

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the  
Clinical and Care Governance Committee  
held in the Boardroom, JB Russell House,  
on Tuesday 3<sup>rd</sup> September 2019 at 1.00pm**

**PRESENT**

Ms Susan Brimelow OBE (in the Chair)

Cllr Caroline Bamforth	Mr Simon Carr
Dr Donald Lyons (From item 38)	Mr Ian Ritchie (Vice Chair)

**IN ATTENDANCE**

Mrs Jane Grant	..	Chief Executive
Dr Jennifer Armstrong	..	Medical Director
Mr Andy Crawford	..	Head of Clinical Governance
Dr Margaret McGuire	..	Nurse Director
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Dr Michael Smith	..	Lead Associate Medical Director Mental Health (For item 40)
Dr David Anderson	..	Respiratory Consultant (For item 35)
Mrs Geraldine Mathew	..	Secretariat Manager (Minutes)

		<b>ACTION BY</b>
<b>31.</b>	<b>WELCOME AND APOLOGIES</b>	
	Apologies for absence were intimated on behalf of Prof Dame Anna Dominiczak, Ms Dorothy McElean, and Mrs Audrey Thompson.	
	<u>NOTED</u>	
<b>32.</b>	<b>DECLARATIONS OF INTEREST</b>	
	The Chair invited Committee members to declare any interests in any of the items to be discussed. There were no declarations made.	
	<u>NOTED</u>	
<b>33.</b>	<b>MINUTES OF THE MEETING HELD 11<sup>th</sup> JUNE 2019</b>	
	The Committee considered the minute of the meeting which took place on Tuesday 11 <sup>th</sup> June 2019 [Paper No. CCG(M)19/02] and were content to approve this as an accurate record, subject to the following amendments:	
	<u>Item 21 – Internal Review of QEUH/RHC – Clinical Review</u>	

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	<p><u>Paragraph 5 –</u> “Dr Armstrong informed Committee members that a review of estates <i>issues</i> will be carried out <i>by Mr Tom Steele, Director of Estates and Facilities.</i>”</p> <p><u>Paragraph 8 –</u> “Dr Armstrong informed Committee members that a letter was received from GMC addressed to the Chairman in relation to the <i>high number of patients reviewed and admitted via the Intermediate Assessment Unit (IAU) at the QEUH.</i> This issue will be included in the report. The issues were mainly in relation to availability of beds and that the unit was very busy. Additional beds <i>have now</i> been identified for use by IAU. The Acute Service Clinical Governance Forum monitored a review of SCI/ Adverse events in the IAU within QEUH (and within all of the Acute Sectors) to confirm completion of all actions that were developed.</p> <p><u>APPROVED</u></p>	
<b>34.</b>	<b>MATTERS ARISING</b>	
<b>a)</b>	<b>ROLLING ACTION LIST</b>	
	<p>The Committee reviewed the items detailed on the Rolling Action List [Paper No. 19/15] and were content to accept the recommendation that 5 actions be closed.</p> <p>In addition, the following actions were discussed:</p> <p><u>Item 25 – Stroke Improvement Programme Update</u> Dr Armstrong noted actions being taken in relation to thrombolysis and discussions continued with colleagues within Clyde Sector, to improve outcomes. The Committee agreed that an update on this would be presented to the Committee meeting in March 2020.</p> <p><u>Item 22b – Internal Review of QEUH/RHC – Estates Work stream</u> The Committee discussed the reporting process of the Internal Review of QEUH/RHC, specifically, the three work streams – Estates and Facilities; Clinical Review; and Demand and Capacity Flow. It was agreed that the Estates and Facilities work stream would report to the Finance, Planning and Performance Committee, as previously agreed by the Board. Therefore, it was agreed that this action could be removed from the Rolling Action List. Ms Brimelow highlighted that the discussions the Committee had were in relation to the clinical impact, if any, of cleanliness standards. It was agreed that Ms Vanhegan, Head of Corporate Governance and Administration, would consider the most appropriate governance structure for this matter.</p> <p><u>AGREED</u></p>	<b>Ms Vanhegan</b>
<b>35.</b>	<b>OVERVIEW OF MANAGED CLINICAL NETWORK FOR COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE)</b>	
	<p>Dr David Anderson, Respiratory Consultant, Clinical Lead for Respiratory MCN, Clinical Lead for Pulmonary Rehabilitation; and Clinical Lead for Glasgow City Community Respiratory Team, was welcomed to the meeting.</p>	

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Dr Anderson provided a presentation which detailed the NHSGGC COPD Service. He provided an overview of the condition, and noted that COPD affected approximately 129,000 people in Scotland, with a predicted increase of 33% within the next 20 years. COPD was the most common cause of presentation to hospital in Scotland and accounted for 6% of all deaths in Scotland. Dr Anderson described the COPD service in NHSGGC; the impact of pulmonary rehabilitation on survival rates; the challenges associated with the management of the condition and potential solutions.

The Chair thanked Dr Anderson for providing a helpful and informative presentation and invited questions and comments from Committee members.

In response to questions from members in relation to the views of staff and the challenges and impact of this, Dr Anderson noted that a series of educational sessions had been undertaken to break down barriers and improve multi-team working.

Questions were raised in relation to outcomes for those within the most deprived areas and what other factors were being considered. Dr Anderson advised that the introduction of Safehaven has allowed collection of data for everyone with a diagnosis of COPD and deprivation index. He noted that patients within deprived areas were less likely to stop smoking, however other factors such as finance, nutrition and birth weights all played a contributory role. The Pulmonary Rehabilitation Team provide advice and assistance to address lifestyle factors.

In response to questions from members in respect of solutions to address the issues described, Dr Anderson was of the opinion that the most effective solution to ensuring the best outcomes for patients would be to develop a team of multi-disciplinary staff to manage the care of patients with COPD.

The Committee noted that, despite a number of factors, such as reduction in prevalence of smoking and better nutrition, prevalence of COPD continued to rise. Dr Anderson explained that this was due to the time delay associated with the causes of COPD, therefore interventions today would likely not yield an impact on prevalence rates until 10 years from now. He also noted that the condition was an accelerated ageing process frequently caused by smoking; however it was not unusual to see milder forms of the condition in older adults, attributable to the natural ageing process.

In response to questions from members in relation to the outcomes of the evaluation of the Hospital at Home service, Dr Anderson advised that this was still being evaluated, however initial evidence demonstrated a reduction in bed days and the financial effect of this was being assessed.

There were questions raised in relation to the potential to track COPD patients who present at hospital, with the intervention of the COPD Team to manage their care. Dr Anderson advised that there was software available which allowed all patients with COPD to be identified, however there was currently no capability within the software to identify the reason for the presentation and/or admission to hospital.

In response to questions from members in relation to utilisation of genotyping, Dr Anderson advised that the genetic markers associated with COPD were not yet fully understood, however he did acknowledge that there were biochemical



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	<p><u>Precision Medicine</u> Dr Armstrong noted progress in relation to precision medicine including recent exploratory discussions regarding bio-medical testing to predict responses to drugs. Dr Armstrong noted that further information with regards to this would be presented to the Board at a Seminar meeting in due course.</p> <p>The Chair thanked Dr McGuire and Dr Armstrong for the update. There were no questions noted by members.</p> <p><u>NOTED</u></p>	<p><b>Dr Armstrong</b></p>
<b>37.</b>	<b>CORPORATE RISK REGISTER</b>	
	<p>The Committee considered the paper 'Corporate Risk Register: Additional Clinical Risks' [Paper No. 19/16] presented by the Head of Clinical Governance, Mr Andy Crawford.</p> <p>The paper described two additional risks to be considered for inclusion in the Corporate Risk Register, those being Person Centred Care and Clinical Quality. Mr Crawford noted that the additional risks had been reviewed by the Board Clinical Governance Forum (BCGF) and the Risk Management Steering Group (RMSG).</p> <p>The Committee noted an error in relation to the risk rating associated with the Clinical Quality Risk. Mr Crawford acknowledged that this should be 20, and not 25 as stated in the document.</p> <p>Dr McGuire was nominated as the Corporate Lead for the Person Centre Care risk and Dr Armstrong was the nominated Corporate Lead for Clinical Quality.</p> <p>Ms Brimelow thanked Mr Crawford for the update. The Committee were content to note the inclusion of the additional risks in the Corporate Risk Register, and were content to approve the amendments as noted above.</p> <p><u>APPROVED</u></p>	
<b>38.</b>	<b>EQUALITY AND HUMAN RIGHTS COMMISSION LEGAL CHALLENGE</b>	
	<p>The Committee considered the paper 'Equality and Human Rights Commission – Legal Challenge' [Paper No. 19/17] presented by the Nurse Director, Dr Margaret McGuire.</p> <p>The paper provided an update to the Committee on the legal challenge made by the Equality and Human Rights Commission (EHRC) regarding accommodating adults with incapacity at the Quayside and Darnley Care Homes.</p> <p>Dr Lyons declared an interest as a Medical Member of the Mental Health Tribunal, however noted that his role does not consider NHSGGC cases.</p> <p>Ms Brimelow thanked Dr McGuire for the update. The Committee recognised governance oversight through the Committee; noted the discussions underway; and noted the prioritisation of patient care. The Committee fully support the</p>	

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	<p>Chief Executive and the Corporate Team in continuing to afford patients the best possible clinical care in the most appropriate setting, whilst addressing the legal challenge.</p> <p><u>NOTED</u></p>	
<b>39.</b>	<b>INTERNAL REVIEW OF QEUH/RHC – CLINICAL REVIEW</b>	
	<p>The Committee considered a paper ‘Internal Review of QEUH/RHC – Clinical Review’ [Paper No. 19/18] presented by the Head of Clinical Governance, Mr Andy Crawford.</p> <p>The paper provided a summary of an internal review of information relating to the QEUH campus including the Royal Hospital for Children (RHC). The report brings together and reconsiders information processed through the existing governance arrangements for services at the Campus. Mr Crawford noted that the report had been presented to the Board Clinical Governance Forum (BCGF) and the Forum were satisfied that there were no unrecognised concerns about clinical quality; that actions were underway where concerns had been identified; and that there was evidence of good levels of quality of care.</p> <p>Ms Brimelow thanked Mr Crawford for the update and invited comments and questions from members.</p> <p>In response to questions from members in relation to the patient experience report of QEUH and whether this could be compared to other hospitals out with the Board area, Dr McGuire informed the Committee that there was national data collected through Patient Experience reports, however it was difficult to compare QEUH with other hospitals nationally, due to its uniqueness. Dr McGuire agreed that the themes of the Patient Experience report could be included in the report, as this would describe that the patient experience was consistent with the prevailing pattern. The Committee also agreed the inclusion of the Scottish Patient Experience Survey results.</p> <p>The Committee requested that further information be included within page 12 of the report, on the TIA section (Transient Ischemic Attack), to include additional explanation of current performance.</p> <p>In summary, the Committee were content to approve the report in principle, subject to the amendments outlined and were assured of the Clinical Quality of the service provided at QEUH. The Committee were content to endorse the report for presentation to the Board.</p> <p><u>APPROVED</u></p>	
<b>40.</b>	<b>MENTAL HEALTH STRATEGY AND REVIEW OF INPATIENT DEATHS</b>	
	<p>The Committee considered the paper ‘Mental Health Services Update’ [Paper No. 19/19] presented by the Lead Associate Medical Director Mental Health, Dr Michael Smith. The paper provided an overview of ongoing service development and governance issues in mental health services, specifically the Mental Health Strategy Implementation Plan; a review of inpatient deaths; Mental Welfare Commission local visits; and a summary of progress of the Moving Forward Together (MFT) Mental Health Care work stream.</p>	

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	<p>Ms Brimelow thanked Dr Smith for the update and invited comments and questions from Committee members.</p> <p>In response to questions from members in relation to the recruitment of staff, Dr Smith noted that there were challenges recruiting across all staff groups nationally.</p> <p>Committee members expressed difficulty in assessing progress of implementation of the strategy, given that there were no timelines detailed within the paper. Dr Smith clarified that implementation of the strategy was reported to a number of fora including the Mental Health Programme Board; IJBs (Integration Joint Boards), and the MFT Mental Health Work Stream. Each report included a different level of granularity dependant on the audience. Dr Smith was happy to provide the timescale detail regularly reported to the Mental Health Programme Board.</p> <p>There followed discussion about the measures of success and the expected outcomes. Dr Smith advised members that this detail was included within the information presented to the MFT work stream group, and Dr Smith would be happy to share this information with Committee members.</p> <p>In response to questions from Committee members in relation to the review of deaths, Dr Smith noted that the review considered all deaths of those patients subject to the Mental Health Act. He noted that there were no patterns identified from the data. Dr Smith agreed to consider a review of all deaths.</p> <p>In relation to the Mental Welfare Commission reports of local visits, Mrs Grant acknowledged that these reports were shared within HSCP's, however further discussion was required to ensure that, in addition, the reports were also reviewed by the Executive Team. Dr Smith assured the Committee that reports were routinely reviewed to identify Board-wide implications, however agreed to discuss the best mechanism by which the Board Executive Team were kept informed.</p> <p>In summary, the Committee were content to note the report, including the three strands of work described. The Committee suggested greater focus on development of the expected outcomes.</p> <p><u>NOTED</u></p>	<p>Dr Smith</p> <p>Dr Smith</p> <p>Dr Smith</p> <p>Dr Armstrong/Dr Smith</p>
<p><b>41.</b></p>	<p><b>CLINICAL GOVERNANCE ANNUAL REPORT</b></p>	
	<p>The Committee considered a paper 'Clinical Governance Annual Report' [Paper No. 19/20] presented by the Head of Clinical Governance, Mr Andy Crawford. The paper provided a selection of quality improvement examples and other developments, with an appraisal of the prevailing clinical governance arrangements. Mr Crawford noted that the report also contained the Duty of Candour Annual report which required to be published as a specific legal obligation. He noted that the Board Clinical Governance Forum (BCGF) had reviewed and approved the report at its last meeting in August.</p> <p>Ms Brimelow thanked Mr Crawford for the update and invited comments and questions from members.</p>	

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	<p>In response to questions from Committee members in relation to the data contained within page 18 of the report, specifically the decrease in the number of SCIs recorded, Mr Crawford highlighted that the levels of SCIs reported generally fluctuates. He did not consider there to be one specific reason for the fluctuation and did not consider SCIs as a metric of clinical quality, more so, that both a significant increase and a significant decrease in reporting would be a cause for concern. He assured the Committee that the level of SCI reporting for the Board remained within expected levels.</p> <p>A question was raised in relation to page 20 of the report, specifically about the information on policies and procedures. Mr Crawford clarified that this related to all staff members and was undertaken as part of the induction programme.</p> <p>In response to questions from members regarding SCIs that have not yet been concluded, Mr Crawford advised the Committee that SCIs were routinely reviewed by the Board Clinical Governance Forum, via the Acute Clinical Governance Forum, and formed part of routine clinical governance monitoring.</p> <p>Discussion took place regarding the level of SCIs reporting for the Women and Children’s Directorate. Mr Crawford explained that there was evidence that SCI reporting was being used as an audit tool. He added that an improvement plan had been requested and guidance on the use of maternal audit tools provided.</p> <p>In relation to the number of deaths noted within the Duty of Candour section of the report, members suggested the inclusion of more qualitative information for the next report.</p> <p>Discussion took place about the level of detail contained within the Duty of Candour report. Mr Crawford explained that this was a legal requirement, was in line with transparency, and was included to enhance openness and transparency. Committee members felt that consideration was required to the type of language used and to ensure that relatives were informed of the inclusion of the information in the report. It was also agreed that Mr Crawford and Ms Vanhegan, would discuss the governance process required for Board approval. Mr Crawford would also share the report with the Scottish Government colleagues to obtain feedback, and would seek information on the reports being developed by other Boards.</p> <p>In summary, the Committee were content to approve the report, subject to the amendments suggested, and noted the sensitivities of the Duty of Candour information.</p> <p><u>APPROVED</u></p>	
<p><b>42.</b></p>	<p><b>PATIENT EXPERIENCE REPORT</b></p>	
	<p>The Committee considered a paper ‘Patient Experience Report – Quarter 1’ [Paper No. 19/21] presented by the Nurse Director, Dr Margaret McGuire.</p> <p>The paper detailed the performance and methods used to identify opportunities to implement service improvements for patients from complaints received, SPSO (Scottish Public Service Ombudsman Investigative Reports and Decision Letters, and feedback opportunities.</p>	

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	<p>Dr McGuire noted amendments made to the format of the report. She thanked all staff involved in the production of the report. Dr McGuire highlighted the key themes of complaints received including communication, attitudes and behaviour of staff and waiting times. She also noted that the main theme arising from Prison Healthcare complaints was clinical treatment.</p> <p>She described a range of work underway with staff teams, led by the Complaints Team, to improve care, patient experience and how complaints are handled. The Complaints Team were currently designing a training package for roll out to staff. Work was also underway with the Scottish Public Services Ombudsman (SPSO) to improve performance in relation to complaints referred to the SPSO. Dr McGuire was pleased to note that performance in relation to Stage 2 complaint responses had improved dramatically, and she commended the staff involved in achieving this. She acknowledged that further work was required and advised that she would be working closely with Ms Vanhegan, Mrs Jennifer Haynes, and Ms Angela Carlin, to further improve the position.</p> <p>Ms Brimelow thanked Dr McGuire for the update and invited comments and questions from members.</p> <p>In response to questions from members in relation to staff awareness of Care Opinion, Dr McGuire highlighted that further sessions had been planned with a range of staff including Doctors, Allied Health Professionals (AHPs), and nursing staff, to increase awareness of Care Opinion.</p> <p>There were questions raised in relation to the percentage of upheld pharmacy complaints and the themes of these. Committee members noted concern regarding prescription errors and the impact of these on patient safety. Dr McGuire described the difficulties associated with obtaining complaints information from pharmacies, given that they are independent contractors, however Dr McGuire agreed to contact the Community Pharmacy Team in order to discuss ways in which this could be improved.</p> <p>In response to questions from members in relation to the methods available to patients to provide feedback, Dr McGuire described a range of methods available in addition to Care Opinion, including the Universal Feedback forms provided to patients on discharge. She informed members that work was underway with colleagues within the eHealth Team to identify ways in which the paper based Universal feedback forms could be replaced with electronic devices.</p> <p>Members also noted concern about how patients with conditions such as dementia, were supported to complete Universal Feedback forms and Dr McGuire agreed to follow this up with relevant colleagues.</p> <p>In summary, the Committee were content to note the report; the improvements made to the structure of the report; and the actions being taken to improve performance in these areas.</p> <p><b><u>NOTED</u></b></p>	<p><b>Dr McGuire</b></p> <p><b>Dr McGuire</b></p>

