

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow Health and Clinical Governance Committee
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow, G3 0YZ
on Thursday 2 March 2006 at 2.00 pm**

P R E S E N T

Professor D H Barlow (in the Chair)

Prof Sir John Arbuthnott
Mrs S Kuenssberg
Ms G Leslie
Mrs J Murray
Mr D Sime
Mrs A Stewart

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

Mr G Barclay	..	Head of Administration, Acute Division
Ms H Borland	..	Head of Clinical Governance and Patient Safety Unit, NHSQIS (Minutes 6 and 7)
Dr B N Cowan	..	Board Medical Director
Mr A Crawford	..	Head of Clinical Governance, Greater Glasgow NHS Board
Mrs R Crocket	..	Board Director of Nursing
Dr L Jordan	..	Medical Director, Greater Renfrewshire Division, Argyll and Clyde Health Board
Mr D J McLure	..	Senior Administrator, Area Clinical Effectiveness Office

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon, Mrs P Bryson, Dr L de Caestaker and Mr R Cleland.

2. MINUTES

The minutes of the meeting held on 13 October 2005 were approved as an accurate record.

3. MEMBERSHIP

Dr Cowan reported that the membership of the Committee had been revised in the light of the new Board structure. A list of the new members was received. There was discussion on the need for representation from the Clyde area of Argyll and Clyde Health Board that would become part of the Board on 1 April 2006.

DECIDED:-

1. That Dr L Jordan, Medical Director, Greater Renfrewshire, should become a member of the Committee.
2. That there should be an additional lay member of the Committee, to represent the public interest from Clyde.
3. That an additional member be obtained from among the new Non Executive Board members from Clyde, to be appointed from 1 April 2006.

Dr JORDAN

SECRETARY

4. REMIT

Dr Cowan reported on discussions that had led to the drafting of a revised remit for the Committee in the light of the new Board structure and the formation of the Clinical Governance Implementation Group (CGIG). Copies of the draft revised remit, together with the remit and membership of the CGIG, had been circulated to members.

The revised remit confirmed the Committee's role as overseeing rather than delivering clinical governance, with responsibility for delivery resting with the Chief Executive. It was envisaged that the future focus of the Committee would be on the development of strategy and the promotion of major clinical governance issues rather than on receiving reports on routine matters.

The role of the CGIG was to be responsible, on behalf of corporate management, for developing policy and establishing decisions on strategic priorities deemed essential to clinical governance and the attainment of its goals. It was also responsible for ensuring appropriate management of the strategic objectives linked to Clinical Governance within the Local Implementation Plan. The membership included representation from across the Acute Division, Care and Health Partnerships (CHPs) and the Mental Health Partnership. The Group would operate as a working group at Area-wide level. It would provide the Committee with reports informing on the coherent development of Clinical Governance throughout Greater Glasgow and Clyde in the Acute Division's Directorates, the CHPs and Mental Health Partnership according to requirements and the strategy agreed by the Committee.

Dr Cowan outlined the pattern of clinical governance arrangements that were being developed within the Acute Division. Responsibility for Clinical Governance rested with the Medical Director, the Associate Medical Directors and the Nurse Director. Clinical Governance would be organised by Directorates. There would not be Clinical Governance Committees at Directorate level. Issues that could not be resolved within Directorates would be referred to the Division's Strategic meetings.

DECIDED

1. That the proposed revised remit of the Committee be accepted.
2. That the remit of the Clinical Governance Implementation Group should be amended to include representation from Clyde.
3. That a paper be provided for the next meeting on the working of Clinical Governance within the Acute Division and the Partnerships.
4. That the Clinical Governance Strategy should be reviewed.
5. That an accelerated mechanism be established to deal with serious issues arising unexpectedly.

Dr COWAN

Dr COWAN

Dr COWAN

Dr COWAN

5. WAYS OF WORKING

Mr Crawford presented a paper that had been compiled following discussions held with the Chairman of the Committee, the Board Chairman and the Board Medical Director on future ways of working for the Committee. A number of proposals had been made, including:

1. A locally tailored education package on Clinical Governance could be developed for current and future members, in response to needs that may be identified by members.
2. Routine reports should not dominate the agenda of meetings. Adequate time should be given for the review of individual services and specific topic areas.
3. Written reports for the Committee should include an executive summary highlighting key aspects.
4. Part of the agenda should be reserved for items of concern that had recently emerged from the service.
5. The Chairman and Vice Chairman of the Committee would meet with the Chairman of the Board, the Board Medical Director, the Head of Clinical Governance and the Committee Secretary to establish the agenda in advance of each meeting.
6. The Clinical Governance Implementation Group (CGIG) would have a key role in highlighting issues within the scope and interest of the Committee. Members may wish to recommend areas for further inquiry when reviewing minutes of CGIG minutes.
7. Provision should be made, as the need arose, for the Committee to meet within any area of the Board or its services. This would be appropriate in circumstances where there could be benefit in the Committee meeting staff within their own environment in order to understand concerns. It was essential that the benefits of proposed visits were first carefully assessed against the effects of interruption to the natural service delivery within these areas before proceeding with arrangements.

Mrs Murray raised the question of the means whereby members of the Committee could be actively involved in formulating strategy.

DECIDED:-

1. That the paper on proposed Ways of Working be agreed.
2. That means of active involvement by members of the Committee in the formulating of strategy be explored.

Dr COWAN
Mr CRAWFORD

6. NHSQIS CLINICAL GOVERNANCE AND PATIENT SAFETY WORK PROGRAMME

Ms Borland gave a presentation on the NHSQIS Clinical Governance and Patient Safety Work programme for 2005-2007. She referred to the origins of clinical governance and the purpose for which NHSQIS had been set up, and then proceeded to describe the purpose of the Clinical Governance and Patient Safety Support Unit, its work programme for 2005-7, progress achieved to date and current publications. She stressed that NHSQIS should not be regarded as an inspectorate, but a body that set standards and arranged for performance to be monitored by peer review. Guidance and support was given to NHS Scotland on effective clinical practice and service improvements.

There was discussion on the relationship between the Unit and the Committee and the influence that the Committee could have on the work of the Unit. Ms Borland indicated that the Unit had developed a programme on the role of non-Executive Board members in relation to Clinical Governance.

NOTED

7. NHSQIS NATIONAL STANDARDS FOR CLINICAL GOVERNANCE AND RISK MANAGEMENT: ACHIEVING SAFE, EFFECTIVE, PATIENT-FOCUSED CARE AND SERVICES

Mr Crawford outlined the implications for the Board of the document published by NHSQIS in October 2005 entitled “National Standards – Clinical Governance and Risk Management: Achieving Safe, Effective, Patient-Focused Care and Services”. He drew attention to the three sets of standards detailed in the document under the headings: “Safe and effective care and services”, “The health, wellbeing and care experience” and “Assurance and accountability”.

NHSQIS had intimated that a Peer Review visit would be made to Greater Glasgow, relative to the national standards, on 26 and 27 September 2006. The standards focused on the maturity of working processes within single-system practice. Consequently Greater Glasgow was at a disadvantage, relative to other Health Boards, in that single-system working would have been in operation for a very short time prior to the visitation. There therefore was apprehension that the report of the peer review would reflect less well on Greater Glasgow than the actual levels of good practice taking place would deserve. Ms Borland pointed out that the publication of the report would be a considerable time after the peer review was completed, by which time Greater Glasgow could demonstrate the progress that had been made since the visit, with the maturing of single-system working.

Mr Crawford indicated that it would be appropriate for there to be representation from the members of the Committee at the discussions between the peer review team and the Board on the second day of their visitation.

NOTED

8. NICE GUIDANCE

Further to Minute 37 of the last meeting, a response had been received from Mr Peter Hamilton, Chairman of the Board’s Involving People Committee (IPC), to the Committee’s recommendation that the IPC consider the issue of the extent of the public’s awareness and perception of NICE Guidance as it affected Scotland. Some members of the IPC felt this was an issue for NICE rather than the IPC. However, he had advised that it had been decided that, space permitting, an article should be included in the April edition of “Health News”.

NOTED

9. FATAL ACCIDENT INQUIRY

Further to Minute 29 of the last meeting, Dr Cowan reported that a letter had been compiled regarding the implementation among doctors of the action plan drawn up in the light of the recommendations of an FAI following the death of a patient with learning difficulties in an acute unit in Tayside. To date, the main response to the letter had questioned the FAI recommendation regarding medical staff looking at nursing notes.

DECIDED:-

That the FAI recommendation regarding medical staff looking at nursing notes be referred for further discussion to the Greater Glasgow Reference Group that produced the action plan.

**Dr COWAN
Mrs CROCKET**

10. DISCHARGE LETTERS

Further to Minute 46 of the last meeting, Dr Cowan reported that the Scottish Executive had written to Health Boards commending the system in operation in England whereby clinic and discharge letters were sent to the patient as well as the General Practitioner. He had written to Associate Medical Directors requesting that they commence discussions with Clinical Directors on this.

Dr Cowan reported that a pilot system had been operating at Yorkhill. It appeared to be proceeding successfully, with the exception of the Orthopaedic specialty. A report on the pilot system would be sought and discussed at a forthcoming meeting of the Board Medical Director with Associate Medical Specialists.

DECIDED:-

That a further report be received from Dr Cowan following discussions with Associate Medical Directors.

Dr COWAN

11. QUARTERLY REPORT ON COMPLAINTS

Mr Barclay presented the report that had been submitted to the Board on complaints covering the period July to September 2005. He drew attention to a number of issues, including:

1. National guidance no longer gave a target of 70% for the completion of written Local Resolution Complaints within 20 working days. The guidance now indicated that complaints should be completed within 20 working days, which implied a target of 100%.
2. The variations between Divisions in the percentages of complaints not upheld had been investigated. The reason had been identified, and guidance was being issued for a standard definition of "not upheld" to be followed throughout Greater Glasgow.
3. A change had been made to the Ombudsman's procedure on receipt of complaints. All would now be formally investigated and the outcome included in the reports to Parliament. Since April 2005 around 2% of complaints in Greater Glasgow had been referred by complainants to the Ombudsman.
4. A new Complaints Handling Policy and Procedure, in the light of national directives, had been approved by the Board and was in the process of being implemented.

There was discussion on a proposal that the current practice of the Committee receiving copies of the full quarterly reports, that had already been discussed at Board meetings, should be replaced by papers highlighting outcomes of specific complaints in relation to influencing clinical practice.

DECIDED:-

1. That the proposal that the Committee should receive papers highlighting outcomes of specific complaints in relation to influencing clinical practice instead of copies of the full quarterly reports be supported.
2. That it would be appropriate for the reports of complaints investigated by the Ombudsman to be submitted to the Committee.

**Mr BARCLAY
Mr CRAWFORD**

**Mr BARCLAY
SECRETARY**

12. MINUTES OF MEETING OF AREA CLINICAL EFFECTIVENESS COMMITTEE

The minutes of the final meeting of the Area Clinical Effectiveness Committee (ACEC) held on 17 November 2005 were received. Dr Cowan reported that the newly formed Clinical Governance Implementation Group had now subsumed the role of ACEC.

Professor Barlow drew attention to a proposal that, henceforth, minutes of all meetings submitted to the Committee should be prefaced by an introduction highlighting issues for the attention of the Committee.

DECIDED:-

That all minutes submitted to the Committee should be accompanied by a paper highlighting relevant issues.

**Mr CRAWFORD
SECRETARY**

13. MINUTES OF MEETINGS OF DIVISIONAL CLINICAL GOVERNANCE COMMITTEES

The minutes of the meetings of the South Glasgow and Yorkhill Divisional Clinical Governance Committees held on 28 October 2005 and 14 December 2005 respectively were received. With the end of the Divisional structure this would cease to be a standing item on the agenda.

NOTED

14. MINUTES OF MEETING OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the first meeting of the Clinical Governance Implementation Group held on 8 February 2006 were received. The dates of future meetings would be arranged to co-ordinate with meetings of the Committee.

NOTED

15. SPIRITUAL CARE COMMITTEE

The minutes of the meeting of the Spiritual Care Committee held on 24 January 2006 were received.

There was discussion on the current status of the Spiritual Care Committee as a subcommittee of the Clinical Governance Committee. It was felt that it would be more appropriate for Spiritual Care to be a subcommittee of the Involving People Committee.

DECIDED:-

That it be recommended to the Board that the Spiritual Care Committee be re-designated as a subcommittee of the Involving People Committee.

SECRETARY

16. MINUTES OF CONTROL OF INFECTION COMMITTEE

The minutes of the meeting of the Control of Infection Committee held on 12 September 2005 were received.

There was discussion on the future organisation of Infection Control in Greater Glasgow in the light of the new single system.

DECIDED:-

That Dr S Ahmed, Consultant in Public Health and Chairman of the Infection Control Committee, be invited to attend a meeting of the Clinical Governance Committee to give a presentation on the future organisation of Infection Control in Greater Glasgow.

SECRETARY

17. MINUTES OF REFERENCE COMMITTEE

The minutes of the meeting of the Reference Committee held on 19 December 2005 were received. Minutes of meetings of the Reference Committee had previously been submitted to the Primary Care Division, but with the disbandment of the Division, the Board had directed that future minutes be referred to the Clinical Governance Committee.

Arising from concerns raised relating to an item in the minutes, there was discussion on the extent of the remit and the issues that were covered by the responsibilities of the Reference Committee and its relationship to Service bodies.

DECIDED:-

That a request be made to the Reference Committee for a presentation on its remit and areas of responsibility to be made to the next meeting of the Clinical Governance Committee.

SECRETARY

18. SCOTTISH PUBLIC SERVICES OMBUDSMAN REPORT 2004-2005

Dr Cowan reported that the Scottish Executive Health Department had written to Health Boards in Scotland regarding three issues highlighted in the Scottish Public Services Ombudsman Report 2004-2005 relating to complaints against the NHS in respect of (i) delays in diagnosis and delays in treatment, (ii) treatment of Hepatitis C and (iii) some aspects of care provided by GPs. The Scottish Executive had requested that these three issues be Clinical Governance Committee agenda items.

Dr Cowan advised that these issues would in the first instance be referred to the Clinical Governance Implementation Group that would arrange for reports to be submitted to the Committee for discussion.

NOTED**19. NHS NATIONAL SERVICES SCOTLAND – BRIEF GUIDE TO INFORMATION GOVERNANCE**

The NHS National Services Scotland had produced an information leaflet entitled “A Brief Guide to Information Governance”. In an accompanying letter it had been stressed that Information Governance had a clear link to the recently published Clinical Governance and Risk Management Standards (Standard 3: Assurance and Accountability) and that it was vital to ensure that NHS Scotland handled information in a confidential and secure manner.

NOTED**20. CLINICAL INCIDENTS**

Dr Cowan intimated that all future clinical incidents featured in the media would be included in Committee meeting agenda.

There had been two featured recently: (i) a patient given radiation overdoses, as reported in the Daily Record and (ii) a patient given the wrong drugs, as reported in the Mail on Sunday. Dr Cowan outlined the background to the two incidents and detailed the action that had been taken as a result of the investigations.

Mrs Murray requested that Board members be informed of such incidents at an early stage.

DECIDED:-

1. That Dr Cowan’s reports on the two incidents be noted.
2. That consideration should be given to setting up a system for informing Board members of incidents at an early stage.

Dr COWAN**21. SCOTTISH AUDIT OF SURGICAL MORTALITY**

Dr Cowan intimated that reports from the Scottish Audit of Surgical Mortality covering the Greater Glasgow and Clyde areas were currently being considered within the Board. Following this exercise he would arrange for reports to be submitted to the Committee, in due course, relating to the Board area as a whole and the individual hospitals concerned.

Dr COWAN

NOTED

22. DATES OF FUTURE MEETINGS

DECIDED:-

1. That the schedule of meetings compiled for 2006 be amended to conform to a bi-monthly system of meetings.
2. That the Secretary would ascertain the availability of members on appropriate dates, and circulate an amended list of meeting dates for the remainder of 2006.

SECRETARY

The meeting ended at 4.15 pm