with adverse events, we aim to influence this change through the following interventions:

- Leadership for Patient Safety
- Reducing Harm in Critical Care
- Reducing Harm from Deterioration (General Ward)
- Reducing Harm in Perioperative Care
- Reducing Harm from High Risk Medicines

Each intervention carries a set of campaign measures so that reliability and outcome can be assessed. A Safety Steering Group was established in April 2009 and is responsible for taking this work forward and will continue to report into the Clinical Governance Committee. From 2011 the programme has also included the QIPP Safer Care workstream which includes reducing catheter associated urinary tract infections, reducing falls, reducing pressure ulcers, and reducing VTEs. These pieces of work are based within the General Ward workstream.

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 is expanding continuously to provide reporting on >60 datasets monthly to the SHA extranet. This allows us to track progress over time. Of note during 2011/12 work is expanding within the General Ward workstream to encompass the QIPP Safer Care initiatives on reducing harm from falls, reducing pressure ulcers, and reducing catheter associated urinary tract infections. These interventions are in the very early phases of gathering baseline data and/or piloting however early feedback is positive e.g. the pilot wards for the SKIN bundle had no hospital acquired pressure ulcers during
November.

- The Critical Care work stream is well established and sustaining changes to practice.
- The perioperative work stream has had a change of clinical leadership with Dr Philippa Swayne now the Lead Clinician for Theatres. In her first months in post she has attended a regional perioperative workshop and is reviewing where the work stream is against the interventions. Detailed work is underway with regards to glucose control interoperatively.
- The Medicines Management Group have made excellent progress since the last update on Medicines Reconciliation and this is now being spread beyond the pilot area. They have also seen positive progress as a result of the work around reducing risks of warfarin and the FMEA (failure Modes and Effects Analysis) score has reduced dramatically as a result.
- The CGC also receives the minutes from the Safety Steering Group in order to access further detail of actions being taken across the workstreams.

Key Next Steps:
- Work is ongoing in all areas
- Details around each intervention are described in the report

TN added that reporting to the SHA will cease in March moving to use of the Safety Thermometer to be undertaken on the same day each month. (measuring terms from falls, VTE, catheter associated urine infections, and pressure ulcers)
TN will be updating the Trust Board and reporting the results of the Thermometer regularly.

It is planned to continue the work internally and report it to the CGC.

CGC0113 – Assurance Framework and Risk Register (T. Nutter)
The Assurance Framework was reviewed together with the risk register.
No new risks identified for the Assurance Framework.
The Trust Risk Register (extract of clinical risks scoring 12 and above) show no areas of major concern that should be on the Assurance Framework. The risks detailed are being managed effectively in the departments.

The Committee noted the report.

CGC0114 – NPSA Compliance Report (T. Nutter)
NPSA Patient Safety Alerts/Notices were reviewed noting progress on actions being taken locally since October 2011:

New reports:
- 2011/RRR002 Keeping newborn babies with a family history of MCADD safe in the first hours and days of life
- 2011/RRR003 Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors

Outstanding reports where the recommended timescale has lapsed:
- None

Newly compliant reports:
- 2010/RRR018 Preventing fatalities from medication loading doses
- 2010/RRR019 Safer Ambulatory Syringe Drivers

The Committee noted the report.
CGC0115 – National Incident Benchmark report (NRLS) – (T. Nutter)
All patient safety incidents are uploaded to the NRLS from the Trust once the investigation is closed, this has been in effect since July 2005. From April 2011 this changed so that all incidents have been submitted as open and are updated when they are closed. The overall position of the Trust is benchmarked against similar size Trusts within a cluster using the number of reported incidents per 100 admissions. The cluster numbers have varied from 29 – 32 Trusts from the period April 2008 – March 2011.

During this period the position of the Trust has varied from the top of the middle quartile to the middle of the middle quartile The Trust continues to encourage incident reporting and the incident data is sent weekly to the NRLS as required. The next report will be available in February 2012.

The Committee noted the report.

CGC0116 – Safeguarding Adults and Children’s Report (T. Nutter)
Included in this half year report are updates on referrals, activity and themes in relation to Safeguarding work in the Trust.

Work and improvements continue around completion of Safeguarding Children and Adults MLE, and the Mental Capacity Act (MCA) MLE.

Awareness of the MCA is increasing, with requests for Independent Mental Capacity Advocates and Deprivation of Liberty Safeguard (DoLS) authorizations made in the last six months.

Internal Audit have completed a report which provides an independent opinion that the organisation is fulfilling its obligations relating to the safeguarding vulnerable adults and children.

SL queried work around safeguarding the elderly.
TN confirmed Gill Cobham is on the Dementia Steering Group to link in with the work she is doing.

The committee noted the report.

CGC0117 – Learning Disabilities Report. (L. Wilkinson)
It has been recognised that people with learning disabilities experience extreme health inequalities, poor health outcomes, and are one of the most marginalised groups in society despite their greater health problems and needs. These problems have come to the fore through the publication of national reports where it has become clear that there is much to be done to improve the experience for those with learning disabilities within acute care. The Trust has responded to this through setting up a Learning Disabilities Working Group who meet every 6 weeks to steer and monitor improvements in the care we deliver to those with a learning disability. The enclosed paper gives a progress update against the 2011/12 action plan.

Of Note:
• Work is ongoing in all areas
• Areas with outstanding action are the development of pictorial menus, PIMs alerts for LD patients, analysis of PPI work
• Our numbers of complaints and incidents regarding patients with Learning Disabilities are very low. There were no concerns or complaints reported for
Q2

- We continue to forge close working links with carers, the Community Learning Disabilities team, and other providers such as Focus Point, Turning Point, and the Douglas Arter Centre. All of whom have been pivotal in identifying our priority areas for improvement in their feedback.
- We now have representation from the South Wiltshire Mencap Board on our Trust Learning Disabilities Working Group.

The Committee noted the report.

CGC0118 – SII90 Update (T. Nutter)

In July 2011 the Trust reported a period of increased incidence of clostridium difficile and carried out an aggregated root cause analysis across all cases, resulting in the publication of SII90. The enclosed report gives committee members information against all of the recommendations to date.

Of Note:
- A diarrhoeal algorithm has been developed by the IPCT and was ratified by the CMB for ratification in November 2011
- Neutropenic sepsis policy and management of side rooms on Pembroke have been reviewed with input from the IPCT.
- Stock levels of specific antibiotics have been increased in the emergency drugs cupboard
- Additional educational sessions have been held for staff
- A process for escalating cleaning concerns has been established
- Credits for cleaning are being signed off by the nurse in charge
- There is ongoing monitoring of infection control and cleaning standards at Infection Control Update meetings, Matrons Monitoring meeting and the 3:3s
- Work continues on improving the drug chart to capture more detailed antibiotic information
- Revised cleaning task lists are currently being piloted
- There is a continued push to ensure that clinical leaders are undertaking a weekly walk round with housekeeping supervisors

The committee noted the report and the progress being made.

PAPERS FOR NOTING

CGC0119 – Clinical Risk Group Minutes (T. Nutter)

Minutes of the Clinical Risk Group from October and November 2011

- Monthly Risk Management Report Card reviewed in detail
- Submission of SII91
- Submission of SII92
- Submission of CR76 (2 of 3)
- Submission of CR78
- Submission of CR79
- Submission of LR49
- Submission of LR58
- Submission of Fracture RCA (FRA01)
- Medical equipment update
- Medicines Management update
- Maternity report card
- Falls Group Update
The Committee noted the minutes.

**CGC0120 – Safety Steering Group (T. Nutter)**

The Safety project workstreams continue to report on a regular basis and are all active.

Full detail and data is provided in the Safety Plan report which is being presented within the main meeting. See Section 0112.

The Committee noted the minutes.

**CGC0121 – Clinical Management Board (November 2011)**

**National Audit of Falls & Bone Health 2010 Action plan**

It was agreed this would be taken to the Primary Care Forum. A plan for the community is in place but not for the Emergency Department as yet.

**Informatics Strategy Update (including Excelicare)**

A governance strategy and Excelicare update were presented.

**National Continence Audit – Action Plan**

The action plan was presented. Link nurses and education programme are now in place.

The catheter UTI care bundle will be in place on all wards by the end of March.

**NCEPOD – Are we there yet? A Review of Organisational & Clinical Aspects of Children’s Surgery**

The report was presented which sets out principal recommendations following a peer review study of children who died within 30 days after surgery. Clinical leads were appointed and a gap analysis and action plan commissioned.

**Patient Reported Outcome Measures (PROMS) Report**

Report discussed considering why some patients who had varicose veins procedures or hernias rated their overall health status as worse than before the operation. Focus groups for varicose veins and groin to be considered and a groin focus group to be set up first.

**NICE IPG 279 Autologous Blood Injection for Tendinopathy**

Two injections have taken place without complications. We will continue to audit all injections in accordance with the guidance.

**Emergency Surgery – Standards for Unscheduled Surgical Care – The Royal College of Surgeons**

Report presented which sets standards to ensure the provision of high quality surgical services for emergency patients. A clinical lead was appointed and a gap analysis and action plan commissioned.

**Terms of Reference Update**
Revised Terms of Reference for the Clinical Management Board meetings were agreed.

Policies Approved
Oral Nutritional Supplement Prescribing
Referral Guidance: Initial Assessment and Management of Haematuria
Central South Coast Cancer Network (CSCCN) Irinotecan Diarrhoea Pathway
Central South Coast Cancer Network (CSCCN) Capecitabine Diarrhoea Pathway
Central South Coast Cancer Network (CSCCN) Diarrhoea Pathway
Guidelines for VTE Prophylaxis following Acute Stroke Policy
Non-Invasive Ventilation BTS Audit
HITT Monitoring Policy
Management of Patients with Diabetes Mellitus Undergoing Surgery

The Committee noted the minutes.

CGC0122 – Executive Walkround: Quality & Safety
The proposal for the amalgamation of the Quality and Safety Walks was agreed at the Clinical Governance Committee in September 2011. Following this, the first Executive Walkround using the agreed new format took place on:

8th November 2011 - Medical/Surgical OPD
15th November 2011 - Leisure Centre
22nd November 2011 - Spinal Treatment Centre
29th November 2011 - Neonatal Intensive Care Unit and Dermatology
20th December 2011 - Informatics

The Committee noted the report.

CGC0123 – Draft Information Governance Steering Group Minutes – September 2011
Items discussed:
- Version 8 IG Toolkit Report Update (Board Assurance required by CFH)
- IG Toolkit V9 Action Plans, Audit & Compliance
- Corporate Records Management
- SFT Policy Audit
- Trust Guidance on the Receipt of Unwanted Email How Do I? Leaflet

The Committee noted the minutes.

ANY OTHER BUSINESS

CGC0124 – Public Health steering Group Terms of Reference (C. Gorzanski)
Background:
Public health is everyone’s business and is a major driver in the new Health and Social Care Bill. The aim is to improve and protect the health of the population especially those with the poorest health. The key to success will be through a new system of integration, localism, partnership and collaboration with the local authority, the NHS, the voluntary sector and local communities. SFT already has good links with partners but these need to be strengthened further and become more focused in the new environment.
A new Public Health Outcomes Framework will set out how we will measure success in public health. One of the aims of the framework is to promote joint
Health and Wellbeing Board(s) are being/have been set up. These Boards will undertake a Joint Strategic Needs Assessment (JSNA) from which a Joint Health and Wellbeing Strategy (JHWS) will be developed. It is envisaged the JHWS will be included in commissioning for CCGs.

In November 11 Maggie Rae, Director of Public Health, Wiltshire set out what is included in JSNA for CCG’s in 12/13:

- Early years – child poverty, LBW, breastfeeding, immunisations, vulnerable families and childhood obesity.
- Lifestyle and risks to health – smoking, alcohol, teenage conceptions, RTAs, domestic violence, mental health, young people not in education, employment or training
- Burden of ill health – cancer, CVS, respiratory disease, diabetes, infectious disease, CRF, falls.
- Screening – cervical, bowel, breast and diabetic retinopathy.
- Mortality – all ages, all causes & premature mortality, cause of death, excess winter deaths and place of death.

Current position at SFT

- The Trust has not explicitly focused on public health, although there are some working groups tackling specific issues such as stop smoking. Given the new context the time seems right to have a multiagency steering group to drive the agenda forward.
- Initial discussions with the Public Health department suggest they are keen to engage with SFT to jointly move the agenda forward.
- The steering group would need to evolve and adapt as the priorities and work streams become clearer.

The Committee agreed that a Public Health Steering Group is required with a view to work streams being developed and embedded in existing practices.

 ACTION:
- The Committee requested a review of the Public Health Steering Group in January 2013

**Michele Romaine**

LB advised the Committee that Michele Romaine has stepped down from her position as a Non-Executive on the Trust Board with immediate effect having accepted a role in New Zealand.

The Committee thanked Michele for her work and commitment to the CGC. The NED position on the CGC has become vacant. John Stokoe, as visiting NED has agreed to step up and become a permanent member of the CGC.

**Date of next meeting:**
Monday 19th March 2012 12noon – 2.30pm Boardroom, SDH

---

C:\Documents and Settings\merrifieldka\Local Settings\Temporary Internet Files\OLKA\January 2012 Final MINUTES v4.doc