Summary of the St George's Healthcare NHS Trust (SGH) Clinical Quality Review Meeting Wednesday 16th July 2014 from 09.00 – 11.00

1.	**February CQC Inspections – Main Themes and Trust Response** • The Trust achieved an overall rating of good, though two issues of compliance were identified (1. Staff Understanding of the Mental Health Capacity Act at Queen Mary's Hospital, and 2. Availability of records in Outpatients) to which an action plan has been developed in response. • It was noted that the issues raised by the CQC were already known to the Trust, and the actions included in the CQC compliance action plan regarding medical records in corporate outpatients are a subset of a wider Corporate Outpatients action plan. Actions include the recruitment of permanent staff to replace temporary staff and a 'perfect week' style tracking event from Monday 28th April to Friday 2nd May to locate and track all notes across the main site, which has been completed and re-audited during the perfect week event in July (3rd – 9th). • Commissioners will monitor the Trust's progress with the CQC action plans on a quarterly basis, as an addition to the established CQR meetings. The monitoring meetings will commence in October 2014 on the third Wednesday of the month, from 10.30-11.30am.
2.	**Patient Story DVD (Cardiology – Patient lost in the system)** • Patient story DVDs are used to share learning from incidents with staff across the Trust. The CQRM group watched the story of a patient whose details had been lost and died while waiting for heart surgery, as told by his two stepdaughters. • TC noted that a similar Serious Incident has taken place recently, in which a patient passed away while awaiting an appointment date regarding candidacy for an implantable cardioverter defibrillator (ICD). This SI is expected to be discussed in August. • The processes and management of cardiology waiting lists will be discussed further at the August CQRM.
3.	**Performance** • **MRSA & C.Diff:** There were an additional 5 C.diff cases (11 YTD) and 1 incidence of MRSA in June. • **Pressure Ulcers:** There were 2 Grade 3 and 4 pressure ulcers in June.
4.	**Quality Reports** • **Clinical Risks:** It was confirmed that the ongoing work to address risk reference B287 (four types of defibrillators in use with non-interchangeable electrodes) is nearly complete. It was noted that risk reference CW060 (delays to patients receiving chemotherapy on the Trevor Howell Day unit) is a new risk and has not yet been discussed at CQRM. The risk has been caused due to physical capacity constraints. Risks related to the failure to follow up on ordered investigations will be included on the risk register for July.

5.	**Serious Incidents**
	• Serious incidents concerning two Misplaced Nasogastric Tubes (one of which was considered a Never Event), Failed Discharge, Missed Follow Up and a Retained Throat Swab (Never Event) were discussed. The following closure reports are expected for discussion in August:
	  ○ Failure to Act on Abnormal Results
	  ○ Length of Wait for an Appointment

NB: This is a summary of minutes that are in draft. The minutes of this meeting will be ratified on Wednesday 20th August 2014.