MINUTES NOT YET APPROVED AS A CORRECT RECORD

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 18 December 2007 at 1.30 pm

P R E S E N T

Prof D H Barlow (in the Chair)

Dr C Benton
Mrs P Bryson
Dr D Colville
Mr D Sime
Mrs Agnes Stewart

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

Dr B N Cowan	..	Board Medical Director
Mr A Crawford	..	Head of Clinical Governance
Mrs R Crocket	..	Director of Nursing
Dr J Dickson	..	Associate Medical Director (Clyde)
Mr D J McLure	..	Senior Administrator
Ms J Paul	..	Audit Scotland
Dr M A Roberts	..	Associate Medical Director (Rehabilitation and Assessment) – Minute 87
Dr R S C Rodger	..	Clinical Director, Renal/Transplant Services - Minute 86
Mr T Welsh	..	Infection Control Manager

ACTION BY

84. APOLOGIES

Apologies for absence were intimated on behalf of Mr R Cleland, Dr L deCaestaker, Mrs J Murray and Councillor A Stewart.

85. MINUTES

The Minutes of the meeting held on 23 October 2007 were approved.

86. RENAL REGISTRY

Dr Rodger presented the findings of the UK Renal Registry analysis of figures for first year after 90 days survival for Western Infirmary and Glasgow Royal Infirmary based renal patients. These had revealed that Glasgow was among three 'outlier' UK centres for patient survival rates, with the figures for the Western Infirmary being lower than Glasgow Royal Infirmary. Dr Rodger described the examination of the figures that had taken place since Glasgow had been alerted to them in February 2007. A number of possible reasons had been identified:-

1. All the haemodialysis and inpatient bed facilities in Glasgow were outdated with no central water plant. Spaces were overcrowded. Satellite dialysis was not available in Paisley and facilities were outdated in Falkirk.
2. The vascular access surgery service was insufficient.
3. There were infection control issues relating to 1 and 2.
4. The transplant rate was low.
5. The IT system was outdated.
6. The difference between the two Glasgow hospitals could be linked to the fact that the prevalence of renal failure in the Clyde area served by the Western Infirmary was 14% higher than in Forth Valley which was served by Glasgow Royal Infirmary.

A range of actions had taken place, and others were being planned. Internal Glasgow and Scottish wide audits had been launched and were ongoing. In 2008 a prospective Scottish-wide audit of deaths was due to commence and a local infection control review would take place. New dialysis facilities were planned, with 60 new stations in two purpose built outpatient units in 2009 with a further 30 stations and an 80 bed in patient unit in 2013 in the new South Glasgow Hospital. Additionally, new satellite haemodialysis facilities were due to open in Paisley (Clyde) and Larbert (Forth Valley) during this time period. Extra haemodialysis stations would also be required in North Glasgow, but agreement about the solution to the current shortfall had yet to be reached. The upgrading of outmoded renal inpatient areas was also a priority in the interim until the inpatient wards were available in the new South Glasgow Hospital. There was an ongoing review of inpatient facilities and utilisation.

A further issue surrounded IT. A scoping exercise had taken place. Plans were now underway to introduce a new modern IT system by 2009, linked to laboratory services throughout the network, to replace the two outdated systems currently in use.

The UK Renal Association had been advised of the matters outlined above, and would be updated regarding the Glasgow renal service in October 2008.

NOTED

87. CLINICAL GOVERNANCE IN REHABILITATION AND ASSESSMENT DIRECTORATE

Dr Roberts gave a comprehensive presentation on Clinical Governance within the Rehabilitation and Assessment Directorate. Given the nature and range of services within the Directorate, there was a wide Clinical Governance structure which was embedded within the overall Directorate management structure. Clinical Governance was a standing item at monthly Directorate meetings.

Clinical Governance within the Directorate was headed by a Clinical Governance Forum whose roles were:- (i) to take a strategic overview; (ii) follow a pan-Directorate approach; (iii) ensure closure of the loop when problems were identified; (iv) identify appropriate Clinical Effectiveness themes and setting strategy. The Forum formulated a work plan that was approved by the Director and reviewed at six-monthly intervals.

There were a range of challenges, including:-

- The need to make Clinical Governance relevant to all members of staff.
- The incorporation of Clyde
- Ensuring that AHPs working in Directorates other than Rehabilitation and Assessment were covered.
- Monitoring the Private and Voluntary sector to ensure that Clinical Governance structures were in existence and identifying any Clinical Governance issues from their reports to the Care Commission.

Dr Roberts outlined in detail the areas of work being carried out, the approaches being followed and the issues and challenges arising under the headings (i) Patient Safety; (ii) Quality Improvement – Clinical Effectiveness; (iii) Clinical Audit; (iv) Sharing Good Practice; (v) Patient Focussed Care and (vi) Overview.

DECIDED:-

That the presentation from Dr Roberts represented a satisfactory approach to Clinical Governance within the Rehabilitation and Assessment Directorate.

88. CLINICAL INCIDENTS

Further to Minute 69, Dr Cowan tabled papers in relation to the cases previously reported affecting the Institute of Neurological Sciences and the Vale of Leven Hospital.

Institute of Neurological Sciences

Dr Cowan gave a resume of the background to the Fatal Accident Inquiry regarding the incident, a summary of the Sheriff's determinations and the Institute's response. The neurosurgery service had undertaken a review of the determinations and had developed an action plan to address the concerns raised by the Sherriff. The action plan had been drawn up with timescales, a copy of which had been submitted for the Committee's information. This was currently being implemented.

NOTED

Vale of Leven

Dr Cowan gave a resume of the background to the incident and presented a detailed Progress Chart giving the action taken, awaited and completed, together with timescales, in relation to the range of issues identified following the incident.

NOTED

Dr Cowan reported on clinical incidents that had arisen since the last meeting relating to the Vale of Leven Hospital, Glasgow Royal Infirmary and the Southern General Hospital. In addition, two Fatal Accident Inquiries had been intimated both involving the Beatson. Dr Dickson reported on a Clinical Incident at the Royal Alexandra Hospital. The Committee would be kept informed of developments. **Dr COWAN** **Dr DICKSON**

NOTED

89. CLINICAL GOVERNANCE IN CLYDE DIRECTORATE ACUTE SERVICES DIVISION

Dr Dickson gave a detailed presentation on Clinical Governance within the Clyde Directorate, Acute Services Division. The Clinical Governance structure was headed by a Clinical Governance Forum which was a large body that met four times a year. Operational matters were directed by Clinical Governance Subgroup that met every six weeks. The Clinical Director (Acute) was the Clinical Governance Lead. Clinical Governance in Clyde faced a number of challenges, the greatest being the fact the Directorate covered all specialities within the geographical area with the recent exception of Rehabilitation and Assessment. Other challenges included:- (i) achieving seamless transfer of reporting; (ii) uncertainty about pattern of service provision; (iii) the demands of the Scottish Patient Safety Programme on Clinical Governance personnel and (iv) finding the means of supporting even prioritised audits.

Dr Dickson outlined the aspects of Clinical Governance that were functioning well within the Directorate. These included: (i) good communication between directorates with sharing of learning; (ii) strong clinical championship of Clinical Effectiveness and Clinical Risk Management; (iii) experience with the Datix system and clinical incident reporting; (iv) a multidisciplinary group of staff trained in Clinical Incident investigation techniques; (v) an effective complaints management system.

There were a number of areas that the Directorate was aware could be improved, including the lack of a data base for appraisal and registration. Dr Cowan reported that the Board had recently launched a new Consultant Appraisal Policy which would ensure a firm annual procedure of appraisal that would be required for all consultants. Failure to fully engage in the process would result in disqualification for pay progression. There was discussion on the question of ensuring that staff had up to date registration with their professional bodies, and examples relating to various staff groups were given.

DECIDED:-

1. That the presentation by Dr Dickson represented a satisfactory approach to Clinical Governance within the Clyde Directorate.
2. That Dr Dickson would provide members with a copy of the Clyde Clinical Governance workplan. **Dr DICKSON**

90. SURGICAL PROFILE REPORT

Dr Cowan advised that the Surgical Profile Report for the current year was now under consideration by the Surgical Directorate. Thereafter the Report and Action Plan would be submitted to the Committee.

NOTED

91. CLINICAL EFFECTIVENESS FRAMEWORK AND ACTION PLAN

Further to Minute 77, Mr Crawford submitted the final version of the Clinical Effectiveness Framework and Action Plan for 2007-2009 which had been approved at the recent meeting of the Clinical Governance Implementation Group.

DECIDED:-

That the Clinical Effectiveness Framework and Action Plan for 2007-2009 be endorsed.

92. SCOTTISH PATIENT SAFETY PROGRAMME

Mr Crawford gave a presentation on the Scottish Patient Safety Programme (SPSP) which was part of the Scottish Patient Safety Alliance (SPSA) launched in March 2007. He outlined the background to the SPSA and described the range of partners and the structure involved. There were three domains, one of which was the SPSP; the others were (i) the National (QIS) Clinical Governance and Risk Management Framework and (ii) local programmes. The SPSP was a requirement on all Health Boards.

Mr Crawford detailed the initial work within the Board for the period November to 19 December 2007. Work Stream Teams had been formed in the Royal Alexandra Hospital and Glasgow Royal Infirmary, with the Southern General Hospital being prepared as a third site for the future. Teams had been formed covering Medicines Management, General Wards, Critical Care and Perioperative Care. A Senior Leadership Work Stream Team had also been formed.

Hospital Self Assessments had been carried out, involving (i) a mortality diagnostic case note review; (ii) an IHI global trigger tool case review; (iii) a global measures assessment and (iv) a medicines safety assessment. Mr Crawford highlighted a number of issues that had emerged as a result of these exercises. The final aspect of the current work would be a learning session for around sixty staff and the Leadership Team to be held from 14 – 16 January 2008. Thereafter there would be (i) a review of the full outline of methods; (ii) a safety and consistency check of interventions for each bundle; (iii) the development and deployment of the support structure and (iv) evaluation and integration.

Due to an underspend in the current NHSQIS budget, the Board had been allocated £90,000 towards the costs of the project.

NOTED

93. OMBUDSMAN QUARTERLY REPORT

Mr Crawford submitted a paper that summarised reports on cases within NHS Greater Glasgow and Clyde that had been considered by the Scottish Public Health Services Ombudsman covering the period July to September 2007. He drew attention to the themes recurring in the reports and the letter that Health Boards had received from Dr Kevin Woods (Minute 67) regarding standards of record keeping. The action plan drawn up by the Board, in response, had now been forwarded to him. The programme that it outlined would be kept under review by the Board's IM&T Department and the Clinical Governance Committee.

A stock-taking exercise on Communications issues in Acute Services had been initiated through Clinical Governance Workplans. Mr Crawford was seeking to have similar work carried out within the Partnerships. He also advised that the Acute Services Strategy Management Team had arranged a retrospective study of past Ombudsman's reports to track the response process. The Committee would be kept informed of developments and improvements taking place. **Mr CRAWFORD**

NOTED

94. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meeting of the Clinical Governance Implementation Group held on 14 November 2007 were received, together with a summary paper highlighting key issues.

NOTED

95. MINUTES OF INFECTION CONTROL COMMITTEE

The minutes of the meeting of the Infection Control Committee held on 17 September 2007 were received, together with a summary paper highlighting key issues.

NOTED

96. MINUTES OF REFERENCE COMMITTEE

The minutes of the meetings of the Reference Committee held on 28 August and 23 October 2007 were received, together with summary papers highlighting key issues.

NOTED

97. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Tuesday 5 February 2008 at 1.30pm in the Conference Room, Dalian House, 350 St Vincent Street, Glasgow.