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**Approved Minute**

**Clinical Governance Committee**

**Tuesday 17 April 2018**

**Members**

Mark MacGregor Chair

Karen Kelly Non-Executive Director

Jane Christie-Flight Non- Executive Director

Jill Young Chief Executive

Anne Marie Cavanagh Director of Nursing

Alistair Macfie Associate Medical Director

Theresa Williamson Associate Director of Nursing

Laura Langan Riach Head of Clinical Governance

**In attendance**

Jennifer Hunter Clinical Specialties Manager

**Minutes**

Lori Cassidy PA to Medical Director

1. **Chair’s Introductory Remarks**
   1. MMacG welcomed everyone to the meeting and thanked them for their attendance.
2. **Apologies**
   1. Apologies were received from::

Phil Cox Non-Executive Director

Hany Eteiba Acting Medical Director

Stewart Craig Cardiothoracic Consultant

Rhona Seigmoth Consultant Anaesthetist

1. **Minutes of Last Meeting**
   1. Minutes of the meeting held on 30 January 2018were approved as accurate.
2. **Matters and Actions Arising**

* The **Cardiac Surgery Form** was circulated prior to the meeting. There was consensus by the Committee that the form was good and that there should be a standard specification for every form which could then be tailored to suit the individual service.
* It was agreed the **M&M Process** was difficult to standardise across the various specialties and this was proving difficult across the NHS. Brian Robson (Health Improvement Scotland) was leading nationally and initially scoping IT issues.
* Action Plan for formal sign off of X-Rays now in place. MMacG noted it would be good to re-visit in a year.
* Annual Report was approved subject to minor changes (LLR)

1. **Safe**
   1. **Regional & National Division Update**

JH presented the Regional and National Medicine Division for the period February to March. The report had previously been circulated to the Committee and the highlights and challenges were discussed as follows:

* JH stated that RCA Panels were frequently rearranged due to clinical commitments, but reinforced that it was worthwhile taking time to ensure a cross section of people on the panel so there was non-biased discussion and correct conclusions agreed.
* MMacG referred to SACCS and Heart Failure patients and noted that it was appropriate that psychological support was available as follow through treatment. There was discussion around the need for additional psychological support and this was being pursued with NSD. It was noted that funding this service was a major challenge throughout the NHS.
* MMacG noted there had been three falls but not harm.
  1. **Surgical Services Division Update**

TW presented an update of the Surgical Services Division for the period February – March 2018. The Falls graph on Page 6 showed a spike in falls (21) but these had returned to normal levels (around 8-10). Two falls with damage were reported; one resulted in a fractured ankle and the other a facial scratch. Every patient who had a fall was interviewed and no linkages were identified. Pressure damage is largely device related in critical care and tests of change are underway to improve this. It was noted we had no pressure damage on one of the wards for over a year and the recent increase in numbers was not reflective of normal standards. Following discussion, the Committee were reassured that reporting and treatment was quickly identified. In answer to MMacG’s question on pressure ulcers and occupied bed days, TW replied that this is 2:1000 (Page 2). KK referred to Page 5 regarding the reliability of Measurement Data and VTE. TW advised that at the moment, nurses recorded information on ICPs and transfer onto EPR. Electronic recording will undoubtedly help reliability and negate the need for recording on paper.

* 1. **Closed Significant Adverse Events**

LLR gave an update on Level 1 investigations closed at CGRM since the last meeting. She stated that although some RCA reports had taken longer to conclude all were thoroughly investigated. The quality of reports has improved significantly and this was commended. The length of reporting time is subject to staff availability and the demands of surgery and clinical priorities. It was agreed that having a broader input into RCA investigations allowed staff to better understand the pressures involved and outlined how clinical governance leads into other areas. Inviting families in to share information helped them understand what had happened and allowed them to move on in the grieving process. LLR stated that honesty and transparency were pivotal to the Duty of Candour legislation. KK agreed with this sentiment stating it was the spirit of the legislation rather than the legal aspect.

Two events were detailed in the report which had previously been discussed at CGRM. The first event involved two patients awaiting cardiac surgery. Their care pathway was examined, improvements identified, what was in place, what was outstanding and potential improvements to our process.

**Action: LLR to check the outcome code against the above cases.**

The second event was a medication error involving an orthopaedic patient who was given the wrong dose of insulin. The patient went on to make a full recovery and the nursing follow up was commended. It was noted however, that it was an unusual and complex case out with normal practice and it was agreed that the Administration of Medicines Policy should be clear on double checking dose before administration by clinicians and nurses.

**Action**:

**5.4 Claims Report**

LLR gave an overview of the report which will be presented to the Committee on a 6-monthly basis**.** She advised the meeting there was a new process in place to retrospectively identify whether investigations were carried out at the time.Currently, two claims have triggered retrospective reviews; a misdiagnoses for a patient who died two years later, and a joint review regarding patient consent.

KK queried a claim that a patient had wakened during surgery. AMacf explained that although there can be equipment or medication failure, these cases were extremely rare at the Golden Jubilee and in general. Our electronic monitoring gives a modified analysis of brain activity during surgery and combined with diligent monitoring, makes it an extremely rare occurrence. The national Audit produces a snapshot figure of 1:100,000 patients.

1. **Effective**
   1. **HAIRT Report (February)**

AMC gave an overview of the February HAIRT Report and highlighted the following points:

* There had been one SAB in ICU2 during February and work was underway to consider devices and how they are inserted. More detailed information on was identified on Page 3, but as nine were within the rolling year we will exceed our local trajectory for 20/17/18. We are however, still below the national trajectory for SAB’s. AMacf commented this was generallydevice related and could be challenging with long term patients. The example cited was balloon pumps but measures had now been put in place for these to be carried out in theatre or the Cath Lab under surgical conditions
* Overall there had been 97% compliance with Hand Hygiene but a dip for medical staff was noted. Although this was representative of a small sample, the need for full compliance and our zero tolerance policy in all areas had been reinforced.
* It was noted that Hand Hygiene and bare below the elbows rule had been reinforced within Outpatients. Measures were in place to support staff and increase awareness of the policy. It was expected there would be an increase in compliance in March.
* No issues within Environment were reported and both Housekeeping and Estates had performed well.
* During February there had been a sharp rise in SSI rates. Initial investigations confirmed there were no linkages around surgeons, theatres and wards. Work was ongoing with a multi professional short life working group within the area to improve this. MRSA screening fell short of full compliance. AMC reported that there had been national research with some members of staff to ascertain the barriers to maintaining full compliance across NHS Scotland. .
  1. **Committee Annual Report and Schedule of Reports**

LLR gave the Committee an overview of the report which had previously been presented at CGRM. The following points were noted.

* Attendance sheet to be completed (LLR)
* Look at wording around SMacK as interim chair attendance (LLR)
* Pg 4 0 identify species relating to Mycobacteria (LLR)
* Replace MH with HE as Acting Medical Director (LLR)
* Work Plan re Duty of Candour: MMacG advised the meeting that work was ongoing around the Clinical Outcomes Framework and would be presented as updates and interim report. LLR to check dates

1. **Person Centre**
   1. **Duty of Candour**

LLR gave a brief update on the legislation relating to Duty of Candour. She advised the Committee that the Adverse Events Policy would reflect data received. Work had been underway with the services over the past year and noted reviews into significant events had been normal practice for some time.

In terms of application she advised the policy was available to review and guidance around events was explicit. We have established drop-in areas for staff with issues and on-line learning was available and detailed all aspects of the application backed up by videos. It is focussed on after the event and staff becoming familiar with the process. LLR recommended this training to the Committee.

It was agreed we were in line with legislation and our paperwork already informs families at the start of the process. JY noted saying ‘sorry’ was not an admission of guilt but part of our process to be open with grieving families. MMacG noted the challenges were often around time, ongoing care, how much information and how many choices we offer. LLR replied it was dependant on individual families and how much they wanted to be involved. However, provided we can evidence our communication and support we are in line with legislation.

KK asked how this legislation was applied in the the Private Sector, patients moving between public and private and the role of the GMC in policing the private sector. JY advised the government had responsibility for the private sector, but as most private practitioners were employed in some capacity with the public sector, they would be aware of the guidelines. They were also registered with the GMC.

KK thanked the Committee for their reassurance and felt comforted by the degree of vigour applied by us.

JCF stated this should be presented at Partnership Forum for information and awareness.

1. **AOCB**
   1. **Clinical Governance Annual Presentation Day (Tuesday 29 May)**

This was on the agenda as a reminder of the date and LLR advised the Committee that this day highlighted our work and presentations were given by different services. JY advised that our new Chair should be invited.

* 1. **Clinical Audit Policy**

LLR advised this policy had been presented to CGRM. JY noted this should now identify our RAG status.

1. **Date and Time of Next Meeting**
   1. The next meeting takes place on Tuesday 31 July at 9.30 am in Level 5 Boardroom.