(CGC)(M)09/5
Minutes: 67 – 83

MINUTE 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 6 October 2009 at 1.30 pm

P R E S E N T

Prof D H Barlow (in the Chair)

Mrs P Bryson	Mr A Robertson
Dr C Benton	Mr D Sime
Mr R Cleland	Councillor A Stewart
Mrs J Murray	Mr B Williamson

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

Dr C Chiang	..	Consultant in Public Health
Mr A Crawford	..	Head of Clinical Governance
Dr J Dickson	..	Associate Medical Director, Clyde
Mr K Hill	..	Director of Oral Health (Minutes 77-78)
Mr R McAndrew	..	Associate Medical Director, Oral Health Directorate (Minutes 77-78)
Mr D McLure	..	Senior Administrator
Dr I W Wallace	..	Associate Medical Director, Women & Children's' Directorate (Minute 76)
Mr T Walsh	..	Infection Control Manager

ACTION BY

67. APOLOGIES

Apologies for absence were intimated on behalf of Dr B N Cowan, Mrs R Crocket and Mrs E Smith.

68. MINUTES

The Minutes of the meeting held on 4 August 2009 were approved, subject to the final paragraph of Minute 58 being amended to read as follows:-

"In considering progress in surgical site infection rates it was noted that the Health Directorate's recommendation to Health Boards was to monitor four sites, three of which related to orthopaedic procedures with very low infection rates around one percent. Since many of the other surgical specialties had infection rates well above this, for example five to ten percent in GI Surgery, it was suggested that a change in the sites to be monitored was appropriate and in the patients' best interests. Dr Cowan felt that the usefulness of current monitoring of infection rates had now run its course and that the focus should now be on other surgical specialities. Mr Walsh indicated that he would approach Health Protection Scotland with this proposal. He would also explore the carrying out of a local survey within the Surgical and Anaesthetics Directorate by the Infection Control surveillance team."

69. MATTERS ARISING FROM MINUTES

Infection Control Update

Further to Minute 55, Professor Barlow intimated that Dr Chiang's concerns that action be taken within NHSGG&C to reduce the 4% rate of new mothers with infection of caesarean section wounds had been submitted to Mrs Crocket. **Mrs CROCKET**

Further to Minute 58, Mr Walsh confirmed that the view that new surgical areas should now be the focus of infection rate monitoring had been raised with Health Protection Scotland. Local initiatives within NHSSGG&C were being pursued within Vascular and Colorectal Surgery **Mr WALSH**

NOTED

70. CLINICAL INCIDENTS AND FAI REVIEWS

Dr Dickson presented a written summary updating the Committee on Clinical Incidents and FAI Reviews. He commented on the situation regarding current cases. One FAI was in the process of being heard and was expected to continue for a further two days. He referred to the outcome of an FAI that had now been reported which had confirmed that there was no further action required, and gave details of two upcoming FAIs, one of which was expected to be particularly high profile. He outlined the preparatory work being carried out in advance to prepare staff for the high profile hearing. He also identified two Clinical Incidents that were currently being investigated for which action plans were being drawn up. He understood that, as a general principle, where all parties agreed that actions following the investigation of a Clinical Incident had been taken resulting in a robust system being in place, the Procurator Fiscal would not seek to take further action.

Mr Cleland commented that there were some particularly complex cases where the process of agreeing an action plan and then achieving implementation was intricate and lengthy. In order for the Committee to be assured of progress and ultimate completion, he proposed that the date of the production of an action plan should be given in the regular reports to the Committee, to be followed by the date of the completion of its implementation.

DECIDED:-

1. That Dr Dickson's report be noted.
2. That the dates of the production and then completion of implementation of actions plans be given in the reporting of each case. **Dr DICKSON**

71. INFECTION CONTROL UPDATE

Mr Walsh submitted the October 2009 NHSGG&C Hospital Acquired Infection (HAI) Monitoring Report which outlined the Board's position and performance in relation to the following:-

S.aureus bacteraemias (HEAT Target)
Should current trends be maintained, NHSGG&C would achieve the target of a 35% reduction by 2010.

C.difficile
The National Report for 2008/9 on annual rates of *C.difficile* infection showed a 0.79 rate per 1000 occupied bed days in NHSGG&C compared with a national rate of 1.09.

Surgical Site Infections
The rates for NHSGG&C remained below the national average for all procedures.

Hand Hygiene Compliance
NHSGG&C had demonstrated a steady rise in Hand Hygiene compliance during the national audit periods from a 62% baseline in February 2007 to the achievement of the 90% target in September 2008, rising to the current figure of 93%.

Monitoring of Cleaning Services
All areas within NHSGG&C scored "green" (greater than 90%) in the most recent report on the National Cleaning Specification. Mrs Bryson proposed that the Committee should be made aware of any areas that had been the subject of "amber" (70-90%) and or "red" scores (less than 70%) but subsequent action had resulted in the required improvements.

DECIDED:-

1. That the report represented good progress within NHSGG&C.
2. That, with regard to Cleaning Services, future update reports would include information on areas that had been subject to "amber" or "red" scores during the auditing process. **Mr WALSH**

72. INFECTION CONTROL ANNUAL REPORT 2008/9

Mr Walsh presented the NHSGG&C Annual Infection Control Report for 2008/9 for consideration. Dr Benton sought clarification whether the list of topics included in the on-line training modules for staff launched in September 2008 by the Board's Infection Control service was being regarded as exhaustive. Mr Walsh advised that the list would be added to whenever further needs were identified.

DECIDED:-

That the report should be approved and commended.

73. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)

Mr Crawford presented a paper updating the Committee on SPSP implementation within NHS Greater Glasgow and Clyde as at mid-September 2009. He drew attention to the following:-

Progress against SPSP Assessment Scale
NHSGG&C was currently assessed at level 2.5. This was in line with most other Health Boards in Scotland. He outlined the conditions required to progress to the next level. Descriptions of progress against these conditions would be developed in the reporting process for the next two months which, with the Institute for Healthcare Improvement feedback, would identify what required to be completed in order to progress to level 3 assessment. **Mr CRAWFORD**

Progress in Phase 1 Front Line Pilot Teams
The phase one General Ward pilot teams had implemented all key changes and data indicated that high levels of process reliability were in place for workstream elements. The phase one Critical Care pilot teams had also implemented all key changes. These teams had been very successful and had demonstrated high reliability in process linked to improvement in outcome measures, with Royal Alexandra Hospital's ITU exceeding the target of 300 days without a central line bloodstream infection.

Measurement Strategy
The full deployment of the measurement strategy was maintained for phase one teams but continued to be a challenge for phase two teams. A gap analysis had been completed with programme staff now linking to teams and their managers to finalise the necessary arrangements. The aim was to have this completed no later than November 2009.

Spread Plan
It was expected that by the end of October 2009, phase 3 would have added a further sixty clinical teams to the exiting thirty that were working within NHSGG&C wards.

Learning Collaborative
The fifth national event for SPSP would take place on 16/17 November 2009 at which NHSGG&C had 80 places. Two applications from the Acute Services Division had been shortlisted for interview to the next cohort of the SPSP Fellowship.

Leadership
The Glasgow Royal Infirmary ITU had been visited by the Cabinet Secretary as part of the National Patient Safety Month The success of the programme had been widely acknowledged but, due to other media events that day, had not received media publicity. Mr Crawford indicated that efforts would be made to re-engage the media with regard to obtaining publicity for the successes within the Board from SPSP. **Mr CRAWFORD**

Mr Williamson enquired of the cost of SPSP in the light of the financial stringencies facing NHSGG&C. Mr Crawford explained the difficulties of establishing costs given that SPSP was being carried out almost entirely by existing staff, many of whom appeared to do so in their own time. It would therefore be difficult to quantify staff time involved. It would also be hard to quantify the benefits due to the difficulty in establishing a base-line and because factors other than SPSP could be contributing to improvements. Mr Williamson was anxious that there should be focus on costs as he was concerned that the programme had been promoted nationally with firm evidence of its benefit having been demonstrated only in Intensive Care.

Mr Crawford confirmed that discussions with regard to extending SPSP to Long Tern Conditions, Community and Mental Health were taking place.

DECIDED:-

1. That the SPSP update report be noted.
2. That there should be focus on seeking to monitor the ongoing effects of SPSP work on staff pressures in the light of the Board's financial stringencies. **Mr CRAWFORD**

74. NHSQIS CLINICAL GOVERNANCE AND RISK MANAGEMENT STANDARDS – PEER REVIEW UPDATE

Mr Crawford reported on the peer review visit to NHSGG&C from NHSQIS on Clinical Governance and Risk Management Standards that took place on 15 and 16 September 2009. He circulated a summary of the initial feedback from the visiting team listing strengths and challenges in each of the three standards. From this preliminary feedback, Mr Crawford anticipated that the Board's current score of 6 should rise. The Local Report on the visit was expected from NHSQIS in November 2009. Mr Crawford would report back to the Committee once it was available. **Mr CRAWFORD**

NOTED

75. OMBUDSMAN QUARTERLY REPORT

Mr Crawford had submitted a paper summarising reports on cases within NHSGG&C that had been considered by the Scottish Public Services Ombudsman covering April to June 2009, together with information on action taken. In commenting on trends and issues across the NHS in Scotland, the Ombudsman had identified some new key issues such as poor communication with families.

Mr Williamson enquired whether the Ombudsman sought feedback from people who had raised complaints on the process and outcome, whether there was any method for reviewing the effectiveness of action taken following a complaint and establishing that preventive measures were operating successfully. Mr Crawford indicated that there were studies on people's expectations from raising complaints which were that an apology would be given and that the problem should not recur. He advised that there were individual cases where the Ombudsman had subsequently enquired of the outcome of measures taken. He acknowledged the difficulties of carrying out follow-up studies on specific cases.

NOTED

76. CLINICAL GOVERNANCE IN WOMEN & CHILDREN'S DIRECTORATE UPDATE

Dr Wallace gave a detailed presentation on Clinical Governance within the Women and Children's Directorate, having earlier submitted the Directorate's Clinical Governance Workplan for 2009. The Directorate was constantly refreshing its Clinical Governance processes, recent examples being:-

- The introduction of a template for reporting on Clinical Governance activities to the Directorate Management Team
- The introduction of service Clinical Governance reports to capture additional activities.
- The refreshing of the Paediatric Effectiveness Group to monitor audit activity and co-ordinate the review, assessment and implementation of clinical guidelines.

He outlined the key workstreams detailed in the Directorate's Workplan. These were:- (i) NHSQIS Standards and Reviews on (a) Asthma Services for Children and Young People with Asthma,(b) Food Fluid and Nutritional Care, (c) Maternity Services and (d) Clinical Governance and Risk Management Standards; (ii) DATIX; (iii) Closure of Queen Mothers Hospital; (iv) SPSP; (v) Maternal Deaths/Morbidity; (vi) Complaints; (vii) Blood Transfusion TAG Compliance; (viii) Quality Improvement. He then explained in detail the actions that had been taken, that were currently underway and were planned in each workstream. He gave many examples of developments and improvements which had taken place. There were a number of issues that were challenging.

He believed that the Directorate could demonstrate that well developed Clinical Governance systems and processes were in place and operating, although there was ongoing monitoring to identify areas requiring improvement. Progress in the main workstreams was reviewed at each Directorate Clinical Governance Forum meeting. The work plan was amended throughout the year to encompass emerging issues and challenges.

In response to a question, Dr Wallace advised that the Directorate was currently looking at comparing its Paediatric Mortality with that of RHSC Edinburgh. RHSC Glasgow was also part of a benchmarking study on patient care with fourteen other Paediatric hospitals in the United Kingdom.

DECIDED:-

That the presentation illustrated satisfactory progress in Clinical Governance within the Women and Children's Directorate.

77. CLINICAL GOVERNANCE IN ORAL HEALTH DIRECTORATE UPDATE

Mr McAndrew gave a detailed presentation on Clinical Governance within the Oral Health Department, having earlier submitted the Directorate's Clinical Governance Workplan for 2009. He explained that the Directorate covered all three strands of the Dental Service within NHSGG&C namely, Hospital, Salaried and Community and General. The Directorate structure had afforded the opportunity for Clinical Governance activities to be standardised. Activities to date covered Audit (including NHSQIS Audit), Pharmacy, eReferral, Child Protection, Equality Impact Assessment and the Role of the Practice Inspector. Clinical Governance structures were now well established with Clinical Governance meetings focussing on agreeing the way forward, raising staff awareness, updates on action plan, presentations on audit results and feedback. Clinical Governance was also an item of the agenda of Directorate management meetings.

Mr McAndrew gave details of work carried out within each strand of activity, highlighting actions taken, work ongoing, areas identified for improvement and benefits that had been demonstrated. He detailed specific challenges that had been identified within Infection Control, Health and Safety, IT and Clinical Governance structures within Glasgow Dental Hospital and School, and outlined the progress being made in addressing these.

In response to a range of questions from members, Mr McAndrew advised of the following:-

- The possibility of *C.difficile* consequences from the use of antibiotics in dentistry was being closely monitored.
- Disposable equipment within Dentistry was mainly with regard to syringes. For other equipment, the main focus had been to improve decontamination standards. There was now a dedicated in-house central dental decontamination facility.
- The reports of Practice Inspectors were confidential, but if a Dental Practice was found to be unsatisfactory there was a system for agreeing an action plan and timescale for improvements. The next stage would be to refer concerns to the Board's Reference Committee. Beyond that, if it was felt that there were challenges to the health of the public, the Board could approach the General Dental Council for closure of the Practice.
- Private Dental Practices that had no NHS component were subject to the Clinical Governance arrangements of the Care Commission. There were very few such practices within the Board's area. There were moves to explore the development of common practice inspection procedures between the NHS and the Care Commission.

DECIDED:-

That the presentation illustrated satisfactory progress in Clinical Governance within the Oral Health Directorate.

78. DENTAL OUT OF HOURS STANDARDS – NHSQIS REVIEW

Mr Hill gave a presentation reporting on the NHSQIS Peer Review visit to NHSGG&C on 10 March 2009 with regard to the Out of Hours Emergency Dental Service.

Three standards had been assessed:-

- Accessibility and Availability at first point of contact.
- Safe and Effective Care relating to Health Care Governance, Clinical Care and Information and Communication.
- Audit, Monitoring and Reporting.

The overall performance in each standard was rated from 1 – 4 (lowest to highest) with individual criteria within each of the standards being assessed in terms of the current service provision. The overall assessment report was positive, with the vast majority being assessed as 3. Seven areas for action had been identified relating to the three standards. Mr Hill detailed the action that had taken place with regard to all seven areas and the progress of work ongoing.

NOTED

79. MINUTES OF INFECTION CONTROL COMMITTEE

The minutes of the meeting of the Infection Control Committee held on 14 September 2009 were received, together with a summary paper highlighting key issues.

NOTED

80. MINUTES OF REFERENCE COMMITTEE

The minutes of the meetings of the Reference Committee held on 24 June and 26 August 2009 were received, together with summary papers highlighting key issues.

NOTED

81. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meetings of the Clinical Governance Implementation Group held on 31 July and 7 September 2009 were received, together with a summary paper highlighting key issues.

NOTED

82. MEETING DATES 2010

The Secretary submitted a list of proposed meeting dates for 2010, based on the arrangement for 2009.

DECIDED:-

That the Committee should continue to meet bi-monthly at 1.30pm on the first Tuesday of the month commencing February 2010. **SECRETARY**

83. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Tuesday 1 December 2009 at 1.30pm in the Conference Room, Dalian House, 350 St Vincent Street, Glasgow.