(CGC)(M)11/1
Minutes: 1 – 13

GREATER GLASGOW AND CLYDE NHS BOARD

Minutes of a Meeting of the
Greater Glasgow and Clyde Clinical Governance Committee
held in the Board Room, J B Russell House,
Gartnavel Royal Hospital, Glasgow, G12 0XH
on Tuesday 1 February 2011 at 1.30 pm

P R E S E N T

Mr R Cleland (in the Chair)

Dr C Benton
Mrs P Bryson
Mr A O Robertson
Mr B Williamson

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

Mr B Gillespie	..	Audit Scotland
Dr B N Cowan	..	NHSGG&C Medical Director
Mr A Crawford	..	Head of Clinical Governance
Dr J Dickson	..	Associate Medical Director, Clyde
Ms M A Kane	..	General Manager, Facilities Directorate (Minute 5)
Mr D McLure	..	Senior Administrator
Mr T Walsh	..	Infection Control Manager

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mrs R Crocket, Dr M Kapasi, Mrs J Murray, Mr D Sime, Mrs E Smith and Councillor Amanda Stewart.

2. ONGOING REVIEW ARRANGEMENTS FOR CLINICAL GOVERNANCE COMMITTEE

Mr Robertson referred to discussions at the Board Seminar held earlier in the day on a paper that had been presented proposing a revised approach to Board level governance arrangements and revised Committee structures. A major reason for the revision was the need for the requirements of the Quality Strategy to be integral to the corporate reporting and governance structures. It was being proposed that a single Governance Committee be created to replace the Performance Review Group, Involving People Committee and the Staff and Clinical Governance Committees. At the Seminar there had been support for the concept underlying the proposed approach but concerns had been expressed at the potential scale and practicalities in managing the agenda of the single Committee. It was understood that a further paper would be submitted to the Board Seminar in March in the light of the discussion that had taken place.

Members of the Committee shared concerns at the potential extent of the agenda of a single Committee and the need to emphasise in future discussions the importance of maintaining the current high level of scrutiny of Clinical Governance that had been developed through the Clinical Governance Committee. **MEMBERS**

NOTED

3. MINUTES

The Minutes of the meeting held on 5 October 2010 were approved.

4. MATTERS ARISING FROM MINUTES

Further to Minute 68, Dr Cowan reported that the external review relating to the Paediatric Neurological service had taken place in November 2010. The report recognised that by 2015 both Paediatrics and Neurosurgery would be united on the Southern General site, but had recommended that in the interim all Paediatric Neurosurgery should take place at the Royal Hospital for Sick Children. These recommendations were now being taken forward. Dr Cowan would keep the Committee informed of developments. **Dr COWAN**

NOTED

5. PATIENT SAFETY

Clinical Incidents and FAI Reviews

Dr Dickson presented a written summary updating the Committee on Clinical Incidents and FAI Reviews. He highlighted seven cases subject to FAIs. In two cases FAIs had been completed. One of these had been reported which had revealed no issues for the Board; in the second case the Determination was awaited. Currently one FAI was taking place, with three others pending. It was understood that the seventh case was now unlikely to proceed to an FAI. This would be confirmed within the next few days. **Dr DICKSON**

Dr Dickson outlined the situation relating to two Significant Clinical Incidents. The first involved the Royal Hospital for Sick Children, with links to Surgery at the Southern General Hospital. The findings of an internal review had now been confirmed by an external review. The recommendations were being taken forward within the Women and Children's Directorate. The second case involved the Royal Alexandra Hospital and the Institute of Neurological Sciences and was currently being internally reviewed.

NOTED

Scottish Patient Safety Programme (SPSP)

Mr Crawford submitted a paper detailing continued progress in SPSP implementation in NHS Greater Glasgow and Clyde. The SPSP national team had confirmed that NHSGG&C had achieved level 3 on the national assessment scale. He also outlined successes relating to Medicines Reconciliation and Critical Care core bundles. Progress was positive on the Paediatric programme and the start-up for Mental Health and Primary Care programmes. There were number of challenges which were being pursued in connection with the Hospital Standardised Mortality Ratio, the Global Trigger Tool and the Congestive Heart Failure programme extension.

NOTED

Mid Staffordshire Inquiries – Follow-up Exercise

Dr Cowan gave a presentation on the implications and lessons arising from the Mid Staffordshire Inquiries. He commenced by outlining the background to the initial Healthcare Commission investigation in 2008 which led on to the full inquiry

The investigation had resulted in a lengthy list of recommendations for each of the following levels:- (i) Board, (ii) Staffing and Clinical, and (iii) National. Dr Cowan commented on the recommendations, indicating NHSGG&C's compliance with those relating to Board and Staffing and Clinical levels, and the extent of compliance throughout Scotland with the national recommendations.

The report following the Healthcare Commission investigation was followed by demands from relatives for a further inquiry at which the experiences of patients could be highlighted. This had resulted in the Francis Report which had exposed the extent of the human suffering. The Committee had previously been made aware of the approach to Boards in Scotland from Dr Kevin Woods arising from the report and the initial response of NHSGG&C. There was a range of national initiatives in Scotland with a bearing on the issues raised, such as SPSP, Hospital Standardised Mortality Ratios and the Quality Strategy.

Dr Cowan detailed the action that had been taken within NHSGG&C and the responses that had been received to the twelve key questions compiled to identify the strengths and weaknesses within the NHSGG&C systems. There were two areas around which further work was particularly required: (i) the Patient Experience and (ii) the views and responsibilities of staff in connection with whistleblowing policy. A report based on the outcome of the responses received would be submitted to the Acute Services and Partnerships Clinical Governance Committees and thence to senior managers. **Dr COWAN**

Mr Crawford confirmed that the Board had also been seeking to establish the situation in other Health Boards within Scotland in relation to the issues emerging from Mid Staffs in order to gauge how NHSGG&C compared. **Mr CRAWFORD**

NOTED

Hospital Standardised Mortality Ratios (HSMR)

Mr Crawford gave a presentation on HSMR, in the context of the finding that one of the NHSGG&C hospitals was an outlier compared to the national average. He commenced by describing the Scottish case-mix model and the selected pathways within it. He then presented statistics in respect of the seven NHSGG&C hospitals involved, covering October 2006 to June 2010, which revealed that the Royal Alexandra Hospital/Vale of Leven Hospital (RAH/VoL) HSMR trend had been rising. He stressed that a high HSMR did not necessarily mean that there were problems with the quality or safety of patient care; there were acknowledged limitations in HSMR modelling. This had been conveyed to the staff at RAH/VoL.

The Board had been asked by NHSQIS to investigate the situation regarding RAH/VoL and to construct an action plan. This had been carried out and submitted to NHSQIS at the end of 2010. The response from NHSQIS had indicated that they were satisfied with the action plan. It was currently being reviewed for re-submission at the end of February 2011. There would be ongoing focus work carried out at RAH/VoL and the consequent learning experience and improvements would be shared with other NHSGG&C hospitals.

In response to questions raised by Mr Williamson, Dr Cowan indicated that (i) it was non-elective care that drove HSMR, (ii) the Board had asked ISD whether separate figures could be provided for RAH and VoL in order to establish whether there were differences between the two hospitals, (iii) it would appear that the outlier figures came from the Palliative care component of the service. Mr Williamson referred to the medical admission arrangements that had been introduced last year relating to RAH and VoL and he sought assurance that the HSMR findings were not a reflection of any deficiencies arising from the medical care consequent to the new arrangements. **Dr COWAN**

NOTED

Infection Control Update

Mr Walsh submitted HAI Monitoring Reports for December 2010 and February 2011. As decided at the last meeting, a section had now been included on Healthcare Environment Inspectorate Reports and Recommendations.

NOTED

6. CLINICAL GOVERNANCE IN FACILITIES DIRECTORATE

Ms Kane gave a presentation on Clinical Governance within the Facilities Directorate. She commenced by outlining the wide range of services covered by the Directorate, all of which supported the delivery of health care. Governance arrangements were currently embedded within the Facilities Management Forum agenda. Reporting took place through various forums, including (i) both the Acute and Board Infection Control Committees, (ii) the Board, Acute and Partnerships Health and Safety Forums, and (iii) Groups within the Facilities Directorate covering Health and Safety, Fire and Security Implementation and Sector Incident Control.

Ms Kane set out in detail the work plan for 2010/11. It had a similar format and remit as those of Clinical Directorates and was focused on prioritising resources to a quality improvement programme in line with the Board's Governance Strategy, and in supporting Facilities Teams in the development and delivery of it. The workplan described (i) the establishment of governance forums at Directorate and Sector level, (ii) the Statutory Compliance Audit and Risk Template reporting mechanism development and implementation, and (iii) the review that had been carried out of Infection Control Groups within the Directorate. The workplan also covered developments in Quality Improvement/Effectiveness, the Regulation of Healthcare Workers, the range of initiatives relating to Control of Infection, Patient Safety, Developing Key Performance Indicators, Resources, Patient Focused Care and the Directorate's Partnership Working and Staff Support initiatives. Efforts were being made to develop better structures by establishing forums within hospital sites. This was part of the Directorate's goal of engaging more closely with the Clinical environment.

Ms Kane sought the perspective of the Committee on the means whereby the Facilities Directorate could relate to Governance forums outwith the Directorate with particular reference to highlighting issues of wider relevance.

DECIDED:-

1. That the presentation reflected good progress in Clinical Governance within the Directorate.
2. That the need for the establishing of links whereby the Directorate could be more vitally connected to the wider governance structures was recognised. Ms Kane was invited to submit a further briefing to the Committee on how this could be taken forward. **Ms KANE**

7. VITAL SYSTEMS SUPPORTING HEALTHCARE IMPROVEMENT IN NHS SCOTLAND

Mr Crawford submitted the final report of the NHSQIS 2009/ 2010 Review Process entitled "Vital Systems Supporting Healthcare Improvement in NHS Scotland". NHSGG&C was last reviewed against the national Clinical Governance and Risk Management Standards in 2009. A copy of the local report had previously been submitted to the Committee, as had the follow-up action plan.

Mr Crawford highlighted the following aspects arising from the final report:-

- Clinical Governance key performance indicators were well developed within Acute Services in NHSGG&C, but work was required to develop these within Mental Health and Community Care.
- Business Continuity and the Equality and Diversity agenda were two of three areas highlighted for further improvement. Each was fully reflected within the action plan previously seen by the Committee. The third area was Fitness to Practice which was currently part of the work being addressed by the follow-up to the Mid-Staffordshire Inquiry reports.
- Further progress was required around arrangements for monitoring clinical quality. This was embedded within the Quality Strategy. Governance relating to clinical quality was expected to be produced as part of a national framework.

DECIDED:-

1. That the national report be noted.
2. That the actions being taken in response to the report within NHSGG&C were appropriate.

8. OMBUDSMAN REPORT

Mr Crawford presented a paper on cases considered by the Scottish Public Services Ombudsman for the period from July to September 2010 together with a commentary on the Ombudsman's Annual Report and Statistics for 2009/10. Mr Crawford drew attention to the fact that there were no reports relating to NHSGG&C for the period July to September 2010 which reflected positively on the Board.

NOTED

9. CONTROLLED DRUGS QUARTERLY REVIEW

Dr McKean, Head of Pharmacy and Prescribing Support Unit, had submitted a quarterly occurrence report in respect of Controlled Drugs covering the period from July to September 2010.

NOTED

10. MINUTES OF REFERENCE COMMITTEE

The minutes of the meetings of the Reference Committee held on 18 August 2010 and 20 October 2010 were received, together with summary papers highlighting key issues.

NOTED

11. MINUTES OF INFECTION CONTROL COMMITTEE

The minutes of the meetings of the Infection Control Committee held on 20 September 2010 and 29 November 2010 were received, together with summary papers highlighting key issues.

NOTED

12. MINUTES OF CLINICAL GOVERNANCE IMPLEMENTATION GROUP

The minutes of the meeting of the Clinical Governance Implementation Group held on 14 January 2011 were received, together with a summary paper highlighting key issues.

NOTED

13. DATE OF NEXT MEETING

The next meeting of the Committee will be held on Tuesday 5 April 2011 at 1.30pm in the Board Room, J B Russell House, NHSGG&C Corporate Headquarters, Gartnavel Royal Hospital, Glasgow.