Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	14
Date of Meeting:	29 January 2020		

Title of Report:	Clinical Governance Committee Update Report
Status:	For Information
Sponsor:	Nigel Stevens, Non-Executive Director
Author:	Kathryn Kelly, Executive Assistant to Director of Nursing & Midwifery and Commercial Director
Appendices:	None

Purpose

To update the Board of Directors on the activity of the Clinical Governance Committee held on 5th December 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 Antimicrobial Stewardship Systems and Processes

The Antimicrobial Stewardship Lead provided an overview of the report, detailing the progress that had been made in 2018/19, savings on CQUIN and drug expenditure.

The Chair requested that a policy should be produced and an update on the Business Case should also be provided. As a result, the Committee noted that no assurance had been gained and so requested that this item should return to the Committee meeting in March 2020.

Effectiveness of Systems and Processes for the Management of Anticoagulants including Warfarin – item withdrawn

The Medical Director reported that this item had been withdrawn as the Consultant Haematologist had resigned from his post. However, there had been an appointment of a new Haematologist and the Thrombosis Committee continued to meet regularly. The Committee requested that this item should return to the meeting in March 2020.

Effectiveness of Systems and Processes for Managing Duty of Candour

The Deputy Director of Nursing and Midwifery provided an overview of the Duty of Candour process, reporting that this continued to be monitored through the Datix and Serious Incident investigation process. KPMG had completed a review of Duty of Candour in May 2019, in which the main objectives were described and an action plan had been provided.

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

Effectiveness of Systems and Processes to ensure NICE Guidance Compliance

The Clinical Guidance Implementation Manager provided an outline of her role, explaining how she checked the NICE guidelines monthly, identifying any gaps and

adding guidelines to the risk register as and when necessary.

The Committee remained assured that a very effective process was in place and gave the process Significant Assurance, requesting that this item should return to the Committee within three years.

Systems and Processes to Guard Against Never Event: Mis-selection of a strong potassium containing solution

The Chief Pharmacist provided an overview of how a strong potassium solution could be life-saving but came with risks if incorrectly diluted. Policies were in existence for strong potassium solution and these related to the storage, supply, prescribing and preparation of the solution.

The Chief Pharmacist described how the Trust relied on Datix reporting and to date none of the 31 Datix incidents reported during the period December 2016 to October 2019 had related to this never event.

The Committee were assured of this strong process and that this was ingrained within the Trust. The Committee gave the process Significant Assurance and asked for this item to come back to the Committee within three years.

Never Event – Unintentional connection of a patient requiring oxygen to an air-flow meter

The Patient Safety Manager, Surgery, Head of Estates and Matron, Critical Care and Outreach to the Committee provided an overview of their report, describing how the air flow meters were rarely used and were stored separately within the unit. The patient concerned in this event had experienced problems with blood gases and it had been decided to use the air flow meter to administer nebulisers. Unfortunately it had become apparent that the staff concerned were not familiar with the kit and had not carried out the appropriate checks.

To prevent a recurrence of this event, the Head of Estates confirmed that the measures outlined in a recent CAS alert had now been added to the Medical Gas training within the Trust. The Matron, Critical Care and Outreach, also described how this event had been discussed at a Critical Care Network meeting and that the RCA had been presented to the CCG.

Learning Disabilities Briefing Paper

The Learning Disabilities Liaison Nurse presented her report, explaining that in June 2018 NHS Improvement had launched the national learning disability standards for NHS Trusts. This applied to people with a learning disability and/or autism and it was recognised that many people in the country had a learning disability and often experienced poorer access to health care. Organisations had a duty to ensure that these patients had good access to health care and this was reinforced by the NHS Long Term plan from January 2019.

National benchmarking had taken place between September and December 2018, to gather the first set of baseline data against the 4 standards, and in July 2019 the findings from the benchmarking process were provided to the Trust in a bespoke report.

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

Management and Mitigation of Clinical Risks associated with the move to EPR in Outpatients

The Informatics Manager provided an overview of how the Paperless Outpatient Project (POP) had launched in 2016 and to date over 90% of specialties across the three clinical divisions were enjoying the advantages of going paper light/paperless. The following three specialties were working on becoming paperless:

- Ophthalmology
- Vascular Studies
- Dermatology

The restructuring of the Medical Records Department had taken place and there were now no longer libraries on site and records had been evacuated to the Trust's secure offsite storage supplier, Restore.

The Committee gave the process Significant Assurance and asked for this item to come back to the Committee within one year.

Patient E Summary

The Deputy Director of Nursing and Midwifery provided an overview of the report regarding Patient E, explaining that this patient had a learning disability and other co-morbidities and was cared for in a supporting living property. Patient E's health began to decline and she was admitted to four separate hospitals. When she deteriorated the cause of death was Hospital Acquired Pneumonia. The LeDer report was currently awaited.

The Committee concluded that they felt the Trust had done all it could in relation to this incident and had learnt all that it was possible to learn.

The Committee were assured by the Deputy Director of Nursing and Midwifery that she had reviewed the incident and was comfortable that the Trust's review was correct. It was highlighted by the Committee that the Trust should have been asked by now to contribute to the report and requested that the Learning Disabilities Liaison Nurse contact the LeDer Programme. The Chair also undertook to provide feedback to the Wiltshire Safeguarding Committee.

The Committee noted the report and was advised that this would be going to Trust Board in December 2019 for further discussion.

Serious Incidents and Inquests Report from OCGC

Claims

The Lead, Claims and Inquests provided an overview of her report, describing how litigation levels had returned to normal levels following a spike in activity in Q1. The consent process was an area which was flagged as requiring more review.

Inquests
It had been a quiet quarter with the Trust only being required to attend one inquest and no concerns were expressed by the Coroner. The Trust did not receive or respond to any Regulation 28 reports during Q2.

Serious Incidents
The Trust had changed the way in which Serious Incidents were now identified. A new Round Table process had been set up and it was hoped that this would speed up the process in future.

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 level of assurance was given in relation to the Effectiveness of Antimicrobial Stewardship Systems and Processes. The Committee requested that this item should return to the Committee meeting in March 2020.

b) That Significant Assurance was given regarding Effectiveness of Systems and Processes for Managing Duty of Candour. The Committee requested that this item should return to the Committee meeting in three years.

c) That Significant Assurance was given regarding Effectiveness of Systems and Processes to ensure NICE Guidance Compliance. The Committee requested that this item should return to the Committee meeting in three years.

d) That Significant Assurance was given regarding Systems and Processes to Guard Against Never Event: Mis-selection of a strong potassium containing solution. The Committee requested that this item should return to the Committee meeting in three years.

e) That Significant Assurance was given regarding the Never Event – Unintentional connection of a patient requiring oxygen to an air-flow meter and considered this item to be completely closed.

f) That Significant Assurance was given regarding the Learning Disabilities Briefing Paper. The Committee requested that this item should return to the Committee meeting in three years.

g) That Significant Assurance was given regarding Management and Mitigation of Clinical Risks associated with the move to EPR in Outpatients. The Committee requested that this item should return to the Committee meeting in one year.

h) That the Committee noted the report titled Patient E Summary would be discussed further at Trust Board in December 2019.

Exceptions and Challenges

None identified.

Governance and Other Business
The meeting was convened under its revised Terms of Reference.
Future Business
Recommendations
It is recommended that the Board of Directors note this report.