**Unapproved Minute**

**Clinical Governance Committee**

**Tuesday 31 July 2018**

**Members**

Mark MacGregor Chair

Karen Kelly Non-Executive Director

Phil Cox Non-Executive Director

Jane Christie-Flight Non- Executive Director

**In attendance**

Jill Young Chief Executive

Anne Marie Cavanagh Director of Nursing

Theresa Williamson Associate Director of Nursing

Jennifer Hunter Clinical Nurse Manager (Interventional Cardiology)

Ashley Calvert Clinical Effectiveness Manager

**Minutes**

Lori Cassidy PA to Medical Director

1. **Chair’s Introductory Remarks**
   1. MMacG welcomed everyone to the meeting and thanked them for their attendance noting AC was attending on behalf of LLR.
2. **Apologies**
   1. Apologies were received from:

Laura Langan Riach Head of Clinical Governance

Mike Higgins Medical Director

Hany Eteiba Acting Medical Director

1. **Minutes of Last Meeting**
   1. Minutes of the meeting held on 17 April 2018 were approved as accurate with the following amendments:

Page 1: (JY)

Page 3: Misdiagnosis (spelling error)

1. **Matters and Actions Arising**

* **Deteriorating Patient Work stream:** In PR’s absence, Clinical Governance leads will delegate. Feedback on the M&M process within each department will be available for future meeting.

1. **Safe**
   1. **5.1 Regional & National Division Update**

JH presented the Regional and National Medicine Division report for the period April – June. This was discussed by the committee and JH highlighted the main points.

Psychological support for SACCS patients had previously been discussed but the service for a wider range of patients was raised. At the moment patients requiring further support were referred back to their GP. The question of increased funding has been raised with NSD by the Associate Director of Nursing. KK enquired what symptoms this service covered. JH advised there was a broad spectrum of issues, but in particular, young patients who found it challenging coming to terms with and accepting any limitations of their illness.

No major issues had been identified from the RCA, with only one action on deteriorating patients. AC was escalating responses.

The question of data correction mentioned in the report was raised by KK. AC advised that data is collated and reported as available at an agreed point in time – if the picture changes after this the reports are not retrospectively updated. Going forward, work is underway to collate and review data on a weekly basis. JY suggested that KK be invited to the SPSP meeting which would help with understanding the process.

**Action: LLR to invite KK to next Patient Safety Group.**

The Clinical Audit process has been revised as previously reported. Actions and recommendations are checked and verified with clinical leads and service managers to ascertain whether they were appropriate.

* 1. **Surgical Services Division Update**

TW presented an update of the Surgical Services Division for the period April – June 2018. She noted there had been some challenges around attendance at Clinical Governance meetings and their frequency given the introduction of the cross divisional forum. The surgical servies Division have now agreed to meet 2 out of every 3 months with the cross divisional taking place on the third month.

Accidents and Falls had decreased by 20% compared to last month with nothing untoward to report. This had been a good month for pressure ulcers with nothing of significance to report.

The committee discussed the ongoing Significant Adverse Events:

* One event has triggered Duty of Candour and is currently under investigation and will report back to Clinical Governance Risk Management (CGRM).
* The investigation relating to the IV Calcium Gluconate administered on the ward has resulted in a protocol as to how we treat in future. The opening of the enhanced monitoring unit will assist clinical staff also.
* The event relating to a missing Pledget was discussed at SSDMT and a decision not to progress to an SAE was agreed. This relates to process and will be presented the SSDCGG in mid August.
* TW advised the Committee that the event relating to a patient transfer from Belfast had been downgraded. Following discussions, it had been agreed that June Rogers (Director of Operations) would lead on taking this forward with the aim of producing a process for future transfers. The patient outcome was positive and transferred back to Belfast.

There were no outstanding issues to escalate at the moment from the SAE, but it was acknowledged that the main theme is documentation. However, the implementation of the new EPR system may go some way to resolve this.

**Monitoring and Control Information:** Following discussion on how to decipher the tables which were presented on the reports, it was agreed to review this at the next meeting via a presentation.

**Action: Presentation at future meeting on tables, charts and how data is gathered and reported.**

There has been a lot of emphasis on this work and it was encouraging to see the Falls Outcome has remained below the medium line. It was noted that ventilator related pneumonia had almost been eradicated. However, this required continual vigilance of all health care professionals and work was being undertaken to put in something longitudinalover the year.

Clinical Governance continues to pursue outstanding audits and action plans for those audits which have been closed.

* 1. **Closed Significant Adverse Events**

AMC gave an update on Level 1 investigations and indicated there had been three which had gone to CGRM for discussion and review. These were discussed by the Committee, and the main points noted. These were as follows:

**DW-2677:**

A standardised structured approach to surgical brief to be devised. Testing is underway using a revised template to implement a structured brief with a checklist and debrief at the end. Equipment requests will form part of the Safety Brief.

A further learning outcome was improved communication with families.

**DW- 2532:**

It was recommended that a review of criteria and documentation on patient transfers be undertaken to ensure consistency with UK approach. Initially an outcome code 4 was assigned but this was subsequently been changed to a Code 3.

**DW-2787:**

Areas for improvement were identified as documentation and recording on MCS procedures.

1. **Effective**
   1. **HAIRT Report (February)**

AMC gave an overview of the May HAIRT Report and highlighted the following points:

* There were no SABs to report during May
* Hand Hygiene had increased in compliance from 92% to 96% thanks to HE’s excellent work with medical teams to reinforce our Zero Tolerance Policy.
* SSI rates in Cardiac breached the upper control limits in February and CABG rates continue 5 points above the median. Infection Control have been scrutinising factors which may impact but no link to any theatre, surgeon or organism has been identified. PCIT are working with tissue viability SCNs, nurse practitioners and SS clinical governance leads to review practice and study in more detail, including discussions with surgeons who have a particularly low rate. Although this is reducing over time, it was acknowledged that we do have clusters which occur. In 2014 we were unable to pinpoint what actually occurred and why it occurred in some areas and not in others. We will continue to apply standard infection control precautions (SICP’s) and work with the multi professional working group to monitor to ensure a meticulous approach in this area.
* Although there were 2 superficial knee infections, Orthopaedic rates remain within control limits.
  1. **Annual Learning Report**

AC gave the Committee a brief summary of this report which had been circulated prior to the meeting. The following key points were noted.

* There had been a 100% increase in RCA’s from 10 – 20 over the last year. No common themes had been identified, and levels were returning to normal this year.
* Deteriorating Patient had been a key element in previous years, but this had improved , largely due to the substantial pieces of work undertaken in all specialities utilising structured response tools.
* Pressure ulcers no longer featured in the Top 5 category. The work undertaken with surgical services on device related and traditional ulcers was reflected in the median decrease throughout the year.
* Communication was a key theme within adverse events and complaints. Work around consent procedures, information and understanding is ongoing.
* AC confirmed that occupied bed days and not patient activity was used in calculations.

The Committee agreed that the Learning Summary was a good resource and reflective tool and that one year was a good time frame. .KK commented on the complexity of the charts on pages 18 and 19. AC explained both; Chart 18 depicted actions by Human Factors and Chart 19 were contributory factors.

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**7. Person Centred**

**7.1 Complaints Report**

AC presented an update on the Complaints Report to the Committee for Quarters 2 &3 which covered 1 October 2017 – 31 March 2018. The main themes highlighted were communication and consent and work is underway to progress and improve in these areas.

The number of complaints in Interventional Cardiology had risen and some related to information given to patients.. The Committee agreed this was a complex area . KK suggested a breakdown of factors and an assessment of exactly what it encompassed be undertaken. AMC stated that in the case of an adverse outcome, people and families may feel they were not given or did not understand the information they were given and that was the learning area and scope for improvement; very challenging. MMacG summarised by agreeing we were about half way there with true information sharing.

1. **AOB**

There being no other items for discussion, the meeting closed.

1. **Date and Time of Next Meeting**
   1. The next meeting takes place on Tuesday 9 October 2018 at 10.00 am in Level 5 Boardroom.