Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**31 October 2018**		

Title of Report:	**Clinical Governance Committee Update Report**
Status:	**For Information**
Sponsor:	**Jane Scadding, Non-Executive Director**
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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 2018.

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

Cardiology – Review of Improvement Plan

The Clinical Lead for Cardiology informed the committee that the motivation for the plan had been the increasing pressure that had been placed on Cardiology as a whole and the key areas for improvement were:

1. Management of patients with acute coronary syndromes (ACS) and the delivery of timely in-patient angiography – A new risk process was now in place and standards were now being met.
2. Heart Failure service – patients requiring this service were frequently in hospital for long stays and it was hoped that hospital admissions could be avoided and length of stay could be reduced.
3. Diagnostic targets (DMO1) for complex echo – it was agreed that this was a challenge and breaches/waits had risen significantly. Additional sessions had now been commenced and it was hoped to reduce breaches to 0 by year end.
4. Out-patients

The Clinical Lead for Cardiology stressed that it had been hard recruiting physiologists and, as a result, experienced staff were being lost to private companies. However the department were currently working on retention and also training senior physiologists to perform stress echo's. This was felt to be a good long-term solution.

Weekly triumvirate meetings had been taking place to identify and review issues and the senior team met daily to pick up outstanding issues. The Committee suggested that a dashboard might also be helpful.

The Committee felt that at present they could not give a level of assurance as there were too many gaps in the information provided. It was requested that the team should come back to a future committee meeting so that a level of assurance could be given. The Deputy Medical Director also agreed to discuss this with the Medical

Director and Head of Medical Division, to ensure that the Cardiology team was receiving the right support to review and deliver its action plan.

Duty of Candour (DoC) Follow-Up

The Lead for Claims, Inquests and Clinical Risk explained that there were 92 incidents reported during quarter 1 that had resulted in moderate or greater harm and which required the implementation of the DoC framework. Three Serious Incidents were reported to not trigger DoC, one related to a safeguarding issue where it was not appropriate to invoke the DoC, one related to another Trust and the third should have been reported as DoC and this had been fed back to the reporter.

The significant number of incomplete fields on Datix made it difficult to establish a clear picture of the Trust's compliance with DoC. However the regularity with which the Risk Team were asked to review DoC letters and give advice suggested that staff were well informed in relation to their responsibilities. Support was currently being provided to divisions to help them to close off any outstanding incidents and it was hoped that this would result in a lower number of incomplete fields, allowing a clearer picture of the Trust's compliance to emerge. The Risk Team had recently recruited to two new part time posts which it was anticipated would support the incident reporting/DoC process.

The Lead for Claims, Inquests and Clinical Risk described that in October 2018 KPMG would be undertaking an external audit in relation to the Trust's systems and processes for DoC.

The Committee felt that significant assurance could not be given due to the number of blank fields in the October audit and gaps in the team. The Committee awarded this item Partial Assurance and asked for it to return for review in six months.

William Budd Improvement Plan

The chemotherapy peer review was undertaken on 31st May 2017 by the Quality Surveillance Team (QST) and they had issued the Trust with a notification of immediate risk:

The nurse staffing levels on the Oncology/Haematology William Budd Ward falls well below the NICE Haematological cancers: improving outcomes guidance, published in 2016, which states that 'The level of staffing required for neutropenic patients is equivalent to that in a high dependency unit'. NHS England's Adult Critical Care service specification states that for Level 2 patients there should be a 1:2 nursing ratios for direct patient care. RUH higher intensity chemotherapy patients are cared for on the 22 bedded William Budd Ward which operates a 1:6 nurse staffing ratio during the day and 1:7 at night. The Trust does not operate an ITU/HDU outreach service.

The QST also issued the Trust with a serious concern, as detailed below:

It is acknowledged that a business case has been agreed for additional staff within the chemotherapy day unit. However there was not a confirmed position regarding the recruitment plan for registered nurses and that this raised a potential risk thus was

identified as a serious concern. Any potential dilution of the skill mix of the chemotherapy team has the potential to adversely impact on patient outcomes as well as staff morale. We would like to suggest that any changes in skill-mix are risk assessed prior to their introduction.

A series of meetings were convened with the Director of Nursing and Midwifery to talk through the action plan. These meetings were chaired by the Head of Division, Medicine. A number of actions had now been completed and closed but recruitment continued to be a problem due to the national shortage of nurses. Overseas nurses had been recruited, open days had taken place and specific adverts had been taken out in an effort to improve the situation. However recruitment continued to be a problem as newly qualified staff seemed to struggle with this particular area given the nature of the care given, the patient mix and the generally high acuity of patients.

The Head of Nursing, Medicine, described how lots of work had been done, including providing a helpline and extra ward clerk support. As a result, relationships with the Intensive Care Unit and Night Sisters were much improved.

The Committee gave the process Significant Assurance and asked for it to come back in 12 months for an update rather than the usual 3 years, given the seriousness of the issues dealt with in the action plan.

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) That no assurance was given in relation to the Cardiology – Review of Improvement Plan as there were too many gaps in the information provided. It was requested that the team should come back to a future Committee meeting in November 2018 so that a level of assurance could be given;
b) The partial assurance provided in respect of Duty of Candour Follow-up and requested to review in six months (March 2019);
c) The significant assurance which was provided in relation to the William Budd Improvement Plan and that the Committee requested to review in 12 months (September 2019);

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 2018/19 work plan. The next meeting of the Clinical Governance Committee, to be held on 29th November 2018 would review the following:

- Effectiveness of systems and processes for the management of Anticoagulants including Warfarin

- Effectiveness of Infection Prevention & Control Systems and Processes (including C.Diff)
- Effectiveness of Antimicrobial Stewardship Systems and Processes
- Lung Cancer Audit Outcomes and Action Plan Delivery
- Inquest – Regulation 28 Action: Baby King Action Plan Follow-up
- Management and Mitigation of Clinical Risks associated with the move to EPR in Outpatients
- Effectiveness of Safeguarding Adults system and processes
- Effectiveness of Safeguarding Children system and processes
- 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 and approve the Terms of Reference.

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~~2018.

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