Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**30 October 2019**		

Title of Report:	**Clinical Governance Committee Update Report**
Status:	**For Information**
Sponsor:	**Nigel Stevens, Non-Executive Director**
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Appendices:	**None**

Purpose

To update Board of Directors on the activity of the Clinical Governance Committee's held on 9th July and 24th September 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 Process for Assessing Capacity and Consent

The Governance Lead, Surgery presented the report and highlighted that the

- The Trust had good policies relating to capacity and consent which had been reviewed in the spring;
- The policy was needed to ensure that The Trust was compliant with current legislation and Care Quality Commission Guidelines;
- The Mental Health Act 2007 introduced a new criminal offence of neglect and ill treatment of a person who lacks capacity. A person who is found guilty of this may face up to five years in prison;
- Currently consent and Mental Capacity Act assessments were undertaken on paper. By using the Millennium electronic patient records system these documents could be scanned into patient records;
- Some barriers may be overcome by flagging capacity assessment and consent onto the EPR systems. This could be overcome with Millennium electronic templates and e-consent strategies.

In relation to Clinicians following due process, the Governance Lead, Surgery confirmed that the team were investigating all cases where process was not followed and had asked all divisions to undertake capacity documentation. The Trust had made consent part of mandatory training but there was no way to ensure the method of consent was being taken appropriately.

The Committee suggested that a qualitative audit was required and it was confirmed that a consent audit took place on a quarterly basis. It was agreed that a cross sectional review at specialty level would be a good idea and the Committee discussed the need for a qualitative review. The Mental Capacity Group could review the training aspect of consent and the Governance Lead, Surgery was requested to look into this.

Delayed Follow-up Appointments – Effectiveness of Patient Follow-up Systems & Processes

The Head of Division, Surgery and the EPR Manager highlighted the following points from the report:

- In January 2019, the Committee gave the process Partial Assurance.
- The written report provided an overview of the current position with delayed patient follow up appointments across the three clinical Divisions and summarised the actions in place to reduce this to an acceptable level.
- The Trust managed follow up appointments by the use of the Cerner Millennium system.
- Delayed Follow ups greater than 3 months had reduced from 18,670 in April 2018 to 5,089 in June 2019, a reduction of 13,581 encounters.
- The Ophthalmology delays were related to capacity issues which was a national problem and the recent Ophthalmology GIRFT review suggested the Trust's position was similar to most acute Trusts. It was hoped that the backlog would be eliminated within 4 months.
- The main area of concern was Cardiology and there had been a longstanding issue with overdue follow-ups. Administrative and clinical validation was in progress; an action plan had been developed and this continued to be an area of focus for the Divisional team.
- The delays in Pain were partly a legacy issue due to the new service model introduced in April 2018, combined with the service closure from 2016-2018. Clinical risk in this patient cohort was very low but would continue to be a risk.
- Cerner had designed a new system called RPAS Millennium which would look at outpatient referrals. This system was already implemented in Oxford and had largely resolved the problem. The plan was to introduce this to the RUH in the next 3-4 months.

It was reported that, although there were no further significant risks, ENT and Urology were now showing warning signs as these departments were heavily reliant on consultants to keep on top of the backlog. In relation to the RPAS system, the EPR Manager confirmed that although the Trust had standard processes and training in place to manage lists within Millennium, the complexity and flexibility of the system, combined with a high turnover of staff made it difficult to achieve a standard approach.

The Committee requested that the Trust should be mindful of unnecessary appointments for patients which could be undertaken via a telephone consultation and it was confirmed that the Trust was undertaking a step change project which focused on a review of outpatients to different ways of delivering care.

With regard to ophthalmology patients waiting longer than 12 months, the team had employed Locum Consultants and developed a clerical handbook to address this backlog which should be cleared within 3-4 months.

Cardiology – Review of Improvement Plan

The Consultant Cardiologist and Specialty Manager attended the meeting to present their report. Previously the Committee had not been able to provide a level of assurance as there were gaps in the information provided. The Consultant

Cardiologist confirmed that the Cardiology action and improvement plan was included within the meeting papers but there was still a lot of work to be done.

The Committee were aware of the landscape in which the action plan was set against and the staffing problems that Cardiology was facing. Cardiology were currently 2 WTEs consultants down as a result of staff sickness and retirements and the team required additional support to deliver the action plan and a number of the actions were interlinked.

The Committee agreed that the action plan in its current format was not precise enough, objectives needed to be made SMART and prioritised with clear timescales documented. It was suggested that a CQC action plan format could provide more structure. The Committee suggested that the project could be taken through the Project Wall at Management Board and it was confirmed that work had already begun to transform the action plan to an Improving Together format.

Systems and Processes to Guard against Never Event: Wrong Route Administration of Medication

The Deputy Chief Pharmacist highlighted the following points from the report:

- The report sought to provide assurance of processes in place to prevent a wrong route administration of medication never event.
- The Trust was compliant with the majority of recommendations identified
- Compliance with NHSi/PSA/RE/2017/004 Resources to support safe transition from the Luer connector to NRFit™ for intrathecal and epidural procedures, and delivery of regional blocks was still outstanding.
- The work to address this risk was dependent on availability of the compatible connectors and other concerns with regard to stability / compatibility of medicines in these. A meeting held in September 2017 highlighted the need to carry out a mapping exercise across the whole hospital to identify all intrathecal / epidural equipment in use. Ideally the whole hospital should use the same but due to availability it was not progressing at pace. Haematology / Oncology (which was one of the highest areas of risk) had implemented this and were now compliant.

The Committee were informed that, in relation to NRFit, it was difficult to identify standard pieces of equipment across departments. By standardising equipment, this would add an element of risk; the Trust would keep the current equipment, but purchase kits to standardise the connectors to NRFit connectors.

In relation to near-miss reporting, it was agreed that the Trust needed to become smarter in terms of capturing near-miss reporting. In relation to policies being up-to-date, it was reported that one policy had expired but it had been agreed to extend its use, the other policy had expired, but would be updated by the end of July.

Getting it Right First Time (GIRFT)

The Medical Director and Programme Director Acute Hospitals Alliance provided an overview of GIRFT.

The Chair stated that the Clinical Governance Committee (CGC) was responsible for

reviewing all clinical external agency visits. The Medical Director stated that he would caution against the CGC having to review all GIRFT visits as it was monitored via other avenues. The Programme Director Acute Hospitals Alliance stated that the process established had been learnt from best practice nationally and the Trust was now within the 'good' category for control and monitoring delivery.

In relation to any benefits being seen GIRFT, the Medical Director stated that the Trust had reduced patient's length of stay following knee and hip surgery as a direct benefit of GIRFT and further benefits had been identified in Ophthalmology.

The Chair questioned whether GIRFT focused on an acute setting and the Programme Director Acute Hospitals Alliance confirmed that the deep focus was within hospital, but flow in and flow out would inevitably be looked at, thus involving the system as a whole.

Effectiveness of Infection Prevention & Control Systems and Processes (including C.Diff) and Annual Director of Infection Prevention and Control Report

The Infection Control Lead Nurse described how there were a number of clear processes that were being worked through and the Infection Prevention & Control Committee currently met bi-monthly to oversee performance. Reports were received from the Divisional Heads of Nursing and these highlighted any issues in relation to cleaning, decontamination and estates.

The Infection Control Lead Nurse described how regular cleaning audits took place with a member of the Infection Control team and a matron/senior sister, and this was where questions were regularly asked. A weekly walkabout also now took place with the Director of Nursing and Midwifery and this was useful to pick up on any outstanding issues. Audit scores had dipped in some areas due to a better audit process being in place. The Committee felt reassured by this process.

The Infection Control Lead Nurse confirmed that the Trust currently remained an outlier for MSSA (methicillin-susceptible Staphylococcus aureus) and there was also a problem with line associated infections. She confirmed that more work was being done on this and it was currently a work in progress.

The Committee asked if there was more that could be done in relation to the education of Bank staff and were concerned about the high numbers of staff not receiving training. The Infection Control Lead Nurse described how specific sessions had been created and the team had looked at different ways to address this issue, e.g. e-learning packages. She described how this was included in the general induction programme but the problem occurred after staff had been in post for two years and it was also difficult for Bank staff to attend mandatory days.

The Infection Control Lead Nurse explained how the Annual Report informed the work plan for the following year. In relation to changes resulting from this report, it was confirmed that there had been a big focus on line infections and C.Diff with targeted work had been done and fortnightly meetings with senior sisters being introduced to provide focus. The biggest influence had been through the wider sharing of the data and this had given staff more impetus to change and staff now felt more able to

challenge poor practice.

Effectiveness of Systems and Processes for Sepsis Identification and Treatment (and effect of E-Obs)
The Consultant Anaesthetist and Patient Safety Lead reported that a permanent team had now been established for the Sepsis and Kidney Injury Prevention (SKIP) team and they continued to focus on early identification of deterioration and management of Sepsis and Acute Kidney Injury. However, further funding was required for the SKIP team for 7 days per week and a business case was being developed.

The Consultant Anaesthetist and Patient Safety Lead reported that E-obs had been implemented on Helena Ward in August 2019. The system was working well and the team were learning about response times. The Consultant Anaesthetist and Patient Safety Lead also highlighted that 90% of patients now received antibiotics within one hour of sepsis diagnosis.

The Chair described how improvements in the statistics were clearly being seen an it hoped this would provide more detailed electronic data in future.

The Medical Director described how the system was still to be tweaked but he was happy with the recording of observations. He reported that the next ward would be William Budd and that the challenge would be in testing areas which were not as robust as those previously tested, e.g. Helena.

Systems and Processes to guard against Never Event: Wrong Site Surgery
The Consultant Anaesthetist and Patient Safety Lead reported that compliance was increasing with the WHO checklists. However, there had been 4 incidents of concern since September 2018, the most recent being in August 2019.

The Consultant Anaesthetist and Patient Safety Lead described how a video had been made, describing the rigid standards expected and this was planned for roll out in August/September 2019. New staff had already seen the video but the challenge remained in arranging for staff currently in place to view it too and for team training time to be reinstated.

The Consultant Anaesthetist and Patient Safety Lead reported that multiple human factors were responsible, The Governance Lead, Surgery, described that a more ‘top down’ focus was required. The Chair requested that this process be discussed again at a committee meeting within six months’ time to understand better the organisational and line management structures.

Cardiology – Review of Improvement Plan
The Medical Director reported that a discussion had taken place regarding Cardiology and a job planning exercise was currently in flight but more dedicated resourcing was required. It had been recognised that Cardiology had suffered challenges within the consultant body and there had been an issue with leadership. The Medical Director confirmed that a new clinical lead was now in place and the focus was on inpatient performance and prioritising laboratory performance. The Committee agreed that this had remained a problem area and they were still not provided with a sufficient level of assurance. It was agreed that a briefing should be provided at the November

meeting.

Delayed follow-up appointments – effectiveness of patient follow-up systems and processes - Ophthalmology
The Clinical Director for Ophthalmology described that the report provided an overview of the current position with regard to delayed patient follow-up appointments in Ophthalmology and summarised the actions and next steps which had been taken to reduce this to an acceptable level. The Committee were asked to note the reduction in Ophthalmology follow-ups overdue by more than 3 months from 2,860 in May 2018 to 372 in August 2019. It was anticipated to keep to this good position going forward.

In relation to patient safety remaining under control, it was confirmed that systems were in place to address this, with an advert currently out for optometry technicians, and a Fail Safe Officer and Visual Fields Officer now in post. It was reported that although the department was in better control, a decline would most likely continue but it was hoped that this would improve within the next few months.

The Deputy Specialty Manager for Ophthalmology confirmed that they were constantly reviewing and prioritising patients correctly and the Committee were assured that they had a grip on the process.

Effectiveness of Appraisal and Revalidation Process
The Consultant Radiologist described that the process had now been running for a few years successfully. It had been clear that this had needed to evolve and become more robust. The formation of a ROAC (Responsible Officer Advisory Committee) would support this and provide a more shared decision making process to take place, thereby strengthening the whole process. It was highlighted that the Trust was lucky to have a fully engaged team of doctors as this was not always the case within other Trusts.

In relation to the Trust's performance in relation to null engagement notifications, the Committee were assured that the ROAC would help in targeting any member of staff who was slipping but this was currently a work in progress.

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 Partial Assurance was given in relation to Effectiveness of Systems and Process for Assessing Capacity and Consent based on the need for digital consent and an improved audit process. A further assurance review would take place at the meeting in six months' time.

b) That no level of assurance was given in relation to Delayed Follow-up Appointments – Effectiveness of Patient Follow-up Systems & Processes. The Director of Nursing and Midwifery suggested that the core services should be reviewed by the Clinical Governance Committee in a few months' time. It was

agreed that Ophthalmology should be added to the work plan.

c) That no level of assurance was given in relation to Cardiology – Review of Improvement Plan. It was requested that the Medical Director provide the Committee with a verbal update on the agenda in September and also update at the November meeting.

d) That no assurance was given in relation to Systems and Processes to Guard against Never Event: Wrong Route Administration of Medication. The Chair of the Committee requested that the Deputy Chief Pharmacist should return to the Committee in January 2020.

e) That no level of assurance was given in relation to Effectiveness of Infection Prevention & Control Systems and Processes (including C.Diff) and Annual Director of Infection Prevention and Control Report. A progress report should be provided in six months' time.

f) That Significant Assurance was given in relation to Effectiveness of systems and processes for sepsis identification and treatment (and effect of E-Obs) and an update should be provided in six months' time.

g) That no level of assurance was provided in relation to Systems and Processes to guard against Never Event: Wrong Site Surgery and an update should be provided in six months' time.

h) That no level of assurance was given in relation to Cardiology – Review of Improvement Plan. It was agreed that a briefing should be provided at the November meeting.

i) That significant assurance was given in relation to Delayed follow-up appointments - effectiveness of patient follow-up systems and processes – Ophthalmology and an update should be provided in three years.

j) That significant assurance was given in relation to Effectiveness of Appraisal and Revalidation Process and a verbal update should be provided within one year.

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 2019/20 work plan. The forthcoming agenda items within the work plan for CGC/NCGC are detailed below for the next meetings in November 2019. We ask members of the NCGC/CGC to advise if they have wished to have visibility of the papers/presentation associated with any of these items'.

CGC

- Unintentional connection of a patient requiring oxygen to an air-flow meter – deferred from September 2019
- Effectiveness of Antimicrobial Stewardship Systems and Processes
- Systems and processes supporting PoCT Equipment oversight and management
- Effectiveness of systems and processes for the management of Anticoagulants including Warfarin
- Effectiveness of systems and processes for managing Duty of Candour
- National Diabetes Inpatient Audit - Update on data collection
- Cardiology - Review of Improvement Plan & Follow-Up Plan
- Systems & Processes to guard against Never Event: Transfusion or Transplantation of ABO Incompatible Blood Components or Organs
- Systems and Processes to guard against Never Event: Mis-selection of a strong potassium containing solution
- Safer Staffing
- Management and Mitigation of Clinical Risks associated with the move to EPR in Outpatients
- Effectiveness of systems and processes to ensure NICE Guidance compliance
- Board Assurance Framework
- External Agency Visits
- Audit Tracker
- Work Plan, Horizon Scanning & Next Agenda Review

NCGC

- TBC - Business Case Process
- Review of People Practices
- Telephony Resilience
- E Rostering
- Energy
- Managing Sickness Absence
- Contract Management
- Volunteer Checks
- Board Assurance Framework
- Audit tracker
- External Agency Visits

Recommendations

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