1. The Chairman opened the meeting noting that a quorum was present and declared that the meeting was duly convened.

Apologies were received from Edward Adams (Director of Corporate Governance), and Azara Mukhtar (Director of Finance).

2. Declaration of Interests

None received.

3. Minutes from the previous meeting

The minutes of the meeting held on 16th April 2014 were approved subject to textual amendments.

4. Matters Arising

From 16th April 2014

- Item 6.5 – Quality Account Priorities – VTE to replace the FFT audit – Auditors informed of decision and are now auditing VTE as part of the quality accounts – Action closed
From 19\textsuperscript{th} March 2014

- Item 13.2 – Q3 CLIP report - NED walkabout with partners to be arranged and confirmed with NEDs. – List ready to be circulated and NEDs advised. Keep Dan Pople Director of Communications informed. – Action closed.
- Item 15.3 – Endoscopy Unit Annual JAG Accreditation – on agenda – Action closed.

From January 2014

- Item 9 – Update on 2012/20591 Inquest – Colorectal Pathway. EA to lead on setting up this review with TORs to be agreed and circulated to members to enable NED involvement.- TORs agreed and review in progress.

5. Quality Improvement Plan

MOB outlined the current position and progress on the Quality Improvement Plan (QIP) and drew attention to a number of options the Committee might consider in preparation for the CQC’s inspection scheduled for autumn this year. She advised that the QIP will be an integral part of the evidence the CQC will use to evaluate the Trust’s progress with quality improvements. One of the issues the Trust still has to address is the appointment of an external reviewer to review evidence and provide assurance that the CQC requirements are being met. This has been discussed with the TDA who have recommended that the Reviewer should be independent of both them and the CQC as this could result in a perceived conflict of interest. JG noted that this is with EA as an action for further discussion. He noted that the Trust is accountable to the TDA for obtaining a good rating. The CCG is an important stakeholder but the Trust is not accountable to them.

Two further actions had been agreed with TDA at the Trust’s monthly monitoring meeting:

- first that the Trust, following the independent review, would undertake discussions with local stakeholders on the priority areas; and
- secondly, actions from the CQC Inspection of the Urgent Care Centre, (UCC) where work with Virgin Health and the Trust to improve the interface between the Trust, the UCC and the Local Authority Adult and Children Services is taking place. JG suggested that once these discussions have been completed they could be followed up at the Quality Summit to be arranged at the end of July 2014.

[EN entered the meeting].

MOB further advised that there were a number of internal assurances that needed to be provided before the next inspection, \textit{i.e.} additional evidence from walk rounds and spot checks. A necessary improvement to prepare for inspection would be the updating of the website.

Another key area was ensuring staff were briefed on key achievements of the Trust performance and patient safety improvements, and these needed to be extended briefings to staff that may not always be involved, \textit{e.g.} Student nurses and porters as they may have valuable ideas in relation to service improvement. The Committee agreed that it would be useful to have sight of the work plan once developed. JG noted it would be useful to link the work plan back to the QIP and that input from the Project Management Office (PMO) could help improve focus and close any gaps on the work plan.
MBE noted that it is important to check with Communications to ensure that the Team are fully involved and engaged around raising awareness with the NEDs and the executive team. He noted that Communications are in the process of recruiting new staff and this was something that new members could work on. MC stated that the NEDs could provide some independent assurance in relation to the website from a public, patient and GP perspective. It was agreed that MOB will clarify the work would be undertaken and the actions required for NED involvement.

ZP acknowledged that preparation for the scheduled CQC visit was necessary but the Trust should also maintain a state of readiness for unannounced inspections. The need to ensure that the Quality Improvement Plan is always current is vital and would form an integral part of the preparation of any spot check. ZP noted that the greatest challenge facing the Trust was maintaining consistency across the organisations. KB noted that the UCC had not yet confirmed their proposed actions to address CQC recommendations because of delays in their legal team. Once these were available, ED would work with the UCC to put them into effect. MBe queried whether or not the UCC should be included in the Quality Summit. It was agreed that the proposal to hold stakeholder sessions would provide an appropriate forum for Virgin’s attendance. JG also advised that at this stage it would be important to get into the rigour of escalating issues to the Turnaround Board to ensure performance management of the QIP; recruitment was underway of a project manager in the PMO to ensure delivery of the QIP.

The Committee agreed the suggestions for preparation of the CQC’s upcoming inspection.

Provide progress update on work plan for forthcoming CQC Inspection.

EA

6. Draft Quality Account

EN presented the draft quality accounts advising that these had been disseminated to external stakeholders as a draft document and requesting the Committee’s feedback on the content and format. The Committee discussed the document at length and it was agreed that manuscript comments should be made on the draft accounts and returned to EN to review and amend accordingly. In summary, the Committee requested that further work be undertaken to:

- Ensure language throughout is more ‘patient friendly’
- Include more information on the role and priorities of the Quality and Clinical Governance Committee
- Include the priorities of the Turnaround plan
- Expand how the priorities for 2014-15 were identified
- The new directorate structure and clinical leadership programmes need to be included
- Clinical coding required more explanation
- Additional information regarding the Transforming Adult Community services (TACS)
- Maternity section requires more detail
- Include a range of pictures to reflect all services, on the front and last page as well as throughout

MBE suggested that once the document had been finalised, Communications
could produce a summarised version for the public domain. JG also noted that the current version had been sent to the statutory stakeholders as a draft for review and comment and it would be important to align their amendments to those suggested by the Committee; he also suggested that work on next year’s Quality Accounts should start earlier to facilitate well-timed review by the Committee. It was agreed that the draft accounts reflected the quality priorities agreed at the previous Committee meeting and the Committee thanked EN for her hard work with the productions of the Quality Accounts recognising the complexity of the task.

7 Annual Safeguarding Declarations (Children & Vulnerable Adults)

ZP explained that the Trust has a statutory obligation to publish an annual safeguarding declaration for both Children and Vulnerable Adults. It has been the practice to use the same format each year by updating the declaration required. MC questioned if something should be noted about training figures in the organisation, and whether there should be a reference to Operation Yew Tree. ZP confirmed that training figures are no longer a requirement. JG advised that consideration needed to be given to the provision of contextual information to accompany the declaration on the Trust’s website: it was agreed there should be discussion with the Head of Communications for clear guidance on how this should be actioned.

MBe asked for clarification on the ratio of staff numbers to Looked After Children (LAC) and whether the balance was right here. ZP confirmed that the role of the Looked After Children team is to carry out health assessments of children who are in care, but that it might be helpful to provide explanations of what the roles are within the team. It was noted that not all children that are looked after are vulnerable. MC suggested that this could be explained more fully in the next Safeguarding Children’s report. ZP noted the need to consider the Care Bill which was to be the subject of a future Board seminar.

Subject to textual amendments, the Committee approved the two Safeguarding Declarations

Actions

Add narrative regarding Operation Yew Tree into declarations;

Include contextual information on Website

Ensure next safeguarding report includes a section of LAC Team roles and responsibilities within the team and some benchmarking with comparable organisations.

(Specify who is responsible for each of these actions)

8 Patient Experience and Financial Improvement Plan- Governance Arrangements

MOB presented the Governance arrangements of the Patient Experience & Financial Improvement Plan (previously known as the Turnaround Plan) and advised that progress on Projects and Milestones would be monitored by the Project Management Office, with Assurance of evidence of achievement reported by the Corporate Governance Directorate to the Committee via the Risk Assurance & Policy Group.

The Committee approved the proposed governance arrangements.
9. **Quality Report – Cancer and Core Functions Directorate**

KM advised that changes had occurred within the directorate where the access team had moved over to the Critical Care and Surgery Directorate and Pathology has now transferred to SWL Pathology effective from 1 April 2014. KM highlighted the quality issues and mitigation plans outlined in the paper.

KB requested an update on the progress of medicines management. MC requested that a deep dive and report be undertaken in respect of medicines management following recent discussions in the Finance & Performance Committee. LC talked through the recently implemented e-prescribing system which had been rolled out across the Trust. The system was well received with very good uptake across wards, and feedback from clinical staff was positive. She highlighted the immediate benefits realised explaining that staff are able to capture data in real time which means that patient notes are updated instantly and freely available to those who need it. This has significantly improved patient care and has made prescribing and administration safer. The system will be closely monitored by the supplier and the Informatics team which will facilitate improvements as required. SE echoed the positive comments received from medical staff and noted that the system has provided an immense benefit to the patients. He added that this system would contribute to better communication to general practice.

ZP commented that there was little mention of sickle cell in the report, and said that, as a pressured service, it was worthy of a mention. KM advised that an update on sickle cell would be reported to the next Improving Patient Experience Committee. MC stated that the report did not include medical 3 specialities and KM confirmed that the directorate had recently become responsible for dermatology, rheumatology and clinical haematology. This would be corrected in the next report.

The Committee noted a decrease in clinical incidents between February 2014 and March 2014 and queried if there was an issue with under-reporting. KM agreed that this was something that had been considered in the directorate but thought that this could be attributed to Cerner as there is potential for under-reporting due to pathology changeover: a detailed investigation would be undertaken to ensure that this is not the case. GA suggested that a cautionary footnote could be added to the report advising the potential issue with Cerner.

MC queried that level 3 safeguarding training was only required by 2 people in the directorate. SE advised that it was a service directorate as opposed to a patient contact directorate and KM confirmed that every effort is made to ensure that the right people are trained. In relation to Cancer services waiting times it was confirmed that a report would be submitted to the next Finance and Performance Committee. MC also noted that the report indicated that there was no dedicated IT support and asked what the directorate was doing to mitigate the risk posed by the lack of IT support. KM confirmed that this issue was being considered by the Informatics Board.

The Committee considered the backlog of health records awaiting destruction noting that a business case had been submitted to the Executive Management Board to proceed with destruction, but that it had not yet been approved. It was agreed that assurance was needed to ensure that there was no risk of destroying good notes. SE argued that there was a greater risk to patients if extra time is taken to search for notes and that as a clinician, notes are more likely to be missing from records due to the difficulties in pulling medical notes.
It was agreed that the authority to proceed with destruction should be made at the Patient Safety Committee. It was noted that the backlog extended to 9 years and that the Trust is currently not fully compliant with legislation or its own Information Governance Policy. MBe agreed that the Trust is concerned with the information governance issue that this problem poses but there is a need to make a decision based on the level of risk to patients in the first instance and the cost and information governance issues as a secondary consideration. It was agreed that a refreshed Business Case should be submitted to EMB for decision.

The Committee considered the directorate’s audit of the neutropenic sepsis pathway. SE explained that the audit was carried out on the back of Cerner implementation which has brought about significant clinical improvements in the way that sepsis is diagnosed and escalated. He also advised that Cerner carries a Sepsis bundle that has yet to be fully implemented in the Trust. JG noted that this was a very important pathway, but recognised that Sepsis is a national problem and is a difficult condition to treat all of the time. SE noted that international data has shown that Cerner will reduce risks with sepsis.

JG commended the authors on the high standard of the report noting that clinical directorates should be encouraged to report on pathways of high risks. GA also stated it would be beneficial to increase the visibility of the benefits that Cerner has for patients. DG added that high risk pathways could reflect this type of information in their risk registers. The Committee agreed that the report was well written and noted the work of the directorate.

**Actions:**

- Carry out a deep dive and report into medicines managements by next meeting.  
  Action LC

- Report on Cancer services be submitted to the next Finance and Performance Committee and then to Quality and Clinical Governance meeting in June.  
  KB/KM

- Add detail regarding sickle cell service in next report. Action : KB/KM

- Resolve destruction of health records issue. SE

### 10. Complaints Report

ZP noted that a new interim complaints manager had been in post for 5 weeks and was successfully dealing with the backlog of complaints. The new manager had effected a service re-design and was looking at trends and themes that had emerged from PALs to address issues in real time. As the report stated, she acknowledged that the Trust is still not meeting its 80% target: ZP would work with the interim manager to re-set the trajectory and also do more work around compliments themes and trends.

KB drew the Committee’s attention to the Trusts website which had not been clear on the complaints processes. She advised that this had been addressed by setting up 3 different inboxes for patients to use, a complaints inbox, a PALs inbox and a “talk to us” inbox for compliments and other issues that patients may wish to raise.

JG noted the definite improvement made in the department but did not expect
the number of emails to the CEO to reduce. It was agreed that GP’s would be informed of the new complaints processes via the bi-monthly newsletter from the Trust. MC noted that over 50% of the complaints to the Trust are related to the Adult Care Pathway directorate and asked what will be done to address this statistic. She also noted the number of complaints in relation to administration. ZP confirmed that this was an issue that the complaints manager is dealing with and that changes should be evident as she progresses with the service re-design. MC also noted that dissatisfied patients from Outpatients were redirected to PALs and suggested they should instead be dealt with in the outpatient departments. KB concurred that new staff have been recruited to the outpatient department and that training should address these issues.

The Committee noted the report.

**Action**

GP’s to be informed of the new complaints processes via the bi-monthly newsletter from the Trust. Action SE

11. **Friends & Family Test Report**

CT noted that the report reflected year one of the National Implementation of the NHS Friends and Family Test, which was to an extent experimental. The main issues around FFT were patient experience scores, where the Trust was currently in the bottom 10. However ITU and HDU have both come on stream which should bring improvements in due course. She noted that some of the negative feedback related to infrastructure issues such as heating on the wards and entertainment systems. MBe asked what progress was being made on infrastructure: JG noted that the capital programme has sanctioned the procurement of a new chiller unit for the Jubilee Wing which historically had overheating issues in the summer and once installed should greatly reduce complaints in this respect over 11 wards; and that the entertainment systems issues will be addressed by the Informatics Board. JG noted NICE has presented its guidance on nurse staffing levels and requested a report on how this would affect CHS for the next Committee meeting as a pathway for reporting to the Board.

MBe asked whether the Trust expected the maternity London Standards to change as a result of NICE guidance on midwife led births. The Trust would need to find out from NHS England their intentions on the London Standards **SE to action**. MC noted that it would be useful in future for reports to have a SWL comparator and a separate table for other Trusts.

**Report to be presented on Nurse Staffing Levels in relation to NICE guidance.** Action ZP

[CT JG and MBe left the meeting]

12. **Infection Control Report**

ZP noted that the Trust ended the year in a strong position in relation to C.diff infections but not with MRSA infections, in respect of which a root cause analysis that has revealed that further screening of patients was needed. In relation to the Deep Dive into C.diff ZP confirmed that the learning from the root cause analysis had been shared with the Infection Control Task Force as well as the Nursing and Midwifery Board and Quality Boards. ZP advised that the work plan for infection control has been agreed. The Trust has had no further MRSA infections but a further incident of C.diff has been reported and a root cause analysis was in progress.
JGi noted that the report listed the wards but not the corresponding specialities. It was agreed that this would be circulated to Committee members for their information. MC noted that there was no detail in the report around hand hygiene, in particular with regard to agency nurses. ZP confirmed that this had been discussed with the Infection Control Task Force where it had been noted that discussions had taken place with NHS Professionals to ensure that training records reflected the standards expected at the Trust. It was requested that a report in relation to the special measures on Duppas ward be reported to the Committee at the next meeting.

[SE left the meeting]

The Committee noted the report.

13. Diagnostics Update

KM highlighted that a substantial number of patients had been cleared but about 900 patients remained as part of the backlog. She confirmed that out of the patients that were scanned in March 2014 there were 2 that were having further investigation of clinical harm and this has been recorded on Datix. Although it is thought that no harm has come to these patients a second level assurance was needed to confirm. A report on patients scanned in April 2014 was still with radiology to assess for clinical harm.

KM advised that the trajectory had changed and it is expected that the target to achieve compliance would now be met by end of August 2014. The committee noted the further delay in achieving target and KM advised that there were capacity issues due to long term sick leave. Additional resources have been commissioned to address the delay together with an additional sonographer and with assistance from a private company which would increase capacity by 250 scans per week from the following week.

In relation to validation the diagnostic position held at 79.49% at the end of March 2014 and is expected to increase in April 2014 to 85%. KM confirmed that an SI investigation was underway together with an HR investigation. The Trust has secured agreement through NHSE for an external expert to carry out the clinical review. KM confirmed that the Trust Development Authority has been informed of all developments and the NHS IMAS would conclude their report confirming their findings of their assessment to feed into assurance around demand and capacity. The report was due by 9th May 2014 and is now overdue and will form an integral part of the SI and HR investigation.

JG noted that the report would be submitted to the Finance & Performance Committee and should be RAG rated red as the report is now overdue, but in terms of actions, planning and impact it is less. MC asked for written assurance that for each and every patient that had been reviewed there was a written record that no harm had come to that patient. KM confirmed that patients were reviewed in clinical order and that the internal clinical assessment of harm has been done by the lead clinician in radiology, who has been given a spreadsheet of patient level data which will provide an audit trail. Further assurance will be provided to the Finance & Performance Committee on 27th May 2014.
JG suggested that in terms of assurance for the next meeting the evidence should show a RAG rating of blue, as target service levels should have been achieved and are being maintained. It was agreed that for corporate memory purposes this information will be stored on the shared drive in the radiology department but all results are in patient notes electronically or otherwise. KB noted wider assurances on waiting listing management as an operational view has been commissioned as well as an internal audit of processes to provide assurances of good practice.

MC queried whether a new backlog of patients awaiting diagnostics would develop while the current backlog is addressed. KB confirmed that in keeping with the rules of access patients would be treated according to the clinical need in the first instance and then in date order; it is likely that new referrals will exceed the 6 week wait until trajectory is met. KB also confirmed that the TDA have a clear understanding as to why the timescale had changed. JGi asked how will this information be disseminated to GPs. KB said that the GPs have not yet been contacted (this would await the results of the assurance investigations), but the incident has been raised with the CCG and communication with the GPs will be discussed with them in due course.

[KM left the meeting] [AP joined the meeting]

14. **JAG Accreditation – Update**
AP summarised the report noting the improvements that have been made within Gastro Intestinal (GI) which has subsequently been admitted for Global Rating Scale scoring in April 2014, showing that our planned surveillance patients which were at 91 outstanding at the end of January 2014 had been reduced to 3 at the end of March 2014. The team were confident that the application for JAG accreditation would be successful. Confirmation should be received towards the end of June 2014. The Committee will be provided with a copy of the letter confirming accreditation to note. Keep on action tracker. [Action for MML]

[AP left the meeting]
Copy letter confirming JAG accreditation to the committee when received. MML

15. **Adult care Pathways Directorate – update**
This report had not been received and the Committee agreed that this item should be carried over to the next meeting.

16. **Clinical Quality Review Group Minutes**
SE advised that NEDs could attend the Clinical Quality Review (CQR) meeting as observers, though for discussion of any confidential issues it might be necessary for them to leave the meeting. It was agreed that JGi would attend the next CQR.

17. **Any other business**
17.1 None

18. **Date of next meeting**
18.1 11th June 2014

Signed: ______________________ Date: _______________
Chair