

**Minutes of the Clinical Quality and Governance Committee (CQuaC)**  
**Thursday 26<sup>th</sup> November 2009**  
**8 – 8.45 am, WGH Executive Meeting Room**

**Present:**

Colin Johnston	Medical Director (Chair)	CJ
Mahdi Hasan	Non-Executive Director	MH
David Evans	Respiratory Consultant / Audit Lead	DE
Andrew Barlow	Clinical Lead – Oncology	AB
Tony Divers	Clinical Director – Radiology	TD
Martin Keble	Chief Pharmacist	MK
Nick Evans	Director for Partnerships	NEv
Russell Griffin	Clinical Director – Surgery	RG
Sarah Childerstone	Director of Workforce	SC
David Griffin	Clinical Director – Gynaecology	DG
Phil Bradley	Deputy Director of Finance	PB
Robin Wiggins	Clinical Director of Pathology	RW
Susan Osborne	Interim Director of Nursing/Patient Services	SO
Kevin Rosenfeld	MSC Chair	KR

**In Attendance**

Pauline Gilroy	Tissue Viability Nurse	PG
Nick Egginton	Clinical Governance & Risk Manager	NEg
Sirajul Islam	Clinical Governance & Risk Manager	SI
Pamela Mudie	PA Clinical Governance & Risk	PM

		Action
<b>09.1</b>	<b>Apologies for Absence:</b>  Mark Jarvis                      Associate Dir. Integrated Governance	
<b>09.2</b>	<b>Minutes of the previous meeting - Thursday 3<sup>rd</sup> September 2009</b>  The Minutes of the CQuaC meeting on 3 <sup>rd</sup> September were approved subject to the date at the bottom of page 2 being changed from 2009 to 2010	
<b>09.3</b>	<b>Matters Arising</b>  CJ opened the meeting and commented that the CQuaC meeting was scheduled at the same time as CPOP meetings in order to increase attendance. CJ noted to the Committee the concerns that the Trust's structures required further development to ensure high level review of governance and risk activity. The matter was considered at the Trust Board who agreed that the General Governance Committee should be constituted as a formal Board sub-committee, chaired by a Non Executive Director. It is intended that meetings of this Committee will take place immediately after	

	<p>the CQuaC meeting. Both meetings will take place bi-monthly. CJ emphasised the importance of maintaining robust clinical input into the business of the CQuaC but that it was anticipated that this clinical input will also add value to the business of the General Governance Committee and it is anticipated that members of CQuaC will attend both committees. CJ confirmed he would chair the CQuaC meeting. MH will chair the General Governance meeting as it was a board sub committee.</p>	
<b>09.3.1</b>	<p><b>Discuss and agree CQuaC Terms of Reference</b></p> <p>MH and CJ will agree the most efficient ways to feed back from the two committees (CQuaC and General Governance) to the Board, trying to ensure there is no duplication of information.</p> <p>PD clarified that as the Asst Director for Clinical Governance and Risk she will provide managerial support to the Chair in relation to the administration of the meetings.</p> <p><b><u>Remit</u></b></p> <p>CJ clarified that the authority of the group is one of advisory to the Chief Executive – it will be for the CEO to take actions as necessary. It was confirmed that access to the Board on issues within the Committee's terms of reference would be via the GGC Chair, MH.</p> <p>CJ noted that the Care Quality Commission (CQC) is introducing a system of registration based on an organisation's 'Fitness for Practice', rather than one based on an annual assessment (as was the case with Core Standards for Better Health). Registration will be based on the Trust achieving specific outcomes for patients and the Trust will have to ensure it is meeting the standards expected within the registration framework. The CQuaC will have an assurance role in relation to registration.</p> <p>In addition, the Department of Health requires that from April 2010 all Trusts publish Quality Accounts – similar to the annual publication of the Annual Report and Accounts (financial). The Trust is currently developing its Quality Accounts, which will summarise how it can demonstrate delivery of quality services and identified quality targets it is working to achieve. A draft will be circulated in early January however it is unlikely to be ratified until March 2010.</p>	<p><i>Action: The completed The Terms of Reference would be ratified at the January meeting.</i></p>
<b>09.3.2</b>	<p><b>Matters Arising - CQuaC Tracker</b></p> <p>The Tracker was reviewed and updated</p>	
<b>09.3.3</b>	<p><b>Pressure Ulcers</b></p> <p>SO introduced Pauline Gilroy who presented the 'Pressure Ulcer Incidents Report for July – September 2009 (Quarter 2)' previously circulated to the Committee. PG pointed out that there were 143 pressure ulcers acquired</p>	<p><b>Actions:</b> <i>It was agreed that pressure ulcer prevalence should be included within Ward Quality</i></p>

	<p>on the wards, which is the highest number since April 2006. SO said this is a 'litmus test' on the nursing care and more work is needed to discover the cause. On many wards such as AAU the staff are very busy so it is a challenge to ensure patients at risk are getting appropriate care. Pressure ulcers can be caused by a number of factors and more likely in immobile patients and older patients with co-morbidities. Nutrition is very important to maintaining skin integrity and helping offset risks through immobility and illness. SO believes this reflects problems at grass root level and is an issue of appropriate nurse leadership and supervision. However SO asked for advice on tackling this as it is not just a nursing problem, it is a clinical quality issue. CJ questioned the accuracy of the figures, and was reassured that all the acquired ulcers are hospital acquired. PG stated that all Grade 3 ulcers and above are reviewed to determine whether they are hospital acquired and AAU undertakes spot checks. Although nursing notes are completed PG noted documentation is variable and needs to be improved. CJ suggested publishing the data at ward level as a driver in a similar way to 'Hand Hygiene'. AB questioned why rates are so high in AAU as these must be 'community acquired'.</p>	<p>and Safety metrics. CJ recommended that the medical team should be included in the monthly team meetings. CJ asked that the medical team should also be at monthly team meetings and involved in root cause analysis. CQuaC to be kept updated on this.</p>
<b>09.4.</b>	<p><b>Reports and Minutes</b></p> <p><b>BISE Monday 12<sup>th</sup> October 2009</b></p> <p>Circulated with minutes for information</p>	
<b>09.5.</b>	<p><b>A.O.B</b></p> <p>DatixWeb presentation to be made at the next meeting in Jan</p>	
<b>09.6.</b>	<p><b>Date of next meeting:</b></p> <p>8 – 8.45 am on Thursday 21<sup>st</sup> January 2010</p> <p>in the Executive Meeting Room (Spice of Life) WGH</p>	