

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 3 August 2010 at 1.30 pm**

P R E S E N T

Prof D H Barlow (in the Chair)

Dr C Benton
Mrs P Bryson
Mr R Cleland
Dr M Kapasi
Mrs J Murray
Mr A O Robertson
Mr D Sime

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

Mr B Gillespie	..	Audit Scotland
Mr A Crawford	..	Head of Clinical Governance
Mrs R Crocket	..	Board Director of Nursing
Dr J Dickson	..	Associate Medical Director, Clyde
Mr M Feinmann	..	Director, East Glasgow CHCP (Minute 56)
Ms D Forsyth	..	NHS Graduate Trainee & Project Manager
Mrs A Hawkins	..	Director, Mental Health Partnership (Minute 57)
Dr G Jackson	..	Associate Medical Director, Mental Health Partnership (Minute 54)
Mrs J Metcalfe	..	Clinical Director, Child & Adolescent Mental Health Services (Minute 56)
Dr A Mitchell	..	Clinical Director, East Renfrewshire CHCP and Renfrewshire CHP (Minute 55)
Mr D McLure	..	Senior Administrator
Dr P Ryan	..	Clinical Director, North Glasgow CHCP (Minute 55)
Mr T Walsh	..	Infection Control Manager
Dr L J Watt	..	Medical Director, Mental Health Partnership (Minute 54)

ACTION BY

50. APOLOGIES

Apologies for absence were intimated on behalf of Mrs E Smith, Councillor Amanda Stewart and Mr B Williamson.

51. MINUTES

The Minutes of the meeting held on 1 June 2010 were approved.

52. MATTERS ARISING FROM MINUTES

Informed Consent

Further to Minute 34, Mr Crawford submitted a written summary of the context of the case in the Department of Obstetrics and Gynaecology at the Southern General Hospital that had been investigated by the Ombudsman relating to proper informed consent.

NOTED

53. ANNUAL CLINICAL GOVERNANCE REPORT 2009/2010

Mr Crawford submitted a draft Annual Clinical Governance Report for 2009/2010 for consideration. He requested that members should examine the report and respond to him with comments and recommendations prior to the final version being produced. He drew attention to a number of aspects of the report:-

- The report was only able to reflect a very small proportion of the total activity intended to evaluate and improve the quality of care throughout NHSGG&C due to the size of the organisation. It sought to give an overview of strategically significant issues and a brief insight into the extent of local improvement practice.
- Following the publication of the findings from the NHSQIS Clinical Governance and Risk Management Review, NHSGG&C was now monitoring the effectiveness of its arrangements for clinical governance and quality improvement.
- With regard to Patient Safety and Clinical Risk Management, there had been an increase in Significant Clinical Incidents (SCIs) over the last three years. This did not mean deterioration in the organisation's approach but reflected a growing confidence on the part of staff in identifying issues and reporting incidents.
- In relation to Clinical Effectiveness, there had been over 100 national guidance publications during 2009/10. Consequently, the Board had to prioritise those issues being addressed locally.
- The section on the outcome of the strategic reflection on the themes arising from the last four years' reports had identified four key themes for further debate and development.

DECIDED:-

1. That members should examine the report and send Mr Crawford individual questions and comments.
2. That, thereafter, Mr Crawford would submit a final version of the report for the Committee's approval.

MEMBERS

Mr CRAWFORD

54. CLINICAL GOVERNANCE IN MENTAL HEALTH PARTNERSHIP UPDATE

Dr Watt referred to the Mental Health Partnership Clinical Governance Annual Report, August 2010, which had been circulated to members previously. The report detailed (i) the Clinical Governance structure and arrangements within the Partnership; (ii) the details of the workplan for the current financial year, and (iii) four examples of Clinical Governance activity which had recently been carried out.

Dr Watt highlighted the four projects which were:-

- ESTEEM Glasgow was an early intervention service providing comprehensive mental health services to people aged 16 to 35 with a first episode of psychosis. The study showed the effectiveness of a dedicated specialised service within NHSGG&C compared with NHS Lothian which did not have such a service. A report had been sent to the Scottish Government to illustrate the justification of greater investment for such a service.
- The Perinatal Mental Health Service provided a comprehensive service for women suffering from mental illness requiring secondary care interventions during pregnancy or in the first postnatal year. The service was audited annually against a set of national standards covering all fifteen such units in the United Kingdom. Mr Robertson raised concerns that the proposed move of the Mother and Baby Mental Health Unit away from the Southern General Hospital campus in proximity to the Maternity Unit, could affect the service provided. Dr Watt advised that it was more advantageous for the patients to be nearer an adult psychiatric unit than a maternity unit. Furthermore there would be swift transport arrangements to the Maternity Unit from the new location.
- Core audit schedules had been developed for both Community Nursing Standards and Ward Management Standards. The core standards related to documentation and record keeping, medication administration, communication, and user and carer involvement. Participation in this systematic self audit was from nursing services across NHSGG&C. There was a widespread view that the project was highly successful with the development of a culture of quality improvement in local areas being among the benefits. Dr Watt indicated that it was hoped that it would become multi-disciplinary.
- The Dementia HEAT target was for the number of people with a diagnosis of dementia to be 61% of expected prevalence. The estimated number of people with dementia in NHSGG&C area was 14,000.

Dr Jackson gave a presentation on the Dementia HEAT target. He explained that Dementia crossed over a range of disciplines other than Mental Health. There had been a steep rise in the incidence of the illness, but there was no resultant significant increase in consultant staffing. Dementia was a national clinical priority, governed by the National Dementia Strategy. NHSGG&C was well in excess of the HEAT target which was that 61% of those with a diagnosis of dementia should be on the GP Dementia Register. There were three supporting measures that the Board had to demonstrate in relation to the target:- (i) the percentage of patients whose care had been reviewed in the previous fifteen months; (ii) that appropriate information was offered to patients and carers on diagnosis, and (iii) the number of people aged 70+years with a diagnosis of dementia recorded from acute hospitals.

Dr Jackson outlined a wide range of current activity taking place throughout NHSGG&C. He highlighted the application that had been submitted to the Scottish Government that South Glasgow should be a Scottish Demonstrator Site for Dementia Strategy.

In response to questions from members, Dr Jackson and Dr Watt confirmed that (i) Downs Syndrome patients were comprehensively provided for by the Learning Disability Service within NHSGG&C and that initial signs of Dementia in these patients would also be identified by General Practitioners, and (ii) there were good links between Old Age Psychiatry and medical specialities.

DECIDED:-

That the presentations reflected satisfactory progress in Clinical Governance within the Mental Health Partnership.

55. CLINICAL GOVERNANCE IN CH(C)PS UPDATE

Dr Ryan referred to the CH(C)P Clinical Governance Forum Development Plan for 2010/11 which had been submitted for members' consideration. This detailed (i) the aims and the actions set out to meet them; (ii) the Leads responsible for taking the aims forward, and (iii) the progress relating to each action point and the anticipated completion date. He also presented the most recent Clinical Governance Forum report which reflected the main points of activity across the CH(C)Ps in the last quarter. He highlighted the progress of Datix Implementation from which a great deal of information was now being submitted. Feedback had been given to those involved in reviewing and approving the progress of logged incidents in order to avoid delays in the process. Training was also being given for existing paper based risk registers to be made electronic. The other main area of activity he outlined was the range of Clinical Effectiveness projects that had led to improvements to services and the patients' experience in CH(C)Ps. He provided summaries of the improvements resulting from each project.

Dr Mitchell gave a presentation on the findings from the participation by all GP Practices within East Renfrewshire CHCP in the Closer Working Clinical Governance work programme for 2010/11 in respect of the management of depression including the prescribing of anti-depressants. All General Practitioners were asked to complete an online questionnaire and Practice Managers were asked to provide details pertaining to the practice depression register. The findings revealed a considerable variation between practices in the prevalence of patients on the depression registers and in the screening and management of patients. Dr Mitchell outlined a range of reasons for the variations.

The findings also revealed that (i) GPs prescribing of antidepressants was within the Board's formulary; (ii) GPs felt there was a need for more access to non-pharmacological treatments such as Cognitive Behavioural Therapy, and (iii) the majority of GPs and Practice Managers were aware of the HEAT Target to reduce anti-depressant prescribing. Dr Mitchell detailed a range of recommendations and actions arising from the findings to be taken forward within Partnerships by GPs, Practice Managers and the Primary Care Mental Health Team.

Dr Benton expressed concern at reports that funding was being withdrawn from some voluntary organisations that had been providing various successful alternative therapies. Mr Sime referred to the success of work in England using the voluntary sector. Mrs Bryson understood that some Community Pharmacists were providing treatments but Dr Mitchell indicated that he was not aware of this. In response to a question from Mrs Murray, he indicated that one possible approach to the need for more non pharmacological resources would be to look at other areas to identify any under-use and then seek to re-align resources.

DECIDED:-

That the presentations reflected satisfactory progress in Clinical Governance within CH(C)Ps.

56. CLINICAL GOVERNANCE FOR CHILDREN AND YOUNG PEOPLE'S SPECIALIST SERVICES - ANNUAL REPORT

Mrs Metcalfe and Mr Feinmann had submitted the Clinical Governance Annual Report 2009/10 for the Children and Young People's Specialist Services (CYPSS). Mrs Metcalfe explained that the CYPSS delivered child health and mental health services within CH(C)Ps to children and young people up to 18 years of age. It was a Secondary Care service.

The annual report set out in detail (i) the scope of the service; (ii) Clinical Governance arrangements; (iii) Patient Safety systems and arrangements; (iv) Clinical Quality Improvement/Clinical Effectiveness; (v) Clinical Supervision/Staff Support, and (vi) the development and use of clinical information.

Mrs Metcalfe then gave a comprehensive presentation on Clinical Governance systems within CYPSS. There was a Care Governance Executive Group whose core functions were to:-

- Review incident reports on the Datix system, to determine patterns and agree learning points.
- Record and share learning points from clinical incidents and complaints across NHS GG&C CYPSS
- Share and co-ordinate patient safety/quality standards policies and actions in response to Scottish Government and Health Board policy.
- Manage links with CH(C)P, Women & Children and Mental Health Partnership clinical governance systems.

Mrs Metcalfe drew attention to the success of the regional Adolescent Psychiatry Inpatient Service which had moved from Gartnavel Royal Hospital to Skye House at Stobhill Hospital in February 2009 with an increase in beds from 16 to 24. Among the positive developments, following the move, had been a dramatic reduction in the number of incident reports from 1,014 in 2008/9 to 140 in 2009/10. Lengths of stay for young people had reduced as had sickness levels in staff. Staff retention rates had increased.

The key priorities for 2010/11 were:-

- Full implementation of national clinical outcome measures across Child and Adolescent Mental Health Services (CAMHS) in GG&C.
- Implementation of a demand and capacity model to improve waiting times and efficiency of service delivery in CAHMS.
- Involvement of outpatient and inpatient mental health teams in a national CAMHS quality assurance process.
- Review of the medical, nursing and AHP workforce in community child health.
- Standardise professional leadership structures across all professions in CYPSS.
- Improve the efficiency of community child services in GG&C.

In response to a question, Mr Feinmann advised that waiting times for access to CAMHS varied considerably between CHCPs. A major factor contributing to this had been the different models operated by local teams. Work was taking place to establish a consistent model across GG&C with the aim of reducing waiting list discrepancies.

Mr Cleland felt that it would be helpful, in order to follow the development of Clinical Governance within CYPSS, for an action plan to be compiled setting out the challenges and the strategy and timing for addressing these. Mrs Metcalfe and Mr Feinmann agreed that this would be compiled and circulated to members.

Mrs METCALFE

DECIDED:-

That the presentation reflected satisfactory progress in Clinical Governance within the CYPSS.

That the Committee should receive a CYPSS action plan for 2010/11

Mrs METCALFE

NOTED

57. ADULTS WITH INCAPACITY – REPORT OF SUPERVISORY BODY FOR 2009

Mrs Hawkins had submitted, for the Committee's consideration, the annual report for 2009 produced by the NHSGG&C Adults with Incapacity Supervisory Body. She explained that the Adults with Incapacity (Scotland) Act 2000, Part 4, provided a framework for decisions to be made on behalf of those 16 years and over who lacked the ability to make decisions about their own finances or welfare. It provided a regulated structure for others to make decisions on their behalf, subject to safeguards and in specific well-defined situations. The Supervisory Body was responsible for monitoring and reviewing the manner in which managers of authorised NHS establishments were conducting the management of resident's funds under Part 4 of the Act.

Within NHSGG&C the responsibilities of the Supervisory Body had been delegated to a Group led by the Director of the Mental Health Partnership. Within the NHS all residential establishments were issued with a Note of Authority to manage patients' financial affairs once the Supervisory Body was satisfied that the necessary procedures were in place. These lasted for a maximum of a year after which they required to be renewed. Patients' funds were managed by authorised managers who were granted Certificates of Authority for each named patient. Additionally Board staff were often appointed to administer State Pension benefits.

Mrs Hawkins outlined the role and remit of the Supervisory Body which had required to meet only four times in 2009 due to the relatively small number of patients involved. She then explained in detail (i) the method of management of the funds; (ii) policy and operational procedures; (iii) training activity; (iv) inspection and monitoring, and (v) future policy. During 2010 guidance would be published for authorised managers and clinical staff on the appropriate application of patients' monies for the benefit of relevant patients consistent with the Act's provisions.

DECIDED:-

That the report be noted.

58. CLINICAL INCIDENTS AND FAI REVIEWS

Dr Dickson presented a written summary updating the Committee on Clinical Incidents and FAI Reviews. Of the 17 new FAIs intimated by the Fiscal's Office, as reported at the last meeting, dates had now been announced for five of these.

Dr Dickson reported that of four current FAI cases listed, one was now completed and closed, two were awaiting publication of formal determinations and an adjournment to the FAI was taking place in respect of the fourth that would be resumed in September.

In response to a question from Mr Robertson, Dr Dickson and Mr Crawford outlined the comprehensive support offered to staff in preparation for and during an FAI.

With regard to Significant Clinical Incidents (SCIs) Mr Crawford advised that these were discussed at officer level on a regular basis but that the emphasis in the regular reports to the Committee had been more focused on FAIs or those SCIs that might lead to FAIs.

DECIDED:-

1. That the current report be noted.
2. That consideration should be given to the method of future reporting of SCIs to the Committee to ensure they received due emphasis along with FAIs.

Mr CRAWFORD

59. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)

Mr Crawford presented a paper updating the Committee on SPSP implementation and progress with NHSGG&C.

Mr Crawford advised of the current attempts to assess progress in achieving a reliable level of sustained implementation of all the key changes in each of the five workstreams in a pilot population. He outlined the situations in respect of the workstreams relating to General Wards, Critical Care, Peri-operative and Medicines Management.

With regard to the Spread Plan, 120 new teams had become involved in the programme in the current year. The Acute Services Division had asked that the adequacy of this volume against the end dates and aims in the programme should be reviewed. He anticipated that this would be completed by September 2010.

Mr CRAWFORD

Mr Crawford drew attention to difficulties arising in the internal education process as a result of staff being unable to be released to attend training events. Recently two such large scale events had to be cancelled for this reason. There were implications for the progress of the programme. This had been discussed at length at the recent meeting of the Clinical Governance Implementation Group and was being taken forward.

DECIDED:-

That the progress report and the issues highlighted be noted.

60. INFECTION CONTROL ANNUAL REPORT 2009/10

Mr Walsh had submitted the NHSGG&C Annual Infection Control Report for 2009/10 for the Committee's consideration and approval. He indicated that the themes in the report were those covered routinely in the bi-monthly update reports submitted to the Committee at each meeting. All the aspects of the action plan had been delivered with the exception of the Educational Training Needs Analysis, the funding for which had been withdrawn by NES Education for Scotland.

Mr Walsh indicated that the Board's focused priority afforded to Infection Control related issues would be continued during 2010/11. Key challenges would include:-

- The further extension of 15% of the HEAT Target for Staphylococcus Aureus Bacteraemia (SABs)
- The ongoing cycle of inspections from the Healthcare Environmental Inspectorate within acute hospitals
- The maintenance of the current low levels of Clostridium Difficile Infection within NHSGG&C to deliver the 2011 HEAT Target.

DECIDED:-

That the Infection Control Annual report for 2009/10 be approved.

61. MINUTES OF REFERENCE COMMITTEE

The minutes of the meeting of the Reference Committee held on 5 May 2010 were received, together with a summary paper highlighting key issues.

NOTED

62. MINUTES OF INFECTION CONTROL COMMITTEE

The minutes of the meeting of the Infection Control Committee held on 24 May 2010 were received, together with a summary paper highlighting key issues.

NOTED

63. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meeting of the Clinical Governance Implementation Group held on 21 July 2010 were received, together with a summary paper highlighting key issues.

NOTED

64. MINUTES OF ORGAN DONATION COMMITTEE

The minutes of the meeting of the Organ Donation Committee held on 2 June 2010 were received, together with a summary paper highlighting key issues.

NOTED

65. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Tuesday 5 October 2010 at 1.30pm in Board Rooms 1 & 2, J B Russell House, NHS GG&C Corporate Headquarters, Gartnavel Royal Hospital, Glasgow.

GREATER GLASGOW AND CLYDE NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow and Clyde Clinical Governance Committee
held in the Board Room, J B Russell House,
Gartnavel Royal Hospital, Glasgow, G12 0XH
on Tuesday 5 October 2010 at 1.30 pm**

P R E S E N T

Mr R Cleland (in the Chair)

Dr C Benton
Mrs P Bryson
Councillor Amanda Stewart
Mr A O Robertson
Mr B Williamson

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

Mr B Gillespie	..	Audit Scotland
Mr A Crawford	..	Head of Clinical Governance
Mrs R Crocket	..	Board Director of Nursing
Dr J Dickson	..	Associate Medical Director, Clyde
Mr R Farrelly	..	Director of Nursing, Acute Services (Minute 70)
Dr R Green	..	Associate Medical Director, Diagnostics Directorate (Minute 69)
Mr D McLure	..	Senior Administrator
Mr T Walsh	..	Infection Control Manager

ACTION BY

66. APOLOGIES

Apologies for absence were intimated on behalf of Prof D H Barlow, Dr B N Cowan, Dr M Kapasi, Mrs J Murray, Mr D Sime and Mrs E Smith.

67. MINUTES

The Minutes of the meeting held on 3 August 2010 were approved.

68. PATIENT SAFETY

Clinical Incidents and FAI Reviews

Dr Dickson presented a written summary updating the Committee on Clinical Incidents and FAI Reviews. He highlighted seven cases subject to FAIs. In three cases FAIs had taken place, two others now had dates set for the Inquiries and the remaining two were awaiting dates. Of the three that had taken place, two determinations were awaited; the third had been published raising no issues for the Board. Dr Dickson understood that other cases were likely to be subject to FAIs. He would advise of these once confirmation was received.

Dr DICKSON

Dr Dickson gave details of two Significant Clinical Incidents (SCIs) that had emerged since the written summary had been produced. The first related to the Vale of Leven Hospital. He described the incident and each stage of the internal investigation. He demonstrated how it had been concluded that, in the circumstances, appropriate decisions had been made in respect of the patient. The investigation had also been a useful exercise both in relation to (i) criteria for transferring patients, and (ii) in confirming that the model set out in the Board's Vale of Leven vision was correct in respect of decisions relating to the hospital of admission, and would lead to a better service. The Fiscal had confirmed that the case would not be taken further.

The second SCI was a complex case relating to the Royal Hospital for Sick Children. Dr Dickson gave details of the incident and of each stage of both the internal investigation and the subsequent external medical review which he had commissioned. The outcome of the external review was awaited, after which an action plan would be implemented. He would keep the Committee informed of developments.

Dr DICKSON

Dr Dickson also reported that the Board Medical Director had commissioned an external review relating to a long standing issue whether elective paediatric neurosurgery should be carried out at the Institute for Neurological Sciences or at the Royal Hospital for Sick Children. There were differing opinions between the two institutions. The four external clinicians carrying out the review were expected to report back by the end of the year. The Committee would be informed of the outcome.

Dr COWAN

In response to questions from Dr Benton, Mrs Crocket explained (i) the ways in which staff would identify undeclared dementia in patients admitted to acute wards, and (ii) the procedures for recording patient falls, the preparation and consideration of monthly reports and the actions taken. In response to a further question from Dr Benton whether doctors in Scotland were adequately aware of TB, Dr Dickson indicated that increasing rates of TB within Scotland was leading to more awareness.

DECIDED:-

That Dr Dickson's report be noted.

Avoiding Serious Events

Mr Crawford gave a presentation on the Avoiding Serious Events Monitoring (ASEM) System which had been approved for testing and development by the Acute Services Clinical Governance Forum in November 2009. The purpose of ASEM was to define a clear set of events that were considered to be useable as indicators of the broader care system.

Mr Crawford presented data from information classified by eight types of events, collected by the DATIX system, on a quarterly basis from April 2008 to March 2010. He then demonstrated, using the example of one type of event (Retention of Surgical Item requiring removal) how mechanisms were put in place to improve situations revealed by an analysis of data. In this case large variations in practice had been found in theatres throughout Greater Glasgow and Clyde. Consequently a Board-wide standard operating procedure had been developed.

Mr Crawford sought members' views on whether this type of information on monitoring serious events and the actions of the Board in response to them should be submitted on a regular basis. Currently, quarterly reports were submitted to the Acute Services Clinical Governance Forum.

DECIDED:-

That the Committee should receive six-monthly update reports which should include the tracking of improvements as a result of actions taken.

Mr CRAWFORD

Scottish Patient Safety Programme (SPSP)

Mr Crawford submitted a paper setting out in detail SPSP progress in Greater Glasgow and Clyde using a revised reporting format with the view of generating greater focus on progress towards the complete implementation of the core programme by the end of 2010. The Board was currently at level 2.5 against the national trajectory. This was in line with most other Scottish Health Boards. To achieve level 3 the Board required to resolve both key change implementation in medicines reconciliation and the measurement limitations for beta blockade in the peri-operative workstream. The report outlined the action being taken to this end. It was anticipated that these issues should be resolved soon, prior to the next report.

Mr CRAWFORD

Mr Crawford drew attention to various issues arising from the report, including the rolling out and managing of good practice throughout all hospital sites, and contact between teams and the support structure.

DECIDED:-

That the progress report and the issues highlighted be noted.

Infection Control Update

Mr Walsh submitted HAI Monitoring Reports for August and October 2010. The August report was in the original reporting format, whereas the October report was in the format now required by the Scottish Government. He drew attention to the section of the October report on Out of Hospital Infections (ie not acquired in hospital) for *c difficile*, MSSA and MRSA. These revealed figures as high as 50%. There could be implications for HEAT targets. In response to a question from Mr Williamson, Mr Walsh advised that all datasets required to be the same for all NHS Boards, therefore it would not be possible to detail the proportion of In-Hospital and Out of Hospital Infections in future reports. However, In-Hospital Infections were included in the Statistical Process Control Charts.

Mr Walsh sought the views of members on the submission of Healthcare Environment Inspectorate Reports and the Board's subsequent action plans.

DECIDED:-

1. That the reports be noted.
2. That in future reports, the front page summary should be expanded to highlight any exceptional figures.
3. That Healthcare Environment Inspectorate Reports should be highlighted in the regular bi-monthly Infection Control Updates to the Committee in terms of issues to which the Committee's attention should be drawn. A link to the full reports would be provided should members wish to access.

Mr WALSH

Mr WALSH

Mr WALSH

Mid Staffordshire Inquiries – Follow-up Exercise

Mr Crawford described the work being carried out within the Board in response to the Mid-Staffordshire Inquiries. Twelve key questions had been identified in the light of the Inquiries, the answers to which were currently being sought and would then be collated to reveal strengths and any weaknesses within Greater Glasgow and Clyde systems. Once the exercise had been completed, Mr Crawford would submit a report, with any recommendations made, to the Committee.

Mr CRAWFORD

Mr Crawford also indicated that a description of the work carried out, and action planned based on the information available by then, would be prepared for the Board's Annual Review on 1 November 2010.

Mr CRAWFORD

NOTED

69. CLINICAL GOVERNANCE IN DIAGNOSTICS DIRECTORATE

Dr Green gave a detailed presentation on Clinical Governance within the Diagnostics Directorate. She commenced by outlining the wide range of services covered by the Directorate under the three main headings of Laboratories, Imaging and Medical Physics. She then described the Clinical Governance Framework that had been set up. Governance was an item at all Directorate Clinical meetings which fed into the Imaging & Physics and Laboratory Governance Committees respectively. These, in turn, reported to the Directorate Governance Committee which also had input from Health and Safety, Radiological Safety and Overarching Transfusion Committees.

Dr Green outlined the legislation and accreditation relating to the Directorate covering Blood Safety and Quality, Ionising Radiation and Radioactive Substances. She then detailed the structures and roles of the Radiation Safety Committee and the Overarching Transfusion Committee. An example of the work in the Directorate arising from legislation was given with regard to the Blood Safety and Quality Regulations 2005 which covered the traceability of blood leaving laboratories. The difference between the monthly figures for initial compliance and final compliance (ie the return of tags attached to all blood items) was extremely small, with final compliance figures being almost 100%. However great effort was involved in chasing tags not initially returned.

Dr Green illustrated the approach taken within the Directorate in respect of responding to incidents. She gave the background to and action taken in respect of specific incidents within Pathology and Imaging. She also referred to the action required within the Directorate to ensure awareness and compliance with policies that might be perceived as impacting mainly on frontline staff working directly with patients, such as Hand Hygiene and Child Protection.

The key current challenges for the Directorate were:-

- Ensuring that the new Clinical Governance structure and processes were embedded and working effectively.
- To continue to raise awareness of Risk Management by discussions at all Clinical Governance meetings and feeding back the results of Incident investigations to all staff.
- Ensuring continuing compliance with NHSGG&C Infection Control Policies.
- Reducing the incidence of HAIs.
- Maintaining accreditation of all laboratories across all sites.
- Ensuring compliance with Blood Safety and Quality and Ionising Radiation (Medical Exposure) Regulations.
- Continuing to review written clinical information giving.

The Directorate had an ongoing Clinical Governance action plan which was part of its annual report.

DECIDED:-

That the presentation reflected good progress in Clinical Governance within the Diagnostics Directorate.

70. SENIOR CHARGE NURSE REVIEW

Mr Farrelly gave a detailed presentation on the Senior Charge Nurse (SCN) Review. He explained that this was part of the implementation of Leading Better Care which also involved Releasing Time to Care, Clinical Quality Indicators and the Patient Experience Programme. He also provided the Committee with a written update on the implementation of Leading Better Care within NHSGG&C Acute and Mental Health Services with particular emphasis on the SCN Development Programme and its impact on the SCN role. A report on the implementation of Clinical Quality Indicators (CQIs) had also been included.

Mr Farrelly explained that the SCN review project had been designed to encourage wide stakeholder involvement including the views of Patients, Healthcare Professionals and NHS Executive Directors. Each SCN had an opportunity to participate. The contributions received had driven the development of both the SCN role and the CQIs. He then outlined the Board-wide process in developing an SCN programme implementation plan and also illustrated the details of the SCN role. The aim was to restore greater levels of responsibility and accountability to SCNs and to empower them in carrying out their increased leadership role. They were also pivotal to the quality agenda and improving the patient experience.

Releasing Time to Care had as its aims:- (i) to increase the time nurses could spend with patients, (ii) the provision of safe and reliable care to help patients get better, more quickly, and (iii) to improve the experience of staff and patients. There had already been good results from local initiatives to increase the time nurses could spend with patients, for example a 20% increase had been achieved at the Vale of Leven Hospital. Mr Farrelly explained that there were various modules in Releasing Time to Care, and he detailed all the components to be addressed in order to achieve the "Productive Ward" concept.

Clinical Quality Indicators had four areas: - (i) Falls Prevention, (ii) Pressure Area Care, (iii) Food, Fluid and Nutrition, and (iv) Observations/Early Warning Systems. Mr Farrelly advised of the processes that were in place for each of the four areas. The next stage would be outcomes exercises.

Safe and Effective Clinical Practice involved: - (i) Visible Clinical Leadership, (ii) Team Working, (iii) Continuous Quality Improvement, (iv) Emphasis on Patient Safety and (v) the Clinical Environment. Mr Farrelly gave examples relating to these, and the challenges facing such a large organisation as NHSGG&C.

The Patient Experience involved the patient being (i) cared for, (ii) respected, (iii) informed of decisions about their care and (iv) listened to. An inpatient patient experience questionnaire had been rolled out to almost 19,000 patients between October 2008 and September 2009. NHSGG&C was a pilot Board to test the questionnaire. The response rate had been 47%. An action plan was now being developed following from the results that had emerged.

Following the presentation, Mr Cleland and Mr Robertson both raised issues relating to the care aspect of the patient experience in hospital as distinct from clinical treatment. It was the caring aspect of the patient experience that, often anecdotally, was felt to be lacking. Members were anxious that the current initiatives should result in significant improvements and that the patient experience of care should be a fundamental priority for the Board. Mr Farrelly explained the range of activity taking place.

DECIDED:-

That Mr Farrelly should report back in nine months time to update the Committee on developments and improvements made, in the light of concerns about improving patients' experience of care.

Mr FARRELLY

71. CLINICAL GOVERNANCE AND RISK MANAGEMENT STANDARDS

Mr Crawford submitted a report confirming the completion of the follow-up review to the NHSGG&C independent peer review for Clinical Governance and Risk Management in September 2009. The report had been submitted to and approved by the Board's Corporate Management Team.

NOTED

72. ANNUAL CLINICAL GOVERNANCE REPORT 2009/2010

Further to Minute 53, Mr Crawford submitted the final version of the Annual Clinical Governance Report for 2009/10 for approval.

DECIDED:-

1. That the Annual Clinical Governance Report for 2009/10 be approved, subject to the annual report of the Organ Donation Committee for 2009/10 being appended to it.
2. That Mr Crawford would now arrange for the Report to be disseminated.

Mr CRAWFORD

Mr CRAWFORD

73. CONTROLLED DRUGS QUARTERLY REVIEW

Dr McKean, Head of Pharmacy and Prescribing Support Unit, had submitted a quarterly occurrence report in respect of Controlled Drugs covering the period from April to June 2010.

NOTED

74. OMBUDSMAN REPORT

Mr Crawford presented a paper on cases considered by the Scottish Public Services Ombudsman for the period from April to June 2010 together with information on action taken. Mr Crawford drew attention to reference in the Ombudsman's overview that greater emphasis would be placed on early resolution of complaints. He confirmed the procedure for action within NHSGG&C following on from a complaint. It was noted that the Ombudsman had commented on receipt of a number of excellent action plans from NHSGG&C.

Mr Williamson raised the reference in the report to a case in NHSGG&C relating to consent and communication when surgical procedures were proposed and subsequently changed. The Ombudsman had made several recommendations including the provision of written information on the potential complications of surgery at the point of gaining consent. Mr Crawford acknowledged that this was a difficult area. Furthermore, no examples had been given linking adverse events to consent procedures. Mr Cleland suggested that developments relating to this issue required to be kept under review.

Mr CRAWFORD

NOTED

75. MINUTES OF REFERENCE COMMITTEE

The minutes of the meeting of the Reference Committee held on 21 July 2010 were received, together with a summary paper highlighting key issues.

NOTED

76. MINUTES OF INFECTION CONTROL COMMITTEE

The minutes of the meeting of the Infection Control Committee held on 26 July 2010 were received, together with a summary paper highlighting key issues.

NOTED

77. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meeting of the Clinical Governance Implementation Group held on 13 September 2010 were received, together with a summary paper highlighting key issues.

NOTED

78. MINUTES OF ORGAN DONATION COMMITTEE

The minutes of the meeting of the Organ Donation Committee held on 1 September 2010 were received, together with a summary paper highlighting key issues.

NOTED

79. DATES OF MEETINGS 2011

The Secretary submitted a proposed schedule of dates for meetings of the Committee in 2011, based on the current arrangement whereby meetings were held after Board Seminars.

DECIDED:-

That in 2011 the Committee should meet bi-monthly at 1.30pm at Board Headquarters, J B Russell House, Gartnavel Royal Hospital, on 1 February, 5 April, 7 June, 2 August, 4 October and 6 December.

SECRETARY

80. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Tuesday 7 December 2010 at 1.30pm in the Board Room, J B Russell House, NHSGG&C Corporate Headquarters, Gartnavel Royal Hospital, Glasgow.