1. Introduction
2. Clinical Governance Management Arrangements
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5. Appendix A : Clinical Governance Standards Committee Membership
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7. Appendix C : Clinical Service Unit Clinical Governance Group Terms of Reference and template agenda
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The Clinical Governance Team of Doncaster & Bassetlaw Hospitals NHS Foundation Trust work hard on behalf of their patients and staff ensuring that the systems and processes underpinning clinical governance support the Trust's highest priority of delivering safe, reliable and consistent services to its health community.

The Clinical Governance Team consists of the Trust's Clinical Governance Lead (and his support team), members of the Clinical Governance Standards Committee, Clinical Governance Leads from Clinical Service Units and their Clinical Governance Group members.

During the period of April to November 2010, the Trust's organisational structure was that of four divisions which encompassed the several specialties within the Trust. From November 2010, the new organisational structure of Clinical Service Units (CSUs) was established. As the specialties of the old structure mirrored the new Clinical Service Units, with the exception of the newly formed CSUs Medical Specialty Federation and Care of Older People, it was agreed that the CSUs would be represented by the existing Clinical Governance Leads in post.

It is important to recognise that although the Clinical Governance Team has a specific role within the organisation to deliver the clinical governance agenda, it is essential that all employees, whatever their particular roles and responsibilities in the organisation, remember they are required to ensure patient safety remains their first priority.

The purpose of this Annual Report is to provide evidence that the Clinical Governance Team has firmly embedded robust clinical governance mechanisms in place to ensure patients consistently receive the safe and reliable care they deserve.

This Clinical Governance Annual Report has been produced with the assistance of members of the Clinical Governance Team and its supporting sub-committees. I would like to acknowledge my thanks to all those members of the Team who have provided their assistance to this Annual Report and for their help to the clinical governance agenda throughout the year.

Dr Robin P Bolton, Medical Director & Trust Clinical Governance Lead
CLINICAL GOVERNANCE MANAGEMENT ARRANGEMENTS

The Board of Directors has overall responsibility for clinical governance. The accountability lies with the Interim Chief Executive, Dr Peter Reading and with the Clinical Governance Lead for the Trust, Dr Robin Bolton, Medical Director.

Evidence of the clinical governance activity within the organisation is delivered by the Trust's Clinical Governance Team. The Team includes the Trust's Clinical Governance Lead, supported by Mr Ray Cuschieri, Deputy Medical Director – Clinical Standards, who has delegated responsibility for clinical governance and patient safety, Mrs Karen Humphries, Clinical Governance Co-ordinator, Clinical Governance Leads (and their clinical governance groups) from each of the Clinical Service Units and members of the Clinical Governance Standards Committee.

The Trust has three core groups to manage and oversee clinical governance and risk management issues within the organisation. These core groups are:

- Clinical Governance Standards Committee
- Patient Safety Review Group
- Audit & Non-Clinical Risk Sub-Committee

This Report must be read in conjunction with the Trust Clinical Governance Strategy (CORP RISK 17 v.2) which describes the relationships and responsibilities, management and assurance of clinical governance systems in the organisation. It is an “umbrella” document covering all aspects of Clinical Governance within Doncaster & Bassetlaw Hospitals NHS Foundation Trust.

This report will focus mainly on the activities of the Clinical Governance Standards Committee, in the financial year 1st April 2010 to 31st March 2011.

CLINICAL GOVERNANCE STANDARDS COMMITTEE

The Clinical Governance Standards Committee (CGSC) is a sub-committee of the Board of Directors (membership : Appendix A). It deals with all aspects of Clinical Governance and Risk and sets the strategy by which the organisation will work.

It is a statutory obligation that CGSC is chaired by a Non-Executive Director of the Board. Mr Joe Barnes, Non-Executive Director, therefore Chairs the Committee and the Medical Director, Dr Robin Bolton, acts as Vice-Chair. CSU Clinical Governance Leads are members of CGSC.
It is the responsibility of CGSC to provide assurance to the Board of Directors that the systems and processes are in place to ensure patient safety. To achieve this, chairs of the following CGSC Sub-Committees and CSU Clinical Governance Leads, accountable to CGSC, are required to present reports on an annual basis. A summary of the reports presented by these Sub-groups can be found in Appendix B.

- Clinical Audit & Effectiveness
- Drug & Therapeutics Committee
- Falls Steering Group
- Hospital Transfusion Committee
- Human Tissue Compliance Group
- Infection Prevention & Control Committee
- Local National Confidential Enquiry Reporter
- Nutrition Steering Group
- Patient Safety Review Group
- Point of Care Testing Governance Committee
- Postgraduate Medical Education
- Safeguarding Children
- Undergraduate Medical Education

The CGSC meetings are held monthly and in confidence. The agenda is set 5 working days before each meeting and contains the following standing items:

- Monthly HSMR figures categorised by CSU
- Monthly Serious Incident Exception Report
- Quarterly DATIX Trust-Wide Risk Management Report
- Quarterly DATIX Maternity Services Risk Management Report
- Resultant action plans from High Level Enquiries for monitoring.

The CGSC also receives minutes, on a monthly basis, from the following key committees:

- Patient Safety Review Group
- Infection Prevention & Control Committee
- Clinical Audit & Effectiveness Committee
- Falls Steering Group
Clinical Service Units are required to appoint a Clinical Governance Lead which forms part of the Trust's Clinical Governance Team. The Lead is supported within the CSU by the Clinical Audit Lead and Risk Management Lead.

From the 1st November 2010, the CSU Clinical Director is accountable to the Trust Clinical Governance Lead, the Medical Director, for clinical governance within the CSU. The CSU Clinical Governance Lead is accountable and professionally responsible to the CSU Clinical Director.

The post of CSU Clinical Governance Lead is a formal appointment, nominated by the CSU Clinical Director, and appointed by the Trust Clinical Governance Lead, with a remuneration of 4 hours of protected time per week.

Current CSU Clinical Governance Leads (March 2011)

- Accident & Emergency: Dr G Shah
- Anaesthetics & Critical Care: Dr P Smith
- Children’s Services: Dr N Brooke
- Clinical Therapies: Ms S Banbury
- ENT (Special Surgery): Mr U Raghavan
- GU Medicine: Dr C Ryan
- Medical Imaging: Mrs W Lee
- Medicine – General & Acute: Dr V Christopher
- Medicine – Specialty Federation: To be advised
- Medicine – Care of Older People: Dr R Ramanath
- OMFS (Special Surgery): Ms A Holmes
- Ophthalmology (Special Surgery): Mr S Dinakaran
- Orthopaedics: Mr H Kumar
- Pathology: Dr R Stott
- Pharmacy: Ms J Kay
- Surgery: Miss C Rogers
- Theatres: Ms L McLoughlin
- Women’s Services: Mr E Emovon

CSU Representation for Clinical Governance

Last year’s annual report highlighted major concerns with regard to the lack of Clinical Governance Lead representation. However, the importance of the role has now been fully recognised within the CSUs and 15 out of the 16 CSUs are represented.

Although the old division of Medicine was re-structured in November 2010, to produce three Clinical Service Units, the Clinical Governance Lead representing the old division represented all three CSUs until February 2011. In March 2011, two of those CSUs had identified Clinical Governance Leads. It is anticipated that
the remaining CSU will appoint within the next few weeks. Meanwhile, the Clinical Director has ensured that a deputy has attended the Clinical Governance Standards Committee to represent the CSU.

**Appraisal process**

During 2009 and 2010, the Deputy Medical Director for Clinical Standards and the Clinical Governance Co-ordinator undertook the appraisals of Clinical Governance Leads. However, from November 2010 it is the responsibility of the CSU Clinical Director to undertake the appraisals of the Clinical Governance Lead, with assistance from the Deputy Medical Director for Clinical Standards, if required.

**CSU Clinical Governance Group**

It is the responsibility of the CSU Clinical Governance Lead to chair the CSU Clinical Governance Group in accordance with the Trust’s generic CSU Clinical Governance Group terms of reference and template agenda (*Appendix C*). On a monthly basis, minutes are provided to the Clinical Governance Co-ordinator for placing on the Trust’s shared V drive to encourage cross-CSU shared learning.

The Clinical Governance Lead is supported by a team including Risk Management Lead (Vice Chair) and Audit Lead, all with specific requirements in the clinical governance agenda.

**Membership of Clinical Governance Standards Committee**

As part of the Trust’s Clinical Governance Team, CSU Clinical Governance Leads form part of the CGSC membership. They have the responsibility to represent their CSU and to raise any issues arising at the CSU Clinical Governance Group meetings that have a strategic implication. Likewise, it is their responsibility to disseminate CGSC information pertinent to their CSU through their clinical governance processes.

During the last year, the CSU Clinical Governance Leads have been required to present two areas of good clinical governance practice and two areas of concern, with identified actions for improvement, to members of CGSC. As members have sight of the CSU Clinical Governance Group meetings on the shared V drive, the opportunity to provide opinion and challenge is encouraged.

CSU Clinical Governance Leads have a responsibility to summarise the CSU clinical governance activity for this Annual Report. These reports can be found in *Appendix D*.

**Clinical Governance Lead Time Outs**

In June 2009, an external Trainer delivered clinical governance training to Clinical Governance Leads. It was the first type of formal training delivered to the Leads and was received very favourably. Following the training event, it was agreed that a forum would be provided for Clinical Governance Leads to meet and informally discuss issues of a clinical governance/risk management nature for which they
require support. This forum consisting of the Deputy Medical Director for Clinical Standards, the Clinical Governance Co-ordinator and the CSU Clinical Governance Leads, was established in November 2009 and is regularly held every two months. Six meetings were held in the period April 2010 to March 2011.

A further training day has been arranged for the 10th May 2011 to deliver training to newly appointed Leads and refresher training to those requiring it.

Clinical Management Teams

It was a concern in the last Annual Report that not all Clinical Governance Leads had communication with their Clinical Management Teams.

It is strongly recommended with the new accountability arrangements that the Clinical Governance Lead is asked to join the Clinical Management Team to support the Clinical Director.

Main areas of concern

Administrative support for CSU Clinical Governance Lead

This issue was recognised as a major concern in last year’s report and unfortunately remains unresolved in many CSUs.

Many CSU Clinical Governance Leads take and type the minutes of their CSU Clinical Governance Group meetings which begs the question Is this an economical and useful use of senior staff time?.

Some Consultant Medical Staff rely heavily on their Medical Secretary to take and type up the minutes and support them administratively when corresponding in their role as Clinical Governance Leads.

There have been instances where CSUs have held meetings without administrative support and therefore minutes have not been recorded.

It is recommended that the CSU Management Team provides administrative support to the Clinical Governance Lead to ensure their role is undertaken to the best of their ability.

Adherence to Generic CSU Clinical Governance Group Terms of Reference

CSU Clinical Governance Leads are required to chair their CSU clinical governance group meetings in accordance with the Trust’s generic terms of reference and agenda template. There have been instances where this has not been adhered resulting in the Trust being unable to monitor the clinical governance processes within that CSU.
Recognised time for CSU Clinical Governance Lead

The CSU Clinical Director nominates the CSU Clinical Governance Lead who is then formally appointed by the Trust’s Clinical Governance Lead, the Medical Director. Formal appointment requires for the Clinical Governance Lead to adopt the agreed job description and to support the Clinical Director who is accountable for the CSU clinical governance processes and as such protected time must be recognised by the CSU Clinical Director.

Thank You

Long-standing specialty clinical governance leads, Dr Mahmoud Al-Khoffash (Medicine), Dr Melanie Dix (Children’s Services), and Karen McAlpine (Theatres) have stood down from their roles during the last year due to other commitments and they have been replaced by equally committed individuals.

Many thanks go to those who have represented their specialties during their term.
APPENDIX A

CLINICAL GOVERNANCE STANDARDS COMMITTEE
MEMBERSHIP

Non-Executive Director - Mr J Barnes (Chair)
Medical Director - Dr R P Bolton (Vice Chair)
Director of Nursing - Mrs H Bond
Deputy Medical Director for Clinical Standards - Mr R J Cuschieri
Director of Infection Prevention & Control - Dr C Hoy
Head of Risk and Legal Services - Ms M Dalton
Patient Advice & Liaison Service Manager - Ms D Gardiner
Non-Executive Director - Mrs N Atkin

Clinical Governance Lead from each Directorate:
Accident & Emergency - Dr G Shah
Anaesthetics & Critical Care - Dr P Smith
Children’s Services - Dr N Brooke
Clinical Therapies - Ms S Banbury
ENT (Special Surgery) - Mr U Raghavan
G U Medicine - Dr C Ryan
Medical Imaging - Mrs W Lee
Medicine – General & Acute - Dr V Christopher
Medicine – Specialty Federation - To be advised
Medicine – Care of Older People - Dr R Ramanath
OMFS (Special Surgery) - Ms A Holmes
Ophthalmology (Special Surgery) - Mr S Dinakaran
Orthopaedics - Mr H Kumar
Pathology - Dr R Stott
Pharmacy - Ms J Kay
Surgery - Miss C Rogers
Theatres - Ms L McLoughlin
Women’s Services - Mr E Emovon

In attendance:
Clinical Governance Co-ordinator - Mrs K L Humphries
Governor Observer - Mrs M Young
Governor Observer - Mr J Plant
Clinical Governance Lead, PCT Doncaster - Dr E Kelly
Clinical Governance Lead, PCT Bassetlaw - Dr P Foster
The aim of the Clinical Audit Department is to support healthcare professionals to measure the gap between ideal practice (determined from evidence and guidelines) and actual practice to bring about change, improve the quality of care to our patients and become clinically effective. The Department engages clinicians, throughout the Trust, to evaluate their clinical practice and support and encourage improvement in the quality of treatment and care. The Strategic Health Authority’s Quality Improvement Plan (2010) specifies that all audit activity should follow the Healthcare Quality Improvement Partnership (HQIP) Criteria and Indicators of Best Practice in Clinical Audit. (2009). As this is a nationally recognised standard and compliance will also achieve NHS-LA standard, the Department has developed processes to ensure these criteria are met.

The Clinical Audit Department continues to be committed to the provision of a high quality service. The Department has a pivotal role in the co-ordination of clinical audit activity across the Trust. It does this by preventing duplication of effort, assisting with dissemination of findings and ensuring a structured approach to audit activity.

In 2010 the Clinical Audit Department completed over 200 registered audit projects across all areas of the Trust, with up to 300 ongoing projects at any time. Audits are now prioritised according to national requirements, Trust priority and local interest. Clinical Audit staff ensure that all audits are completed according to the HQIP criteria and follow departmental templates. In addition to the registered audit activity, the Department provides evidence and audits for national, regional and local CQUINS standards, co-ordinates, analyses and reports a rolling casenote audit programme for NHS-LA, evidence for CQC and evidence for response to complaints received by the Trust.

The Clinical Audit and Effectiveness (CA&E) Group continues to ensure that clinical audit and clinical effectiveness activity remains focused on the service user via consultation and participation as well as through identifying local and national priorities.

The Department participates in National Audits that are relevant to the Trust as they become available. It is important for us to be able to benchmark with other local Trusts and General Hospitals, of an equivalent size, in order to
ensure that we attain the highest possible standards to become the local hospital of choice.

The Audit Department attends meetings of the Yorkshire Effectiveness and Audit Regional Network (YEARN) to share experiences with other Trusts within the Yorkshire and Humber regions. The aim of this group is to share experiences and standardise procedures across the network. Attendance has highlighted that our Audit Department is involved in more areas than other local Trusts albeit with fewer and lower graded staff.

The Department is currently reviewing its Policy and Strategy documents to bring them in line with HQIP guidance

National Institute for Health and Clinical Excellence (NICE)

The Department has a robust programme for monitoring and collating evidence (eg audits, policy, posters, information, prescribing data etc) on adherence to NICE Clinical Guidelines, Technological Appraisals, Interventional Procedure Guidelines, Public Health Guidance and Quality Standards. The Trust position is reported to Clinical Audit & Effectiveness Committee on a monthly basis (and filtered up as appropriate) and to the Joint Quality meetings on a quarterly basis.

Integrated Pathways of Care (IPOC)

The IPOC Manager has a central role in ensuring that the results of audit are integrated into current care documentation. With the advent of the latest local, regional and national CQUIN schemes and criteria from the NHS contract (and various other evidence sources) it is essential that these criteria are included onto current documentation to aid compliance and ensure high quality care is given to our patients.

Over the past year, 446 documents (309 in 2009/10) have had amendments made to them as a result of audit and latest guidelines, with 95 new documents/IPOCs being developed (132 in 2009/10) and 338 documents being implemented and used throughout the Trust (155 in 2009/10). There is a robust programme of documentation review within the Trust; all documents are reviewed every two years (or one year if they are newly implemented) to ensure that all the documentation is up-to-date and relates to latest audit results/guidelines.

Re-brand and re-launch of Department

In order to raise the profile of the Clinical Audit Department, staff have worked collaboratively to re-brand and re-launch the service they provide throughout the Trust. As part of the re-branding process the Department has:

- developed new Audit and IPOC leaflets
- created posters and banners
- had team and individual photographs taken
- developed a new intranet site
• had articles published in ‘Interactive’ and the Clinical Governance Bulletin
• streamlined processes across sites
• ensured all Audit forms and processes are available electronically
• held a roadshow throughout November 2010.

As a result of this, the Department has increased awareness of Audit and the support available, the need to register all audits and awareness of the IPOC/Clinical Documentation processes.

Training & Education

During 2010, the Clinical Audit Department organised five workshops open to all staff within the Trust. The workshops were held at Doncaster, Bassetlaw and Mexborough and were attended by an average of 7 personnel per workshop. Feedback from attendees continues to be very positive. Workshops are now a regular event and are organised on a bi-monthly basis. Workshops can be arranged for individual specialties to fit round schedules.

Trust Annual Audit Presentation Day

The Trust Annual Audit Presentation day is usually held in January but has this year been postponed to March 25th. Uptake has so far exceeded expectations; all proposals will be reviewed and ten audits will be selected to present on the day. For the first time all presentations submitted for consideration are registered with the Audit Department. Prizes of £100, £50 and £25 in book tokens will be presented to the three best presentations.

Research : Dr Trevor Rogers

Research governance is taking place within the Trust in accordance with the Research Governance Framework (2004). All research applications are processed using the online IRAS system, which allows all research projects to obtain the necessary permissions. In addition, all projects running at the Trust are logged onto a database, held within the Research Management & Governance department. This database holds information regarding all upcoming, ongoing and archived research studies.

In late 2010, the Research Management & Governance department at DBHft merged with the equivalent department at NHS Doncaster to form Doncaster Clinical Research. This joint office is now in place to help with all matters in relation to running research, through the aid of the Research Management & Governance Manager Emma Hannaford and Amy Beckitt.

A key workstream within the Research department is looking at the current procedures within the Trust in order to ensure that the processes in place adhere to the legislative guidance, particularly in reference to those enforced by the Medicines and Healthcare products Regulatory Agency (MHRA), prior to an anticipated inspection.
The Research Design Service in Sheffield is offering help on study design. Dr El Kossi is providing advice on statistical methods. We have a research advisory group available to help in particular research areas. Sue Bowmer (finance department) is taking a lead for research.

**DRUG AND THERAPEUTICS COMMITTEE : Andrew Barker**  
*(Presented on the 15th October 2010)*

In addition to continuing to discharge its responsibilities for maintaining the Trust’s Medicines Formulary and medicines related policies, the Drug and Therapeutics Committee (D&TC) has undertaken two major pieces of work in the last twelve months:

1. **Review of the Trust Policy for the Safe and Secure Handling of Medicines.**

   This is the Trust’s main ‘medicines policy’ which has undergone a comprehensive review and rewrite to ensure it is fully up to date and reflects modern medicines management practice.

2. **Revision of the Terms of Reference of the D&TC.**

   The Terms of Reference have been revised to ensure that medicines risk is given equal priority to the more traditional roles of the D&TC of formulary and policy development.

   The role of the D&TC in identifying, assessing and evaluation of risks associated with medicines use and taking steps to eliminate or reduce such risks has been established. Specific new responsibilities include:

   - Establishing an organisation wide risk register for medicines risk, in line with the principles of the Trust’s Risk Management Strategy.
   - Ensuring that actions required to eradicate or mitigate identified risks are prioritised and included in the Trust’s Medicines Management Strategy.
   - Monitoring and reporting on the implementation of actions which form part of the agreed Medicines Management Strategy.

   The membership of the D&TC has been extended to ensure it is appropriate for its new role, and now additionally includes two senior nurses and a middle grade doctor.

**FALLS STEERING GROUP : Chris Ellingworth**  
*(Presented on the 20th August 2010).*

1. **Introduction**

   The Falls Steering Group continues to meet bi-monthly. The key responsibilities of the Group are:
To develop and establish a robust infrastructure in order to safeguard those patients within the Trust at risk or assessed to be at risk of falling

To support the development and delivery of training and the provision of evidence-based practice

To ensure the lessons learned from adverse incidents, both within and external to the Trust, are considered and the relevant actions and changes are implemented across all the Trust sites

To ensure that mechanisms are in place to ensure that working practice is in line with the outcomes from the NPSA Report

To provide mutual support and raise the profile and awareness of issues associated with Slips, Trips and Falls with patients, carers, the general public and all staff groups within the Trust

To ensure the monitoring of slips, trips and falls across the organisation

To report on a regular basis to the Trust Clinical Governance Standards Committee

2. Activities

The Group has achieved the following in relation to those key responsibilities:

- A further three training and education events for the prevention and management of Slips, Trips and Falls have been held through the year for both Falls Champions and Falls Link Persons. The events focused on:
  - guidance about observations and investigations when a patient has fallen and banged their head.
  - specific emphasis on the use of the combined risk screening and assessment tool; the roles and responsibilities of Champions and Link Persons; pathway of care, including risk assessment tools and the Falls Care Plan
  - continued guidance on of how to carry out some of the detail required for the Care Plan once intrinsic and extrinsic factors have been assessed e.g. lying and standing Blood Pressure; how to complete a Clinical Adverse Incident Form; the continuing need to raise the awareness about falls and the elderly
  - As a result of feedback from various staff groups, Matrons and Medical staff, the Doncaster Falls Service information booklet will be reviewed and refreshed and re-launched across the Trust and wider Health Community

- The Falls Root Cause Analysis Protocol is now in use across the Trust. This Tool has been acknowledged as an exemplar of good practice through the national nursing network.
- The Patient Falls and Injuries Prevention Guidelines have been approved and are in use in conjunction with the Trust’s Falls Policy.
- The Slips, Trips and Falls Policy has been reviewed, updated and approved.
The Trust along with both host PCTs has been involved in the 2010 Royal College of Physicians’ National Audit on Falls and Bone Health. This Audit focused on both organisational and clinical pathways involving samples of both fragility fractures and fracture neck of femur. The results are due to be published towards the end of April / beginning of May 2011.

The current reported position against the Trust objective for 2010/11 to reduce the 2009/10 number of patient falls by a further 5% indicated areas for concern. As a consequence, the following action plan was put in place to address the issues as follows:

i. Retrospective audit / root cause analysis of incidence forms by ward
ii. Audit compliance of completed Falls Risk assessments and care plans especially in relation to Category C reported risk
iii. Target those high areas reporting falls for specific training in the management and reduction of patient falls
iv. Increase the number of planned Management and Reduction of Patient Falls training throughout the year.

All the above will be monitored throughout 2011 – 2012.

HOSPITAL TRANSFUSION COMMITTEE : Dr Youssef Sorour
(Presented on the 19th November 2010).

Blood Bank Activity Nov 2009-Nov 2010

DRI & Bassetlaw Hospital

Units of red cells 13,411 transfused : 145 wasted

Our wastage of red cells is very good and the lowest in Yorkshire & Humberside SHA.

DRI & Bassetlaw Hospital

Units of platelets 1,618 units transfused, 80 wasted

Fresh Frozen Plasma (FFP) sometimes wasted when requested for surgical bleeds and then not used.

Platelet and Cryoprecipitate (Cryo) wastage within acceptable regional limits.

Achievements

- Successful BARS live at DRI & BDGH.
- Mexborough will go live with BARS November, achieving 100% for the Trust.
- Achieved MHRA compliance with BSQR
- Secured the contract with the PCT’s for the antenatal serology work being divested from NHSBT.
Audit

- Blood stocks management scheme
- For NHSLA level 2
- National Audits - Audit of Platelets (in progress)
- Blood Bank audit calendar on track.

SHOT Report 2009 Key Recommendations & Concerns

- Standardisation of national IT lab systems
- Standardised competency assessments (transferable between Trusts)
- Highlighting pulmonary complications of transfusion – under reported and misdiagnosed.
- Patient identification, patients need to be empowered to ask “Do you know who I am?” before clinical interventions.
- Clinical handover highlighted as an issue.
- Transfusion guidelines regarding Blood Banks, achieving compliance ongoing.
- SABRE / SHOT reportable incidents 2010. 1 suspected case of TRALI found to be impunity level 0

2010 / 2011 work plan

- Introduce new antenatal serology service
- Implementation of version 10 of the laboratory computer system.
- Introduction of single dose Anti D - stringent electronic audit trail.
- Work towards introduction of PBARS to meet NPSA SPN14.
- Respond to NPSA rapid response notice on massive haemorrhage. Plan in place and implemented 26th April 2011
- Review Transfusion policy and MBOS (maximum blood order schedule)
- Cell salvage- promote use and availability.

HUMAN TISSUE COMPLIANCE GROUP : Dr Robin Bolton
(Presented on the 17th December 2010).

HTA Post Mortem Sector Overview 2010

- DBHFT still currently only holds one HTA licence: This covers the Post Mortem Sector only covering Doncaster Royal Infirmary (DRI), Bassetlaw District General Hospital (BDGH), & Mexborough Montagu Hospital (MMH). However as the mortuary at Mexborough Montagu is used only for body storage, this site was removed from our licence in September 2010 after further clarification of the licensing rules with the HTA.

- Post mortem licence has moved to a continuous licence system.
- The Corporate body on the licence (ie licence holder) is DBHFT
- The contact for the Licence Holder was changed to Interim Chief Executive, Dr Peter Reading in September 2010.
Designated Individual (DI) for this licence is Medical Director, Dr Robin Bolton.

Human Tissue Authority (HTA) Regulatory Directions & Requirements

In April 2010 two General Directions were issued by the HTA for the Post Mortem sector for action:

1. **Direction 001/2010:** Submission of an annual Compliance self-assessment report.

   The purposes of the compliance self-assessment exercise are:
   - to obtain up to date information regarding establishment compliance with HTA standards;
   - to ensure Designated Individuals understand how to evaluate whether their establishment is compliant with HTA standards. For this reason, establishments which have recently been inspected by the HTA are still required to complete this exercise.

   This direction was completed successfully and submitted in a timely manner to the HTA in June 2010.

2. **Direction 002/2010:** This Direction set out two exercises which licensed post mortem sector establishments were required to undertake in relation to relevant material removed from deceased persons during post mortem examination:

   - **Undertake an inventory of whole organs and wet tissues** - The purpose of the inventory was to identify all organs and items of wet tissue removed from the body of a deceased person since the commencement of the HT Act in September 2006 that were currently retained at licensed post mortem premises.
   - **Undertake an audit of cases where relevant material removed from a deceased person was processed into tissue blocks and slides** - The purpose of the audit was to review a representative sample of completed cases where organs and/or tissue were retained as part of the post mortem examination, and was to include a review of records and documentation which provided traceability and verify reason(s) for retention and/or disposal.

   This direction was completed successfully and submitted in a timely manner to the HTA on 26th August 2010.

3. **Reporting of SUI's to HTA** : From 1 May 2010 establishments were required to report any serious untoward incidents, including near misses, in post mortem licensed establishments, to the HTA as soon as the SUI is internally reported. A link to the website giving details of this requirement and proposed reporting template:
   http://www.hta.gov.uk/licensingandinspections/reportingtothehta/seriousuntowardincidentreporting.cfm
After discussion with the Trust Head of Legal and Risk, the new requirements from this notice have now been included within Trust and local policy.

HTA Inspection Visit (Post Mortem Sector):

In the summer 2010 the Trust was given 4 weeks notice that the HTA were due to undertake an on-site assessment, described as a phase two inspection, focusing on a review of our operational policies and procedures, inspection of our premises and scrutiny of our practices. This was to be our first inspection from the HTA since the grant of our license in 2006.

The 2 day inspection was performed on the 2\textsuperscript{nd} and 3\textsuperscript{rd} September 2010. The outcome from the inspection was extremely favourable and complementary with several areas of good practice being highlighted throughout the visit.

Summary of the findings from the official HTA report are quoted below:

\textit{During the inspection process, the HTA has made judgements about the suitability of the Designated Individual, the Licence Holder, the premises and the practices taking place on the premises under the supervision of the Designated Individual.}

\textbf{Suitability of DI and LH}

The HTA is satisfied that Dr. Robin Bolton is a suitable individual for the role of DI. However, as Dr. Bolton is the Medical Director he is removed from the operational activities and licensable activities being under taken in the mortuary. The establishment is encouraged to consider appointing a DI who is more closely linked to the licensed activities such as the Quality Manager or Head of Pathology. The establishment is also encouraged to consider appointing Persons Designated who are directly involved in the daily activities at both the hub and the satellite to support the DI in the oversight of the licensable activities.

DRI is the licence holder with a named individual, Peter Reading, as the contact; this represents the HTA’s preferred model and is considered suitable.

\textbf{Suitability of the Premises}

The HTA is satisfied that the premises are suitable for the activities being undertaken.

\textbf{Suitability of Practices}

The HTA is satisfied that suitable practices are being used to carry out all licensable activities.

\textbf{Summary comment}

The HTA is satisfied that the establishment is suitable to be licensed for the purposes that it has set out.

\textbf{Conditions (requirements) on the licence at the time of the site visit inspection}
These were no conditions on the licence at the time of the site visit inspection.

Conditions (requirements) related to areas of non-compliance identified during the inspection process
There were no areas of non-compliance identified during the inspection process.

Conclusion and Actions for 2011

- Identify time commitment, backfill funding and individual within Pathology CSU to undertake role of Designated Individual for the license
- Implement further guidance given by HTA during inspection visit
- Ensure annual completion and submission of annual compliance assessment in a timely manner

INFECTION PREVENTION AND CONTROL COMMITTEE: Dr Christine Hoy
(Presented on the 18th June 2010).

The Infection Prevention and Control Committee oversee the prevention and appropriate management of healthcare associated infections. The committee, chaired by the Director of Infection Prevention and Control (DIPC), meets every two months and membership includes representatives from Clinical staff, Microbiology, Infection Prevention and Control, Consultants in Communicable Disease Control, Occupational Health, Pharmacy, Facilities and Hotel Services.

Mandatory surveillance shows considerable improvement in Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemias, with just one Trust apportioned case so far this year. *Clostridium difficile* infections have remained at a similar number to last year; performance is better than the contracted trajectory but numbers have exceeded the Trust’s internal stretch target of 60 cases. The graphs below show the position, against trajectory, at the end of February 2011. Mandatory reporting of Meticillin sensitive *S. aureus* (MSSA) bacteraemias started in January 2011.

Notable interventions in the last year, contributing to prevention and management of HCAIs include:
- Appointment to two vacant Consultant Microbiologists posts – this has allowed Microbiologists to undertake additional ward rounds to review
antibiotic use and management of patients with HCAI and, to again, take on the DIPC role.

- A new cleaning product – Difficile-S – with improved activity against *C. difficile*, has been introduced in clinical areas.
- Two hydrogen peroxide vapour machines have been purchased, to enhance decontamination of clinical areas, particularly when *C. difficile* or norovirus infections occur.
- Intensive care units have participated in “Matching Michigan”, a national audit of central venous catheter (CVC) associated infections and the IPC team have audited patients receiving parenteral nutrition (PN). Interventions, such as improved CVC dressings, nutrition workshops and development of a PN pathway of care, have contributed to significant reductions in these infections.
- Occupational Health’s proactive approach led to considerably increased rates of staff influenza vaccination, with around 59% uptake.
- Development of an in-house IPC case management system, has allowed proactive monitoring of ‘alert’ patients, with immediate feedback to clinical staff.
- Continuous development of the ward accreditation system, allows all wards to be assessed for compliance with aspects such as hand hygiene, invasive devices and isolation.

**NATIONAL CONFIDENTIAL ENQUIRY REPORTER : Dr David Northwood (Presented on the 16th July 2010).**

The distinctive feature of NCEPOD's role is the critical examination, by senior and appropriately chosen specialists, of what has actually happened to the patients. NCEPOD studies produce recommendations which have covered everything from individual clinical practice to national healthcare organisation, always with the aim of improving patient care and safety.

Recommendations from completed studies are subject to the Trust’s “Policy for the receipt, distribution and review of national reports and guidance.” The recommendations may be already in place, considered irrelevant to the services provided by the Trust, or in various stages of planning for action. Documentary evidence that they have been considered and placed into one of these categories is not consistent, but is improving.

The function of NCEPOD and its relevance to the Trust will be emphasised to clinicians throughout the next year, especially as information about Trust involvement with NCEPOD studies is now a requirement for the annual Quality Accounts. A database will be developed to collect the required information and ensure it is readily available.

The Local Reporter role is now subject to annual appraisal by the Medical Director.
Recent NCEPOD reports

1. **Parenteral Nutrition**  Publication date : 24th June 2010  
**Aims:** A national audit of parenteral nutrition, and to establish the extent of compliance with NICE guidelines. Study period was from 1st January 2008 to 31st March 2008. 41 questionnaires sent out by NCEPOD, 15 replies returned by Trust clinicians (10 with case notes). This study together with local audit has led to the production of an adult parenteral nutrition IPOC which deals with most of the recommendations made by NCEPOD.

2. **Emergency and Elective Surgery in the Elderly**  Publication date : 11th November 2010.  
**Aim:** To examine the processes of care of elderly (>80 years) patients undergoing surgery who die within 30 days of the surgical procedure. Surgeons were asked for details about 13 patients; 8 questionnaires returned, 2 with casenotes. Nine anaesthetists returned 5 questionnaires, (3 being not applicable). Two questionnaires had a reason for not being completed and 1 set of patient details proved to be irretrievable. Moderate speciality response to gap analysis. Working group to be established involving key Clinical Directors.

3. **Cosmetic Surgery**  Publication date : 16th September 2010  
**Aim:** This is a small-scale study, which will investigate the structure and case mix of teams providing cosmetic surgery, the type and number of procedures performed, the existence of protocols, records of patient information, consent and clinical audit. Parkhill Hospital has participated.  

Ongoing NCEPOD studies

1. **Surgery in Children**  
**Aim:** Looking at surgery in children between April 2008 to March 2010. Data collection and reporting to NCEPOD has been completed. The report is due in the Spring of 2011.

2. **Peri-operative care**  
**Aim:** Examination of peri-operative care experienced by adults having inpatient elective and emergency surgery during the first week in March 2010. Questionnaires returned from DRI = 59%, and BDGH = 33% of those possible. Report due November/December 2011.

3. **Cardiac Arrest Procedures**  
**Aim:** This study will describe variability and identify remediable factors in the process of care of adult patients (aged 16 and older) who received resuscitation in an in-hospital setting, between 1st – 14th November 2010. Replies have been sent to NCEPOD for all cases identified with the study criteria. Questionnaires are awaited. The expected publication date is in the summer 2012.
The Nutrition Steering Committee has continued to support implementation of best practice during 2010/11, with three main aims: communicating best practice, training and education and performance and quality monitoring.

Raising nutrition awareness across the Trust

*Productive Ward mealtimes module* has enhanced the organisation of practice in 32 wards, with lessons learned and good practice implemented. The remaining wards have now also commenced the programme.

*Nutrition Awareness Day* 26 November 2010. This annual event focused on improving nutritional and highlighted improvements in practice at ward level. Nutrition link nurses completed two audits within their ward as part of this education and training day. This forms an important part of their contribution to local evidence relating to the nutrition ward accreditation process which has been implemented.

*Intranet web page* – gives access to all the clinical nutrition resources that are required by the wards to keep abreast of local and national nutritional initiatives, guidelines and protocols relevant to the nutritional care of their patients.

Training and education of staff

The following new initiatives have been introduced during 2010/11:

- nutrition module for healthcare assistants / support workers. Nutrition link nurses have responsibility for ensuring that their support staff are up to date with this module.
- A national web based e-learning packages relating to Malnutrition Universal Screening Tool (MUST) has been purchased by the Trust. Staff are required to complete this module as part of their training and annual updating relating to the nutritional screening of patients. Attendance at the annual rolling MUST training during 2010/11 has been variable. Confirming compliance and competence is assigned to the ward managers work plan with support from the matrons.
- A gastrostomy nurse specialist was appointed to coordinate and improve the care given to patients with a gastrostomy within the Trust.

Performance and Quality Monitoring

Despite the lack of technology, data is recorded and analysed for performance monitoring purposes eg CQUIN, PEAT, CQC – outcome 5, national nutritional screening initiatives. Most data collection involves manual systems, is time consuming and risks errors. The Trust would benefit from investment in the time and skills of a data analyst to facilitate these processes. The following actions support improvements in nutritional care across the Trust:

- Through internal assurance processes the Trust is able to satisfy the food and nutrition standards required for the Care Quality Commission Registration requirements – Outcome 5 (2010)
Food Service Group was established in summer 2010 to ensure that there is a robust structure in place to pro-actively address and monitor standards and processes associated with the provision of food and hydration to patients in our care.

Contributed data to the NCEPOD enquiry into parenteral nutrition, the trust responded to recommendations in the report (published June 2010):
- Developed an IPOC for parenteral nutrition – this is currently being piloted
- Provided educational sessions on parenteral nutrition – held in October and December 2010 for medical and other clinical staff in

Nutritional screening audits indicated that the Trust is improving its’ compliance with this aspect of care, supported by the development of the nutrition clinical dashboard currently in a pilot phase and will ‘go live’ in April 2011.

Developed a ward accreditation programme relating to improving the nutritional care which will be implemented in April 2011. Wards will have 12 months to demonstrate compliance.

A business case is being developed for the implementation of a Nutrition Support Team including a Specialist Nutrition Nurse (a key recommendation in the NICE guidance on Nutrition Support in adults, 2006) following publication of A Strategic Framework for Intestinal Failure and Home Parenteral Services for Adults in England (HIFNET) in 2009. This will be required if the Trust is to continue to provide tier 1 or 2 care by April 2012. Without these developments it will be currently difficult for the Trust to perform well in specialist aspects of nutrition that require compliance with NICE guidance and will fail commissioning requirements for Tier 1 and 2 of the national HIFNET plan.

PATIENT SAFETY REVIEW GROUP : Mr Ray Cuschieri
(Presented on the 15th October 2010).

The purpose of the Group is to ensure that there is continuous and measurable improvement in patient safety and that the Board of Directors is assured that the risks associated with clinical activity are appropriately managed. The Group has the operational responsibility to ensure that the impact of risk is minimised and that learning is shared across the organisation. The Group is chaired by the Deputy Medical Director Clinical Standards, with the Director of Nursing and Quality as Vice Chair. The Group meets monthly and its membership consists predominantly of specialty risk management leads (who act as vice chairs to their specialty clinical governance groups).

The work of the Patient Safety Review Group over the last year has included:

a) Monthly review of serious incidents. The Trust has an obligation to report incidents which meet a certain criteria to NHS Doncaster, our leading commissioners. They monitor the Trust’s reporting and investigation of serious incidents (SI’s) and the implementation of recommendations arising from action plans. In 2010 126 cases were
reported to NHS Doncaster, 33 of these were downgraded from SI status following review and 41 of these 2010 cases were closed.

b) Each month a case review following a complaint, incident or claim is presented by the clinical governance lead, risk lead or treating clinician for learning and implementation of actions. Examples of learning have included escalation and handover processes, recognising a deteriorating patient, documentation, communication and accountability.

c) The Group receives a quarterly DATIX report on incidents, complaints, claims and PALS activity. Any lessons learnt from the analysis of data are taken to Clinical Governance Groups for action. The Group also receives monthly reports on legal cases and any clinical risk issues arising from claims are disseminated to the Group. A quarterly DATIX report for maternity is also received. One of the top five incidents in obstetrics was communication failure the CSU has therefore successfully implemented the SBAR (Situation, Background, Assessment and Recommendation) tool to improve communication between healthcare professionals which the Group has endorsed and recommended for roll out to other areas.

d) The Group considers risk management standards, procedures and recommendations provided by other organisations, including National Patient Safety Agency (NPSA) NCEPOD reports, National Health Service Litigation Authority, (NHSLA) Care Quality Commission and MHRA. Actions from NPSA alerts are monitored via identified leads to ensure compliance against timescales. Examples include safer spinal intrathecal epidural and regional devices, safer lithium therapy, safer use of intravenous gentamicin for neonates, reducing harm from omitted and delayed medicines in hospital and checking pregnancy before surgery.

e) The Group received reports on safeguarding policy and practice as well as shared learning from serious case reviews and monitoring implementation of associated action plans. Completed action plans from serious case reviews have been presented by the Safeguarding Children’s Lead which have led to a number of practice developments.

f) A number of policies and new procedures have been approved by the Group, examples include prevention of VTE in patients admitted to hospital, contrast induced nephropathy, handover, being open, use of fascia iliaca compartment blocks and pressure ulcer root cause analysis protocol.

The Patient Safety Review Group provides advice and recommendations to CSU’s and specialties on improvements in practice arising out of consideration of the above areas of work.

In addition to its annual report, the Group’s minutes are a standing item on the Clinical Governance Standards Committee (CGSC) agenda which enables CGSC members to raise any issues either with Chair or Vice Chair of the Patient Safety Review Group who are also members of the CGSC
Introduction

Point of Care Testing (POCT) has been highlighted in Lord Carter’s report on pathology as a growing trend in response to the government’s policy of providing a service which is patient centred. The drivers are to improve patient pathways by devolution of control to primary care with greater emphasis on the prediction and prevention of disease. Another identified driver is that patients requiring further control over their own healthcare. New technologies have profoundly altered the delivery of pathology services. With the ever growing plethora of devices on the market and the exponential increase in the number of tests available on such devices, POCT is becoming a vital extension to pathology and offers an alternative to centralised testing.

Several standards have been introduced to manage the extensive governance requirements for POCT based on ISO 22870:2006 (POCT-Requirements for quality and competence) and CPA standards for the Medical Laboratory which incorporate ISO 15189:2007.

Clinical services may be unaware of the consequences of POCT and try to initiate new tests without the support or guidance of the laboratory. The POCT Policy (CORP/RISK 8v3 - Policy and Guidance for Point of Care Testing) is in the process of being embedded within the Trust and the POCT governance committee has been appointed to provide guidance and management of POC. In addition, organisation and management at a ward level has been expanded from the already established diabetes and renal link nurses (identified in 2009 after a questionnaire).

Quality Management

POCT is subject to the same document control system as the laboratory. Document control encompasses management of quality forms, memos, risk assessments (for more complicated instruments), change validation, user feedback summary sheets and Standard Operating Procedures (SOP). Alerts of any kind, especially from MHRA, are dealt with promptly and recorded.

Auditing

POCT team performs regular audits. In 2010, annual ‘operational and maintenance’ audits and follow-up audits have been carried out. For glucose monitors and INR meters these have been conducted under contractual agreement by the equipment vendor. Audits for blood gas analysers and urinalysis have been carried out by the POCT and/or infection control team. It is hoped that haemoglobin estimation devices and Clearview urine pregnancy testing (UPT) will be included in the next year. Results of audits are shared at the POCT Governance Committee.
Management Review

Overall POCT clinical effectiveness will be reviewed by Pathology CSU and brought to POCT Governance Committee.

Staff records, training and education

Lists of staff at initial training, which is accompanied by preliminary competency testing, are recorded in the POCT access database. Additionally, scanned images of attendance lists are uploaded onto the Pathology shared drive (a hard copy of which should also be kept by each ward manager). During 2010 18 staff members were trained in Clearview urine pregnancy testing, 6 members were trained on urinalysis, 21 staff trained in INR meter usage, a total of 29 staff were trained in blood gas analyser operation (including 7 on capillary blood gas sampling). After introductory competency testing, there has been limited update testing thereafter. An exception to this is for glucometers (where Abbott, the parent company, conduct annual update training). In the future, POCT team plan to effect examination/witness audits or implement oral examinations. Regular proficiency testing is on-going and may well rely in part on vendor specific IT software packages.

EQA Scheme registration recommendations

EQA involves the analysis of samples with unknown values from an external source. Results are then subject to peer group assessment and statistical analysis to compare results across different sites. The POCT Policy (CORP/RISK 8 - Policy and Guidance for Point of Care Testing) refers to the mandatory requirement that all POCT is to register with an EQA scheme and perform adequately as part of clinical governance. For year ending 2010, a summary of all EQA performance was issued to each ward with performance for every POCT device in use in that area. Feedback was welcomed along with a signed receipt slip identifying the ward manager to update POCT records. EQA performance is also reported to POCT Governance Committee.

Mid-term Projects

With regards to POCT and information technology, bidirectional connectivity and secure password protection for trained operator access can be used for governance purposes. Lock out facilities can be used to monitor operator competency and so safeguard the patient. It is hoped to that this will be started to roll out for blood gas analysers and other connectable devises during the next year.
POSTGRADUATE MEDICAL EDUCATION : Dr Jo Sayer  
(Presented on the 17th December 2010).

Background

For all acute specialties, medical training on all sites within the Trust suffered through the introduction of the EWTD in 2009. Coupled with the restrictions on immigration and employment of medical graduates from overseas, the Trust started 2010 with over-stretched rotas, multiple unfilled posts at junior doctor level and consultant trainers who were not only expected to supply improved medical training to the trainees within the 48 hour week but also provide cover for the hours lost and for the gaps in the rota. The impact of these changes on the provision of medical training across many specialties within the Trust is reflected in the critical responses from the trainees in the national PMETB survey. It is a credit both to the trainees and the trainers that despite the criticisms for most specialties, the survey and the Deanery found the training to be acceptable or good in most aspects.

Achievements within Postgraduate Medical Education in 2010

- Production and implementation of a Trust policy for safe medical handover of patients.
- Re-instatement of registrar training in the A and E department on the Doncaster site
- Completion of the transfer of Paediatric inpatient care to the Women's hospital with improved training opportunities for Paediatric SHOs and registrars
- Introduction of consent training and standardised training for taking blood cultures for all newly employed doctors
- Use of the laparascopic simulator to support surgical training
- Majority of educational supervisors now trained to meet Deanery standards, DPGMEs trained to provide educational supervisor training in house.
- Recognition of the need to provide time for educational supervision and other aspects of medical training within the consultant job plans
- Recognition of the quality of training provided on all sites for all acute specialties by the Deanery, with particular commendation for the training provided for the Paediatric trainees in Doncaster
- Provision of training courses for SAS doctors using the nationally agreed funding paid by the Deanery

Future Plans

- All educational supervisors to be trained and all consultants and associate specialists to be trained in workplace-based assessments and provision of career counselling to enhance the training they provide.
- All rotas to be compliant with Deanery standards, with not more than 4 continuous nights on duty.
- Implementation of written or electronic handover within all acute specialties
□ Closer working with clinical governance to ensure the learning from SUIs is disseminated and where appropriate trainees receive pastoral support or directed training.
□ Extension of clinical skills training, generic training for foundation trainees and allied health professionals, development of a teaching faculty for delivery of specialty specific training
□ Further development of the training provided to doctors outside the Deanery training scheme, both at SAS doctor level and for Trust doctors, to support provision of safe medical cover without relying on doctors in training
□ Expansion and development of the Postgraduate Centres to improve capacity and offer opportunities for more in-house and multi-professional training
□ Introduction of more skills training and courses, to be opened to doctors from outside the Trust in order to generate an income for the Postgraduate Centre

The Directors of Postgraduate Medical Education and the Head of Education feel that the Board should recognise provision of professional education for all health professionals as one of the Trust’s essential duties. The Trust’s future strategy should include an acknowledgement of the importance of sustaining this role so that the Trust can be recognised as a centre of excellence for training. Given the uncertainties over the future of postgraduate training, with the loss of the strategic health authorities and possibly also the Deanery, it is imperative that the Board seeks excellence in training to help protect not only the quality of training provided within the Trust but also the funding associated with it.

SAFEGUARDING CHILDREN : Gill Genders

(Presented on the 21st May 2010).

During 2010/11, the Trust continued to work actively with the local health and social care community, fulfilling its statutory responsibilities as a partner agency with Local Safeguarding Children Boards (LSCB) in both Doncaster and Nottinghamshire. The local context has been challenging with government intervention in Doncaster, and an inadequate Ofsted/CQC rating following an inspection of Safeguarding and ‘Looked After’ children Services in Nottinghamshire. The Trust is contributing to both Improvement Plans. There have been continued efforts by the Trust and there have been recent improvements in communication with refreshed meetings between hospital staff, Consultants and managers within Children’s Social Care.

NHS Doncaster and NHS Bassetlaw have developed a joint specification for Safeguarding which includes the three Designated Doctor roles - Safeguarding, Unexpected Child Deaths and Looked After Children. Recruitment of consultant paediatricians into these functions is difficult locally and nationally and the Trust is working with commissioners to support delivery of these roles into the future.
Under the leadership of the safeguarding children team, the Trust continues to strengthen safeguarding standards in all specialties and services, and working collaboratively with the health community developed and implemented new training, supervision and audit strategies for safeguarding children practice.

Within the Trust, the safeguarding children team remain actively involved in the organisation, planning, design, delivery and evaluation of education and audit, of safeguarding children standards, performance indicators and clinical practice. Reporting processes are in place to ensure regular feedback to commissioners regarding implementation of action plans, safeguarding children activities and to provide evidence of compliance with Care Quality Commission standards.

Delivering the Business 2010 resulted in the appointment of a Deputy Director of Nursing and Quality with responsibility for safety and safeguarding, and the integration of both children and adults safeguarding into one team within the Directorate of Nursing and Quality. This will help to streamline safeguarding activities, making best use of resources, sharing knowledge and good practice through an amalgamated Safeguarding Operational Group which has a joint work plan, audit plan and a structured communication pathway with Clinical Service Units whose representation is essential in order to demonstrate local and national safeguarding standards are met. Since November 2010 the group provided valuable feedback on

- development of a new Safeguarding Children Supervision Document (approved by the Trust Clinical Governance Standards Committee Jan 2011),
- a proposal for the organisation of staff training arrangements
- development of CSU safeguarding children implementation plans.

During 2010/11 the safeguarding team

- implemented all actions from 2008/9 Serious Case Reviews (SCR)
- contributed to a DSCB “Lessons Learned Review” (March 2010) and the resulting action plan is now closed.
- conducted an Individual Management Review for a SCR commissioned by NSCB
- identified from these IMRs training needs specific to the Trust:
  - Staff knowledge relating to information sharing when children who are looked after by the health authority present for hospital care.
  - Staff knowledge about children that self-harm and issues relating to relevant safeguarding children processes.
  - The quality of staff record keeping and documentation within health records.

Additionally, the Trust is currently undertaking two further “Lessons Learned Reviews” in line with requests from the DSCB. The progress of all action plans is monitored not only by the respective Safeguarding Children Board but also by the Trust’s Strategic Safeguarding People Board and the Patient Safety Review Group within the Trust.
Uptake of Safeguarding Children training recorded on the Trust’s OLM system indicates that 94% of staff within the Trust accessed Safeguarding Children Training during the past 3 years. Further work is ongoing to develop a performance monitoring tool to ensure that managers have a significant overview of safeguarding training needs and progress within their individual services to ensure 100% compliance with safeguarding training and supervision systems.

**UNDERGRADUATE MEDICAL EDUCATION** : Dr Mukhlis Madlom  
*(Presented on the 17th December 2010).*

The Sheffield Curriculum teaching is based on the principles of integrating basic sciences and clinical practice from year one. Such integration policy dictates contact with real patients in clinical settings throughout the course.

To ensure the success of this policy, the trust has to ensure strict clinical governance guidance to students. These are highlighted clearly in the students booklet entitled “Medical Undergraduate information”. This guidance is given under the title of confidentiality, student doctors within the hospital policy and equality and diversity.

We have recently added two sections to this guidance to emphasis the issue of patient safety. These came under the headings of *the responsibilities of students in “Tomorrow’s Doctors” and Patient Safety.*

**Student Doctors within the Hospital Policy**

**Students must not in any circumstances:**

- Initiate, alter or stop the treatment of a patient on their own diagnosis: both diagnosis and treatment must be confirmed by the registered medical practitioner supervising them
- Prescribe, request radiological examinations or other diagnostic investigations, or order blood to be cross-matched. If the students complete an order form for any of these purposes, it must be signed by the registered medical practitioner supervising them before it is executed
- Take any part in obtaining or witnessing the signature by or on behalf of a patient on a form of consent to treatment
- Take a history from, examine or undertake a procedure on a patient unless *his/her prior informed consent has been obtained.* If it is not practicable to obtain specific consent, the student must seek authorisation in advance from a supervising registered practitioner. This will apply in the case of those patients unable, for whatever reason, to make a decision or consent. Exceptionally, this may include some anaesthetised patients, though normally such consent should have been sought from the patient in advance
- The student acting in an emergency, e.g. a cardiac arrest, has the same rights and responsibilities as any other citizen.
Patient Safety

Standards
The safety of patients and their care must not be put at risk by students’ duties, access to patients and supervision on placements or by the performance, health or conduct of any individual student.

To ensure the future safety and care of patients, students who do not meet the outcomes set out in *Tomorrow’s Doctors* or are otherwise not fit to practise must not be allowed to graduate with a medical degree.

Criteria
Systems and procedures will:

a. ensure that medical students undertake only appropriate tasks in which they are competent or are learning to be competent, and with adequate supervision
b. identify and address immediately any concerns about patient safety arising from the education of medical students
c. identify and address immediately any concerns about a medical student whose conduct gives cause for concern or whose health is affected to such a degree that it could harm the public, where possible through providing support to the student
d. ensure that medical students who are not fit to practice are not allowed to graduate with a medical degree
e. inform students, and those delivering medical education, of their responsibility to raise concerns if they identify risks to patient safety, and provide ways to do this.

RISK MANAGEMENT: Mandy Dalton

Risk management is about focussing upon experiences and learning, in order to improve upon clinical outcomes, improve the working environment, assess and where possible, anticipate risk and also eliminate or reduce risk or harm.

The department of risk and legal services works closely with risk management leads throughout the organisation to ensure that all risks are identified, investigated and reduced, with the overarching desire to improve safety.

NHSLA Risk management standards.

In January 2010 the NHSLA published revised risk management standards. These standards comprise of five risk areas:

- Governance
- Competent and capable workforce
- Safe environment
- Clinical care
- Learning from experience.

For each of the 5 areas, there are 10 criterion. In July 2010 we were successful in achieving level 1.
This demonstrates that we have sound policies and procedures in place to manage risk. In order to advance to level 2 we need to ensure that these policies are embedded into practice in each clinical service unit throughout the organisation.

**Serious Incidents**

As a Foundation Trust, the Trust is obliged to report Serious Incidents (SIs) which fall within a defined category list, to our lead commissioners, NHS Doncaster. The definition of a Serious Untoward Incident can be found in the Trust’s *Policy for the management of Serious Untoward Incidents* CORP/RISK 15 v1. NHS Doncaster has the responsibility to monitor the Trust’s investigation of reported SIs and the implementation of recommendations arising from action plans.

**Internal Processes**

The internal mechanism for the monitoring of SIs is that all new SIs are reported monthly to the Patient Safety Review Group who has the responsibility of identifying issues to be covered during the investigation. Following the root cause analysis a report is produced, including recommendations and action plan. The action plan is the responsibility of the author to take to the CSU governance group and to ensure that all the actions are completed. The risk management department will request confirmation of completed action plans within 6 months. If any actions remain outstanding, these will feature on the CSU risk register and then be reported to the Clinical Governance Standards Committee.

**Quarterly DATIX Risk Management Reports**

The Head of Risk and Legal Services produces a quarterly risk management report which identifies incidents, complaints and cases of litigation in the Trust. This report is presented on a quarterly basis to the Patient Safety Review Group and an Executive Summary is presented to Clinical Governance Standards Committee.
1. The Clinical Service Unit Clinical Governance Group (CSU CGG) is a sub-committee of the Clinical Governance Standards Committee. The CSU CGG meets monthly and the minutes are circulated to:
   - Clinical Governance Standards Committee
   - Divisional Clinical Management Team

   The minutes of the CSU CGG will include the names and designations of attendees.

2. The CSU CGG will have the following multi-professional membership:
   - CSU Clinical Governance Lead (Chair)
   - CSU Modern Matron or individuals of a similar status (Vice Chair)
   - CSU Clinical Audit Lead
   - Multi-disciplinary and multi-site representatives from CSU
   - PALS/Patient Representative, where possible
   - Nominated Junior Doctor in training

3. The CSU CGG will only be deemed quorate if the following requirements are met:
   - The Chair and/or Vice Chair is present
   - There must be at least half of the members in attendance, including the Chair and/or Vice Chair, one of which must hold Consultant status within the CSU
   - In the event of the group being non-quorate, the meeting may continue on an “information exchange” basis at the discretion of the chair

4. The CSU CGG’s objectives are to:
   - Review complaints and claims
   - Encourage appropriate incident reporting within the CSU
   - Review all adverse events to identify significant risks to facilitate improvement of patient safety, and to influence audit
   - Ensure all serious and dangerous incidents are reported to the Medical Director, within the required timescale, using the standard reporting form
   - Recommend and facilitate all investigations of adverse incidents and complaints, including root cause analysis, and to ensure
shared learning throughout the CSU and Trust-wide, as appropriate

- Assist the Trust in NHSLA Risk Management Assessment compliance
- Assist the Trust in compliance with the Standards for Better Health
- Review local Policies and Procedures and initiate identified training requirements
- Discuss any relevant Clinical Governance Standard Committee and Patient Safety Review Group issues, pertinent to the CSU and to minute those discussions in the Group meeting.
- Review and implement the findings and recommendations of National Confidential Enquiry Reports pertinent to the CSU
- Review and implement the findings and recommendations of any High Level Enquiries pertinent to the CSU
- Review and implement the National Institute of Clinical Excellence (NICE) Guidance, as appropriate and to take into account nationally agreed guidance when planning and delivery treatment and care, and to report back to the Clinical Audit department using the appropriate reporting form.
- Monitor infection prevention and control issues and ensure compliance with policies.

5. The CSU CGG Agenda will follow the standard pro-forma attached at Appendix C1. Further items for inclusion on to the agenda will be given to the Chair or Vice Chair one week in advance of the meeting date and an Agenda will be prepared and distributed to members in advance of each meeting.

6. In addition to presenting the minutes of its meetings, the CSU CGG will report to the Clinical Governance Standards Committee annually. The report will include the Specialty’s action plan which will outline the key actions/objectives the Specialty will undertake to develop clinical governance and improve the quality of care to patients within the next twelve months.

7. The CSU CGG will report to the Patient Safety Review Group on an annual basis. The report will include detailed analysis (with actions and/or recommendations) of the following:

- Complaints
- Claims
- Adverse Incident Reports
1. Apologies for Absence

2. Minutes of last meeting

3. Matters arising

4. Review of adverse incidents and instigate investigation, if appropriate

5. Feedback on outcomes and actions from adverse incident investigations

6. Review of complaints

7. Review of claims

8. Review local policies and procedures and initiate identified training requirements

9. Discuss relevant Clinical Governance Standards Committee and Patient Safety Review Group issues, pertinent to the Specialty

10. Review and implement the findings and recommendations of the following, pertinent to the CSU:
   a. National Confidential Enquiry Reports
   b. High Level Enquiries
   c. National Institute of Clinical (NICE) Guidance

11. Assist the Trust in compliance with:
   a. NHSLA Risk Management Assessment

12. Training, Education and Staffing Issues

13. Infection Prevention and Control Issues

14. Any Other Business
This section includes summaries of clinical governance activity within Clinical Service Units as prepared by Clinical Service Unit Clinical Governance Leads with the assistance of their Clinical Service Unit Clinical Governance Group

ACCIDENT AND EMERGENCY : Dr G Shah

The Accident & Emergency (A&E) Clinical Governance Group met eight times during 2010 and attendance improved. Doncaster (DRI) and Bassetlaw (BDGH) sites are represented while the Matron at DRI over views Mexborough Montagu Hospital (MMH) minor injuries unit as well. Complaints and incidents management sub-committee of A&E Clinical Governance Group met on five occasions at BDGH during 2010. In November 2010 the Department became an individual Clinical Service Unit (CSU). Over 157000 thousand patients are seen in the CSU on all three sites.

Serious Incidents (SIs): In 2010 we had 8 SIs. Themes were: Unexpected deaths x 5 (death due to medication of another patient x 1), Misidentified/ mislabelled body x 1, Missed diagnosis x 1

Complaints: CSU received over 143 complaints this year. Delay in diagnosis, delay in treatment, prolonged waiting and staff attitude were main areas of concerns.

Critical Incidents: The department has reported over 644 incidents during 2010. 354 were near miss, 225 were minor and 62 incidents were recorded of medium severity. Top 10 incidents were Health and safety-123, Missing patients-103, Discharge-issues-63, Communication failure-52, Breaching treatment targets-38, Medication errors-30, Staff shortages- 29, Admissions-23, Inappropriate care- 21 and Environmental issues-15.

Guidelines/ Policies and Procedures

National: the group reviewed six relevant NICE Guidance that were published during 2010 and currently reviewing Guidance on LOC, Hypoglycaemia and sedation in Children.

All Twenty Standards of Care published by the College of Emergency Medicine (CEM) were adopted by the group and are fully implemented in the department. Regular audits and teaching for every group of doctors joining four times a year actively takes place

Local procedures:
- YAS inter facility transfer policy
Conscious sedation protocol
Pneumothorax management protocol
C spine injury investigation procedures were also reviewed and updated

Legal Claims Report: Seventeen inquests and legal claims were dealt with by the legal office for the emergency department during 2010

Staffing levels
Medical: BDGH: Reviewed in line with CEM staffing guidelines will increase to seven SDs and three AS doctors. DRI has 14 specialty doctors, running a 09 to 2200 SAT in UCC, three consultants and two associate specialist working on the senior doctors rota. Department now has one part time SpR.

Nursing: BDGH: Nursing establishment reviewed. Plans are to have five ENPs to support the decision maker rota. Department now has 5.5 band 7s, 6.08 band 6s, 18.4 Band 5s, and 6.8 HCAs. DRI: currently four Paediatric nurses work in the designated peads area in UCC. CSU has tried to increase the Nursing establishment unsuccessfully due to vacancy control issues. Department now has 1 band 8-Matron, 13.4 band 7s (out them 11.4 are ENPs), 6.6 band 6s(one is ENP), 42.3 Band 5s and 13.4 HCAs. ENPS and ANPs: although counted as part of Nursing establishment now the department have 12.4 ENPs five of them are ANPs

Education and Training of the Staff:
Medical: Kay Stenton and Mr El-Hag are the designated consultants. “Standards of care” outlined by CEM is now part of the induction programme.

Level of training required for each of the medical group is clearly defined by the College tutor Dr Stenton and staff are encouraged to meet these levels. Most of the Specialty doctors are trained in ALS/ EPLS/ ATLS, HMIMMS, Children and adult safeguarding and CBRN. Consultant body is working hard towards achieving the ST3 level of competency in all SDs this year and ST4 level by 2012. BDGH medical staff started to catch up with the DRI and now we plan to have joint teaching for the junior and specialty doctors on Tuesdays.

Nursing: we lost the nursing clinical educator towards the end of 2010. Nursing training is now one of the ongoing concerns for the group and we hope to get someone in place to continue with the process on continued education.

Infection Control: The department achieved 92% on the infection control audit this year. There is strict adherence to BBE policy and hand hygiene audits were complete. Three environmental audits were completed and we expect to achieve full accreditation with the trust infection control policies. Lastly, most staff will go into scrubs in few months time.

Audits: Over 20 Audits were completed across both sites, mainly about the standards of care set by College of emergency medicine, NICE and other professional bodies.
Areas of Good Practice: Clinical Governance improved overall, Complaints and incidents management committee. ED Management protocols update and some still in process, CDU protocols introduced., over 20 Major Audits were done. Implementation of CEM standards started to materialize. NHSLA documentation audit completed twice and established local standards of documentation. Recommended blood test lists for triage introduced. Frequent attendant (Patient) management plans started to role in. Induction of new staff (M&N) became more robust. Patient satisfaction survey completed. Mandatory training of Medical staff established.

Areas of Concerns: OOH GP integration in ED has a long way to go. Need to meet target of 100% Hand over. Triage in SAT area need be improved and facilitated on operational issues. Complaints, Incidents and SUIs- need robust action plans and their implementation. NICE guidance for Radiology in head injuries needs 100% implementation. Mislabelled deceased patients need RCA. CDU admissions protocol not being followed. M&N Staff training and education centralised inventory needs establishing. Paediatrics emergency area need consultant medical and nursing input. Staffing (Medical, Nursing, Admin) short in OOH. Secretarial support for Clinical Governance Group scarce for six months. Patient care plans for frequent attenders are not in place. Back pressure of beds in hospital, winter pressure and staff shortages are compromising patient safety every now and then. Infection control accreditation still out standing for the department. Patient information leaflets overview is outstanding for a long time.

ANAESTHETICS AND CRITICAL CARE & PAIN MANAGEMENT: Dr Peter Smith

The Group schedules 12 half-day meetings per year. There is no meeting in August, so we normally have an all-day meeting in September. This year, we only managed a half-day meeting in September, so by the end of the 2010-11 cycle we will have met 11 times. Our membership is in accordance with the Trust’s strategy. We have tried to introduce an element of rotation, and Dr Rashid has given up his position for Dr Michel. Our former Clinical Director, Dr Harris has left the group, but was not replaced, as the new CD is already a member. We have representation from all three clinical areas within the CSU. Currently there are 13 members, and attendance over the year has been 71%. All meetings were quorate.

Incident reports, claims, complaints: The group considered about 70% of reported incidents (the remainder were dealt with outside meetings). From April 10 to mid-February 2011, we received 277 incident reports (19% fewer than in the equivalent period for the previous year). Of these 92%, were classified as either minor or near-misses. There were 17 incidents of moderate severity and 3 serious incidents; one of which has been reported to the PCT.
We have received 9 complaints, 7 were related to the Pain Clinic and 2 to anaesthetics. Many verbal complaints are settled informally, and we were briefed about these at meetings.

Hospital-acquired infection: This was discussed and minuted at 5 out of the 10 meetings. We also had a presentation by the Director of Infection Control, to discuss catheter-related sepsis.

NPSA/ MHRA alerts: We discussed 15 MHRA (medical devices) alerts, and 8 NPSA Rapid Response Alerts.

NICE guidelines: Only 2 guidelines were felt to be relevant to our specialities – Sedation in Children (CG112), and fixation of flail chests (IPG 361).

NCEPOD: We have responded to 2 reports published in the last year – on Parenteral Nutrition – a Mixed Bag, and surgery in the elderly (An Age Old Problem).

Local issues and guidelines: We agreed policies on fascia-iliaca regional analgesia, and anaphylaxis management. We are currently considering 3 other local policies.

Challenges: dissemination of clinical governance matters has continued to improve, due to the efforts of the editorial team of our departmental magazine (the Gasmeter). We have also established that minutes of meetings can be made available to all staff. We have discussed membership of the group, and have managed to attract some fresh faces.

CHILDREN’S SERVICES: Dr Nigel Brooke

Organisational Progress/Issues:
January 2010 saw the move of acute paediatric services in DRI to the newly built Children’s Ward and Children’s Observation Unit (COU) on level 3 of the Women’s and Children’s Hospital. This is good progress for risk management as the previous issues with split site acute paediatric work are resolved, bringing the trust in line with the previous recommendations from the PMETB report.

Dr Nigel Brooke took over as Children’s Services Clinical Governance (CSCG) Lead in July 2010 following relocation of CAMHS and Dr Dix to RDaSH. CSCG monthly meetings are now being held at DRI and BDGH on alternate months, leading to improved attendance and involvement by the BDGH paediatric team. The meetings are more multidisciplinary, the group consisting of 3 Paediatric Consultants (2 DRI; 1 BDGH), Andrea Bliss (Matron, Children’s Services), Chris Beattie (Senior Nurse, Neonates) and Anne Lundy (Senior Sister).

Dates of the meetings were changed to allow attendance of administrative support. Unfortunately, following commencement of CSU’s, the planned
arrangement for admin support has been lost and the group currently have no admin support provided from the CSU. This issue was recently reported to the CSU general manager with hope of resolution in the near future.

**Serious Untoward Incidents (SUI’s):**
CSCG were involved in 2 SUI’s this year:

- A case of death due to neonatal herpes – the investigation revealed the root cause to be an issue in information sharing and communication between midwifery staff on CDS and staff on the neonatal unit. Admission policies and the neonatal IPOC have been altered to improve information sharing and documentation. A guideline for management of neonatal herpes has been produced. Concerns over blood gas management were also identified, resulting in an audit of blood gasses on NNU. A guideline for the management of blood gasses is expected is to be produced to help reduce the risk of inappropriate management, especially by locum staff.

- A case of respiratory arrest due to acute upper airway obstruction. The investigation revealed issues in out of hours anaesthetic cover for the BDGH site which are currently on going. This was also highlighted as an area of concern in the independent clinical services review of acute children’s services at Doncaster and Bassetlaw Hospitals. Following investigation, the PCT agreed to downgrade this from a SUI.

**Infection Control:**

- We have had one case of C.Difficile on the children’s ward at DRI, due to concurrent antibiotic usage. This was well contained with no spread.

- We had an outbreak of HINI influenza on NNU at DRI with 3 cases identified. The case demonstrated limitations in isolation facilities on NNU, but despite this, the outbreak was contained with no further spread.

**Other areas of Good Practice:**

- The risk register for Children’s Services is regularly reviewed on a monthly basis at CSCG meetings.

- NICE guidelines for the last year have been reviewed, and if necessary, audited. We have good practice for enuresis and constipation. We had poor compliance in several areas of the NICE neonatal jaundice guidance, resulting in a review of our local guideline which is currently in progress.

- The Paediatric Global Trigger Tool was commenced in April 2010. Feedback is being monitored through CSCG meetings.

**Areas of On-going Concerns:**

- The lack of a Clinical Director for Children’s CSU.

- Shortages in both medical and nursing staffing levels. Shortages in middle grades at DRI have led to the majority of out of hours cover being provided by locums, carrying increased risk. Work is on-going with the medical workforce plan but no immediate solution has been identified. Recruitment is on going for nursing shortages.
CLINICAL THERAPIES: Sylvia Banbury

Meetings: The Clinical Therapy Clinical Governance Group includes representatives from each profession in the Clinical Therapy CSU and meets monthly for 2 hours. The group has met 9 times during the year. Surgical Podiatry will be joining the CSU in April 2011 when we will review clinical governance arrangements.

Adverse Incidents: From 1st April 2010 140 incidents were recorded on the DATIX system as follows:

- Physiotherapy 89  64%
- Occupational Therapy 20  14%
- Dietetics 13  9%
- Orthotics 11  8%
- SALT 6  4%

The top 5 categories were:

- Health and Safety (52)
- Equipment (26)
- Deterioration in Condition (23)
- Communication Failure (9)
- Security, Property Loss etc. (6)

There has been significant learning associated with the adverse incident reporting process with changes in practice as a result. Examples are as follows:

- change to MH training exercises in response to staff injury
- emergency procedure review (outlined in further detail below)

Infection Prevention Control: Training, including Hand Hygiene, is included in Induction training for all new staff and a mandatory programme of updates for existing staff is available throughout the year in each specialty profession. Physiotherapy have been involved in Mask Fit training relating to the management of swine flu for several staff groups.

Handover of patients: Physiotherapy contributed to the Trust handover policy and their ‘on-call’ handover procedure is now included in the policy.

VTE: Whilst not directly involved in the assessment for VTE, staff working on the wards are aware of the VTE form and the need for this to be completed Clinical Therapy staff will identify to ward staff when this has not been done.

NICE: NICE alerts are now sent to all CG leads and recommendations for action are identified through the Clinical Therapy Audit Group.

Bariatric Audit: Clinical Therapy Staff have contributed to an environmental audit for the management of Bariatric patients looking at Out Patient areas.
Documentation: Standards for documentation have been reviewed within Clinical Therapy and approved abbreviations agreed. Annual audits are undertaken to ensure compliance.

Emergency Procedure: As a result of reported incidents relating to outpatients becoming unwell during physiotherapy treatment, the process for responding to an emergency has been reviewed. Emergency procedure flow charts are to be introduced in each department, including on-going training sessions and exercises to test the procedure. This has been shared and approved by the Resuscitation Lead for the Trust. This will also be included in induction for all physiotherapy staff and will be rolled out to other Clinical Therapy departments.

Induction: The Induction process for new staff has been reviewed and improved for all new staff. Induction programmes have been developed and Physiotherapy and Occupational Therapy now hold Induction days each month.

EAR, NOSE & THROAT (ENT) : Mr Ullas Raghavan

ENT clinical Governance meetings run alongside the ENT audit meeting with set clinical governance items including incidents, complaints, claims, SUI’s, compliments and relevant other clinical governance issues. The Clinical Governance Lead works closely with the one of the Surgical Division Matrons, Clinical audit lead and clinical director to move the issue of patient safety to the for front.

Adverse incidents: Reporting of incidents continues within the speciality and staff are actively encouraged to report incidents and near misses in order to escalate problems, resolve issues and monitor trends. The Speciality welcomes the new process of trigger incidents and the process of closing the loop. More than normal incidence of post tonsillectomy bleeds were noticed. A prospective audit is in progress. Meanwhile the clinical governance lead and audit lead together is monitoring each post tonsillectomy episodes every month. A pattern of adverse incidents noticed with a colleague was highlighted to the clinical director and previous surgical unit manager.

Complaints: Complaints remain low in numbers and in general highlight the need to improve communication with patients and clarify their understanding and expectations during consultations. Each complaints were discussed during the meeting, solutions were suggested and lessons learned and passed on to other colleagues.

Infection control: MRSA and C.diff. Up-dates are discussed at the monthly Sisters meeting and shared within the team. Infection Control link nurses are within each department and Infection Control is a standing item on the Speciality Junior Doctor training programme. The Speciality is involved in MRSA screening of all elective and emergency patients and monthly analysis
is carried out of compliance. The Speciality has no MRSA bacteraemia or C Diff cases to report on.

Clinical Audit: The department has continued with set audits. Audits for next year has already been allotted to the junior doctors and will include issues highlighted through incidents, complaints and national issues.

Guidelines: All NICE guidelines were discussed in the meeting and information disseminated to all members. VTE prophylaxis has been discussed and guidelines implemented and to avoid mistakes the green form is now files as the first page in the notes. Importance for writing relevant details in the radiology forms have been stressed.

GENITOURINARY MEDICINE: Dr Claire Ryan

The department of Genitourinary Medicine will retain its own clinical governance group, despite becoming part of the Women’s, Maternity and Genitourinary Medicine CSU. The group’s meetings remain well attended, with quorate meetings held on 10 monthly occasions out of the past year.

Infection Prevention and Control: Information for staff regarding hand washing, bare below the elbows and other infection prevention policies is well disseminated, with good compliance. All prescribers have been made aware of Trust antibiotic prescribing policy, and where it can be found on the intranet.

There have been a very small number of cases of flu amongst the HIV cohort. HIV patients were reminded about the need for seasonal flu vaccination this year, with a prompt given at each attendance in clinic.

Equipment at the Retford St GUM site requires updating in order to meet infection control standards. Discussions are taking place with the PCT, who are owners of the building.

Complaints: We received four complaints in the last year. All were reported directly to the department and all were handled to satisfactory conclusion following one to one discussion. Issues: one patient felt his wait was too long and was unhappy with the way his complaint was handled in clinic at the time. Another patient made a specific complaint regarding handling of his clinical information in relation to a police matter.

‘Your Opinion Counts’ forms. Most have been positive. The few complaints we have had, have focussed on long waits to be seen and a dislike of Jeremy Kyle on the TV!

Incident Forms: 82 incident forms have been completed since 1/4/10. Mislabelling of lab specimens remains a frequently occurring issue. We have been discussing the possibility of bar codes with microbiology, to prevent this issue.
Serious incidents involved: A handful of patients over treated by one junior doctor with liquid nitrogen. None made complaints. The doctor was re-trained and junior doctor training was revised.

A set of patient notes was left in a waiting room, where they were viewed by a member of the public. Outcome - No patients to be discussed outside of a clinical room.

Training and Education: All senior doctors in clinic have completed level 2 child protection training. Nurse practitioners are currently undertaking this training. Band 5 nurses are being actively trained to see asymptomatic patients and some follow up patients.

Staffing: Lack of senior medical cover remains an issue, with doctors regularly having to cover clinical sessions during their admin time. A shortage of consultant expertise in HIV medicine, and a need for a further consultant to provide this causes this issue to remain at red on our risk register. Nurse practitioners have developed very well in their roles, requiring less supervision from doctors.

Sickness absence in the department continues to breach targets. This is being actively managed in conjunction with human resources.

Audit: Presentation of audit has been incorporated into the monthly clinical governance meeting. Topics have included Hepatitis B screening and the CD4 CQUIN target. An audit plan is being prepared for the next 1-2 years.

As well as completing national and regional audits, some of the topics we plan to audit are CQUIN targets (re-audit), offered and accepted rates of HIV testing and offered and accepted rates of Hep B testing in men who have sex with men.

Goals for the Oncoming Year: Our main challenge will be to ensure that clinical governance is equitable cross sites. Representation from the Retford clinic will be assured for most meetings so that audits and updates in clinical practice will be rolled out equally throughout the Trust’s GUM department in the future.

MEDICINE: Dr Mahmoud Al-Khoffash

Achievements: There have been few significant achievements during the year, which I will mention but will not dwell on them in detail; neither there would be any figures, which obviously can be obtained if needed.

1. Infection control: Over the last twelve months there has been a significant improvement in infection control. There was only one case reported of mild septicaemia. As well, there has been significant reduction in the numbers of C-Diff infection in the first two quarters but towards the later end of the third quarter and the beginning of the fourth quarter we had a
couple of outbreaks of C-Diff infections, which I am glad to say were controlled quite quickly but they had impact on the figures of C-Diff infections.

There has been significant improvement in anti-biotic prescribing due to hard work of all colleagues.

2. VTE prophylaxis and documentation: There has been significant improvement in the documentation and prophylaxis of VTE over the past twelve months. Over 90% target achieved but the aim is for 100% achievement. The first hurdle has been overcome, which is getting everybody involved with regards to VTE prophylaxis and documentation and I have no reason to believe that 100% will not be achievable.

3. Complaints: There was a reduction in the number of complaints until the winter pressure months, when the number has increased, which is expected usually during those months. As well, there has been significant improvement in handling of the complaints in that now over half of them are dealt with within the appropriate period. Further work needs to continue with regards to handling of the complaints, as we need to achieve over 75% handling within the appropriate period of time.

JUNIOR DOCTORS HANDOVER: The system of handover has improved significantly and it is near perfect at Bassetlaw Hospital, where it is attended by all juniors and one of the Consultants, daily. It is also much better than it was at DRI.

All of the above is related to the morning handover but we are now working towards similar improvements on the evening handover for the on call teams, where there should be some form of handover at 5.00 pm and another at 9.00 pm when the on call teams change.

In Medicine we have two contributions to the TAPS programme; one regarding handover and the other regarding VTE prophylaxis and I am sure both of them will result in significant improvements of both, which is already showing.

FUTURE ARRANGEMENTS FOR CLINICAL GOVERNANCE: As the Clinical Division of Medicine ceased to exist from 1st November 2010 and was replaced by CSU’s, it was agreed that the three CSU’s (General and Acute medicine, Medical Specialists Federation and Care of the Elderly), will have their own Clinical Governance Groups and Leads. The current Clinical Governance Group was therefore disbanded from 9th February 2011 following its last meeting and I stepped down as Clinical Governance Lead, clearing the way for the appointment of three Clinical Governance Leads for the three CSU’s.
Organisational Structure: Within Medical Imaging 2 Clinical Governance Groups are well established - the membership and prescriptive agenda suggested in the Clinical Governance Strategy forms the basis of the main Clinical Governance Group, however a sub group monitors radiation safety and compliance with Ionising Radiation Legislation. Both groups meet monthly and cross-site representation is reflected in the membership. In order to disseminate information and share learning, Clinical Governance and Risk Management forms a standing item at the Medical Imaging Clinical Management Team and staff meetings.

Complaints Handling: Fortunately, Medical Imaging receives relatively few complaints, however all formal complaints are investigated fully and resultant action plans monitored by the Clinical Governance Team. The number of complaints relating to staff attitudes has decreased over the past few months.

Risk Management: The Senior Sister for Medical Imaging was appointed Patient Safety Champion a year ago, and has recently become a member of the Patient Safety Review Group. Her role includes monitoring and reviewing adverse incidents and risk assessments, with the assistance of the Quality Specialist Radiographer and Clinical Governance Lead.

Infection Control: The Infection Control Lead continues to audit and monitor compliance with Infection Control Procedures. Failure of referring teams to inform staff in Medical Imaging of potential infection control issues remains a concern; however, it is hoped that with the introduction of Order Comms- an electronic system for requesting diagnostic imaging – the situation should improve, as referrers will have the opportunity to document this electronically at the time a referral is made.

Training and Development: PDA’s have been completed and some staff have recently been appointed to training opportunities in specialist imaging modalities including Ultrasound and Mammography.

Patient Information: A review of patient information has recently been undertaken and standardisation of appointment letters in almost complete.

Areas of continuing concern:

Consent for Radiological Interventional Procedures: Non -Compliance with the Trust Consent Policy (PAT/PA2 v3) poses a significant risk to patient safety and to the Trust in terms of potential litigation and loss of reputation. Systems have been introduced by staff in Medical Imaging to try to ensure that referrers consent their patients prior to them attending the department, however despite the efforts made by staff in Medical Imaging, the last Audit in May 2010 demonstrated 27% non-compliance by referrers (reaudit is taking place in March 2011). It is anticipated that the introduction of Order Comms
and the WHO Checklist for interventional radiological procedures will improve compliance.

**Contrast Induced Nephropathy**

The CIN Guidelines were agreed at the Patient Safety Review Group in June 2010, however many referrers fail to document information relating to patients’ renal function on imaging requests. This poses a significant risk to patients. Documentation of recent blood results will become a mandatory field on Order Comms for relevant examinations.

**OMFS and ORTHODONTICS : Ms Ann Holmes**

There were 11 CG meetings in 2010/11, with 9 of the 11 meetings quorate. Membership of the group increased to 9 during 2010, with the inclusion of a second OMFS Staff Grade, to give the group a better balance and to hopefully ensure OMFS representation at the meetings. The Staff Grade is able to feedback, where appropriate, into the monthly OMFS Clinical Governance/audit meetings which are held jointly with the OMFS Department at RDGH, [OMFS working on split sites at Montagu and RDGH]. The group meets on the Wednesday following the CGSC meeting to allow prompt dissemination and cascading of relevant information. We also have the monthly audit meeting and the bimonthly staff meeting on the same afternoon to hopefully target relevant information in a timely fashion. Membership of the group has fluctuated throughout the year with colleagues on maternity leave and sick leave. The advent of the CSUs saw us loose a valued member of the CG group and the PSRG, Matron Kirsty Clarke, who has joined the Medical CSU. She has been replaced by Rosie Mews and we look forward to welcoming her to the team.

This year the CG Lead presented to the CGSC 2 issues where improvements had been made and 1 issue of concern that had been raised within the CG group. The Departments main area of improvement came from a reduction in the DNA rates, which fell dramatically, following the introduction of an appointment telephone reminder system. The Department requested to be part of the pilot scheme having seen the results from such schemes in General Dental Practice. The main area of concern focused on the lack of accurate and timely information produced in reports. It was felt that clinician involvement at the earlier draft stage of reports would enable some of the errors to be uncovered and rectified allowing decisions to be made on correct rather than misinformation.

**CG Lead Timeout**

The bimonthly lead time out sessions, introduced in 2009/10, continue to enable discussion of issues and guidance outside the CGSC which has proved helpful and supportive.

**Review of CG minutes**

reviews carried out by a member of the CGS working group has helped improve the minute taking and function of the group.

**Adverse incidents**

Staff have been encouraged to report all incidents. Incident reporting in the speciality is relatively low but as a predominantly out-patient
speciality and in orthodontics involving predominantly fit, healthy young individuals we are perhaps at ‘lower risk’ although we cannot afford to be complacent and this is an area where we need to improve. A recurring theme of incidents seem to be those of communication issues, with the absence of patient’s notes, leading to patient delays, repeatedly causing the most problems possibly due to our multi site working.

**Infection control** : MRSA and C.diff. up-dates are a standing agenda item. Regular hand hygiene audits are carried out by the infection control nurse.

**NICE** : There were no new NICE guidelines during 2010 for the Specialty.

**Clinical Audit** : Orthodontics play an active role in local and all regional and national orthodontic audits. We participated in 2 regional audits and 4 National audits in addition to in house DNA and patient satisfaction audits. The audit lead is present at all CG meetings and the monthly audit meeting follows on from the CG meeting. Given the small number of staff in the Department, we are justifiably pleased with the quality and number of audits that we complete each year involving staff of all grades.

**Staffing** : OMFS continues to rely heavily on the use of locum staff and incentive lists to maintain access times and treatment targets. The inability to attract and recruit a substantive second OMFS Consultant is an ongoing problem.

**OPHTHALMOLOGY : Mr Subramanian Dinakaran**

Ophthalmology did not have a Clinical Governance Lead for a long time. The following report is the limited activity that happened since September 2010 when I became the Lead.

- Regular monthly subspecialty meetings to discuss critical incidents and other issues based on the standard agenda.
- Streamlining and identifying the roles and responsibilities of Locum appointments in the department.
- Orientation package for doctors completed and circulated.
- An audit on cataract surgery complications commenced [Completion depends on the support from audit department]
- Concerns about Eye Clinic accommodation are being addressed by the CSU.
- Concerns about old phacoemulsification machines are being addressed and a business case is being prepared for replacements.

**Meetings:** Regular Subspecialty clinical governance sessions are held along with audit and business meetings. Meetings have representatives from all grades of staff including trainees.

**Audits:** Regular audits sessions precede the Clinical Governance sessions. We recently audited compliance for Venous Thromboembolism [VTE] and the
compliance was good. However some recommendations have been made. The audit details have been sent to Trust VTE Lead.

Complications audit: This audit could not be completed as planned due to lack of resources in the audit department and we could only get hold of one third of the planned volume of notes. This meant that we could not arrive at any definitive conclusion.

**Complaints:** Complaints are dealt with by the Business Manager and Matron and regular summaries provided to the subspecialty meetings.

**Critical Incidents:** All levels of staff are encouraged to report incidents that are initially dealt with by the matron and then discussed with the Clinical Governance Lead. These are then discussed in the monthly subspecialty meetings.

**Infection Control:** No major issues identified. Our team has been awarded Robert Storrs Trust Award by the Trust for Infection Control and Prevention. This was for a major change of practice adopted by our team to reduce risk of infection following cataract surgery.

**Staffing:** Due to lack of substantive staff the service has become dependent on locums. This is being addressed now. Two consultant posts have been advertised to fill the gap due to retirement of 2 existing consultants. Middle grade posts are to be advertised in the near future.

Appointment of Locum doctors as Locum Consultants have been regularised to allow appropriate responsibility being allocated to these post holders.

**Infrastructure / Equipment:** The eye clinic area is very inadequate for over 225 patients who visit the department every day. Most of the consulting rooms are very small with potential risks to many visiting the department. This issue I believe has been taken up with the Trust Board.

Our old phaco machines used for cataract surgery need replacing and we are in the process of getting a business case through for the procurement of new machines to improve safety and quality of care to our patients. In the mean time we are arranging for trial of new machines to identify the best for our needs.

**NICE Guidelines:** All appropriate NICE guidelines are implemented.

**VTE Prophylaxis:** Most of our patients could be exempt from the VTE prophylaxis in view the nature of the procedures but currently all of these patients are put through the trust wide assessment process.
ORTHOPAEDICS : Mr Hari Kumar

Membership: We have continued to have combined Clinical Governance meetings involving representatives from the DRI and Bassetlaw. Whenever possible we try and alternate the venue for the meeting between the two sites.

The Agenda: We have been using the recommended agenda, which addresses the relevant fields of concerns.

Incidents: The most significant incidents this year were three deaths, which occurred during cementing of prosthetic joints for fracture neck of femur in very sick patients.

This important matter was discussed at great length in our departmental meeting, and we also had a root cause analysis on the subject to try and minimize the risk of this happening in very sick patients undergoing hemi arthroplasty of the hip joint. It was decided that the Anaesthetist and the operating surgeon should communicate more with each other just prior to surgery and during surgery. This would definitely help to improve the situation. It was also decided to try to avoid cementing hemi arthroplasties in very sick patients and to use prostheses without cement in such patients. However, this decision had to be left to the operating team, who know the patient best.

Two incidents of patients being admitted with cellulitis and subsequently having PE were discussed earlier in the year. The importance of putting such patients on prophylactic anticoagulation was circulated to all the staff in the department. Subsequent reviews by Matron Kate Carville showed that the message has filtered through and such patients were being given thrombo-prophylaxis.

The next important issue is ensuring that thrombo-prophylaxis is administered and not just ordered. More work is underway to ensure that this becomes a foolproof system.

Infection control: The orthopaedic wards at the Bassetlaw Hospital encountered a problem with C difficile infection. Following this, regular antibiotic ward rounds were done and beds were ring-fenced for patients coming in for elective surgery. The importance of maintaining good hand hygiene was stressed to everyone in the department. All these measures brought the problem under control.

Complaints: As before, all formal complaints are discussed at our meetings and an action plan is drawn up. Education days for nursing staff are organized regularly at these meetings. Attitudes and behaviour as well as customer care issues are studied. This has helped dealing with complaints to a great extent.

Serious incident reporting has improved considerably. Matron tables all the serious incidents, which are discussed at our regular Clinical Governance
meetings, and lessons learnt from them are circulated to all members of the medical staff.

Area for improvement: The DVT prophylaxis reminders being put on the JAC system to regularly remind the junior doctors would certainly help in further reducing the incidence of DVTs and PEs.

Our top risk is falls and we are currently educating staff and improving the compliance to the Falls Policy, as recommended by the NPSA alert.

PATHOLOGY : Dr Richard Stott

2010 continued for Pathology with the constant background issues around patient identification, specimen labelling and blood transfusion risks.

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<th>Total Number logged</th>
<th>Graded as a Serious / Dangerous issue</th>
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</tbody>
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Implementation of the “order comms” software was delayed but, following a lot of work by Medical Imaging, Pathology and IT staff should now be delivered in 2011. For Pathology, it appears realistic to expect to eliminate 60 to 70 % of the medium & low risk errors made both in the laboratory and at requesting locations which use the system. This will include labelling the required sample tubes at the patient’s side using data scanned from barcodes on their ID wristband and therefore eliminates almost all high-risk errors for inpatients as well as ensuring we perform the tests intended by the doctor.

Implementation of the Blood Audit and Release System (BARS) was initially delayed due to insufficient ward staff having attended the available training, however the last blood issue fridge was locked down in November 2010. It is therefore no-longer possible for un-trained staff to collect blood units for transfusion and all staff members will need to demonstrate continued competence on a 3 yearly basis to retain their access rights. This completed the laboratory aspects required in response to the NPSA Right Patient, Right Blood alert. Ward based training and competencies remain an ongoing issue for all other aspects of the transfusion process. The remaining risk cannot be resolved by pathology staff alone, however it should be significantly reduced.
during 2011 via the implementation of the patient phase of the BARS system across two areas of the trust with the highest blood use. This will include automated sample labelling from the ID band, ensure correct storage and pre-transfusion compatibility checks occur and encourage post-transfusion monitoring. It will also record data from post-transfusion checks and which competent member of staff carried out each step of the process.

2010 also saw the recruitment of consultants and scientific staff into almost all of the vacant posts across pathology.

**PHARMACY : Julie Kay**

The pharmacy clinical governance group meet on a monthly basis. Meetings last approximately 2 to 3 hours. We follow the standard agenda as recommended by the clinical governance strategy. We have met on eleven occasions in the last 12 months

**Adverse Incident Forms:** Review of every Adverse Incident Form has highlighted trends and areas of concern. We review an average of 25 incident forms per month taking action as appropriate. Understandably, for a pharmacy department many of the incident forms are related to dispensing errors. The pharmacy has a rigorous approach to managing dispensing errors with all dispensing errors that have not been picked up by our checking procedures in pharmacy being put on a trust incident report. We audit our error rate on a monthly basis and take action if the rate increases above our standard. Action is taken as appropriate and frequency of monitoring increased until the situation is resolved. We also regularly audit the dispensing process reporting all captured errors and feedback these to our governance group and staff. The department has a dispensing training package that is undertaken with each new member of staff. There is a formal competency assessment of dispensing after approximately two months. All checking staff are revalidated every 12 months. We have training for staff undertaking checking competencies, which puts the individual through a simulation before undertaking their checking validation in the pressures of a busy dispensary. The error rates for individuals are also monitored and staff retrained and revalidated as appropriate.

**Production of new Guidelines :** The clinical governance group approves all new practice guidelines ensuring training packages are in place, competency assessments were appropriate have been designed and the guideline added to our audit plan.

Practice guidelines that have been implemented this year include

- Omitted and delayed medication-in response to NPSA/2010/RRR009
- Closing the loop-in response to previous medicines reconciliation audit
- Antimicrobials-ongoing trust priority
- Nomads-in response to incident reports
- Practice guidelines on documentation of medicines reconciliation-in response to SI involving medicines reconciliation issues
- Practice guidelines on medicines reconciliation-in response to SI involving medicines reconciliation issues
- Standard operating procedure on Medication History taking-in response to SI involving medicine reconciliation
- Prescription amendments to the electronic prescribing system-following widespread implementation of electronic prescribing

**SURGERY : Miss Clare Rogers**

Lead to July 2010: Niraj Khetan, Consultant Colorectal Surgeon  
Lead from September 2010: Clare Rogers, Consultant Breast Surgeon  
Deputy Lead: Michelle Corbett, Lead for Risk for Surgery

Meetings have been held monthly, except for the months of April and June 2010 when we were not quorate. A wide range of issues have been discussed through the year, some only briefly and some on a monthly basis. The Clinical Governance agendas have fed into the Clinical Audit programme and vice versa and clinical governance issues have also provided topics for education and training events.

There have been several standing items on the agenda. In general, we can report success meeting targets in relation to Healthcare associated infection and MRSA screening. Unfortunately, Louise Lowry's report into sepsis in feeding lines showed poor performance with an urgent need for training. The postgraduate department responded and doctors can now access the appropriate training. We hope to see an improvement in the coming year. Cefuroxime over-prescribing has been identified and is being monitored.

DVT prophylaxis has also been discussed monthly. We started the year performing poorly. Risk assessment has improved through the use of digital pens and following encouragement of juniors by consultants. We will not take this off the agenda until all patients consistently receive appropriate risk assessment and prescribing. Our General Manager, Peter Watson (now working for General and Acute Medicine), also secured funding for intermittent compression devices (SCDs) in theatre. Yvonne Walley, Matron for theatres and day surgery, has had a patient group directive for TED stockings approved for TAU. Staff training is now required before nursing staff can give TEDS on TAU.

In no particular order, other issues discussed included Bariatric Surgery, Fasting guidelines, management of Chest Trauma, staff shortages, medical handover, paediatric testicular torsion, blood cultures, reducing cardiac arrest calls, cell salvage, contrast induced nephropathy, medical outliers and the winter bed plan, group and save policies, consent training, death certification, NICE guidelines, new policies, complaints, staffing problems, the Francis report, Safeguarding Children, NPSA alerts, Trigger incidents, the NCEPOD report ‘An Age Old Problem’ and incident reporting. For the latter, we have agreed to set up a sub-committee to analyse reports and extract themes for discussion and further work. Complaints, incidents and the coroners report on

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rule 43 all show the importance of good communication, following procedures correctly, staff training, staff attitude and the need for support for patients being discharged.

Training and education events have been organised around issues including chest trauma, consent training and blood culture training. A new IPOC has been produced to support staff managing patients with chest trauma.

We are grateful for the support of our previous general manager, Peter Watson, his successor, Gaby Sadowyj, our Clinical Director, Willy Pillay and Deputy Medical Director, Ray Cuschieri. We also thank Niraj Khetan for leaving the Clinical Governance team in such a healthy state.

THEATRES : Linda McLoughlin

This is the third annual report on clinical governance for the newly named Theatres, Day Surgery and Endoscopy Clinical Services Unit (CSU). The report has been produced by the Clinical Governance Lead on behalf of the CSU Clinical Governance Team. The previous report provided an overview of the top 5 categories of adverse incidents reported and an action plan to address the identified themes. Since the last report much work/improvement have been achieved as follows:-

**Equipment**

- Improved and closer working relationship with the Medical Engineering department and theatre equipment is identified as priority.
- Commence weekly theatre scheduling meetings – as part of these meetings all equipment required is assessed and documented in order to ensure its provision/availability.
- The Productive Theatre Project (TPOT) – the CSU now has a Project Manager in post (since August 2010). Project groups were set up for each theatre site including all disciplines and various aspects of innovation and improvement are being explore. These include:-
  - team working
  - theatre restructuring/relocation of staff rest room
  - stocktaking/audit of consumables
  - storage/new storage racking
  - performance boards in each theatre complex
- A TPOT Team working and Human Factors Learning Event was arranged and delivered on the January 2011 Audit day.

**HSDU**

The key issues identified are currently being addressed as follows:-

- Torn wraps – particularly in Orthopaedics – new racking for trays has been installed and all heavy and consignment loan kits are now kept in rigid containers
Dirty instruments – the trend does seem to have reduced and is still currently being audited.

Broken/damaged instruments – work in still ongoing looking at the possibility of acquiring funding for implementing a rolling programme of purchasing and replacing instrumentation.

Unavailability of instruments – a process is now in place where possible to order instruments 24 hours in advance.

Audits are now undertaken on all Laparoscopy/Cystoscopy and Arthroscopy instruments checking functionality and quality. HSDU staff are awaiting retraining on Quality Control checking of all small/fine instruments.

Communication

The Bluespier System has recently been updated allowing even more data to be recorded and has resolved some of the previously identified issues.

The WHO checklist has also been implemented and recently updated which has had great impact on the safety aspect of checking patients into Theatre. This also fits into the Time Out Initiative which has also been introduced.

Total Number of Adverse Incidents – April 2010 – December 2010

<table>
<thead>
<tr>
<th>Month</th>
<th>No of incidents</th>
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<tbody>
<tr>
<td>April</td>
<td>40</td>
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<tr>
<td>May</td>
<td>41</td>
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<td>October</td>
<td>55</td>
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<td>November</td>
<td>58</td>
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<tr>
<td>December</td>
<td>49</td>
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</tbody>
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SUIs: There have been no SUIs from Theatres during this period.

Regular Activities within the Theatres, DSU & Endoscopy CSU: The Matron for Theatre is leading on a number of audits. An audit plan is to be compiled and submitted for all the CSU audits to be undertaken during the 2011/12 period. The plan will continue to be a live document.

Patient Safety First Campaign: The Theatre Matron is the CSU Lead regarding reducing surgical harm and surgical site infection. Audits currently carried out include:-

- WHO checklist audit – monthly and added to the infection control dashboard.
- Consent audit completed in January 2011 – awaiting results which will be fed back to the Patient Safety Review Group and Infection Control.
Reducing the risk audit – completed and passed 2009, 2010 and is scheduled for March 2011 in all areas/sites.

**Patient Transfer Audit** – concerns regarding the previous results of this audit were taken to the Patient Safety Review Group and highlighted as one of our concerns at the Patient Safety Sub Group. These included inappropriate escort and handover. Therefore escorting training was introduced from the Theatre CSU and rolled out to include Ward Staff/Service Assistants. The Patient Transfer Policy has been updated.

**Warming Devices Audit** – was carried out in February 2010 in accordance with Nice Guidelines. Work is currently ongoing to assess the requirement to increase the number of warming devices and core temperature monitoring.

**VTE Assessment** - A Directive for nurse prescribing TEDS has been agreed by the Patient Safety Review Group for the Day Surgery Units. This will improve patient care. The CSU plans to run a study day for VTE prophylaxis in June/July 2011.

**WOMEN’S SERVICES : Mr Eki Emovon**

- CNST Level 1 was achieved by the Women’s Directorate in December 2010. This was achieved following a 62 day improvement notice served in September 2010 as it became apparent on the day of the assessments that systems and processes in relation to policies and guidelines were unsafe. We are now working towards undertaking Level 2 in June 2012.

- A Patient Safety Team has been implemented in order to embed patient safety further within the culture of maternity services. This team consists of 2 senior midwives who are also Supervisors of midwives. The CSU envisage that a Deputy Matron post will be implemented with the remit also of Patient Safety Lead. Patient safety meetings are held on a weekly basis incorporating a multidisciplinary team. All wards and departments have patient safety boards and two members of the multidisciplinary team undertake a weekly patient safety walk round. Any themes or recommendations are distributed via the weekly patient safety bulletin.

- Following the Directorate CNST, assessment, held in December 2010 there, has been a large number of changes implemented within the Clinical Governance Forum within the Women’s Directorate. The Directorate viewed this as a positive change as Clinical Governance has always and continues to be implemented in a very robust manner. The Clinical Governance Forum, membership and Terms of Reference have been reviewed and altered accordingly. The maternity risk management strategy has been revised and approved by Trust board. Attendance at the Monthly meetings is mandate and if attendance cannot be facilitated a designated deputy must attend. A designated secretary attends all CG meetings and takes appropriate minutes, which will leave all members free to concentrate and contribute. A concise Maternity Services Quarterly Risk Management Report is produced by the
Patient Safety team and Matron and is discussed at the MGCGG meeting. This report is distributed to all wards and Departments and displayed on their Clinical Governance Boards/Patient Safety Boards.

- The agenda is now specifically set out and includes all pertinent headings to ensure that National, Trust and Divisional Clinical Governance Directives are discussed and addressed. The minutes taken and distributed reflect these discussions in a robust and concise manner. The minutes also have an action plan which is evolved from the discussions that take place during the meeting and this action plan is readdressed at the next meeting to ensure that actions are occurring and are implemented accordingly.

- The Quarterly Maternity Risk Management Report is now fed back to the Patient Safety Review Group and Trust Clinical Governance Standards Committee.

- Clinical Governance is now a designated agenda item on all other Directorate Forums such as Perinatal Mortality Meeting and Audit to ensure that the Clinical Governance loop is closed within all areas.

- All Directorate investigations and Root Cause Analysis information is disseminated to all wards and Departments to be displayed on their Clinical Governance Boards. Serious Incidents are investigated as per Trust SI policy and action plans are implemented and revisited on a quarterly basis. Feedback from all RCA’s is given to all members involved in the discussions and meeting. The Division also produce a Serious Incident progress/feedback report on a monthly basis which is discussed at the MGCGG meeting.

- The Family Service Division Have devised and updated the Maternity Risk Register from 2008 and liaises closely with the Trust Risk Office in relation to this.

- A review of the Maternity Risk Management Strategy key objectives in also undertaken within the Clinical Governance forum to ensure compliance with the NPSA risk management assessments.

- The Directorate has acknowledged that both midwifery and Medical staffing levels have continued to be an issue and have recently appointed new midwives to address this problem. The appointment of a number of new Consultant Obstetricians is currently under review.

- Recurring themes and trends are recognised and audited in a robust and prompt manner.

- The Directorate have worked very closely with the Maternity Services Liaison Committee to engage user representatives within the Clinical Governance and Audit Forums. There is now a user representative on each of these Forums.
The CSU has also implemented use of the SBAR communication tool which is discussed with all staff on the mandatory ‘Big Issues’ study day.