Board C&CG(M)17/04
Minutes: 39 - 49

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 5 September 2017 at 1.30pm**

PRESENT

Ms S Brimelow OBE - in the Chair

Mr A Cowan
Dr D Lyons
Ms D McErlean
Mr I Ritchie
Ms A Thompson

IN ATTENDANCE

Dr J Armstrong	Medical Director
Mr A Crawford	Head of Clinical Governance
Ms M Farrell	Director, Clyde Sector [For Minute 45]
Ms J Grant	Chief Executive
Dr C Jones	Chief of Medicine, Clyde Sector [For Minute 45]
Dr M McGuire	Nurse Director
Ms M Smith	Secretariat Manager

ACTION BY

39. APOLOGIES & WELCOME

Apologies for absence were intimated on behalf of Professor Dominiczak, Mr Fraser and Cllr McColl.

NOTED

40. 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

41. MINUTES

Mr Cowan proposed that the minute of the meeting (which took place on 6 June 2017) was an accurate record (subject to minor amendment) and this was seconded by Mr Ritchie.

NOTED

42. MATTERS ARISING FROM THE MINUTES

(a) Rolling Actions List

Seven actions were recommended and agreed for closure, including the following:

- It was noted that an update would be provided in respect of the protocol and process for obtaining patient consent, within the Clinical governance overview in Item 9 and this action was recommended and agreed for closure.

- Dr Mcguire provided the Committee with a further update in respect of staff engagement and the actions taken to ensure this was a valuable process: using core brief, local feedback as well as PACE groups. It was also noted that the main NHS Board would receive Patient Stories by filmed link, at each Board Meeting in the future. This action was recommended and agreed for closure.

NOTED

43. OVERVIEW

Dr McGuire updated Members on a recent inspection carried out by Healthcare Improvement Scotland (HIS) at Royal Alexandra Hospital. The report was expected in September 2017, and an update would be brought to this Committee. **Nurse Director/ December Agenda**

Dr McGuire also advised that there had been an unannounced inspection by HEI at Low Moss Prison, and once the report had been made available, an update would be brought to this Committee with regard to the healthcare aspects. Ms McErlean asked about the training and support provided to healthcare staff at Low Moss Prison and Dr McGuire emphasised the ongoing training and support offered, and acknowledged the staff turnover rate within prison healthcare. The report was expected in approximately one month. Ms Grant noted that Mr D Williams (Chief Officer for Glasgow City HSCP) was due to attend the Prison Convener meeting in September. It was agreed that it would be helpful for this Committee to receive an overview and update report and that the Service Manager for Prison Healthcare would be invited to the next meeting of the Committee. **Nurse Director/ December Agenda** **Secretary/ December Agenda**

Dr Armstrong provided an update with regard to Ward 15 at Royal Alexandra Hospital (RAH) which provided paediatric inpatient care. There were vacancies in the nursing complement and this was being managed carefully with the Chief Nurse in conjunction with the recruitment service. Difficulty in recruitment of registered paediatric nurses was being experienced on a national level and that a national workforce planning group had been formed.

Dr McGuire went on to provide an overview of person-centred visiting within NHSGGC. This meant open visiting being made possible in most wards between the hours of 11.30am and 8pm. The involvement of staff in

enacting this policy was recognised, and it was noted that it had particularly good effect for older patients and their carers. At the same time, patient feedback had indicated that this visiting pattern would not be suitable in some areas, particularly in maternity wards - where this had therefore not been adopted.

Dr Armstrong advised that an internal audit was being carried out by PWC, in respect of risk assessment of patients with a risk of suicide attending Emergency Departments to test operating effectiveness of key controls. Dr Armstrong would bring an update to future meeting of this Committee. Dr Lyons noted that self harm could often be seen in crisis team and emphasised that the assessment of risk could not be completed in isolation; there needed to be an appropriate care pathway in place for a patients at risk. **Dr Armstrong**

She outlined actions taken in respect of a rapid access clinic for paediatric dentistry in the Royal Hospital for Children (RHC) to improve waiting times. An update would be brought back to this Committee. **Dr Armstrong**

Dr Armstrong also indicated that a review was being carried out in respect of governance within mental health services, to ensure that updates were being presented to the Committee structure in a well directed, co-ordinated and timely way.

NOTED

44. HIS REVIEW OF AYRSHIRE MATERNITY UNIT, NHS AYRSHIRE & ARRAN

A Paper from the Nurse Director [Paper17/16] asked the Committee to note the summary of the recommendations from the Health Improvement Scotland (HIS) Review of Ayrshire Maternity Unit (NHS Ayrshire & Arran) and the work NHSGGC was taking forward in the light of these recommendations.

The report recommendations were noted as follows:

- Strengthen the review process
- Improve family engagement
- Support for Staff
- Promote shared learning
- Improve Staff training and education

Dr McGuire advised that NHSGGC had been reviewing current risk management within maternity services in preparation for the HIS report, This had focussed on the clinical incident review process and the role of the clinical risk midwife. The recommendations from the HIS report were being scoped by the Clinical Governance Support Unit and Maternity MDTs to implement and consolidate identified improvements to clinical and care governance.

She provided a further update to the Committee, advising that Ms Yvonne Bronsky had been invited to provide a review for NHSGGC on risk and clinical and care structure within maternity services as the Board moves forward to Best Start as an early adopter - a report would be presented to

the NHS Board in December 2017. It was agreed that Dr McGuire would bring a more detailed report to the next meeting of this Committee and that it would be helpful for the Clinical Director and a senior member of the Midwifery team were also in attendance to facilitate detailed discussion and assurance.

Dr McGuire/ December Agenda

It was also noted that BadgerNet would be piloted in November 2017, and it was expected that this would lead to the provision of more in depth data for review.

NOTED

45. HOSPITAL STANDARDISED MORTALITY RATIO

A paper from the Medical Director [paper 17/17] asked the Committee to note the reported HSMR for hospitals within NHSGGC, that the HSMR in RAH and Vale of Leven (VoL) was deemed to be significantly different from the Scottish average and that publication of site specific data indicated greater level of difference at VoL. The Committee was asked to consider the follow up process within NHSGGC, and the actions being developed.

It was noted that a detailed overview had been reported to Board Members at their Seminar held earlier on the same day as this Committee. This had been finalised more recently that the report to this Committee and therefore had contained updated data and advice. Discussion was opened by Dr Armstrong noting that Dr Jones and Ms Farrell were in attendance to facilitate detailed consideration.

It was noted that RAH/VoL which are reported as one hospital was above the national and Board average for the first quarter of 2017.

Dr Lyons noted the difficulty in interpreting the data and suggested consideration as to whether there was a difference in the population using these hospitals, as well as the validity of the coding for the data itself. He asked if the data could be considered compared to Glasgow and the West of Scotland as a whole. Dr Jones advised that although the ratio was in excess, it was important to note that mortality rate had remained unchanged. HSMR was designed as a measurement tool within acute hospital, and there were differences in the patient groups being compared e.g. comparing VoL to QEUH.

Discussion was around how the population engaged with different acute hospitals and the difference that this could make. As part of the review, consideration would be given to the stage of diagnosis for the patient at the point of admission, as well as palliative care pathways within acute services and the community.

Members emphasised that it was essential that patients and their carers were provided with appropriate assurance in respect of the safety of care at RAH and VoL.

Dr Armstrong acknowledged that the validity of the data was also under review in terms of whether the ratio change could be related to coding anomalies. This was under review with the HSMR data being re-examined for the period January to March 2017. Mr Ritchie picked up this point emphasising that the difficulty presented by coding issues, and the impact

this could have on public perception of the services offered at VoL.

Mr Cowan noted that disproportionate effect on variation that occurred with low data set, and emphasised the need to offer public reassurance in user friendly language.

Ms Farrell noted the technical problems experienced in this context when Trak care was introduced, and the work carried out to ensure that data was entered accurately which included input from clinical colleagues. She acknowledged that timeous interface was required between coders and the clinical team to build up confidence in the process. Dr Jones commented that review had taken place each time a weakness had been identified in the process e.g. timely issue of final discharge letter (FDL) meant decreasing rick of coders using information entered on admission and which then become out of date. A new process was put in place to ensure that consultants completed all FDLs at VoL, and this practice had been transferred across Clyde Sector.

Mr Crawford noted that the challenge was accuracy of coding across NHSGGC, with differences in abilities across the coding teams, and that the experience and lessons learnt in Clyde Sector would be used to inform coding practice across NHSGGC. The need for this was underlined by Ms Grant who confirmed that leadership in this area would be taken by her in conjunction with Dr Armstrong.

Dr Armstrong confirmed that HIS have been invited in to review and that their report would be shared with this Committee for review prior to being submitted to the NHS Board. **J Armstrong**

Ms Brimelow thanked Ms Farrell and Dr Jones for attending Committee and providing further background information to aid discussion and review.

NOTED

46. CHILD PROTECTION GOVERNANCE

A paper from the Nurse Director [paper 17/18] asked Members of the Committee to note the details of improved governance arrangements and actions underway within NHSGGC Child Protection Service.

Dr McGuire noted that the recommendations following a detailed case study had been submitted to the Board Clinical Governance Forum meeting in August 2017. This report would be amended to ensure it was appropriate to share with Members. The Nurse Director would provide this for the Secretary to add to the supplemental papers available on Admin Control. **Nurse Director**

Members discussed the need for greater detail of the type of incidents faced, along with the need for assurance that processes were in place to manage these incidents.

Mr Ritchie asked for assurance in relation to this issue being given appropriate profile within training for junior doctors and further, what the role of the Emergency Department doctors would be in these types of cases. Dr Armstrong noted that each unit would have a child protection consultant and suggested that it would be helpful to being this issue back to this Committee to outline the policy and process in place. This would be placed **Future Agenda/ Secretary**

on a future agenda for the Committee.

There was further discussion on governance surrounding reporting to the Committee, and it was noted that this would form part of the agenda at the Board Member Away Sessions in November 2017.

NOTED

47. CLINICAL & CARE GOVERNANCE – OVERVIEW REPORT; INCLUDING CLINICAL GOVERNANCE ANNUAL REPORT 2016/17 AND CLINICAL GOVERNANCE STRATEGY

A report from the Head of Clinical Governance [Paper17/19] asked the Committee to note the publication of the Clinical Governance Annual Report and to consider and comment on the plan to review adverse event management in NHSGGC. The Committee was also asked to note and comment on the driver diagram on developing clinical quality; to note the areas where the corporate objectives overlap with pre-existing themes on the Committee agenda and to comments on the response to queries about consent policy and practice.

Firstly, Mr Crawford introduced the Clinical Governance Annual Report which had been approved at the NHS Board Meeting on 15 August 2017 and published to Staffnet. Going forward, the intention was for the Clinical and Care Governance Committee to have the opportunity to review and comments upon the Annual Report prior to it being submitted to the main NHS Board. This would allow the Committee to review the main themes as well as have oversight of local examples of good practice that the Committee may not otherwise have had awareness of.

Ms Brimelow noted that as Chair she had arranged pre-agenda meetings for this Committee and that the Secretary would prepare a Future Look to be discussed and updated on an ongoing basis. **Secretary**

Mr Ritchie noted that the report provided good evidence of the achievements within NHSGGC which lent confidence

Mr Crawford led Members through the details of the paper including an overview of the Healthcare Improvement Scotland (HIS Review of Ayrshire Maternity Unit, University Hospital Crosshouse within NHS Ayrshire and Arran).

He also provided Members with an update on the potential impact on clinical quality and governance following the publication of the NHSGGC Corporate Objectives 2017/18 highlighting the work being undertaken to review, update and implement the Clinical Governance Strategy for the NHS Board.

Mr Crawford outlined the Clinical Quality Improvement Driver Diagram providing Members with early sight of the background and context to this to allow them to review and comment as the work progressed. Members agreed that this was helpful and would welcome a further update from Mr Crawford with an updated Action Plan. **A Crawford/ Future Agenda**

The report from Mr Crawford provided an update to Committee in relation to the NHS Board's practice on obtaining patient consent which included

the a recognition that that colleagues have to consent on behalf of their colleagues provided that the consenting clinician was competent to consent the patient, with full knowledge of the procedure. Further that where written consent was required, should a significant time have elapsed between the consent and the procedure or a significant change in the patient's condition, the existing consent should be reviewed. It was also good practice to confirm consent with the patient immediately prior to the procedure, to ensure that the patient had not had a change of mind.

Mr Ritchie asked for further clarification to ensure that a patient could not be progressed to a procedure without consent having being obtained appropriately. Mr Crawford confirmed that such an eventuality would be subject to a Significant Clinical Incident, and that no such adverse incident had been recorded.

Dr McGuire underlined the need to demonstrate that all of the details of informed consent had been taken. Dr Lyons referred to delivering treatment within the psychiatric setting, and the need to ensure that the patient was capable of providing consent to a procedure. This was noted as an issue the Committee would like to revisit for further review in the future. **Future Agenda**

Members also discussed the issue of whether consent for anaesthesia would be taken separately from consent to the procedure itself. NHSGGC policy was to take consent for one episode of care with the anaesthetist carrying out a risk assessment for the patient, but not taking consent separately.

NOTED

48. BOARD CLINICAL GOVERNANCE FORUM - UPDATE

A report from the Head of Clinical Governance [Paper17/20] asked the Committee to note the update on the key points from the meeting held in June 2017.

NOTED

49. DATE OF NEXT MEETING

Date: Tuesday 5th December 2017
Venue: Boardroom, J B Russell House
Time: 1.30pm

The meeting ended at 3.50pm