SALISBURY NHS FOUNDATION TRUST

PAPER: SFT 3079

TITLE: Clinical Governance Committee Meeting Minutes

PURPOSE OF PAPER:
To inform the Trust Board about the matters discussed at the Clinical Governance Committee on 15th November 2010.

EXECUTIVE SUMMARY:
The key items from the Clinical Governance Committee are as follows:

- **CGC 1102 Patient Story**
The Committee heard its second story, this time in the style of a question and answer session. Further improvements to the process were agreed including developing a ‘who’s who’ of CGC members for the visitor and investigating adding a line to final complaint letters inviting people to present their experience to the Committee.

- **CGC1103 / CGC1104 Surgery / MSK Directorate presentations**
Both Directorate teams presented assurance on the quality of care within their Directorate supported by evidence – trigger tool outcomes, quality indicator reports. The Committee noted the improvements in structure and assurance of quality over the past 12 months.

- **CGC1106 – Quality Strategy Objectives**
SO / TN presented the early work underway to develop a quality strategy for the Trust, starting with the merging of the clinical effectiveness and nursing Directorates in October. Following an away day with the Directorate staff, some goals have been agreed:
  1. There will be a shared understanding of Quality across the Trust
  2. That the achievement of Quality is a core activity of all Trust staff who understand their individual roles and responsibilities
  3. That the Trust has a Quality measurement system to support evaluation and improvement
  4. To drive and innovate Quality Thinking

ACTION REQUIRED BY THE BOARD:
1. To note the minutes.

Lydia Brown
Chair of the Clinical Governance Committee, Non Executive
November 2010
Minutes of the Clinical Governance Committee  
held on 15th November 2010  
in The Boardroom, Salisbury District Hospital

Present:  
Lydia Brown (Chair)  
Tracey Nutter  
Mo Neville  
Sean O’Kelly  
Peter Hill  
Nigel Atkinson  
Lorna Wilkinson  
Maggie Cherry  
Emma Taylor (Sally Tomlin)

In attendance:  
Owen Ainsley (CGC1105)  
Caroline Brunt (CGC1112)  
Caroline Clarke (CGC1104)  
Mandy Cripps (CGC1104)  
Lisa Dye (Note taker)  
Claire Gorzanski (CGC1105)  
Duncan McCallum (CGC1104)

Apologies:  
Stephen Long  
Michele Romaine  
Sally Tomlin

Welcome
Sections CGC1101 – 1102 Chaired by Nigel Atkinson. The reminder of the meeting was Chaired by Lydia Brown.

Minutes of previous meeting (20th September 2010)
The minutes were accepted by the Committee as a true record of the meeting.

CGC1101–Matters arising / Actions Tracker

CGC0703 – Patient Story  
MC to review what is happening at other hospitals

CGC0905 – Information Governance toolkit  
LB to write to Chair of Medical Records Committee

CGC0908 – Dr Foster Mortality Report  
SOK reported that a majority of deaths were cancer patients and that there is an issue with coding of commodities that is being reviewed. There are no issues for the CGC.

CGC0911 – Patient Story  
MN clarified that the sponsor of the person brought to present at the CGC is to write a report which will be followed up at the Quality Management Meetings to ensure key issues are carried forward.  
MN said routine articles would be added to the Clinical Governance Newsletter.

CGC0917 – Safeguarding Children and Vulnerable Adults  
Janine Osmond has confirmed there is still an issue with the types of reports that are being run from the MLE. Janine Osmond to be asked to add to Risk Register.
CGC1102 – Patient Story (L. Brown)
LB introduced **** who presented his story about his wife Susan’s experience as an Oncology patient in the 18 months up to her death.

The key point he made was that he felt that the issues surrounding her treatment were due to staff only seeing and treating the symptoms, not the patient and the communications skills of some staff. The Committee also queried the appropriateness of admitting this patient to MAU and the spiritual side of care – lack of assurance by staff.

NA conveyed a message of thanks to ****, appreciating how difficult it was to present.

LB confirmed she would also write a letter of thanks.

The Committee agreed an introduction paper for guests, detailing who is who and the purpose of the committee is required.

Post Meeting Note: MC and LB discussed adding a line to the response to complaints letter to invite people to present their story to the Committee.

**ACTION**
- The Committee requested a letter of thanks to be sent
- The Committee requested an introduction paper for guests to be developed
- The Committee requested a line to be added to the response to complaints letter, to invite people to present their story to the Committee.

CGC1103 - Directorate Quality Report – Surgery - Presentation (M. Cripps, C. Clarke, D. McCallum)
The Surgery DMT presented their Quality Report. Changes in figures in part due to the restructuring of the directorates and gaining new departments.

**Key Achievements:**
- Established Quarterly Quality meetings at Directorate level.
- Action plans developed
- Performance monitored through 3:3 and mid/end year reviews
- Dept. level performance monitoring

**Areas of Good Practice:**
- Organisational Trigger tool undertaken for General Surgery, Urology, Ophthalmology, ENT, Retinal Screening. Action plans being developed.
- Key Quality Indicators used to identify trends and target areas, i.e. reduction in pressure ulcers, needlestick injury, reduction in absence.
- Reductions in number of complaints linked to real time feedback

**End of Year Review Clinical Governance Summary Report:**
- Number of incidents reported increased last year, by all staff groups.
- Increase in needlestick injuries last year (9-15). Reduction in sharps (9-1)
- No clinical reviews. 1 SUI. Practice changed as a result.
- Penlon Anaesthetic machine replacement
- Perioperative Safety Workstream
- Increase in concerns/comments
- Waiting times in OPD clinics
- Timing of entries in clinical records
- Audits completed
Highlights

- Reductions in litigation 18-6
- Significant improvement in meal time experience
- Active portfolio of patients involvement
- Good PEAT scores

Work Going Forward:

- Productive ward
- Safety briefing and bedside handover impact on real time feedback and reduction in complaints
  - Privacy and dignity Q1 89%. July 100%
  - Recommend Q1 89.5% July 95%
- Enhanced Recovery
- Productive Operating Theatre
- VTE compliance. Q1 86% (improving Q2)
- MLE compliance variable – low uptake by consultants
- Trigger tool for remaining services

NA queried how the absence rate had been improved. MC confirmed it was by raising the profile with teams and ensuring the process is being used correctly. Reduction of contract staff has meant better team working as well.

MN added that ongoing work included using the Key Quality Indicators at departmental level.

The Committee thanked the team for their presentation.

CGC1104 - Directorate Quality Report – Musculo-Skeletal - Presentation (O. Ainsley, C. Gorzanski)

The Musculo-Skeletal DMT presented their Quality Report as follows:

Directorate Structure and Process:

- Each speciality/dept has an MDT mortality & morbidity meeting – learning & improvement
- Senior MDT speciality staff meet monthly with MSK DMT – quality & service improvement agenda items
- DMT quarterly meeting with Head of Quality, Risk, Customer Care, PPI – detailed assurance
- 3 to 3 DMT/Executive meetings monthly – quality indicator card & organisational trigger tools
- Executive quality walks & walkabouts
- National standards NICE & peer review (National Hip fracture database, National Joint Registry, National Burns Care Standards, Head & Neck (DAHNO), Early Rheumatoid Arthritis (ERAN), National SCI standards)
- Ward based standards Outcomes 1/4/10 – 31/10/10 (VTE risk assessment 93.7%, Zero MRSA blood stream infections = 0, Zero Clostridium Difficile = 7, Pressure ulcers (grade 3 & 4 only) = 2. Reduction in medication incidents = 31 incidents in Q1, Reduction in renal failures (Orthopaedics) = 3)

Actions following Organisation Trigger Tool use:

- Improved record keeping & better information systems – 3 quality indicators
- Orthopaedics – risk meeting to improve incident reporting
- Burns – work with procurement on dressings
• Spinal unit – leadership & attendance management
• Rheumatology – absence impact on capacity, excessively hot working environment

Patient Experience:
• Inpatient real time feedback – all rated quality of care as good to excellent
• Outpatient survey – plastics OPD poor waiting experience & customer care
• Highest number of complaints – orthopaedics OPD, orthodontic & rheumatology

Service Improvement Going Forward:
• Orthopaedics – ERP hip, Kings Fund point of care project
• Plastics – ERP breast reconstruction (DIEP), Physio led hand clinics.
• Oral surgery – ERP osteotomy
• Productive theatre & productive ward
• Plastics OPD – customer care work with receptionists, processes & flow

Next Steps:
• Agree & combine ward & speciality quality indicator reports & data source
• Develop outcome measures & where possible link to consultant revalidation
• Action plan to improve hip fracture care
• Improve OPD experience & reduce complaints

The Committee thanked the team for their presentation.

CGC1105 – Learning From Quality Walks (L. Brown)
The initial aims of the quality walks are being met but there are areas where issues have been raised and where improvement / change is required:
• Medical records filing
• Maintenance delays - ETS and PFI
• Ownership of PFI processes for maintenance
• Focus of service improvement projects
• Number of demands on wards / depts. from various projects
• Use of volunteers across Trust

There are also areas where good leadership and services can be seen – are there key principles that can be spread across the Trust

The Committee agreed that the walks were very useful and helpful to all those attending. This was evident from the Directorate Quality Reports presented earlier in the meeting.

MN confirmed that it is expected that the DMT’s will follow up on feedback via the Directorate Quality meetings.

In future Directorate Quality Reports it would be useful to hear about actions as a result of the Quality Walks.

At the second round of walks, the checklist from the first should be included as a comparator of progress.

It is hoped best practice will be shared amongst teams to help Service Improvement.

The Committee noted the evaluation.
Following the Clinical Effectiveness Directorate and Nursing Directorate merging on the 1st October 2010, TN & SOK presented the Quality Directorate plan.

TN noted that it was felt that by merging the two directorates the MDT model would be reflected by the Quality Directorate, led by the Medical Director and Director of Nursing.

Goals for the Quality Directorate:
1. There will be a shared understanding of Quality across the Trust
2. That the achievement of Quality is a core activity of all Trust staff who understand their individual roles and responsibilities
3. That the Trust has a Quality measurement system to support evaluation and improvement
4. To drive and innovate Quality Thinking

ASSURING PATIENT SAFETY

CGC1107 – Risk report Card Q2
Deferred to January 2011

CGC1108 – Assurance Framework (T. Nutter & L. Wilkinson)
The Assurance Framework must be reviewed and updated quarterly by the delegated Assurance Committees to ensure that scrutiny is applied to assure the Board that the Trust’s principal risks are being managed and controlled effectively in order for the corporate objectives to be achieved. A proforma is attached as a guide.

A Trust Board reporting template is also attached identifying key changes since the last meeting. Those changes are also highlighted in red within the main body of the document

The Trust Risk Register (extract of clinical risks scoring 12 and above) is submitted for reference so that the Assurance Committee can either be assured that specific risks are being managed effectively locally or if not to identify how this may be ascertained.

LW highlighted minor changes since the Assurance Framework report was produced:
- Pages 4 & 5 re: gap in Control – dependent on full implementation of Revalidation process. SOK confirmed that work was in progress which included attendance of national and regional study days.
- The Committee discussed the possibility of a trigger tool around positive assurance. To be discussed external to the meeting
- Page 6 – MLE Regarding the inconsistencies in reporting. A meeting has been planned with Janine Osmond.

Risk Register
The Committee agreed their was no need for additional scrutiny of the report Pandemic flu risks to be reviewed.
LB queried the Risk in filing and medical records/record keeping.

The Committee reviewed the proforma and Assurance Framework.

ACTION
- The Committee requested for the pandemic flu risks to be reviewed
- The Committee requested Medical Records report to be added to the January CGC agenda.

TN
MN
CGC1109 - Medication Safety Report (E. Taylor)
The revised format of the report has been consolidated, improved and expanded to provide a more comprehensive account of the medication governance work underway within SFT.

The report identifies key issues and work streams and details the action planned, underway or completed since the last report. Text in black appeared in the previous report, text red is new for this report, and work streams with boxes outlined in green are considered complete and will not be shown on the next report.

The Committee complimented the report for being easy to read and understand. The Committee noted the work completed and ongoing within the Trust with regards to medicines governance.

CGC1110 – Risk Annual Report (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 (2009)
- Progress against the Annual Risk Management Plan 2009/10 (Appendix 1)
- Mid Year progress report against the Annual Risk Management Plan 2010/11 (Appendix 2)
- Annual Report Card 2009/10

The Committee noted the achievements within the annual report and the Annual Risk Management Plan.

CGC1111 - Learning Disabilities Mid Year Review. (L. Wilkinson)
The enclosed report updates the committee members on the progress being made against all agreed actions. Key highlights to note:

- the Learning Disabilities Working Group (LDWG) is now meeting monthly and is coordinating the work within the action plan
- the LDWG has enjoyed excellent input and commitment from the Hospital Liaison Nurse for the Community Learning Disabilities Team
- a patient passport system has been developed which holds key information regarding a patient with learning disabilities for staff to use within the care planning in acute care.

- a Learning Disabilities Policy is currently in draft (awaiting approval at the December CMB) which sets out roles and responsibilities, key resources for staff, and guidance on planning the care of patients with a learning disability
- some training and awareness sessions have already been run by the Community Learning Disability Team.
- a peer review was carried out (coordinated by the SHA) in September 2010. We are still awaiting the report.

LW reported that there is concern over the SHA peer review in that the standards were developed by the SHA, and the review concentrated on whether SFT had processes
solely for learning disabilities. Learning disabilities at SFT sits in a process that encompasses all sections of the community, as it is difficult to separate patients in to particular categories as they may come under more than one.

The Committee recognised and congratulated the team for the work that has been done to date.

**ACTION**
- The Committee requested an update at the January 2011 CGC.

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**ASSURING A QUALITY PATIENT EXPERIENCE**

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**CGC1112 – National Maternity Survey results / Action Plan (C. Brunt)**

The survey demonstrated high satisfaction amongst users of the service alongside improvements based on the 2007 survey findings. An action plan is submitted to address areas of development required to further improve the quality of the service for families.

Key areas of comparative improvement on the 2007 national annual survey:

- Only 11% of women felt they were not given the choice of having their baby at home; a decrease from 22% in 2007.
- Only 5% of women felt they couldn’t move around freely and choose the position that made them most comfortable during their labour and birth compared to 16% in 2007.
- There was a comparative reduction in women who felt that they and/or their partner or companion were left alone by midwives or doctors at a time that worried them from 23% in 2007 to 15% in the recent survey.
- Only 2% of women felt that they were not involved enough in decisions about their care during the labour and birth; this represents a significant improvement as 9% felt this was the case in 2007.

The women supplemented their answers with comments about the service and there was an equal proportion of acknowledgement of high standards (61) alongside feedback regarding areas for improvement (65) many of which referred to minor issues and some referenced this in relation to being happy with their care overall. Numerous staff were commended for their care and professionalism. these members of the team have been nominated for local awards.

The Committee commended CB for her approach to set an Action Plan based on feedback from Mothers, rather than just the survey results.

The Committee noted the positive feedback within the survey and the actions being taken with in the department to address the areas requiring improvement.

**ACTION**
- The Committee requested a progress report at January 2011 CGC once the national benchmark report had been published.
ASSURING CLINICAL EFFECTIVENESS

CGC1113 – Internal Audit Report (S. O’Kelly)
The overarching program of internal audit is not widely published and once again this year there were extra audits undertaken that were not part of the Clinical Governance program e.g. Clinical audit department currently being audited.

The program for 2009 has not been completed. Once the program has been agreed by the audit committee, the communication with the internal audit department has been minimal.

There have been improvements with the 2010 program but the process for monitoring the completion of audits and recommendations needs review.

The proposed program for 2011 could be derived from the assurance framework, NHSLA, contract or CQC regulation requirements or an agreement. The current CQC assurance approach covers the Clinical Governance aspects.

The Committee agreed the report was unclear as to progress of audits.

LB queried with the committee whether the Internal Audit work was doing what it set out to do.

The Committee questioned whether using internal audit was the most efficient/cost effective way of doing the work or should it be done differently?

The Committee agreed there could be better communication between Internal Audit and Audit Committee.

Post Meeting Update:
Following clarification, it has been found that the Appraisal and Induction Audits have taken place. It was confirmed that the 2009/2010 work programme for South Coast Audit has been completed.

ACTION
- The Committee requested clarification on the red areas of the report
- The Committee requested for the queries raised to be taken to the Audit Committee.

MN NA

CGC1114 – Dr Foster Report (S. O’Kelly)
The aim of the report is to give an overview of the Trusts current position nationally and against peers for HSMR for the 2009-2010 financial year, after re-benchmarking.

The report focuses on the resetting of the benchmark which shows that Salisbury has an improved mortality but it has not improved as fast as the national picture.

The Trust total HSMR is 100.4;
Elective patient HSMR is 76.1
Non elective patient HSMR is 101.1

Further investigation is required in the RR ratio for palliative medicine and critical care medicine and this is currently underway.

SOK reported that a new measurement will start in April 2011.
MN confirmed a meeting regarding Dr Foster is due in the next two weeks.
SOK to present the report to Council of Governors.
The Committee noted the report

**ACTION**
- The Committee requested feedback on the further analysis of palliative medicine and critical care medicine

**CGC1115 – Annual HTA Report**
Deferred to January 2011

**CGC1116 – Annual NSF Report (S. O’Kelly)**
There have been no new NSF’s published this year and there are unlikely to any further ones published in the future

The two key strategies published in the last 2 years - End of Life and Dementia both have working groups in place and report to either the OMB / CMB.

Any future strategies published should be reviewed individually and agreement made by the Executives on how they should be managed – this is in line with the implementation of External Enquiries Process – Implementation and Monitoring section within the Policy on the Implementation of National Service Frameworks (NSF); National Confidential Enquiries (NCEPOD) and other High Level Enquiries. This policy will require updating to take account of any agreed changes and to fulfill NHSLA requirements

This should still offer sufficient assurance to the Committee

The Committee support the proposed changes to the management of NSF’s / strategies

**ACTION**
- The Committee requests the Policy on the Implementation of National Service Frameworks (NSF); National Confidential Enquiries (NCEPOD) and other High Level Enquiries is updated to take account of these changes.

**CGC1117 – Major Issues Sheet (S. O’Kelly)**
Publications:
- NHS SW Process for Reporting and Learning from Serious Incidents Requiring Investigation
- New essence of care guidelines published
- NCEPOD – operating on the elderly, published beginning of November.

Internally of note:
- SHA Learning Disabilities Peer Review carried out in the Trust September 2010. Awaiting report
- ‘Modernising Scientific Careers’ – national programme to design and now implement a new career and learning structure for all the scientific workforce.
- The Equality Act 2010 came into effect on 1st October 2010. The Trust has immediately made some changes to the pre employment health screening process as a result.
- Workforce redesign steering group meeting regularly and commissioning projects to develop workforce design in the Trust

The Committee Noted the report

**CGC1118 – no paper allocated**
CGC1119 – Quality Indicator Report incl. DSSA (S. O’Kelly)
Overall the performance against the quality measures is satisfactory. The report has some gaps in data for Thrombolysis due to staff vacancies. Work is ongoing to resolve this issue.

Of particular note –
- Mortality rates remain as expected
- MRSA – there have been no in hospital cases to date this year
- There has been an increase in hospital acquired C.Diff infections with an outbreak noted in September involving 3 patients which is now the subject of a SII
- There has been 1 never event, involving plastic surgery which is also the subject of a SII
- There remains a constant number of falls resulting in fracture or major harm, with similar incidence to last year
- Pressure sore figures remain low and on target.
- VTE compliance has improved in September and is on national target
- The indicator for #NOF has been revised in line with the ‘best practice tariff’ to within 36 hours and puts us in the top quartile nationally at >80% achievement YTD
- The use of escalation beds remains high due to emergency pressures
- Delivering Same Sex Accommodation (DSSA) – this is the first time this has been reported on the indicator report and shows there have been 18 non clinical breaches in 2 months (Only Hants contract contains DSSA with financial penalty but they have not invoked this to date)
- Patient experience around recommending the hospital has deteriorated with 2% of patients stating they would not recommend for the first time this quarter.

SOK noted that the blip in the stroke figures was likely to be due to new doctor in take. Farley is showing slow improvement.

The Committee noted the report

PAPERS FOR NOTING

CGC1120 – Clinical Risk Group Minutes August & September 2010. (T. Nutter)
- Monthly Risk Management Report Card reviewed in detail
- Submission of LR32
- NPSA compliance update presented
- NPSA NRLS report presented
- Safeguarding quarterly report
- Paediatric report card
- Maternity report card
- Update of risk assessment matrix

The Committee noted the minutes
CGC1121 – Infection Control Minutes October 2010 (T. Nutter)
The committee reviewed progress of all areas of infection, prevention and control, and noted that Quarter 2 infection rates had continued to demonstrate the Trust has a robust process in place for the prevention and control of infection.

The minutes contain details about specific actions such as hand hygiene audits, policy development and implementation.

The Committee noted the minutes and the actions being taken

CGC1122 – Clinical Management Board August & October 2010 (S. O’Kelly)

AUGUST
Clinical Outcomes Programme
Four clinical dashboards are now live, ENT, Urology, Stroke Medicine and GP Practice. These are currently being used to varying degrees in order to monitor performance. The Board were asked to consider three recommendations with option 2 being supported – ‘To engage with clinical teams to explore the development of suitable clinical outcome measures so that clinical performance can be assessed and areas of service improvement identified if appropriate’ - Directorates were asked to feedback at Quality meetings.

Mastectomy Audit
Data had been collected on clinical practice, treatment options, inpatient outcomes, patient-reported outcomes and experience of care. 18,216 women nationally completed the information. Salisbury had 179 women enter data and we are at or above average for the criteria measured with high levels of patient satisfaction. Some improvements are required with patient information.

Transfusion update
Feedback was received on:
1. Training and competency assessments (deadline November 2010)
2. Wastage of blood stock
3. Adverse events related to Transfusion
4. Traceability – BSQR Regulation

Annual R&D report – Stef Scott
Another successful year for R&D. Highlights for 2009/10 included:

- 94 projects were eligible for the UKCRN portfolio (this is a marker of quality)
- The majority of the projects were Cancer studies led from outside of the Trust and in collaboration with the Cancer Research Network
- 380 study participants from Salisbury were recruited into these studies as compared to 191 during 2008/09
- Additional money secured to fund 2 new research nurses (Cancer/Stroke and Rheumatology) to support portfolio studies

OCTOBER
Discharge Audit
The current work on discharge taking place in the downstream wards RTRTRP programme was discussed and noted.
- patient discharge experience questionnaires are being used on Pitton and
Redlynch wards for a two week period;
- A PDSA will start on 11 October for 4 weeks providing hot meals in Discharge Centre. This is to encourage staff to send patients to the centre earlier in the day, particularly elderly patients;
- Two adverse events relating to discharge from a medical ward is being explored by both community and acute staff. If successful, this may be a good way to improve learning for both Acute and Community teams in the future.

Real Time Feedback
Real-time feedback for patients discharged between April and August 2010 was tabled. Hampshire commissioners had carried out a recent audit which showed that only 58% of discharge summaries had been fully completed. Wiltshire had carried out an audit of one GP practice which showed that only 65% were complete. In future, SFT will be fined £20,000 per quarter if they fail to achieve 90% completeness. DMT’s need to speak to their teams.

Oxygen Audit
An audit was carried out in 2008 and repeated in 2009. Despite initiatives for improvement our local results were not as good as the national results in any area, and the national results were not high. Actions are required.

Quality Indicator Report
It was advised that there were problems with the number of stroke patients on Farley Ward and the number of stroke patients who get a CT scan within 24 hours. There was an issue with trainees and requesting investigations earlier.

The Committee noted the minutes

Date of next meeting:
Monday 15th March 2010 12noon – 2.30pm Boardroom, SDH

ALL