Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**24 April 2019**		

Title of Report:	**Clinical Governance Committee Update Report**
Status:	**For Information**
Sponsor:	**Jane Scadding, Non-Executive Director**
Author:	**Kathryn Kelly, Executive Assistant to Director of Nursing & Midwifery and Chief Operating Officer**
Appendices:	

Purpose

To update Board of Directors on the activity of the Clinical Governance Committee held on 19th March 2019.

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

Effectiveness of Systems and Processes for managing 52 week breaches

The Divisional Manager, Surgery, attended to present her report on 52 week breaches. She summarised that although a robust action plan was in place, unfortunately patients were waiting longer than desirable for treatment but assured the Committee that there was a process in place for identifying when breaches occurred.

The Non-Executive Director asked how assurance would be provided in future. The Director of Nursing and Midwifery stated that the Millennium system would not stop staff recording the wrong outcome in future and this was mainly the result of human error. The Committee discussed the fact that this item was mainly about capturing the breaches and then managing them appropriately. Once this was understood and the process was reviewed, the committee were assured of the process.

The Divisional Manager, Surgery confirmed that it would always be identified when breaches occurred and these were mainly for non-surgical procedures. She reported that the process was very robust and it was also hoped that the implementation of RPAS (a more streamlined and easy to use version of the scheduling application) would further reduce numbers and that all actions were monitored through a robust action log.

The Committee gave the process Significant Assurance with Minor Improvements and asked for this item to come back to the Committee within two years.

Effectiveness of Systems and Processes for sepsis identification and treatment (and effect of E-Obs)

The Consultant Anaesthetist and Patient Safety Lead reported that the introduction of NEWS2 (in full) (New Early Warning Score) had been supported by the Sepsis team

in November 2018 and their focus continued to be on the early recognition of Sepsis.

The Consultant Anaesthetist and Patient Safety Lead confirmed that a business case for permanent funding for two Sepsis nurse posts was to be developed in the SKIP (Sepsis and Kidney Injury Prevention) team and a further Band 6 was required for the SKIP service for 7 days per week. The Consultant Anaesthetist and Patient Safety Lead reported that electronic recording of E-Obs was currently being implemented starting on one ward in April 2019.

In relation to the project support for Sepsis and AKI post not being funded, the Director of Nursing and Midwifery reported that it was hoped to amalgamate this post with a current Band 5 position within the QI (Quality Improvement) Centre.

The Consultant Anaesthetist and Patient Safety Lead reported that the Trust provided more information on Sepsis compared to other national organisations and were performing slightly better. It was also acknowledged that a huge amount of work had been undertaken in the Emergency Department in relation to paediatric Sepsis screening.

The Chair concluded that there were ongoing concerns in relation to the screening and that the expected positive effects of E-obs on this should be brought back to a future committee.

The Committee gave this process Partial Assurance with Minor Improvements and asked for this item to come back to the Committee within six months.

Systems and Processes to guard against Never Event: Wrong Site Surgery
The Consultant Anaesthetist and Patient Safety Lead reported that there had been three Never Events since the last report and these spanned all three divisions.

These cases each hold opportunities for learning. For example the checklist for chest drain insertion has been modified to take account of the rare instance of a CT scan being carried out with the patient supine rather than prone.

A video has been produced, circulated to all staff to demonstrate the process to be followed for checklists and highlight human factors, and the Theatre Safety Lead has requested re-instigation of the weekly hour-long multidisciplinary training time to support human factor training.

The third case is in the early stages of review and learning will follow.

The Deputy Medical Director noted that all the above events were unconnected and no theme could be identified. It had been agreed to raise the profile of quality audits and to enforce Stop and Listen when conducting check lists.

The Committee gave this process Significant Assurance with Minor Improvements and asked for this item to come back to the Committee within six months.

Effectiveness and robustness of Ward Accreditation Process
The Senior Nurse, Quality Improvement, reported that this report had last been to the Committee in July 2016 and received Significant Assurance.

The Senior Nurse, Quality Improvement reported that the first ward to be assessed at Silver level was Helena Ward and this would be taking place during March and April 2019.

In response to a question from the committee relating to why some areas had not achieved Bronze level, the Senior Nurse, Quality Improvement, reported that robustness of data in terms of audit affected the process but that meetings did take place with staff in the areas concerned to address any issues. The Senior Nurse, Quality Improvement, reported that wards saw obtaining Bronze level as a real achievement.

In relation to recognising achievement to Silver level, the Senior Nurse, Quality Improvement reported that a certificate was displayed in the ward but agreed to follow up ways of recognising Silver level through the Innovation Panel.

The Senior Nurse, Quality Improvement reported that it was hoped that 50% of wards would achieve Silver Level within twelve months or more. The Senior Nurse, Quality Improvement and Director of Nursing and Midwifery confirmed that this information would be shared in two articles being written for the British Medical Journal.

The Committee gave this process Significant Assurance and asked for this to come back to the Committee within three years.

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 Significant Assurance with Minor Improvements was provided in relation to Effectiveness of Systems and Processes for managing 52 week breaches and the Committee asked for it to come back in two years.

b) That Partial Assurance with Improvements Required was provided in relation to Effectiveness of Systems and Processes for sepsis identification and treatment (and effect of E-Obs) and asked for it to return in six months.

c) That Significant Assurance with Minor Improvements was provided in relation to Systems and Processes to guard against Never Event: Wrong Site Surgery and asked for it to return in six months.

d) That Significant Assurance was provided in relation to Effectiveness and robustness of Ward Accreditation Process and asked for it to return in three years.

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 forthcoming agenda items within the work plan for CGC/NCGC are detailed below for the next meetings in May 2019. We ask members of the NCGC/CGC to advise if they have wish to have visibility of the papers/presentation associated with any of these items'.

CGC

- Systems and processes supporting PoCT Equipment oversight and management
- Effectiveness of systems and processes for the management of Anticoagulants including Warfarin
- Cardiology – Review of Improvement Plan and Follow-Up Plan
- Board Assurance Framework
- External Agency Visits
- Audit Tracker
- Work Plan, Horizon Scanning & Next Agenda Review

NCGC

- Legionella
- Managing Complaints
- Clinical Coding
- Telephone Resilience

Recommendations

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