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Minutes: 23 - 36

GREATER GLASGOW AND CLYDE NHS BOARD

Minutes of a Meeting of the
Greater Glasgow and Clyde Health and Clinical Governance Committee
held in the Meeting Room B, Dalian House,
350 St Vincent Street, Glasgow, G3 8YZ
on Friday 5 May 2006 at 2.00 pm

P R E S E N T

Professor D H Barlow (in the Chair)

Professor Sir John Arbuthnott	Mrs J Murray
Mr R Cleland	Mr D Sime
Mrs G Leslie	Mrs A Stewart

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

Dr W G Anderson	..	Board Associate Medical Director
Mr G Barclay	..	Head of Administration, Acute Division
Dr B N Cowan	..	Board Medical Director
Mr A Crawford	..	Head of Clinical Governance, Greater Glasgow & Clyde NHS Board
Dr L de Caestecker	..	Acting Director of Public Health
Dr L Jordan	..	Associate Medical Director (Clyde)
Mr L McNair	..	Head of Service, Department of Clinical Psychology
Mrs M McGuinness	..	Secretariat Department
Dr L Watt	..	Medical Director of Mental Health Partnership

ACTION BY

23. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon, Mrs R Crocket and Mrs S Kuenssberg.

24. MINUTES

The Minutes of the meeting held on 2 March 2006 were approved subject to the inclusion of Mr R Cleland in the list of Apologies.

25. MATTERS ARISING FROM THE MINUTES

(i) Membership

The Chairman advised Members that the process of identifying candidates for lay membership from Clyde was ongoing. He also indicated that Non Executive Members from Clyde had still to be appointed to the Board.

NOTED

ACTION BY

(ii) Remit

The Chairman indicated that Dr Liz Jordan, Associate Medical Director (Clyde) was now a Member of the Greater Glasgow and Clyde Clinical Governance Implementation Group.

NOTED

(iii) Spiritual Care Committee

The Chairman advised that Mr Peter Hamilton, Chair of the Involving People Committee, had agreed that the Spiritual Care Committee would be a Subcommittee of the Involving People Committee.

NOTED

(iv) The Chairman intimated that Dr John Nugent, Clinical Director, West Glasgow CHP, would attend the next meeting of the Clinical Governance Committee to outline the work of Clinical Governance within CHPs.

NOTED

(v) Clinical Incidents

Mrs Stewart enquired of the progress of the investigation into the incident involving the patient who had been given the wrong drugs. Dr Cowan advised that all interviews had been concluded. A report was in progress.

NOTED

26. NHSQIS NATIONAL OVERVIEW REPORT ON LEARNING DISABILITY SERVICES

Mr Lindsay McNair circulated a paper to the Committee on the NHSQIS review of NHS Greater Glasgow Learning Disability Services dated February 2006. The paper summarised the review of Learning Disability Services by NHSQIS which involved the completion of self-assessment and a peer review visit on 18th and 19th May 2005 which was part of an overall review of Learning Disability Services in Scotland.

This first national review concentrated on the theme of quality of care and services for people with learning disabilities in the context of hospital closure and service redesign. Although the review considered services for children and adults with a learning disability, this report considered only those services for adults as, at the time of the review, Glasgow Learning Disability Partnership was responsible only for adult services. Local reports were available on the QIS website. The review of Greater Glasgow had considered performance against four of the six NHS QIS quality indicators (1, 4, 5 and 6).

Quality Indicator 1 – Involvement of People with Learning Disabilities Through Representation and Advocacy

QIS had indicated that the strengths were (i) involving people in the planning and delivery of services, (ii) the ongoing development of complaints procedure and (iii) existing opportunities for service users to comment on services.

In relation to the challenges, he advised that these included advocacy. Although there was a range of services available, there was a need to better inform users how to access services. There were gaps in services for carers and siblings. QIS also felt that there was a need to formalise training for staff in accessing and promoting the use of advocacy services. Advocacy services were well used and were currently running at capacity but were insufficient to meet demand.

Quality Indicator 4 – Meeting Complex Health Needs.

The challenges identified by QIS related to the functional integration of specialist and general health services. QIS did recognise that there was some integration but this was variable. In relation to transitions, both age related and between services, QIS noted that protocols were being developed, and commended the "bottom up" approach being used.

In relation to services for individuals with profound and multi-impairment, QIS indicated that services were in place but a number of different protocols were being used.

With regard to services for epilepsy, QIS identified the need to ensure greater cohesion between community and clinical services and for care plans to be kept up to date. QIS had noted that this issue was currently being addressed.

Quality Indicator 5 – Inpatient Services – Daily Life

QIS had identified the challenges as maintaining good quality décor and ensuring prompt repair. The strengths included the protection of patients' privacy and having the environment personalised to individual needs and choices. QIS also identified that individuals were given choice in how they spent their time during the day.

Quality Indicator 6 – Planning Services and Partnership Working

QIS had recognised that one of the strengths of last year's organisational change was that community services had the use of the Care First information system. Workforce planning and staff education/training programmes, particularly in hospitals, was a further strength identified by QIS.

In relation to the challenges identified by QIS, Mr McNair advised that, although CHCPs were at an early stage in their planning, the needs of people with learning disabilities needed to be considered. QIS had also stated that, in relation to health improvement strategies, there was a need to re-instate the health screening programme.

In conclusion, the report summarised the challenges which existed across learning disability services as

- providing accessible information for service users to ensure more effective user involvement;

- managing transitions (both age and service related);

- managing the response to individuals whose behaviour challenged services, ensuring timely discharge from residential settings and responding to new demands on services;

- ensuring effective engagement with CHCPs to ensure their planning took account of the needs of individuals with learning disabilities.

Progress had been made in relation to vulnerable adults and a risk framework had been developed. With regard to service user involvement, individuals had been identified to take this work forward. Child services were reasonably well developed but Mr McNair acknowledged that large gaps existed in specialist adolescent disability services.

Mr McNair ended his presentation by stating that effective clinical links had been made. The QIS report had concluded that NHS Greater Glasgow Learning Disability Services were providing a high quality of care to individuals and that much progress had been made since the closure of Lennox Castle Hospital in April 2002. The report commented that "hospital closure had effectively achieved for people with learning disabilities in NHS Greater Glasgow, and a range of services have been developed to meet the needs of people in the community. The remaining challenge is to address the financial investment required to meet the needs of the increasing number of people with learning disabilities and to support the transition from children to adult services. There is a clear commitment within NHS Greater Glasgow to take this agenda forward, building on the work already undertaken to date".

In response to a question from Sir John Arbuthnott, Mr McNair advised that CHCP Directors would be responsible for ensuring that learning disabilities and mental health services were integrated into the Board's general objectives and targets. There were also health improvement targets for mental health and addiction services.

Currently there was no timescale for the next set of QIS visits. In future these would be joint inspections with Social Work Services. At the next QIS visit, challenges would be reviewed, as would other standards that had not been reviewed previously.

NOTED

27. UPDATE ON RECENT MENTAL WELFARE COMMISSION REPORT

Dr Linda Watt, Medical Director of the Mental Health Partnership, circulated a paper to Committee Members on a recent enquiry by the Mental Welfare Commission.

As a result of the recommendations made in the report, a small Working Group was being set up by Dr Watt to produce an implementation plan for the management of all restricted patients. The Mental Health Division at the Scottish Executive was going to look at care planning and risk management across Scotland and the risk assessment tools and plans required. The Working Group intended to produce standards for mental health services.

Dr Watt referred to local issues and advised that the recommendations from the report would be circulated to all staff. Recruiting a Consultant was proving difficult but even more so with the recruitment of specialist nurses. She felt that there had not been a consistent approach to the training of nursing staff. There had been a number of criticisms around clinical governance where there had been little audit of services and poor record keeping. This was going to be addressed. A senior manager in charge of Forensic Services, together with a Clinical Director who was a General Psychiatrist and Social Work Mental Health Officers were looking at opportunities to improve the quality of assessment of patients' internal governance processes.

With regard to the opening of the Forensic Unit in Greater Glasgow on the site of Stobhill Hospital, Dr Watt indicated that she understood this would be in the summer/autumn of 2007. Discussions were ongoing with the Scottish Executive on a West of Scotland Forensic Unit that had been proposed for Dykebar. Mr Tom Divers and Ms Ann Hawkins (Mental Health Partnership) were shortly to meet with the Minister to discuss this matter. Dr Watt indicated that it would be easy to revise the clinical strategy in relation to Clyde services.

Sir John Arbuthnott referred to the changes in regulations regarding residents of the State Mental Hospital at Carstairs. These included the facility to appeal regarding the level of care they required. It was understood that a monthly report would go to Ministers on how this process was progressing. Dr Watt advised that patients could appeal to Mental Health Tribunals regarding levels of security and if the appeals were upheld they would require to be moved to medium secure facilities. She was currently working on predictions of future numbers and costs as a result of this change in the regulations. Normally, over a third of the population of the State Mental Hospital in medium secure facilities were from Greater Glasgow and Clyde.

DECIDED:-

That, in due course, Dr Watt should give a further presentation to the Committee on the implementation of the plan of the Working Group. **Dr WATT**

28. CLINICAL GOVERNANCE IN GREATER GLASGOW AND CLYDE : TRANSITION/INTEGRATION ARRANGEMENTS

Mr Crawford submitted a draft consultation paper setting out a proposed revised strategy for clinical governance within Greater Glasgow and Clyde. He outlined progress that had already taken place and advised that a corporate level clinical governance committee structure would be submitted for approval in due course.

He advised that a training seminar would be arranged for Committee members. QIS was establishing a network for Non Executive Members of the Committee and had recently published a national education programme through Glasgow Caledonian University that Non Executives Board members could attend. However, this involved a study commitment of 15 hours per week which might not be feasible for those with busy schedules. He would circulate details of this course to Non Executive Members. **Mr CRAWFORD**

In response to questions regarding aspects of the relationship between the Committee and Directorates, Dr Cowan confirmed that issues which the Committee wished to be addressed would be referred to the Clinical Governance Implementation Group (CGIG). The Group would routinely keep the Committee informed of all issues being investigated.

There was considerable discussion regarding the reporting of clinical incidents to the Committee. Mr Crawford referred to the Clinical Risk Management system, which included baseline reporting, and to the national assessment matrix categories 4 and 5 which triggered an investigation. The system should identify common themes across the service and was already picking up incidents quickly. Reports on incidents would be submitted to the GCIG and the Committee.

DECIDED:

1. That members of the Committee should have input into the draft consultation paper, and submit comments to Mr Crawford. **MEMBERS**
2. That members of the Committee should routinely receive copies of statements from the Board's Director of Communications on clinical incidents. **Mr McLAWS**
3. That a report from the Board's Medical Director should be a standing top agenda item for all future Committee meetings. The report should include an outline of the clustering of clinical incidents. **Dr COWAN**

29. CLINICAL GOVERNANCE DEVELOPMENT FRAMEWORK

There was a wide-ranging discussion on the draft consultation paper, prepared by Mr Crawford, setting out a proposed revised strategy for Clinical Governance within Greater Glasgow and Clyde. There was consensus that there was a need for more specific reference in the paper to routes of reporting, sources of responsibility, roles, remits and accountability, and for the roles of the Committee and CGIG to be more clearly stated. It was also felt that an explicit statement should be included to the effect that the Board's Chief Executive was responsible for services through Directors. Mr Sime indicated that the Area Partnership Forum would wish to be involved in the consultation process on the draft paper. **Mr CRAWFORD**

DECIDED:-

1. That the consultation paper should be redrafted in the light of the Committee's comments regarding the need for greater clarity on roles and responsibilities and more specific references to the areas highlighted. **Mr CRAWFORD**
2. That a seminar should be organised for the Committee chairman and members on the proposed strategy for clinical governance in Greater Glasgow and Clyde. **Mr CRAWFORD SECRETARY**

30. STATEMENT OF ASSURANCE ON CLINICAL GOVERNANCE ARRANGEMENTS 2005/2006

Dr Cowan advised that in the past the Primary Care Clinical Governance Committee had used statements of internal control setting out clinical governance responsibilities. He felt there should be some statement of assurance as part of the audit process and the Committee was being asked to consider a draft statement of assurance on clinical governance arrangements for clinical services within NHS Greater Glasgow for 2005/2006 which, if approved, would be submitted to the Board's Audit Committee and become part of the Board's accounts.

DECIDED:-

That the draft statement of assurance be approved. **Dr COWAN Mr CRAWFORD**

31. ANNUAL INFECTION CONTROL PROGRAMME FOR 2006/07

Dr Anderson, in his capacity as the Board's Infection Control Manager, presented the final draft of the Annual Infection Control Programme for 2006/07 that had been developed and approved by the Board's Infection Control Committee which was chaired by Dr Syed Ahmed, Consultant in Public Health. The Clinical Standards Board, which was now QIS, had developed infection control standards in 2001. The 2006/07 programme had been developed in response to organisational change within the Board. There was a need to deliver genuine improvements. Core management systems were required. There would also be greater emphasis on producing data to demonstrate improvements in outcomes.

Dr Anderson advised that it was anticipated that, by the time of the next meeting, the Infection Control Report on activity for 2005/06 would be available.

DECIDED:-

1. That the Annual Infection Control Programme for 2006/07 be noted.
2. That it be recommended that a glossary of the acronyms used throughout the document be included in the final version. **Dr ANDERSON**
3. That the Committee should receive the Infection Control Report for 2005/06 at the next meeting. **Dr ANDERSON**

32. MINUTES OF CONTROL OF INFECTION COMMITTEE

The minutes of the meeting of the Control of Infection Committee held on 12 December 2005 were received, together with a summary paper from the committee chairman, Dr Ahmed, highlighting key points.

Dr Anderson advised that MRSA was reported nationally and on a Divisional basis within Greater Glasgow. In relation to MRSA incidents, Yorkhill was very low, South Glasgow was low and North Glasgow was high. He suggested that the high rate for North Glasgow might be due to case mix. North Glasgow would probably continue to have higher levels than other parts of Greater Glasgow, but they were going down. Dr Anderson reported that he was a member of a group that was examining whether the prescribing of antibiotics could be leading to the growing infection rates of *C.difficile.*

Dr Anderson also reported on the volume of work being carried out within the Board on pandemic flu. There was a pandemic flu plan which was part of an overall civil contingency plan.

NOTED

33. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meetings of the Clinical Governance Implementation Group held on 9 March and 10 April 2006 were received, together with a summary paper highlighting key points.

A number of points arising from the minutes were raised:

1. It was anticipated that a revised robust system for the circulation of HDLs would soon be in operation.
2. An updated version of the Risk Register Policy would be submitted to the next meeting of the Risk Management Steering Group.
3. It had been confirmed that all relevant groups had addressed HDL(2006)11 on Safe Handling of Intrathecal and Intraventricular Injections.
4. Dr A Mathers of the Women and Children's Services Directorate had produced the Scottish Confidential Audit of Severe Maternal Morbidity.
5. Dr Cowan confirmed that he was arranging for a presentation to be made to the next meeting of the Committee on the Scottish Audit of Surgical Mortality. **Dr COWAN**

NOTED

34. MINUTES OF REFERENCE COMMITTEE

The minutes of the meetings of the Reference Committee held on 25 January and 21 February 2006 were received together with summary papers highlighting key issues.

NOTED

35. ANY OTHER BUSINESS

(a) Theatre at Southern General Hospital

Dr Cowan advised that a crack in the floor of the oldest theatre in the Southern General Hospital had been the subject of a newspaper article. The relevant Director was making plans to deal with this matter locally. There was no evidence of increased rates of infection arising from this situation.

NOTED

(b) Fatal Accident Inquiry - Victoria Infirmary

Dr Cowan advised there had been an incident of anaesthetic death at the Victoria Infirmary. The Procurator Fiscal had been notified by the hospital. Hospital staff had met with the family and advised them about the investigation that was taking place.

Sir John Arbuthnott referred to a report into an incident at a hospital in Southampton which had contained the phrase "failing to supervise doctors". Dr Cowan understood that this was in connection with Consultant ward rounds not having taken place. The Scottish Central Legal Office was looking into this matter.

NOTED

36. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Monday 3 July 2006 at 2.00pm in Dalian House, 350 St Vincent Street, Glasgow.