APPROVED

Minutes of a meeting of the **Clinical Governance Committee** held on 29th November 2017 at 2pm in the BGH Committee Room.

Present:	Dr Stephen Mather (Chair)	David Davidson
	Alison Wilson	Malcolm Dickson
In Attendance:	Dr David Love	Dr Keith Allan
	Claire Pearce	Sam Whiting
	Dr Cliff Sharp	Peter Lerpiniere
	Nicky Berry	Jane Davidson
	Ros Gray	Sheila Macdougall
	Erica Reid	Dr Jane Montgomery (item 8.1)
	Dr Imogen Hayward (item 8.3)	

1. APOLOGIES AND ANNOUNCEMENTS

The Chair noted apologies had been received from Dr Annabel Howell, Dr Janet Bennison, Simon Burt, Irene Bonnar, Laura Jones and Philip Lunts. The Chair confirmed the meeting was quorate.

The Chair welcomed everyone to the meeting and noted some amendments to the running order of the agenda.

2. DECLARATIONS OF INTEREST

The **CLINICAL GOVERNANCE COMMITTEE** noted there were none.

3. Minutes of the Previous Meeting

The Chair noted one amendment required to the previous minutes. On the HSMR update on page 3, the wording should read that Healthcare Improvement Scotland (HIS) are 'unwilling' to remove palliative care patients from our data set, not 'unable'. The minutes were then approved as a true record.

4. MATTERS ARISING

The **CLINICAL GOVERNANCE COMMITTEE** updated and noted the Action Tracker accordingly.

5.1 Infection Control Report

Sam Whiting noted two updates since the report was circulated to the Committee. Further progress has been made against the workplan with actions completed now sitting at 60%. Sam also noted that as part of the infection control audit program all action plans have now been received from the areas. David Davidson queried the staffing challenges that the department has faced and whether this was a long term issue. Sam confirmed that there was a short term acute issue around reduced capacity alongside changes in working practice but also a longer term issue related to increase in clinical activity. Malcolm Dickson asked if there were any lessons that could be learnt from previous Norovirus outbreaks and Sam confirmed that a Norovirus preparedness meeting had taken place earlier in the year. Sam added that the recent outbreak had been challenging due to infection being in multiple locations. An initial debrief and lessons learned took place after this incident. Malcolm queried if monitoring took place in GP practices. Sam was unable to confirm but agreed to report back to the committee. Stephen Mather asked if blood taken by the Scottish Ambulance Service (SAS) follows the same protocol as NHS Borders. Sam replied that they should but would seek confirmation and report back to the Committee. Stephen queried the breast surgery infections on page 6 of the report. Sam stated that data collation had commenced in April and confirmed that each case has been reviewed but there had been no common theme or identified learning to date. Jane Davidson queried whether NHS Borders were an outlier based on totals, Sam confirmed that only hip and caesarean sections are compared nationally and noted that we are not an outlier for either of these procedures. Stephen Mather asked if Sam had any concerns in relation to surgical site infections. Sam provided assurance that every SSI case is reviewed and the Surgical Site Infection Group continues to have oversight on this agenda.

ACTION: Sam to report back to the Committee regarding monitoring in GP practices

ACTION: Sam to seek confirmation of procedures used by SAS in relation to taking blood

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

8.2 Infection Control Annual Update

Sam informed the Committee that one of the HIS standards is to produce an annual report. Sam noted that work plan detailed actions outstanding to the end of March. Sam added that this is not where we planned to be but progress has been made.
The Committee discussed the use of antibiotics rising steadily and this needs to be read in common with infection control. Sam also noted that work is ongoing to try to reduce the 4 C's antibiotics (clindamycin, cephalosporin, co-amoxiclav and ciprofloxacin). Alison Wilson added that we are now dealing with more unwell patients and because of the need to reduce the use of the 4C antibiotics there is often a need to use 2 antibiotics instead of 1. This could be leading to an increase in antibiotic use in secondary care.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

9.1 Back to Basics

Ros Gray informed the Committee that the running order of the agenda was amended so we could cover our approach to improvement in advance of the other items which might then address issues arising from them in advance. Ros noted that she hoped the presentation would set the scene and our priorities while giving Committee members assurance that we are going in the right direction. Ros also noted the ongoing support we are receiving from the Improvement Hub and Scottish Government colleagues.

Our priorities have emerged from the HSMR and unannounced inspection action plans as well as other intelligence (e.g. adverse events, complaints).
Ros highlighted to the Committee a breach to the crude mortality rate upper control limit which indicated there were more inpatient deaths than usual. There were 21 patients identified, which included 6 in the Margaret Kerr Unit. An investigation into each death is now required to ensure that all appropriate actions were taken and that the coding was accurate.
Ros highlighted that our HSMR is not where we would like it to be and that no sustained improvement has been seen relating to pressure ulcers and falls. Our complaints numbers were higher than zero and there has been an increase in adverse events.
The Back to Basics improvement collaborative, which contains 5 workstreams, was formally launched in October 2017. Each workstream will have specific metrics and HIS are providing support to identify mechanisms to create improvements.
Ros explained that early data on the use of the Person Centred Coaching Tool indicates that there are further opportunities for improvement with Senior Charge Nurses at the point of service delivery.

The Significant Adverse Event Review (SAER) process is being reviewed and driver diagrams have been created for the deteriorating patient and falls workstreams. HIS and Scottish Government have also offered to come to support NHS Borders and contribute to Executive Team QI development. Coaching programmes will be provided at all levels, particularly the Senior Charge Nurses. Claire Pearce noted that this was a work in progress and that a steering group has been set up to facilitate the planning. Claire noted that is a period of change and we must maintain focus on what we are trying to achieve as this will require time. Cliff Sharp echoed Claire's thoughts and noted that we need to give the cycles of change enough time to mature and be confident that we have the right plan with flexibility to adjust if required.
David Davidson noted his surprise that there had been no Healthcare Support Worker training in a long time. It was noted that training was usually carried out on job, on-site. Discussion took place around whether we have enough support to carry out onsite training as well as maintaining roles. Claire replied that refresher training would be provided off site for current staff and all new staff into the organisation would be given training as part of their induction. It was also noted that update training on IV therapy is also being provided for Registered Nurses. Training is being provided in shorter sessions and Nicky noted that positive feedback has been received from the Senior Charge Nurses on this type of training as it has meant the wards haven't been left short of staff. Nicky added that as a result of this we have learned that this is how we will deliver training going forward. Jane Davidson agreed that organisation has shifted its approach to training. Alison Wilson said she was interested to see multi disciplinary teams involved in learning sessions and asked if the training was applicable to

other professionals could they be included to share learning. Claire replied that she would be happy to consider other professions.
Keith Allan noted that there was some good work going on in the community and a good range of metrics set out in the paper. Malcolm Dickson agreed and said it was encouraging to see what is happening, however his only suggestion was not to aim too high and queried the figure of zero pressure ulcers from April 2018.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

5.2 Hospital Standard Mortality Rate (HSMR) Update

David Love provided the Committee with a verbal update however noted that Ros had given a comprehensive summary in the previous update. The latest published quarter shows our HSMR at .89 which shows a slight improvement and we are coming back to where we were before our last increase. David noted that advice given by HIS is not to compare with other boards but with our own performance. We are at the start of a journey and if we focus on QI our performance will improve. David also noted that we had taken our eye off the ball with monitoring real time crude mortality and highlighted the 21 deaths last week when our monthly average is around 47. David noted that all of these deaths will be reviewed using the global trigger tool. A potential correlation between mortality, HSMR and sepsis gives us a degree of assurance that there may have been some clinical reason for the change. Our HSMR may also be related to flu and peaks in sepsis related deaths. It was noted that coding was important and ensuring the correct data has been entered as it is from this that the HSMR is calculated. Further work around coding is required and there is a need to look at our systems in the clinical areas to support the medical teams, David highlighted for example that letters following a death are often written by junior doctors in a stressful environment, when they may not be in possession of all the patient related details. Colleagues from the Information Statistics Division (ISD) are willing to help us with quality assurance and to provide support with speaking to our clinicians around importance of accurate data.

5.3 Mortality Reviews

David Love presented the paper on mortality reviews which provides additional information on harms and themes that have been drawn from these reviews since the last report. David noted that a sampling methodology has been used to identify cases and the global trigger tool has been used to review them. David noted that there hadn't been a huge change in figures or harms detected and that the rate detected reflected better than the national average. Malcolm Dickson queried the process of selecting random cases and how secure this process is. Ros confirmed that the cases are selected using a random number generator and that no members of staff would be able to use this process to subvert the system. Discussion took place around post mortems and that the vast majority of deaths are not subject to a post mortem. David explained that clinicians note the cause of death, if this is not clear then a conversation with the Procurator Fiscal takes place. Malcolm noted that he would like to understand the process a bit more and Ros and David agreed to support him with that. Discussion took place around the sampling technique and David agreed to consider different sampling strategies to include highest volume areas. David also confirmed the arrangements for follow up with consultants after the case note review.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

5.6 Pressure Ulcer Thematic Report

Erica Reid presented the paper which provides an update on pressure injuries in the BGH, community hospitals and mental health units.
Erica noted that it has been over 100 days since a developed pressure ulcer has been recorded in the community hospitals. Erica noted that the zero tolerance approach to pressure injuries from April 2018 is an aspiration, that no patient should develop a pressure ulcer under our care. David Davidson noted that there was no mention in the report of pressure ulcers developed in care homes and asked how we get this information. Erica answered that community nurses document some instances and further work is ongoing in this area. Erica added that as the tissue viability nurse will be full time, there is an expectation that this post will eventually link into care homes with the aspiration to work deeper in the community. Peter Lerpiniere added that pressure ulcers that are reported in care homes must be reported to Care Commission. Jane Davidson added that notable improvements had been made in the community hospitals and we have assurance there and the plan to address the identified problems in the BGH will form part of the improvement programme. Ros added that she hopes our approach to improvement assures the committee that we can demonstrate improvements. Jane stated that the improvement programme requires organisational buy in and suggested that this is taken to a Board development session. Ros noted that a version of the Clinical Governance Committee paper on improvement had already been submitted to the Board secretary but that she would liaise with Iris Bishop regarding a Board development session in either January or February. Ros also noted that the Clinical Governance and Quality update paper being taken to the next Board meeting is a special edition paper that outlines our improvement approach. The Committee agreed that this would sit better as a development session and that the paper should go to the Strategy Group and then to the Board.

ACTION: Ros to liaise with Iris Bishop regarding a Board Development Session in January/February

ACTION: Ros to pull the Quality Improvement update paper from the Board and take to the Strategy Group first. **Post meeting note – Board papers have already been submitted to the Board Secretary and the decision was subsequently taken to take the paper to the next Board as originally planned.**

The **CLINICAL GOVERNANCE COMMITTEE** noted the update.

8.3 Blood Transfusion Report

Dr Imogen Hayward, Chair of NHS Borders Transfusion Committee, presented the report to the Committee. Imogen highlighted recent remodelling to a regional workforce model in a bid to achieve savings means that the support we currently have will be significantly reduced. Our Transfusion Practitioner now works 1 day per week, the Support Assistant post has been lost and there is no administration support to the service. The restriction of resource has already made a significant impact on service. Cliff Sharp echoed Imogen's concerns and added this is potentially a high risk publicity issue and that we need to look further at how we

can support administrative and clinical function. Jane Davidson advised that she is due to discuss this issue with Cliff and that the Committee's focus should be on the annual report. Cliff added that he would come back and provide an update after this meeting has taken place. Nicky added that a process is in place to address the issue around wrong blood in tubes with the obstetric team. Imogen agreed to provide a verbal update in 3 months time.

ACTION: Cliff to provide feedback to the Committee and his meeting with Jane Davidson regarding the blood transfusion service

ACTION: Imogen Hayward to come back to the Committee in March to provide a verbal update

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

8.1 Medical Education Update

Dr Jane Montgomery attended the Committee to present the Medical Education Report. Jane was pleased to report that improvements had been made in medical education. Paediatrics had been awarded 2 places for GPST training and Obstetrics and Gynaecology had won a national award for their gynaecology training. Malcolm Dickson passed on his congratulations to Obstetrics and Gynaecology. Jane also explained plans to refurnish the room in the Education Centre and the need to employ a simulation technician. Funding is being sought for this. David Davidson asked for assurance that we will not face the same issues we faced a year ago. Jane Davidson advised that an internal audit report going to audit committee should also come to this Committee. Jane Montgomery agreed to provide a verbal update to the Committee in March.

ACTION: Jane Montgomery to come back to the Committee in March to provide a verbal update

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

8.4 Inspection Reports and Action Plans

The Chair asked if any members of the Committee had any questions on HIS report and action plan.
Malcolm queried why the training for consultants on capacity for decision making is annual. Nicky Berry answered that this is update training delivered from a Learnpro module. This is included in the action plan as we need to know that this is ongoing and should be included in consultant's job plans. The Committee noted that the majority of the improvement action plan is on target. 85% of all BGH nurses have been trained or received update training in Malnutrition Universal Screening Tool (MUST). The nutritional care policy was agreed at Clinical Executive Operational Group last week. Claire confirmed that the target around care plans won't be achieved by March 2018 and that she had spoken to the inspectors about this and informed them that we need to have a documentation plan but it won't be by the 31 March 2018, with which they were comfortable. The Committee discussed timescales for updates and agreed that an updated action plan, with an additional column included highlighting progress should come to the meeting in March.

Peter Lerpiniere provided context around the Joint Older Peoples inspection report, which consisted of 13 recommendations, inspected against 9 indicators. Peter added that 3 areas were graded as weak, which are worth noting by the Committee. Adult protection was a focus, where our risk assessment was criticised, as a result of this a new risk assessment tool has been approved. The action plan is still in draft format and still needs to be signed off at board level. David Davidson queried the weak areas and what we picked up from these. Peter confirmed that these included the transitional period for Leadership, which was due to interim posts being held. It was noted that the Chief Officer has been trying to get in contact with HIS as is looking to meet with inspectors to help understand what good performance looks like. It was agreed that there is a need to bring this back to Committee with social care colleagues to provide assurance. It is important for the Committee to consider what is coming out of these reports and that Back to Basics covers the recommendations in this report as well as nutritional care. David Davidson added that the subject needs to be aimed correctly at the Integrated Joint Board as not all members are in health and care sector, he noted that this was an important learning tool and wished they didn't affect the staff so badly. Stephen Mather agreed that the draft action plan needs to be finalised after any dialogue with HIS and a half hour discussion at the next meeting with the Chief Officer and Murray Lees attend to present. It was agreed that a clear cover paper would also be required.

ACTION: An updated nutritional care action plan highlighting progress made to come to the March meeting

ACTION: Joint Older People's action plan to be given a 30 minute slot at the next meeting and Murray Lees and Robert McCulloch-Graham asked to attend

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

5.4 Very High Risk Management Report

Sheila Macdougall presented the paper and confirmed that these risks are monitored by the Clinical Executive Operational Group. Sheila noted that the aggression and violence review is going through the process. Discussion took place around risk inequalities and Sheila confirmed that there are 15 risk assessments that include an element of this.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

5.5 Claims Update

Sheila Macdougall also presented this report and explained that this report details the themes that are within our claims.
Malcolm Dickson queried mesh claims and whether these were ours or whether they were national. Sheila advised that out of 340 total national claims, NHS Borders have 12 and that this has a significant financial implication.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

6.1 SPSO Update

Ros Gray explained to the Committee that more detail around grading had been included in this update as per the agreed action. Ros highlighted that there was one new case that had implications on both medical and nursing and we are waiting to hear on the outcome from the SPSO. Ros highlighted that annual statistics from SPSO were also included in this paper. Ros agreed to consider how we can benchmark against complaints departments in other Boards.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

7.1 Clinical Board Update (BGH)

Nicky was not available to present this paper but Erica Reid agreed to take any questions back to Nicky. Ros Gray suggested that future reporting might be against the 5 themes outlined in the improvement approach in each of the clinical board reports. It was agreed that this would be helpful. The number of SAERs was discussed and Ros reported that a recent session to look at the process resulted in a triage process being tested. Ros noted that she had asked that the Clinical Governance groups specifically report on complaints and adverse events improvement and actions.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

7.2 Clinical Board Update (Primary and Community Services)

Erica Reid highlighted to the Committee that the focus of this report was on learning. The same adverse event issue was identified and the Committee was assured that this will be looked into and improved.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

7.3 Clinical Board Update (Mental Health)

There were no questions for Peter on the Mental Health Clinical Board update.

7.4 Clinical Board Update (Learning Disabilities)

Peter noted that following on from the last update, the service has reviewed its workforce and is recruiting to try and overcome this hurdle. David Davidson queried the change in SBC systems and asked whether this has settled down. Peter confirmed that the 2 IT systems had changed and there had been some issues but we would seek an update on this and report back to the Committee.

ACTION: Peter to seek an update on the IT system issues and report back to the Committee

The **CLINICAL GOVERNANCE COMMITTEE** noted the report.

10 ITEMS FOR NOTING

10.1 Minutes and Papers

The following minutes and papers for:

- Child Protection Committee Minutes
- Adult Protection Committee Minutes
- BGH Clinical Governance Minutes
- Primary and Community Services Clinical Governance
- LD Clinical Governance Minutes
- Mental Health Clinical Governance Minutes
- Joint Executive Team Minutes
- Annual Controlled Drugs Report
- SPSO Annual Letter
- SPSO Tables
- SPSO Explanatory Note

The **CLINICAL GOVERNANCE COMMITTEE** noted the minutes and papers.

11 ANY OTHER BUSINESS

Jane Davidson informed the Committee that she has asked Cliff Sharp and John Cowie, Interim Director of Workforce, alongside Carol Gillie as the governance expert, to look at the Clinical Governance Committee and Staff Governance Committee to ensure that the Committees are doing what we need to be doing and looking at what we need to look at. This includes how agendas are put together.

Malcolm Dickson noted that some documents are circulated as read only, which doesn't allow for comments to be added as members are now managing papers electronically. Amie agreed to look into this.

Jane added that the Tree of Light lighting ceremony takes place on Tuesday 5th December.

ACTION: Amie to ensure that all papers are not in a read-only format

12 DATE AND TIME OF NEXT MEETING

The next Clinical Governance Meeting will be held on the 31st January at 2pm in the BGH Committee Room.

The meeting concluded at 16.40