Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**29 November 2017**		

Title of Report:	**Clinical Governance Committee Update Report**
Status:	**For Information**
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Appendices:	**Appendix 1: Terms of Reference**

Purpose

To update Board of Directors on the activity of the Clinical Governance Committee's held on 18th September and 1st November 2017.

Background

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

Business Undertaken

Safeguarding Children Follow Up

The Named Nurse Safeguarding Children and Young People (Named Nurse) provided an update on Safeguarding Children outlining risks that were documented on the Risk Register:

Safeguarding Children Training Compliance Level 2 and 3

A trajectory target of 90% compliance by Christmas had been set for level two and three training, with the current compliance at 87.6% and 89.3% respectively. The Named Nurse meets with the Compliance Manager on a quarterly basis to review relevant areas to ensure staff who are out of date on their training have been directly contacted. Maternity services continued to sustain training compliance at over 90% (currently 96.67%).

Implementation of Safeguarding Children Supervision

Twenty seven members of staff had attended Level 4 safeguarding children supervision training with supervisors now supported by the Safeguarding Team to facilitate safeguarding group supervision within a number of specialties.

Paediatric Medical Safeguarding Cover

The Community Paediatricians have been working with commissioners and the RUH Head of Division for Women and Children's in relation to their ability to cover out of hours child protection provision. This is being reviewed with regards to our acute Paediatricians ability to meet the proposal of providing cover for out of hours safely.

Child Protection Information System (CP-IS) Implementation

The Trust was behind implementation of national CP-IS due to challenges integrating it within the Emergency Department because of the introduction of new IT systems in November. The current safeguarding process would remain within the Emergency Department until it was implemented.

The Committee resolved to provide the Board of Directors with significant assurance in relation to the Safeguarding Children Follow Up and asked to review again in one year to focus on key issues facing the systems and process related to safeguarding children

Safeguarding Adults Follow Up
The Specialist Practitioner for Adult Safeguarding presented the follow up report advising there had been a reduction in level two training compliance, with current compliance at 88.30%, against a target of 90%. Prevent WRAP compliance was 67.6%, levels one and two were available via e-learning and at induction.

The NHS England Intercollegiate Healthcare Competency framework document remained unpublished as was now twelve months overdue. Once available, the document would detail the training and supervision compliance expected by staff role. The draft document had outlined a requirement for a greater number of staff to be trained at Level 3 and this would have an impact for the safeguarding team to deliver further training. An action plan was being developed to address the training requirements.

The number of Safeguarding Adult concerns raised had seen a significant increase from the previous year which may be due to increased awareness by staff.

The Committee resolved to provide the Board of Directors with a significant assurance with minor improvement opportunities in relation to the Safeguarding Adults Follow Up and asked to review in one year, or earlier should the Intercollegiate Healthcare Competency framework document be published.

Pressure Ulcer Prevention Follow Up
The Lead Tissue Viability Nurse presented the follow up report highlighting the final number of avoidable hospital acquired pressure ulcers for 2016/17, against a target of no more than two category 2 pressure ulcers a month and the elimination of all avoidable hospital acquired category 3 and 4 pressure ulcers.

- There were thirty five category 2 avoidable pressure ulcers – eleven over trajectory;
- There were three category 3 avoidable pressure ulcers;
- There was one category 4 avoidable pressure ulcer which occurred in January 2017 – the first in four years;
- There were fifteen cases of avoidable medical device related pressure ulcers which was a 50% reduction on the previous year. Between November 2016 and July 2017 there had been no devised related pressure ulcers.

A prevalence audit was carried out on all wards in July 2016 which outlined that the overall Trust pressure ulcer prevalence was 0.57%. There were no hospital acquired category 3 or 4 pressure ulcers recorded during the audit. The audit was repeated in July 2017 and the prevalence figure had seen an improvement. The overall Trust pressure ulcer prevalence was 0.16%.

The pressure ulcer prevention pathway had been refreshed towards the end of 2016 due to the increasing number of hospital acquired pressure ulcers. An action plan was

devised to reduce avoidable harm to the patients with an internal target set to reduce avoidable harm for 2017/18 by reducing the incidence of avoidable category 2 pressure ulcers by 25%, to eliminate all avoidable category 3 and 4 pressure ulcers, to reduce the incidence of avoidable medical device related pressure ulcers by 50%.

The Committee resolved to provide the Board of Directors with significant assurance and requested to review in three years, or earlier should the number of pressure ulcer incidences increase again. The Committee noted that this would be reported through the monthly Quality report to Board of Directors'.

Response to 2016 National Diabetes Inpatient Audit
The Consultant in Diabetes and Endocrinology presented an update on the 2016 National Diabetes Inpatient Audit (NDIA) report advising that the NDIA was a spot audit carried out on a single day in September in approximately 200 Trusts around the country. It used questionnaires filled in on all the inpatients in a Trust on that day that have a diagnosis of diabetes. This reflected the care they had received during their stay. This data was then used to benchmark each individual Trust. This had highlighted that the RUH had high levels of medication errors, hypoglycaemic events and poor staff knowledge and confidence in managing diabetes.

Over the last two years the Acute Diabetes Team had undertaken a quality improvement project to improve the care for patients with diabetes which had produced impressive results, although these were not replicated within the NDIA results. A number of interventions had been introduced to include, robust continuous data collection on target wards to guide interventions, new self-administration of insulin protocol, new diabetes prescribing chart, mandatory e-learning for all nurses and doctors that use insulin, stream-lining the inpatient diabetes team and developing a network of diabetes link nurses who perform cascade training for their wards in common diabetes problems.

The reason why the Trust was sighted as an outlier may include a lack of agreement on some of the metrics used in the audit. The audit measures late administration of insulin without defining the timeframe that constitutes being late. The Trust had chosen to submit data in accordance with its local definition; this included any administration behind 45 mins, of the intended time, meeting the definition of late. Other Trusts record late administration as being beyond 4 hours.

To ensure performance improved in the next NDIA, the Acute Diabetes Team plan to repeat the snapshot of medication errors on the RUH wards with a separation of the medication errors questions to avoid double counting to try and determine where the discrepancy originates.

The Committee was unable to give a level of assurance but asked to review the NDIA findings in one year to see if the Trust was managing the process correctly.

Compliance of Training to Prevent Hospital Acquired Clostridium Difficile
The Infection Control Lead Nurse and Infection Control Nurse presented the Compliance of Training to Prevent Hospital Acquired Clostridium Difficile report advising that the target for level 2 Infection Prevention and Control training compliance was 90% with performance currently at 88%. Lead practitioners were in

place on all wards and undertaking some work on refresher training. Training was to be completed once every two years to keep the figures up.

Mandatory training sessions had been cancelled during November due to implementation of the Big 3 IT project which was expected to have an impact on achievement of 90% compliance with Level 2 infection prevention and control training by the end of December. However, the Infection Prevention and Control Team continued to offer ward based sessions during November and one to one training were also offered to staff and group sessions to increase compliance.

Antimicrobial e-learning had been introduced for prescribers since August 2016 with a target of 90%; 72% of eligible staff had completed the training programme.

Areas of low compliance had been targeted and training had been taken to the areas where staff had not been released.

The Committee resolved to provide the Board of Directors with significant assurance with minor improvements and requested to review in one year.

Discharge Services Follow Up

The Senior Nurse Quality Improvement presented the Discharge Services Follow Up advising that a review of pathways had taken place with these being revamped and updated as a result. Content of the electronic discharge checklist on Millennium had been updated in line with recent changes that had occurred within the Trust, i.e. pathways had been added, and end of life information had also been incorporated. A trigger system then alerted when patients were ready for discharge. The Safe and Proactive Group had been working with the Speciality Big Room, looking at the standardisation of whiteboard rounds. The concept of the "Four Questions" had been introduced as part of the white board round standardisation, i.e. each patient should know their diagnosis and information regarding their discharge.

The Senior Nurse Quality Improvement reported that collaboration had taken place with nineteen other trusts, implementing and improving Criteria Led Discharge. The following three pathways had been selected which had varying levels of success and were at differing stages of implementation:

Pathway 1: Cardiac non elective patients having procedures
Pathway 2: - Orthopaedic Major Joint Replacement surgery
Pathway 3: Surgical Day Case procedures.

The Home First initiative had been implemented in May 2017 as a discharge pathway for patients who:

- were medically fit but needed additional support at home
- could go home to usual place of residence (home/residential home)
- were safe between visits and had no night needs

The initiative had a target of 62 Home First discharges per week across all four CCG's (BaNES, Wiltshire, Somerset and South Gloucestershire).

The Senior Nurse Quality Improvement explained that from an end of life point of view, the enhanced discharge service was flourishing and now covered both Wiltshire and BaNES. Patients in the last four weeks of their life were now supported in their homes by Dorothy House.

The Committee resolved to provide the Board of Directors with partial assurance with improvements required and requested to review in six months.

Board Assurance Framework (BAF)
The Board of Directors' Secretary presented risks three, five and eight that related to the Committee, which were approved.

External Agency Visits
The Committee reviewed the External Agency visits scheduled and agreed to close the following as no recommendations had been raised:

ID55 – BANES CCG quality assurance visit to maternity on 22nd September 2016
ID67 – Home Office Licence Inspection (Pharmacy) on 1st February 2017

The Committee also agreed to close the following on the basis that the recommendations had been met:

ID57 - Ofsted, CQC, Police, Probation Joint Targeted Areas Inspection on 31st October 2016
ID66 - MHRA Pharmacy Wholesale Dealers Inspection on 2nd February 2017
ID60 – NHS England and Local Supervisory Visit (Local Supervisory of Midwives) – Annual Review on 22nd June 2016
ID65 – Ionising Radiation Regulations Inspection on 8th February 2017

Audit Tracker
The Committee reviewed every action assigned to the assurance committee and asked for a further update on progress of outstanding actions at their next meeting.

Terms of Reference
The Committee reviewed the revised Terms of Reference and approved subject to the following amendments:

- Removal of Associate Medical Director for Quality Improvement;
- Divisional attendance by either the Head of Division or Divisional Governance Lead (or a nominated Deputy);
- Quorum to be revised.

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

- Prevention of Never Event: Mis-Selection of High Strength Midazolam for Conscious Sedation - the Committee agreed to provide a significant level of assurance once they had received clarity from the Chief Pharmacist on the use of the drug on the Care of the Elderly wards;
- Prevention of Never Event: Wrong Implant/Prosthesis – the Committee agreed to provide a significant level of assurance and asked to review in three years;
- Prevention of Never Event: Chest of Neck Entrapment in Bedrails – the

Committee agreed to provide a significant level of assurance and requested to review in three years;
- Prevention of Never Event: Wrong Route Administration of Medication – the Chief Pharmacist was asked to amend the report to include assurance of safety checking processes which would be circulated to the Committee with the minutes in anticipation of Significant Assurance.

Key Risks and their impact on the Organisation

No key risks were raised at the Committee.

Key Decisions

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

a) The significant assurance provided in relation to the Safeguarding Children Follow Up with a request to review in one year to look at the key issues facing the systems and process related to safeguarding children;
b) The significant assurance with minor improvement provided in respect of Safeguarding Adults Follow Up with a request to review in one year, or earlier should the Intercollegiate Healthcare Competency framework document be published;
c) The significant assurance provided in respect of Pressure Ulcer Prevention with a request to review in three years, or earlier should the number of pressure ulcer incidences increase;
d) That no level of assurance was provided for the National Diabetes Inpatient Audit and that the Committee requested to review in one year to ensure the Trust was managing the process correctly;
e) The significant assurance with minor improvement provided in respect of Compliance of Training to Prevent Hospital Acquired Clostridium Difficile with a request to review in one year;
f) The partial assurance with improvements provided in respect of Discharge Service Follow-up with a request to review in six months;
g) The external agency visits that had been closed;
h) The revisions to the Terms of Reference

Exceptions and Challenges

None identified.

Governance and Other Business

The meeting was convened under its revised Terms of Reference.

Future Business

The Committee conducted business in accordance with the 2017/18 work plan. The next meeting of the Clinical Governance Committee, to be held on 15th January 2018 would review the following:

- Results of Microbiology Accreditation for C.diff and Norovirus
- Sepsis – Paediatrics Systems and Processes/Staff Training
- Outcome of Accreditation Visit for Blood Sciences (includes Haematology and Biochemistry)
- Medicine Reconciliation
- Prevention of Never Event: Wrong route administration of medication from
- QIPP Management Framework

- Clinical Risks Associated with Move to Electronic Patient Records in Outpatients
- Anticoagulants including Warfarin
- External Agency Visits
- Audit Tracker
- Board Assurance Framework;
- Work Plan, Horizon Scanning and Next Agenda Review

Recommendations

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

Appendix 1

Clinical Governance Committee
Terms of Reference

1. Constitution

The Board of Directors ("Board") has established a Committee to the Board to be known as the Clinical Governance Committee. The Committee ("Committee") has no executive powers other than those specifically delegated in these Terms of Reference.

2. Terms of Reference

2.1 Purpose

To provide assurance to the Board that the Trust has a robust framework for the management of key critical clinical systems and processes

2.2 Objectives

The primary objective of the Committee is to provide assurance to the Board that the key critical clinical systems and processes are effective and robust. These systems will include, but are not limited to:

- Incident Management and Reporting;
- Quality Improvement;
- Quality Care which is safe, effective with positive patient experience
- Compliance with the CQC Essential standards of quality and safety;
- NHS Resolution Compliance;
- Medical Records;
- Patient Experience;
- Research and Development;
- Maintaining clinical competence.

In addition the Committee will:

- Review the controls and assurances against relevant risks on the Board Assurance Framework, in order to assure the Board that priority risks to the organisation are being managed and to facilitate the completion of the Annual Governance Statement which forms part of the Trust's Annual Report.
- Consider external and internal assurance reports and monitor action plans, in relation to clinical governance, resulting from improvement reviews/notices from the Care Quality Commission, Health and Safety Executive and other external assessors.
- Monitor Serious Incident Action Plans. Horizon scan for matters for consideration.

3. Membership

The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors as well as representation of the views of users, carers and Trust services.

The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- Non-Executive Director
- Director of Nursing & Midwifery (Lead Executive)
- Medical Director

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

The following participants are required to attend meetings of the Management Board (mandatory participants):

- Board of Directors' Secretary
- Divisional attendance by either the Head of Division or Divisional Governance Lead (or nominated Deputy)

4. Quorum

Business will only be conducted if the meeting is quorate. The Committee will be quorate with three members, including at least one Non-Executive Director (who may be the Chair) and either the Director of Nursing or the Medical Director (or their formally nominated deputy), being present.

5. Attendance by Members

The Chair and Lead Executive, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members and mandatory participants will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

6. Attendance by Others

The Chief Executive and Chair of the Board may attend.

The Committee shall co-opt as it deems necessary.

7. Accountability and Reporting Arrangements

The Committee will be accountable to the Board. The Chair of the Committee will as soon as practicable, present a report to the Board of Directors on the activity of the Committee at its last meeting. The report shall draw to the attention of the Board issues that require disclosure to the full Board, or that require executive action

The Committee shall refer to the other Board Assurance Committees (the Audit Committee and the Non-Clinical Governance Committee) matters considered by the Committee deemed relevant for their attention. The Committee will consider matters referred to it by those two Assurance Committees.

The Committee will develop and maintain a work plan which will describe the key reports it will consider during the year.

8. Frequency

The Committee will meet at least four times a year.

Additional meetings may be arranged when required to support the effective functioning of the Trust.

9. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its duties. This review will be presented to the Board in the form of the Committee's annual report.

11. Other Matters

The servicing, administrative and appropriate support to the Chair and Committee will be undertaken by a nominated Executive Assistance who will record minutes of the meeting. The planning of the meetings is the responsibility of the Chair.

12. Review

These terms of reference will be reviewed at least every three years as part of the monitoring effectiveness process.

Terms of Reference reviewed by the Clinical Governance Committee on 18th September 2017.

Ratified by the Board of Directors on 29th November 2017.