

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 2 February 2010 at 1.30 pm**

P R E S E N T

Prof D H Barlow (in the Chair)

Dr C Benton
Mrs P Bryson
Mr R Cleland
Dr M Kapasi
Mrs J Murray
Mrs E Smith
Mr B Williamson

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

Mr R W Copland	..	Director of Health Information & Technology (Minute 6)
Dr B N Cowan	..	Board Medical Director
Mr A Crawford	..	Head of Clinical Governance
Dr J Dickson	..	Associate Medical Director, Clyde
Mr B Gillespie	..	Auditor, Audit Scotland
Prof R Hunter	..	Associate Director, Research & Development, NHSGG&C (Minute 8)
Dr C E McKean	..	Head of Pharmacy & Prescribing Unit (Minute 5)
Mr A Maclaren	..	Lead Pharmacist for Clinical Governance (Minute 5)
Mr D McLure	..	Senior Administrator

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mrs R Crocket and Mr A O Robertson.

2. MINUTES

The Minutes of the meeting held on 1 December 2009 were approved subject to the inclusion of Mrs E Smith in the list of apologies.

3. 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. Determinations were awaited from a number of FAIs and two FAIs were pending. These would be reported to the Committee in due course. He also drew attention to an FAI determination that had just been published which raised no issues for the Board.

Reference was made to two Significant Clinical Incidents listed as having been reported to the Committee in 2008 and mid 2009 which appeared to still be awaiting action plans. Mr Crawford explained that in both cases (relating to Laboratories) action plans for the discipline concerned had been completed but the Associate Medical Director for Diagnostics had then decided that these should be rolled out to other laboratory disciplines. This was ongoing.

DECIDED:-

1. That the progress report be noted.
2. That, in respect of the two Significant Clinical Incidents, future reports should state that local action plans had been completed but were now being rolled out throughout the Directorate.

**Dr DICKSON
Mr CRAWFORD**

4. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP)

Mr Crawford presented a paper updating the Committee on SPSP implementation within NHS Greater Glasgow and Clyde. He drew attention to the good progress made in implementing all key changes in the pilot populations. Overall improvement had been observed in over three quarters of the measures across all work streams. However, the Board's progress towards the next national level was not likely to be secured until next year due to challenges within the medicines management work stream. Mr Crawford explained that this was due to it being found that there were insufficient suitable admissions for the purposes of the study within the wards that had originally been selected.

The Acute Services Division had reached its target of 60 new teams commencing the programme during 2009. The process of working with each Directorate was now underway to agree the next wards to be included and to plan necessary preparations. The target of 90 new wards was expected to be achieved. Discussions were ongoing with the Acute Services Director on the resources required.

A programme for implementation of a Paediatric workstream was progressing in Women and Children's Services linked to a dedicated national steering group. Discussions were taking place in Mental Health and it was expected that a programme would be established during 2010. Preliminary work was also taking place with Primary Care.

Dr Benton understood that a DVT screening system was being rolled out in England. She enquired whether there were any plans for a similar system in Scotland. Dr Cowan indicated that he was unaware of any proposals at this stage.

Mr Crawford drew attention to the fact that the current endorsed aim relating to SPSP within NHSGG&C referred only to the Acute Services Division. He proposed that, as the programme was now being rolled out beyond Acute Services, it was appropriate for a NHSGG&C SPSP aim to be produced.

DECIDED:-

1. That the report represented continued good progress within NHSGG&C.
2. That Mr Crawford would submit a Board-wide SPSP aim for consideration at the next meeting.

Mr CRAWFORD

5. PHARMACY AND PRESCRIBING SUPPORT UNIT (PPSU) AND MEDICINES ADVISORY COMMITTEES – MEDICINES GOVERNANCE

Mr Maclaren gave a detailed presentation updating the Committee on Clinical Governance within the PPSU and Medicines Advisory Committees. He also submitted an updated PPSU Clinical Governance Workplan.

Mr Maclaren stressed that Pharmacy, while taking responsibility as the driver for initiatives relating to medicines, could only work within a multidisciplinary input. The need for collaboration was reflected in the workplan which addressed a number of system wide medicines governance issues.

Mr Maclaren gave details of the following initiatives impacting on patient safety and care:-

Redesign of Acute Pharmacy Services

The focus would move from product to direct patient care, leading to safer, more effective and efficient use of medicines. A single distribution site with use of robotics would release staff for greater involvement in direct patient care. By December 2010 the aim was that patients' own medicines would be used in 74% of beds.

Antimicrobial Management

The programme involved (i) the reduction in the use of antibiotics associated with C.Difficile infection, (ii) 90% compliance with hospital antibiotic prescribing guidelines, (iii) new guidelines for primary care and surgical prophylaxis and (iv) a rolling programme of audit, including risks associated with antibiotic prescribing.

Gentamicin/Vancomycin

There were particular challenges in respect of these key drugs within the antimicrobial guidelines. Increased use had been associated with a rise in the number of incidents reported. There were issues around the complexity of the administration of these drugs and staff lacking familiarity with them. Consequently a detailed action plan was being implemented across NHSGG&C.

Medication Incidents

Collaboration with Directorates and Partnerships had improved communication of medication incidents, enabling appropriate pharmacy input to incident reviews and implementation of actions. A broader range of medication incident reports were being produced and interpreted. There was an ongoing challenge to improve the coding of medication incidents on Datix and share effective actions across the organisation that had been taken in one service area.

Risk Management of Medicines

A Substantial Risk Management of Medicines Plan, informed by national alerts or local incident reporting, had been drawn up. Organisational priorities had been agreed in conjunction with the Safer Use of Medicines sub group of the Area Drugs and Therapeutics Committee. There was a challenge in establishing a process of prioritisation and patient outcome measures.

Plans for further development in 2010 involved:-

Redesign of Acute Pharmacy Services

This covered (i) the automation and consolidation of dispensaries, (ii) consolidation of aseptic services to five sites, (iii) a single centralised pharmacy clinical trials service, (iv) medicines reconciliation measures and (v) the consideration of a business case for a Hospital Electronic Prescribing and Medicines Administration System.

eGuidelines

A database of clinical guidelines accessible through Staffnet already had over 100 eGuidelines. A governance framework for the production and maintenance of NHSGG&C clinical guidelines would be developed.

In response to an enquiry by Mr Williamson, Mr Maclaren confirmed that regular audits were carried out on all acute sites plus central monitoring of Datix reports relating to the use of Gentamicin/Vancomycin. Dr Cowan advised that renal Units had been looking for any increase in renal failure arising from the use of these drugs.

Mr Williamson proposed that an exercise be carried out in twelve months time to give assurance that an effective monitoring system was in place in respect of these two drugs.

Dr Kapasi referred to past reservations within medical practice regarding the use of Gentamicin due to toxicity. He expressed concern at the possible impact on General Practitioner prescribing from the use now being made of it in Secondary Care, and sought clarification on training for GPs in monitoring the effects of Gentamicin/Vancomycin. Dr McKean advised that the Antimicrobial Management Team covered both Primary and Secondary care and there was always input from Primary Care when framing guidelines. Electronic Guidelines could be accessed by all clinicians and were written to cover both generalists and specialists.

DECIDED:-

1. That the presentation and report reflected ongoing satisfactory progress in Clinical Governance within the PPSU and Medicines Advisory Committees.
2. That Dr McKean would approach the Antimicrobial Management Team about carrying out a study in twelve months time of the effectiveness of the monitoring system with regard to the use of Gentamicin/Vancomycin.

Dr McKEAN

6. NHSGG&C ELECTRONIC MAIL SYSTEMS

Mr Copland presented a paper proposing the use of ggc mail for sending and receiving routine patient identifiable information. Difficulties had existed for some time with the current NHSMail which was restricted to NHS staff and was also found to be awkward to use. An appraisal of ggc mail had concluded that it was as secure as NHSMail with e-mails never going out across the internet which was where security could be compromised.

Following the appraisal of the ggc mail for security/risks issues, discussions were held with both the Information Commissioner's Office and the Scottish Government Health Department. The Board's Planning, Policy and Performance Group then approved the proposal which would allow patient identifiable information to be exchanged between all ggc e-mail addresses and between Health Board and CH(C)Ps and Care Partnerships where a secure inter-connect was in place. The proposal was for existing legitimate users. There was potential that this approach could be used with universities, but further detailed investigation would require to be undertaken before any proposal to extend in this direction could be addressed.

Mr Copland also advised that additional work was taking place on drafting guidelines for all staff about the use of e-mail, including clear statements that only encrypted USB memory sticks could be used for any Health Board business.

DECIDED:-

That the proposal regarding the use of ggc mail, as outlined in the paper, be approved.

Mr COPLAND

7. INFECTION CONTROL UPDATE

In the absence of Mr Walsh, Prof Barlow invited comments from members on the NHSGG&C Healthcare Associated Action Plan progress update for February 2010. Mrs Murray drew attention to the figures showing a recent decline in the rate of Hand Hygiene compliance among NHSGG&C doctors. There was discussion regarding the significance of this, the potential impact or otherwise on infection rates, and the need to maintain a safety climate across all staff groups.

NOTED

8. RESEARCH GOVERNANCE

Prof Hunter gave a detailed presentation on the Research and Development (R&D) assurance process within NHSGG&C. He commenced by outlining the roles and responsibilities of the R&D Management Office which comprised a multidisciplinary team which promoted, co-ordinated and facilitated all aspects of high quality research within NHSGG&C.

Prof Hunter then set out the R&D management approval process which ensured a formal review of all research conducted within the NHS and indemnity/insurance for research activity. It applied to all studies involving the participation of NHS employees and where the use of NHS resources or facilities were involved. Ethical approval was a condition of R&D management approval. There were ten elements of management approval:- Scientific Quality, Ethics, Regulatory Approvals, Risk Benefit Analysis, Insurance/Indemnity, Finance and Resource, Responsibilities and Accountabilities, Health and Safety, Quality Research Culture and Study Sponsorship. He then detailed the management approval processes distinctive to both commercial and academic research.

Prof Hunter quoted a description of Research Governance as being the continuous improvement of standards and the reduction of unacceptable variations in research practice across health and social care. The Research Governance Framework in NHSGG&C (i) set out principles, requirements and standards (ii) defined mechanisms (iii) monitored and assessed arrangements and (iv) improved research quality and safeguarded the public. The auditing and monitoring process required the sponsor of a clinical trial to put, and keep in place, arrangements for the purpose of ensuring that the conditions and principles of good clinical practice were satisfied and adhered to in the trial. These included the protection of the rights and well-being of human subjects and the credibility of trial data.

There were a number of partners and collaborators involved in the R&D quality assurance process. These were:-

- The Glasgow Clinical Trials Unit which supported clinical trial research from concept to analysis and reporting.
- The Glasgow Clinical Research Facility which provided researchers with the clinical infrastructure necessary to conduct high quality research.
- The Chief Scientist Office which supported and promoted high quality research and aimed to improve the quality and cost-effectiveness of services offered by the NHS in Scotland.

Mrs Smith sought clarification on the role of Scottish Health Innovations Limited (SHIL) within the governance framework. Prof Hunter indicated that he would report back following discussions with Prof David Wyper of SHIL.

Prof HUNTER

There was discussion on the reporting of Research Governance to the Board. There was consensus that an annual report should be submitted to the Committee setting out the scope of research that had taken place, the governance measures that had been carried out and any patient safety issues. It was noted that Prof Chris Packard was a member of the Clinical Governance Implementation Group at the meetings of which concerns could be raised arising from incident reporting. Dr Cowan confirmed that any patient harmed in the course of research would be reported to the Committee in a similar way to all other Clinical Incidents.

DECIDED:-

1. That the presentation reflected satisfactory Research Governance structures and processes within NHSGG&C.

2. That Mr Crawford would liaise with Prof Hunter on submitting annual Research Governance reports to the Committee.

Mr CRAWFORD
Prof HUNTER

9. CLINICAL GOVERNANCE PROGRESS AND IMPLEMENTATION PLAN UPDATE

Mr Crawford presented a paper setting out progress to December 2009 against specific objectives in the Clinical Governance outline development. He pointed out that a number of objectives had consumed a disproportionate amount of attention and resource, for example the one relating to the NHSQIS Clinical Governance and Risk Management Standards review. Consequently some slippage had occurred. Slippage had also occurred where support and engagement had been required from external bodies. However no key area had been affected.

DECIDED:-

That the report represented an acceptable level of progress against the objects described.

10. CLINICAL GOVERNANCE STRATEGY AND FRAMEWORK

Mr Crawford presented the post-consultation version of the NHSGG&C Clinical Strategy and Framework document. Previously this had been approved in principle by the Committee but it had been decided to await the publication of the Scottish Government Health Care Quality Strategy. This had been considered at the last meeting (Minute 89).

DECIDED:-

That the Clinical Governance Strategy and Framework document should be approved for publication.

Mr CRAWFORD

11. NHSQIS CLINICAL GOVERNANCE AND RISK MANAGEMENT STANDARDS REPORT

Mr Crawford had submitted the NHSGG&C Local Report from NHSQIS in respect of NHS Clinical Governance and Risk Management Standards together with a paper summarising the findings. The Board had attained level 9, with all standards and all core areas showing improvement since the last assessment in 2006 when Level 6 was achieved. The achievement of Level 9 in the September 2009 independent peer review was in advance of the timescale which would have been required (to the end of March 2010) on the basis of annual single incremental rises.

Mr Crawford drew attention to the report's developmental recommendation encouraging the Board to move towards a rolling programme to ensure that there was a documented, planned and systematic approach to evaluation demonstrating that changes made to the system were as a result of a co-ordinated review of current arrangements. He referred to previous discussions surrounding this issue within NHSGG&C which had highlighted concerns at the very substantial increase in levels of bureaucracy that would be involved given the size of the Board. It was noted that other Boards which had produced greater amounts of written material had not outperformed NHSGG&C in clinical issues. The culture embedded within the Board of critical evaluation of all developments had been previously debated and supported within the Committee. However, he indicated that it would be helpful to explore the recommendation from NHSQIS with a view to reaching a firmer conclusion how NHSGG&C should respond.

DECIDED:-

1. That the Local Report be noted.
2. That Mr Crawford and his colleagues be commended for the work that had produced such a successful achievement.

12. MINUTES OF REFERENCE COMMITTEE

The minutes of the meeting of the Reference Committee held on 20 October 2009 were received, together with summary papers highlighting key issues.

NOTED

13. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meeting of the Clinical Governance Implementation Group held on 11 January 2010 were received, together with a summary paper highlighting key issues.

NOTED

14. MINUTES OF ORGAN DONATION COMMITTEE

The minutes of the meeting of the Organ Donation Committee held on 2 December 2009 were received, together with a summary paper highlighting key issues.

NOTED

15. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Tuesday 6 April 2010 at 1.30pm in the Conference Room, Dalian House, 350 St Vincent Street, Glasgow.