

BoardC&CG(M)17/01

Minutes: 1 - 13

GREATER GLASGOW AND CLYDE NHS BOARD

**Minutes of a Meeting of the
Board Clinical & Care Governance Committee
held in the Boardroom, J B Russell House,
Corporate Headquarters, Gartnavel Royal Hospital,
1055 Great Western Road, Glasgow, G12 0XH
on Thursday 12 January 2017 at 2pm**

PRESENT

Ms S Brimelow - in the Chair

Dr H Cameron	Mrs T McAuley OBE
Cllr G Casey	Dr M McGuire
Mr A Cowan	Mrs A Monaghan
Mr A Crawford	Mr I Ritchie
Dr D Lyons	

IN ATTENDANCE

Jennifer Armstrong	Medical Director
Mr P Cannon	Deputy Head of Administration (To Minute No. 9)
Mr F Gibbons	Prison Healthcare Manager
Mr K Hill	Director, Women and Children's Directorate (To Minute No. 8)
Dr A Mathers	Chief of Medicine, Women and Children (To Minute No. 8)
Margaret Smith	Secretariat Manager

ACTION BY

01. APOLOGIES & WELCOME

Apologies for absence were intimated on behalf of Professor A Dominiczak, Ms D McErlean and Mr M O'Donnell.

Ms Brimelow welcomed Members to the first meeting of this new committee.

NOTED

02. DECLARATION(S) OF INTEREST(S)

No declaration(s) of interest(s) were raised in relation to any of the agenda items to be discussed.

NOTED

03. INTRODUCTION TO CLINICAL GOVERNANCE

Mr Crawford presented "An Introduction to Clinical Governance" which took the committee through the definition of clinical governance i.e. the

duty of quality, emphasising individual responsibility for the quality of care.

Mr Crawford outlined the key components of clinical governance, informed by NHS Scotland's Quality Strategy: Clinical safety, Clinical effectiveness, Person-centred care and Structures and Support Systems.

Looking at Clinical Risk through the strategy of a learning organisation highlighted the need for effective incident reporting so that meaningful information was available about knowledge of harm. Incident investigation through root cause analysis would give knowledge of causes of clinical risk.

Leading on from this review would be evaluation work providing knowledge of improvement with a need to pitch this response at the right level. Finally, effective practice and systems change.

Mr Crawford took the committee through the tools used in clinical risk management explaining that Datix was used for incident reporting as well as for recording claims, complaints and freedom of Information requests so that there was a triangulation of resources. Mr Crawford outlined the widespread use of Datix amongst NHS Boards in Scotland as well as the robust use of the system with NHSGGC.

The Healthcare Improvement Scotland Adverse Event Framework was developed following the NHS Ayrshire & Arran Review and NHSGGC had taken this seriously as a regulatory framework.

Mr Crawford emphasised the local challenges of maintain a useful risk register in constantly processing and following up on incidents. Whilst NHSGGC had met all the national requirements of doing so, this could constantly present challenges for the Board.

In relation to clinical effectiveness, Mr Crawford highlighted worldwide research and development, and the requirement to keep abreast of national guidelines as well as to review and update local guidelines.

NHSGGC participated in monitoring of clinical effectiveness including clinical audits locally and nationally. The Board offered support for clinical quality improvement through e.g. staff training and the Patient Safety Programme. NHSGGC had ensured quality management through data collection and review meaning that this work could be focussed and prioritised appropriately.

Mr Crawford led the committee through the ways in which person-centred care has been enforced throughout NHSGGC especially given the responsibilities placed on the Board through the Patient Rights (Scotland) Act 2011. He highlighted the value of informed choice and good communication. It was important to remember that patient feedback had demonstrated a 95% approval rating for services within NHSGGC. Review of the care experience required consideration of the staff experience as well as that of patients (as the way staff were perceived to be treated could also have an effect on the patient's overall experience). Mr Crawford emphasised the importance of enabling self-management and the co-productive nature of person-centred care.

Mr Crawford presented a diagram showing "Corporate Level Clinical Governance Arrangements". This detailed the different forums as well as the specialisation of interests into particular fields. This would support the

exchange between elements of the structure to ensure appropriate clinical governance.

Concluding the presentation, Mr Crawford detailed the support systems which underpin clinical governance. These included professional regulation, education and the dissemination of knowledge. Data and information (eHealth and IT) were of increasing importance. In relation to quality improvement capability, there had been a move away from audit and toward evidence based test environments. The Clinical Governance Support Unit work would include integrating themes and setting priorities across sector and directorate management teams.

Ms Brimelow thanked Mr Crawford for a detailed and helpful guide to clinical governance and opened the discussion to Members of the Committee who expressed their gratitude to Mr Crawford for such for such a clear introduction. Ms Brimelow advised that should Members wish a fuller induction, this could be arranged with the agenda of the committee shaped to accommodate this.

Mr Ritchie asked whether there could be an issue with a corporate view sitting separately from that of daily practitioners. Mr Crawford provided reassurance that within clinical governance there would no longer be a perception of corporate and local agenda diverging. Clinical governance was increasingly led through the addressing the concerns of clinical professionals rather than sitting outwith the delivery of the service.

NOTED

04. DRAFT REMIT

A paper “Draft Remit” (Paper 17/01) from the Deputy Head of Administration, Mr P Cannon asked the Committee to review its remit in light of the impact of the establishment of two new Sub Committees (Clinical & Care Governance and Finance & Planning Committees).

Mr Cannon highlighted that work was ongoing to agree separate remits with each of these committees; further, that changes would also be required to the remit for the Acute Services Committee to reflect this.

The intention was that there should be a high degree of consistency between the remits for the three revised Sub Committees which would be presented to the Board in early 2017. Mr Cannon asked the Clinical & Care Governance Committee Members for their views in shaping and adjusting the remit in this light and confirmed that an updated version of the remit would be circulated at the next meeting.

It was noted that it would be helpful to include the diagram “Corporate Level Clinical Governance Arrangements” from the previous presentation.

Dr Lyons agreed that the draft remit was appropriate and underlined the point that the remits of each of the three Sub Committees needed to be reviewed carefully and in relation to each other to ensure that there was no duplication.

Ms McAuley advised that it had been timely that the Committee had received a reminder that safe effective, person-centred care was at the heart

of clinical governance and agreed that duplication with other committees should be avoided.

Dr Armstrong advised that the Board Clinical Governance Forum was the overarching forum encompassing acute, primary and mental health services and would be central to the robust structure in place to consider any major risks. The Board Clinical Governance Forum reported directly to the Board Clinical and Care Governance Committee. This would allow assurance in terms of risk as well as the ability to comment on Board strategy.

Dr Armstrong confirmed that there had been debate about the possible duplication between the Sub Committees, however, it was important for there to be Non Executive Board Member oversight. Experience, in the future, would inform the need to adjust each remit if appropriate. Briefly, the Acute Services Committee would continue in its remit to look particularly at performance targets within the acute sector, rather than on finance issues which would be for Finance & Planning; or on the specifically clinical issues that would form the basis of the remit for this committee.

Ms McAuley found this reassuring and added that this would be a helpful forum to consider the impact of service changes before consideration of these at the Board.

Dr Cameron thought that establishment of this committee was a positive development as it provided a system wide look across the Board.

Mr Cowan suggested placing the definition of clinical Governance (from Mr Crawford's presentation) into the remit. He also added that the further guidance from Dr Armstrong was helpful in focusing on where this committee would sit within the framework.

Ms Brimelow thanked Members for their comments and summed up the discussion. Mr Cannon and Mr Crawford would review the definition of clinical governance for suitable wording to be included in the remit. Further, the remit should reflect the system wide assurance of governance and quality. The three Sub Committee remits would be reviewed in conjunction.

**Deputy Head of
Administration/Head
of Clinical
Governance**

NOTED

05. HAI INSPECTION AT THE QUEEN ELIZABETH UNIVERSITY HOSPITAL – DECEMBER 2016

Dr Armstrong advised that there had been an HAI Inspection at the Queen Elizabeth Hospital during 12th to 15th December 2016. The Nurse Director emphasised that this had been an opportunity to remind staff that responsibility for quality and person-centred care lay with everyone. The report was expected in March 2017, and in accordance with usual practice the improvement plan had been completed and returned to HIS.

Mrs Monaghan thought it positive that HIS come into hospitals to carry out these type of inspections as it helps the Board in its commitment to get care right for patients.

Mr Ritchie wished to record thanks to the team in its work, especially when

the inspection took place during a very busy period.

NOTED

06. REVIEW OF MATERNITY SERVICES IN NHS AYRSHIRE & ARRAN

The Nurse Director provided a verbal report to the Committee in respect of the “Review of Maternity Services in NHS Ayrshire & Arran” carried out by HIS following a request by the Scottish Government to do so.

NHSGGC had also been contacted by the Scottish Government, and were carrying out data and background analysis as a result. The lead on the review was a senior obstetrician and the bulk of the assessors came from outside Scotland. HIS plan was to make an inspection in NHS Ayrshire and Arran and then report to the Scottish Government in March 2017. This would have ramifications for all Boards in terms of clinical and care governance as well as process and systems.

It was noted that the National Maternity Strategy had not been published at the time of the meeting.

The Committee discussed this in further detail and the following points being made:-

- Focus on natural births and community maternity units;
- Aging obstetric population;
- Increase of obesity in obstetric population;
- Impact of artificial conception;
- Increasing demand for caesarean section;
- Need to communicate with patient/family;
- Improvement in rate of still births within NHSGGC.

NOTED

07. PAEDIATRIC CARDIAC SERVICES

A report from the Chief of Medicine, Women and Children’s Services (Paper17/02) asked the committee to note the progress to improvement in paediatric Cardiac Services.

The background to this was that paediatric cardiac surgical outcomes are subject to National Review Processes that look at 30 day mortality. In addition, the wider paediatric cardiac services had been subject to internal and external review processes that focussed on human factors.

Dr Mathers provided further background in terms of the clinical complexity of paediatric cardiac surgery and the need for external review and high level of scrutiny. The external review team followed up work carried out in August 2015, with report in December 2015. The Action Plan included with the paper was the most up to date position and demonstrated that a lot of progress has been made both in terms of physical change regarding the geography of the building as well as human relationships within the team.

Mr Hill reinforced the point previously made in respect of the complexity of this type of surgery. The team sees 240 cases per annum with less than 3-5 diverted to London for specialised care. It was planned to repatriate this work by Summer 2017.

Ms McAuley asked whether there had been a move toward a culture of more cohesion within the team, and also whether there was any adverse clinical impact due to the transfer of patients to London.

Dr Mathers advised that the team had changed over time and that bespoke training had also been implemented which had been considered helpful. In terms of clinical impact, the outcomes were not worse but it should be noted that this was a highly complex and high risk group of patients. There had not been negative feedback from the families regarding the need to travel to London.

Ms McAuley asked whether this was maximising performance of the teams and Dr Mathers gave reassurance that diverting this area of care had assisted in doing so over this period of time.

Mr Ritchie raised the issue of the team structure and relationships within the team, in the context of caring for staff, and asked for reassurance that this issue had been addressed. Dr Mathers confirmed that there this had been addressed appropriately in accordance with Board HR policy and that there had been an open door policy in place to develop the team structure and a more positive tone. Dr Armstrong added that progress had been made with dual operating system in place which had added to stability. She added that that paediatric congenital heart disease (through Central Cardiac Audit Database (CCAD) results were good.

Dr Lyons added his view that the departmental pathologies should be considered as a whole and Dr Mathers agreed that there had been a need to review the team structure. There was a continued focus of training needs.

Ms Brimelow thanked Dr Mathers and Mr Hill for their advice and to the Members for their comments, and summed up that the committee would take note as follows:-

- Review of the Action Plan;
- Note the actions already completed;
- Note outcomes for children (CCAD);
- Record ongoing work to support the team.

NOTED

08. INTERNAL AUDIT (PRICE WATERHOUSE COOPERS) –ACTION PLAN FINAL REPORT

A report from the Head of Clinical Governance (Paper17/03) asked the committee to note the Final Report from the Internal Audit carried out by Price Waterhouse Coopers).

Mr Crawford explained that the first report had been made in early 2015 and reflected a plan made in 2014 which had preceded organisational change within acute services as well as the creation of the HSCPs. For this reason the fieldwork was not completed in 2016 and there had been 3 open

findings from the previous report.

There had been some anxieties in respect of clinical risk oversight particularly in respect to:-

- Clinical Governance Forums may not have had sufficient oversight of clinical risks from sector, directorates and partnerships.
- Reassurance that the HSCPs would meet their legislative requirements for implementing clinical governance arrangements for April 2016.
- That the Board did not have awareness of full clinical governance framework to allow efficient dissemination of standards and policy.

Mr Crawford confirmed that the 3 open findings had been successfully concluded and asked the committee to accept the report as a reasonable set of descriptors.

NOTED

09. PRISON HEALTH SERVICES

A report from the Service Manager, Prison Healthcare (Paper 17/04) asked the committee to note the content of a report of the HM Inspectorate of Prisons for Scotland following an inspection which took place during 16th to 27th May 2016.

Mr Gibbons led the committee through the report, highlighting that healthcare within Barlinnie had received a rating of “satisfactory”. This should be seen in the context that 3 previous inspections had been seen as “poor” with NHSGGC taking over the delivery of healthcare within the prison in 2012. Following this report, the prison healthcare service had been asked to share some good practice with other prisons. Professional leadership with respect to clinical governance had been rated as good notably that regular clinical governance meetings were held, Datix was used for incident reporting, there were nurse led clinics in place.

Mr Gibbons provided further background in terms of the numbers of prisoners held in HM Barlinnie as well as the possibility of large numbers being transferred from other prisons due to security issues.

The report had also highlighted some areas of concern e.g. risks involved when transporting prisoner to clinics. Mr Gibbons also outlined the different cultures within the prison between prison service and healthcare professionals. Dr Armstrong confirmed that there would be an Action Plan put in place through the Prison Sub Group in response to the report.

There was discussion of the main issues within the report which highlighted the following areas:-

- Patient Confidentiality;
- Pressure to carry out interventions more quickly;
- Safe Cells (as suicide prevention method);
- Risk to staff within the environment;

The report was noted and it was agreed that contact should be made with the Executive Lead, Mr M Smith, and that the committee would return to this

**Medical Director/
Nurse Director**

subject for further discussion.

NOTED

10. PUTTING PATIENTS FIRST – IMPLEMENTING THE PATIENTS RIGHTS ACT

A report from the Nurse Director (paper 17/) asked the committee to note the update on developments in implementing the Patients Rights (Scotland) Act 2011 as well as an overview of Patient and Carer feedback between August and September 2016.

Dr McGuire provided a high level resume of the key issues relating to communications, staff attitude and behaviour as well as suitability of facilities. She provided an assurance that although progress has been made, there is no complacency in this area and recognition that there was still a lot of work to be completed in this area. It was noted that there were high levels of satisfaction amongst patients using NHSGGC services.

NOTED

11. OVERVIEW REPORT

A report of the Head of Clinical Governance (paper 17/06) asked the committee to note the consolidated strategic overview on clinical governance which drew upon and summarised a range of supporting reports and information.

The committee Members were asked to advise on areas where the information supports assurance, or requires further action. Further, to advise on changes or inclusions to the report so it can be used in more effectively supporting Non Executive oversight and the Board's corporate accountabilities for clinical governance.

Mr Crawford provided an overview of the report, indicating that it was structured around:

- Clinical Safety;
- Clinical Effectiveness;
- Person Centred Care;
- Clinical Governance structure, leadership & developments.

Mr Crawford referred to the table of contributing sources explaining that a summary of each had been provided and that all the reports could be made available if so required. In future, it would be planned to provide thematic report as well as case studies for the committee.

Dr Lyons and Mr Ritchie expressed a desire to access the more detailed reports, and it was agreed that it would be helpful for Non Executives to have a link to this electronically. Mr Crawford agreed to look into this matter for the committee.

**Head of Clinical
Governance**

Ms MacAulay added that it would be helpful to see thematic report especially relating to cultural issues as this may allow a closer look at the focus on change within the organisation.

Mr Cowan that SCIs are not a metric of safety as there are a number of SCIs wherein there is no harm to the patient e.g. maternity services using the process is cases of clinical complexity. He also asked why paediatric patients were not included in the universal feedback. Dr McGuire responded that feedback from children cannot be usefully recorded and measured in this format hence the exclusion. There were alternative methodologies in place.

Dr Cameron raised a query in relation to the review of clinical guidelines and how the Board measured the way in which these guidelines were being implemented. Further, the need to look at whether there was a culture of ending poor practice only; or were there proactive steps taken toward good practice, highlighting the need to shift from reactive to proactive culture. Mr Crawford agreed that the practice of clinical audit was no longer considered helpful and that the report demonstrated the impact assessments carried out against clinical guidelines.

NOTED

12. BOARD CLINICAL GOVERNANCE FORUM – KEY POINTS FROM DECEMBER 2016 MEETING

A report from the Head of Clinical Governance (paper17/07) asked the committee to note the key points from the December 2016 meeting of the Board Clinical Governance Forum including:-

- Scottish intensive Care Society Audit Group;
- PDRU Review Report;
- Child Protection Update;
- HSMR at Royal Alexandra Hospital/ Vale of Leven Hospital;
- Workshop Update re Developing a Clinical Governance strategy;
- Risk Management – Datix update;
- Adult Support and Protection;
- Care Assurance Dashboard: Progress Update.

In addition, key updates from the Service leads in relation to: Mental Health, Acute Services, Primary Care, Infection Control, Pharmacy and Research & Development.

Members agreed that this was a very helpful way of highlighting the main issues and Ms Brimelow thanked them for their supportive comments.

NOTED

13. DATE OF NEXT MEETING

Date: Thursday 7 March 2017
Venue: Boardroom, J B Russell House
Time: 1pm - 3pm