

GREATER GLASGOW AND CLYDE NHS BOARD

**Minutes of a Meeting of the  
Greater Glasgow and Clyde Clinical Governance Committee  
held in the Conference Room, Dalian House,  
350 St Vincent Street, Glasgow, G3 8YZ  
on Tuesday 6 April 2010 at 1.30 pm**

**P R E S E N T**

Prof D H Barlow (in the Chair)

Dr C Benton  
Mrs J Murray  
Councillor Amanda Stewart

**I N A T T E N D A N C E**

Ms J Brown	..	Head of Nursing, Emergency Care & Medical Directorate (Minute 23)
Dr B N Cowan	..	Board Medical Director
Mr A Crawford	..	Head of Clinical Governance
Mrs R Crocket	..	Board Director of Nursing
Dr J Dickson	..	Associate Medical Director, Clyde
Mr B Gillespie	..	Auditor, Audit Scotland
Ms A Hawkins	..	Director of Mental Health Partnership (Minute 24)
Mr D McLure	..	Senior Administrator
Dr D A Stewart	..	Associate Medical Director, Emergency Care & Medical Directorate (Minute 23)

**ACTION BY**

**16. APOLOGIES**

Apologies for absence were intimated on behalf of Mrs P Bryson, Mr R Cleland, Dr M Kapasi, Mrs E Smith and Mr A O Robertson.

**17. MINUTES**

The Minutes of the meeting held on 2 February 2010 were approved.

**18. MATTERS ARISING FROM MINUTES**

Research Governance

Further to Minute 8, Professor Barlow advised that Professor Hunter was in the process of seeking clarification from Professor Wyper on the role of Scottish Health Innovations Limited (SHIL) within the governance framework. It was anticipated that a report would be available for the next meeting.

**Prof HUNTER**

**NOTED**

## **19. LOCAL SUPERVISING AUTHORITY (LSA) ANNUAL REPORT**

Mrs Crocket presented a paper on the West of Scotland Local Supervising Authorities' Annual Report to the Nursing and Midwifery Council (NMC) for the period 2008/9 on the supervision of Midwives. NHSGG&C was one of four Local Supervising Authorities (LSA) in the West of Scotland. Each Health Board had a statutory responsibility to ensure that the appropriate arrangements were in place for the supervision of their midwives. Each LSA was responsible for ensuring the safety of the public through the effective supervision of midwifery practice which was achieved through the promotion of best practice, preventing poor practice and intervening in unacceptable practice. It was a requirement of the reporting arrangements that annual reports were brought to the attention of the Clinical Governance Committee. The Board's Chief Executive had signed off the LSA Report for NHSGG&C.

Mrs Crocket gave a detailed list of key achievements over the reporting year 2008/9. NHSGG&C was complying with all the NMC stipulations with the exception of the requirement to have one supervisor to fifteen midwives. The report described the NHSSGG&C ratio as being 1:17, but had recognised that plans were well developed to achieve a ratio of 1:14 by September 2010.

In response to questions from members, Mrs Crocket outlined the procedures in cases where concerns had been raised about a midwife's practice or where a midwife felt that inappropriate requirements were being made by management. She also confirmed that private midwives within the Board's area were also subject to the NMC standards and LSA supervision.

### **NOTED**

## **20. CLINICAL INCIDENTS AND FAI REVIEWS**

Dr Dickson presented a written summary updating the Committee on Clinical Incidents and FAI Reviews. He commented on the situation regarding current cases. One expected FAI had not taken place. Determinations were awaited in respect of three FAIs, while three FAIs were pending.

At the last meeting it had been noted that while action plans had been completed for two Significant Clinical Incidents in the specific Laboratory disciplines concerned, the Associate Medical Director for Diagnostics had then decided that these should be rolled out to other laboratory disciplines. Dr Dickson advised that this had now taken place.

### **NOTED**

## **21. OMBUDSMAN REPORT**

Dr Cowan raised concerns surrounding a case in the recent Ombudsman's report to the Scottish Parliament which had also been profiled in the Press. The Ombudsman had been critical both of the clinical approach that had been followed and the handling of the complaint. Dr Cowan gave a detailed outline of the criticisms. The Board fully accepted those relating to the handling of the complaint and Dr Cowan explained the actions that had been taken in response. However the Board did not concur with the criticism of the clinical approach to the case. There was a divergence of view between the Ombudsman's clinical experts and those of the Board who had reviewed the case. This was one of a number of similar cases where it seemed to the Board that the Ombudsman's reports did not appear to have taken into account expert clinical opinion that differed from that obtained by the Ombudsman.

Mr Crawford presented a paper on cases considered by the Scottish Public Services Ombudsman for the period October to December 2009 together with information on action taken. He drew attention to the fact that the Ombudsman had highlighted consent as one of the key issues emerging from the investigation of complaints across the NHS in Scotland. In response he had reviewed the Board's Consent Policy. It appeared to be adequate although he had been aware of the need to ensure that sufficient time was being spent on the consent process at pre-assessment clinics. Professor Barlow sought clarification on the term "proper informed consent" as used in the report. Mr Crawford agreed to report back on this to the next meeting.

**Mr CRAWFORD**

Mrs Murray referred to one of the cases in the report relating to the Department of Obstetrics and Gynaecology at the Southern General Hospital. She was concerned that the issues being highlighted included those which she had been aware of some two years previously and then had raised with the Director of Nursing. It was possible that the case related to that time period. This would be checked by Mr Crawford.

**Mr CRAWFORD**

### **NOTED**

## **22. INFECTION CONTROL UPDATE**

Mr Walsh presented the NHSGG&C Healthcare Associated Action Plan progress update for April 2010. The current figures relating to the Board's performance in respect of each of the five areas (*S.aureus* Bacteraemias, *C.difficile*, Surgical Site Infections, Hand Hygiene Compliance and Monitoring of Cleaning Services) showed satisfactory compliance with each of the national targets.

Mr Welsh advised that the format for future reports would be changing due to new national requirements. It was expected that the new format would move away from the current emphasis on Statistical Process Charts. He invited comments from members on the form that future reports should take. Professor Barlow felt that the current charts were a helpful facility in seeing progress and trends over periods of time. Mr Walsh agreed that when the report was presented according to the new requirements, a parallel report should also be submitted to the Committee using the current format in order that the usefulness of both could be compared.

**Mr WALSH**

Councillor Stewart drew attention to the lack of detail within the National Cleaning Services Monitoring section of the report on the implementation of action plans in areas that had received a red score, which equated to less than 70%. Mr Walsh agreed that such information should be obtained from the Facilities Directorate for inclusion in future reports.

**Mr WALSH**

Dr Benton enquired of trends relating to the utilisation of Antibiotics and whether these could be brought into future reports. Mr Walsh advised that the Board had an Antimicrobial Utilisation Subcommittee which reported through the Pharmacy and Prescribing Unit headed by Dr McKean. Mr Crawford would approach Dr McKean about giving a presentation to the Committee on the work of the Antimicrobial Management Team.

**Mr CRAWFORD**

### **NOTED**

## **23. CLINICAL GOVERNANCE IN EMERGENCY CARE AND MEDICAL DIRECTORATE UPDATE**

Dr Stewart commenced the presentation updating the Committee on Clinical Governance within the Emergency Care and Medical Services Directorate by outlining the scope of the Directorate, the specialities involved and the Clinical Governance structure. He highlighted five challenges facing the Directorate:-

- Increasing demands on services
- Bed pressures
- HEAT targets
- Achieving financial savings
- Winter pressures.

Turning to the Clinical Governance agenda, he identified five major successes:-

1. A full structure of Clinical Governance arrangements were in place within each specialty, monitored by the Directorate Clinical Governance Committee.
2. Systems such as DATIX had been implemented to analyse complaints and clinical incidents. The dramatic improvement in dealing with complaints that had been reported at the last presentation had been well sustained.
3. Quality measurement systems had been developed such as Clinical Quality Indicators and SPSP care bundles.
4. Learning reports had been developed to disseminate learning.
5. Collegiate working relationships had been established with child protection and learning disability teams.

Dr Stewart then dealt with four areas illustrative of Clinical Governance activity within the Directorate:-

#### The Medicines Governance Group

The focus of the group, which was multidisciplinary, was on the safer use of medicines. It provided a forum for the monitoring of quality, the development of solutions, the dissemination of learning and the commissioning and reviewing of audit. The group produced a medicines governance report which included the highlighting of incidents, learning points and good practice.

#### Infection Control Group

The group had been formed since the last presentation given to the Committee. Its membership covered medical, nursing, pharmacy, infection control and Antimicrobial Team representation. Its activities included the review of policy implementation on such as hand hygiene and antibiotics. He illustrated successes within the Directorate both in terms of the reduction in new MRSA cases and, even more impressively, in new *c.difficile* cases.

#### Monthly Directorate Clinical Governance Reports

The reports were compendiums of clinical governance reports covering infection control, clinical incidents, complaints, child protection, SPSP progress and other relevant areas. They were circulated widely to clinical staff and managers, were discussed in detail at monthly Directorate Management Team meetings and reviewed bi-monthly at the Clinical Governance Forum.

#### Patient Safety Matters Event

The Clinical Governance Forum had organised a Patient Safety Matters event in June 2009 at the Beardmore Hotel which had been attended by over 100 staff, invitations having been extended to all clinical staff and managers. The programme had illustrated governance activities that had made a difference. Feedback had been excellent and a further meeting was planned for June 2010.

Dr Stewart advised that the new NHSQIS Quality Strategy was awaited in order to inform the Directorate work plan for next year. SPSP would be further developed in collaboration with the Board's Head of Clinical Governance. The Leading Better Care programme would be implemented.

**DECIDED:-**

That the presentation and report reflected ongoing satisfactory progress in Clinical Governance within the Emergency Care and Medical Directorate.

**24. MULTI AGENCY PUBLIC PROTECTION ARRANGEMENTS (MAPPA) GOVERNANCE REPORT**

Ms Hawkins presented a report giving an overview of the introduction of MAPPA and the role of NHSGG&C in the process. The report covered the three years (2007-2010) that MAPPA had been operational.

MAPPA were the arrangements put in place following legislation covering multi-agency assessment and management of potential risk from categories of offenders considered to pose a risk of serious harm. Restricted patients (whether violent or sexual offenders) had been included since April 2008 which had brought the Health Service into "Responsible Authority" status. The statutory responsibilities of NHSGG&C were (i) the duty to co-operate with other agencies where an individual came within the MAPPA process and (ii) to be the Responsible Authority for all restricted patients under the care of the Mental Health Services in Greater Glasgow and Clyde. The range of duties included:-

- Sharing information, securely and in accordance with the law and MAPPA guidance;
- Receiving such information in order that risks within the health settings could be managed;
- Ensuring that clinicians worked with the other agencies involved where an individual was receiving ongoing contact with the health service;
- Ensuring that resources within NHSGG&C were made available in such ways as to effectively manage the risk of harm to others;
- Acting as a single point of contact for other agencies;
- Playing a role in the strategic and operational development of MAPPA;
- Providing a central role in risk assessment and management.

Ms Hawkins outlined the MAPPA organisational structure and the NHSGG&C representation on the various Strategic and Operational Groups. She gave details of the three MAPPA levels which reflected the current risk posed by the individual and the complexity of risk management, together with the current numbers of individuals at each level within the Board's area.

In the light of the developing and evolving nature of the current process, NHSGG&C had established an internal MAPPA Reflection Group chaired by the Director of the Mental Health Partnership. The objective was to review the implementation and operation of MAPPA in the Board's area and the role that health played in the process. Ms Hawkins highlighted the various outcomes that had been developed. She also submitted, for the Committee's information, a range of guidance documentation that had been produced for relevant categories of staff.

**DECIDED:-**

1. That the arrangements and processes in place for handling MAPPA within NHSGG&C be noted.
2. That the Committee should receive annual reports on the development and handling of MAPPA.

**Ms HAWKINS**

**25. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)**

Mr Crawford presented a paper updating the Committee on SPSP implementation within NHS Greater Glasgow and Clyde. He drew attention to the continuing good progress being made in implementing all key changes in the pilot populations.

The Medical Director had approved the initial development of a support structure to facilitate Directorates in meeting the target of 90 new ward teams within the Acute Services Division. Discussions within Directorates were progressing well. Consequently it was anticipated that both the Rehabilitation & Assessment and Surgery & Anaesthetics Directorates would be fully involved through phase four, together with all adult in patient theatre areas and all wards in the Royal Alexandra Hospital.

A programme for implementation of a Paediatric workstream was almost complete in Women and Children's Services, linked to a dedicated national steering group. The development of a local Mental Health programme was progressing steadily, with a number of staff having attending a training event in February.

Following discussion at last meeting (Minute 4), Mr Crawford submitted a revised version of the NHSCC&C aim in respect of implementing SPSP to reflect the rolling out of the programme beyond the Acute Services Division. This was discussed.

**DECIDED:-**

1. That the report represented continued good progress within NHSGG&C.
2. That the wording of the Board-wide SPSP aim should be:-  
"The overall NHSGG&C aim is to ensure the care we provide to every patient is safe and reliable. The local implementation of the Scottish Patient Safety Programme will contribute to this aim".

**Mr CRAWFORD**

**26. CONTROLLED DRUGS QUARTERLY REPORT**

Dr McKean, Head of Pharmacy and Prescribing Support Unit, had submitted a quarterly occurrence report in respect of Controlled Drugs covering the period from October to December 2009.

**NOTED**

**27. MINUTES OF REFERENCE COMMITTEE**

The minutes of the meeting of the Reference Committee held on 16 December 2009 were received, together with a summary paper highlighting key issues.

**NOTED**

**28. MINUTES OF INFECTION CONTROL COMMITTEE**

The minutes of the meeting of the Infection Control Committee held on 25 January 2010 were received, together with a summary paper highlighting key issues.

**NOTED**

**29. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP**

The minutes of the meeting of the Clinical Governance Implementation Group held on 19 March 2010 were received, together with a summary paper highlighting key issues.

**NOTED**

**30. MINUTES OF ORGAN DONATION COMMITTEE**

The minutes of the meeting of the Organ Donation Committee held on 3 March 2010 were received, together with a summary paper highlighting key issues.

**NOTED**

**31. DATE OF NEXT MEETING**

The next meeting of the Committee will be held on Tuesday 1 June 2010 at 1.30pm in the Conference Room, Dalian House, 350 St Vincent Street, Glasgow.