BoardC&CG(M)17/02
Minutes: 14 - 26

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 Tuesday 7 March 2017 at 1.30pm

PRESENT

Ms S Brimelow OBE - in the Chair

Dr H Cameron
Dr D Lyons (to Item 19)
Ms D McErlean
Mr I Ritchie

IN ATTENDANCE

Dr J Armstrong	Medical Director
Mr A Crawford	Head of Clinical Governance
Ms G Jordan	Head of Clinical Effectiveness
Dr M McGuire	Nurse Director
Ms M Smith	Secretariat Manager
Dr D Stewart	Deputy Medical Director (for Item 22)

ACTION BY

14. APOLOGIES & WELCOME

Apologies for absence were intimated on behalf of Professor A Dominiczak, Mr I Fraser and Cllr M O'Donnell.

NOTED

15. 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

16. MINUTES

Dr Cameron proposed that the minute of the meeting (which took place on 7 January) was an accurate record and this was seconded by Mr Ritchie.

NOTED

17. MATTERS ARISING FROM THE MINUTES

(a) Rolling Actions List

- Mr Ritchie raised the availability of the committee papers on Admin Control and it was confirmed that it was the intention to do so moving forward. Mr Lyons also raised the quality of the wifi within Board Headquarters and the possibility of Non Executives being given access to the Board's internal wifi. The Secretary would query this with the Deputy Head of Administration. **Secretary**

- It was noted that the Clinical & Care Governance Committee's Terms of reference were approved at the latest Board meeting which took place on 21st February 2017.

NOTED

18. REVIEW OF GGC DATA ON STILL BIRTHS

Dr McGuire updated 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. There had been an extension whereby the report would go to the Cabinet Secretary at the end of April.

The paper being prepared within NHSGGC was not finalised as it needed to take on board the extended timeframe and the data would require to be validated. Dr Mcguire advised that there had been 25 incidents reported between November 2015 and October 2016 and that all cases reviewed to date had found no systemic defects in care. Of the 25, 7 had Significant Clinical Incident (SCI) reviews. 2 were pending decision and 18 were subject to local review. Of the 5 completed SCIs, the recommended actions had been discussed at the obstetric clinical governance committee – the Actions Plans devised would be monitored until complete.

It was noted that this paper will go to the Board Clinical Governance Forum and to this Committee, as assurance that this was subject to internal review. **June Agenda**

Dr McGuire advised the Committee that a report would come to a future meeting in respect of child protection issues, and this would highlight clinical governance **September/ December Agenda**

NOTED

19. OVERVIEW

Dr Armstrong provided the Committee with a verbal update on supporting the Scottish Patient Safety Programme within the Primary Care. There was a discussion in respect of the provision of funding for the SPSP programme. Dr Armstrong advised that the HSCPs were responsible for the continuation of the SPSP programme and that there was a clinical governance structure in place in all of the 6 IJBs. Dr Armstrong would report further to this Committee in this respect at future meetings.

Dr Armstrong confirmed that the GP clusters had all been appointed and

would work within the Board's clinical governance structure.

There is a system in place to undertake regular reviews of clinical governance within Sectors and Directorates in acute services,

Dr Armstrong provided an overview of the reviews in place. A review in orthopaedics was bringing together all the orthopaedic teams throughout NHSGGC. She updated the Committee in respect of the review of unscheduled care, and highlighted the opportunity to respond as a Committee to the Scottish Government consultation led by Dr H Burns. A response would be prepared and submitted through the Board Clinical Governance Forum firstly.

Reviewing themes taken from SCIs, Dr Armstrong highlighted incidents wherein patients with mental health issues had come into Emergency Departments and then left whilst waiting to be seen and subsequently attempted suicide or self harm. There would be work undertaken in conjunction with Dr Michael Smith, Lead Associate Director for Mental Health. A further theme from SCIs was a review into maternal deaths.

On a national level, Dr Armstrong updated the Committee on the Duty of Candour legislation and suggested that the Committee should take some time to look into the proposed change towards organisational duty of candour. Dr Armstrong outlined the Board's responsibility in providing annual reporting in incidents and staff training. Mr Ritchie commented that this had already come into being in NHS England and so there was an opportunity to learn from their experience

Dr Armstrong provided an update to the Committee on the roll out of Quality Improvement training including QI fellowships. There was an opportunity to link with NHS Lothian to benefit from learning from their QI Plan.

Dr Armstrong also updated the Committee in respect of the Acute Services Review, and advised that a paper had gone to the Acute Services Committee, and this would also be brought to this committee to provide overview of the proposed changes. **June Agenda**

NOTED

20. HEALTHCARE ENVIRONMENT INSPECTIONS

Dr McGuire advised that there had been an unannounced follow up inspection at QEUH, following the previous inspection in December 2016. There would be a full report and this was due 29th March 2017. Following this, Dr McGuire would report further to the Committee. **June Agenda**

NOTED

21. PUTTING PATIENTS FIRST – IMP{LEMENTING THE PATIENTS RIGHT ACT

A paper from the Nurse Director [paper 17/07] asked Members of the Committee to note the update on developments in implementing the The Patients Rights Act (2012) and an overview of patient and carer feedback

between October and November 2016.

Dr McGuire led the Committee through the report, highlighting the progress made around the delivery of patient centred care where some improvement could be seen. There were some common themes especially relating to communications and work was underway to work with staff groups to help to manage communication skills more effectively.

Dr Cameron commented that the report was very positive as a whole but would like some feedback regarding what was being done about any areas of weakness; and whether it was possible to marry the learning from this report with other areas (e.g. complaints, SCIs) where similar themes may be seen. Dr McGuire agreed that there was an opportunity to do more work in these areas, and emphasised the work already underway with senior nursing staff being asked to feedback significant complaints and the actions taken from those complaints.

Ms Brimelow agreed that it would be helpful to have assurance of actions taken and Dr Cameron echoed this in terms of the importance of structured learning and appropriate escalation. Dr McGuire advised that ward profiles/ dashboards were being developed with Lead Nurses being expected to summarise problems experienced.

Dr Armstrong commented on the positive nature of the report and that this should be fed back to staff as an achievement. Dr McGuire confirmed that this does happen to both nursing and medical colleagues. Ms McErlean emphasised the importance of engaging with staff as a supportive mechanism. It was agreed that it would be helpful for the Chair of the Committee to draft a letter highlighting this for inclusion in a Core Brief. Dr McGuire would liaise with Ms Brimelow in this regard. **Nurse Director/ Chair**

NOTED

22. SPSP ACUTE ADULT DETERIORATING PATIENT – UPDATE

A report from the Deputy Medical Director [paper 17/03] asked Members of the Committee to consider the update on the implementation of the Acute Adult Deteriorating Patient workstream of the Scottish Patient Safety Programme.

Dr Stewart took the Committee through the key issues to be considered.

- Recognising patients at risk of deteriorating in acute adult settings;
- Targeted spread plan across acute services;
- Clinical teams showing process reliability;
- Challenges with the measurement generally;
- Coordinating group to enable continued progress and progress implementation.

Dr Stewart emphasised some to the difficulties in collating data, and the work being carried out asking clinical teams to fill out audit forms when get a cardiac arrest call and ways of making this process meaningful for staff so as to win their engagement. It was important to remember that although this was progressing slowly, there was a huge amount of interest in the project.

The Committee discussed this in more detail and the following points were

highlighted:

- Variability of staff experience;
- Role of technology in recording vital signs;
- Nursing link with the patients;
- Ceiling of care discussion;
- Frequency of observations.

The Committee noted the report and implementation of this workstream.

NOTED

23. CLINICAL & CARE GOVERNANCE PRIORITIES – DEVELOPING CLINICAL GOVERNANCE & CLINICAL QUALITY IMPROVEMENT

A report from the Head of Clinical Governance [Paper17/04] asked the committee to note and consider the output of a recent engagement process which described how we should develop clinical and care governance, and the actions proposed to respond to these needs. This was being shared with the Committee prior to finalisation to allow Members to influence the plan developed.

The paper described some of the key needs and Mr Crawford emphasised:

- Need to think systematically and act collectively;
- Develop real time clinical data within quality management to support evidence based decision making;
- Enable more effective sharing of knowledge on clinical risks and safety solutions;
- Clearer strategy for developing QI skills.

The initial proposals were:

- Develop QI strategy
- Develop clinical informatics/analytics strategy
- Specific commissions to enable contributions from diverse groups;
- Enhance NHSGGC's reputation for clinical quality with recognised centres of excellence.

This was still in a formative stage and will be co-ordinated through the Board's Clinical Governance Forum, and this Committee would have oversight.

Mr Ritchie commented on the difficulty of disseminating these principles to junior medical staff, and Mr Crawford advised that although strategic oversight was required the intention was to focus on supporting teams at a local level. Ms Brimelow added that this was essential and this focus on QI should also be included within undergraduate programmes. Dr Armstrong advised on the numbers of medical staff attending national groups, and the need for this to develop into locally managed projects.

Ms Brimelow enquired about the QI health fellowships and Ms Jardine clarified how this worked in practice.

Mr Ritchie asked for clarification around how to measure how successfully

QI principles were being put into effect. Mr Crawford detailed the number of areas of interest within which QI projects were underway e.g. tissue viability. Part of the challenge was to make the work more visible and to evaluate the success of the project work.

Dr Cameron commented on the positive nature of the report, and welcomed the structured approach. At the same time, it was important not to stifle innovation and to emphasise cross-pathways of care thus encouraging collaborative working.

The Committee noted the engagement process and development of a framework document around the QI strategy which would be led by the Head of Clinical Governance. **Head of Clinical Governance**

NOTED

24. HOSPITAL STANDARDISED MORTALITY RATIO (HMSR)

A report from the Medical Director [Paper17/05] asked the committee to note and the HMSR figures in the latest publication; and to consider the position of the HMSR at RAH/VoL/IRH Hospitals; to consider the process of ongoing review to identify factors explaining the relatively high HMSR at two locations in NHSGGC.

Dr Armstrong led Committee Members through the detail of the report, describing the HMSR data for the third quarter in 2016 for NHS GGC hospitals and the marked variation in HMSR between the hospital complexes. The data illustrated that for sites with smaller patient volumes, such as the IRH, small shifts in the predicted mortality could have a large impact on HMSR.

The RAH has consistently reported a comparatively high HMSR and was subject to ongoing review, and HIS had indicated that they were content with the action taken. HIS had also advised that the recent notification from IRH did not require any specific action. Although it was widely recognised that HMSR is a poor quality indicator, NHSGGC would continue to seek to use the data in a formative way and would continue to work closely with HIS in this regard.

The Committee noted that HMSR figures particularly for RAH and IRH. The continued review was noted and it was agreed that this would come back to the Committee in the future

NOTED

25. CLINICAL EFFECTIVENESS: OUTLINE AND UPDATE

A report from the Head of Clinical Governance [Paper17/06] asked the committee to note the update on aspects of the centrally supported processes which relate to clinical effectiveness. Further, to consider the "Juran trilogy" and its implications for the scope and quality of monitoring activities relating to clinical effectiveness.

Mr Crawford provided this report to the Committee to support Members understanding of routinely reported information set within a broader

description of what clinical effectiveness may involve. Mr Crawford outlined the information that was available from a number of well established managed processes to maintain local clinical guidelines and monitor external clinical quality related publications. Mr Crawford provided a brief outline for Members highlighting the following:

- Clinical Guidelines
- Clinical Governance Related Guidance & Clinical Quality Publications
- Quality Improvement capacity and capability
- Quality Improvement projects
- Library Services

Mr Crawford also outlined "Juran's trilogy" – a quality model perspective on local clinical effectiveness activity.

Dr Cameron noted that given the helpful, positive nature of the report, assurance should be sought for the continuation of this work by the Clinical effectiveness team so that this would continue to grow within the ongoing financial constraints. She commented that non patient facing services were essential for quality improvement.

Mr Crawford described the need to acknowledge the requirement to reduce costs but to approach this in ways which minimised the impact. However he also acknowledged that the demand for education and support was already significantly greater than could be supported and other development approaches were required. The Clinical Governance Support Unit will continue to explore ways in which the Board can maximise the value of their support to QI.

The Committee noted that, whilst the budget for the team was affected by the need for savings across the Board, there was assurance that there was ongoing review of different, effective ways of working. The Committee would monitor this and bring this back for review by the end of the calendar year **December Agenda**

NOTED

26. DATE OF NEXT MEETING

Date: Tuesday 6th June 2017
Venue: Boardroom, J B Russell House
Time: 1pm - 3pm

The meeting ended at 4 pm