APPROVED

Minutes of a meeting of the **Clinical Governance Committee** held on 19th July 2017 at 2pm in the BGH Committee Room.

Present:	Dr Stephen Mather (Chair)	David Davidson
	Alison Wilson	
In Attendance:	Ros Gray	Dr David Love
	Jane Davidson	Claire Pearce
	Sam Whiting	Dr Cliff Sharp
	Peter Lerpiniere	Dr Janet Bennison
	Dr Annabel Howell	Sheila MacDougall
	Dr Allyson McCollam	Nicky Berry
	Dawn Moss	

1. APOLOGIES AND ANNOUNCEMENTS

The Chair noted apologies had been received from Elaine Torrance, Simon Burt, Phillip Lunts, Irene Bonnar and Dr Tim Patterson.

The Chair welcomed Dr Allyson McCollam who was in attendance on behalf of Dr Tim Patterson and to speak to item 8.2. The Chair also noted some slight amendments to the agenda.

2. DECLARATIONS OF INTEREST

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

3. Minutes of the Previous Meeting

The minutes of the previous meeting of the Clinical Governance Committee held on the 14th June 2017 were amended at:

- Page 3 (fourth paragraph) the Risk, Health and Safety team are now able to review 'risk assessments' not 'action plans'.

The minutes were then approved as a true record.

4. MATTERS ARISING

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

5. PATIENT SAFETY

5.1 Infection Control Report

Sam Whiting informed the Committee that his report included the additional details that were requested at the last meeting and noted in the action tracker. Sam provided an update on the two linked CDI cases and confirmed that that there have not been any further related cases. A review showed that the two cases had been treated appropriately. Sam described information relation to hand hygiene, cleanliness monitoring and spot check data that had been reviewed to identify possible opportunities for cross transmission. A meeting is now being arranged with the relevant clinicians to explore this further. Sam informed the Committee that with regard to the Surgical Site Infections (SSIs), data has been collected to facilitate another deep dive into the arthroplasty SSI cases in 2017, which will be disused at the SSI Group and brought back to this Committee.

David Davidson queried the data on page 7, item 6 regarding Cleanliness Monitoring and what corrective action can be taken to address the challenges within Mental Health. It was suggested that 2 additional lines are included on the Cleaning Compliance chart to show clinical areas and non clinical areas in total, which could replace figure 8.

ACTION: Sam to liaise with the Facilities Manager regarding Cleanliness Monitoring to seek an update.

Jane Davidson asked whether we should be aiming to achieve a reduction in reduce Staphylococcus aureus Bacteraemias (SABs) as we have never managed to achieve this. Stephen Mather queried whether or not we would hit our target if we take out the community acquired SABs. Sam confirmed that there were issues related to SABs that were the same across the country and considered to be out with our control. The most concerning areas were high risk interventions around PVCs and CAUTI. In the 2 cases that were related to PVCs, in both cases the documentation was completed.

ACTION: Sam to look into community acquired SABs and provide the Committee with an update.

David Davidson asked whether the Discovery system would be useful and Sam commented that he wasn't aware what information was available but has requested access to the system. He noted that it was unlikely to add much due to the time lag related to ISD cleared data.

Sam asked if the new format of the report was helpful for the future. The Committee agreed that the format was helpful as problems were easily identified.

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

5.2 Hospital Standard Mortality Rate (HSMR) Update

Dr David Love provided an update on progress regarding HSMR. David informed the Committee that if palliative care patients were removed from the statistics, this would

decrease our HSMR from 0.92 to 0.78. David provided an update on the structured judgement mortality reviews that are currently ongoing. The objective was to carry out reviews on all deaths during the month of April, of which there were 48 to inform the broader picture of HSMR. So far 31 have been completed and the remainder will be concluded in advance of the meeting with HIS on the 23rd August. David reported that there is national work around M&Ms to improve standardisation ongoing, in which NHS Borders is engaged. We now have a list of M&M leads in each department. The plan is to bring the leads together to look at the guidelines that will be published from the Scottish M&M group and consider how we can adapt these locally. Peter Lerpiniere added that he and David would be discussing how this can be linked with other parts of NHS Borders, including ensuring the LD and MH patient deaths have been followed up.

There is work in progress to combine M&M outcomes, SAERs, complaints feedback and safety monitoring to maximise potential learning opportunities.

Jane Davidson asked whether removing our specialist palliative care patients was a valid extraction and whether this was unusual. David confirmed that many of our palliative care patients are on site and included in the hospital numbers, which includes patients that have palliative care input, not just those patients in MKU. NHS Borders is unusual in this respect. Dr Cliff Sharp added that approximately 60% of people in the Borders die in the BGH, which is an increase and asked if this is something the Committee needs to consider. Jane added that palliative care patients must die in other hospitals and asked that this be looked at in advance of the HIS visit in August. The Chair confirmed that this would be brought back to the September meeting as a specific item.

ACTION: HSMR to be brought back to the next meeting (September).

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

5.3 Adverse Event Overview and Thematic Reports

Ros Gray apologised for the incorrect paper being circulated at the last meeting and noted that Caroline Wylie, Clinical Risk Facilitator was currently on leave but would present the Adverse Events paper in the future. Ros informed the Committee that the format of the paper is a work in progress and is happy to take comments or suggestions for improvement.

Ros reminded the Committee of the definitions of each of the incident categories and noted that the data has been streamlined and only the last quarter has been included. In the future Ros will ensure the mean is removed and more data is provided.

The Committee noted that the Health & Safety Executive is specifically interested in falls after an incident at NHS Grampian who have been issued with an enforcement notice. We may be able to learn from their experiences for the benefit of our patients.

Ros added that there is a 12 week timeframe for investigations to be concluded, however a quantity are currently out with this timeframe. Ros confirmed that all but one of the reviews outstanding was awaiting final approval from an Executive Director. Ros assured the

Committee that we do have a robust process for Adverse Event management, which is being followed.

Alison Wilson suggested it would be helpful to have two years of data included in the report. It was also noted that the 2 incidents involving a fall that resulted in a patient death had different outcomes, one noted as major and one extreme. Ros explained that the decision regarding the outcome category rests with the Senior Manager. Nicky Berry added that work was underway in Ward 12 to look at correlations between falls and the time of day they occur. Sheila MacDougall added that the Risk, Health and Safety team can help with providing detail around falls and liaise with Peter Lerpiniere to look further at falls that occurred within Mental Health. The Committee noted that the situation within the Community had improved. David Davidson suggested information around where each fall has taken place over the last few years is looked at to see if anything can be learned in designing areas in the future. Janet Bennison informed the Committee that there is a project underway within MAU looking at this. A 'measles map' of the ward is displayed on the wall and a point is added to the map to highlight where a patient has had a fall. This will inform the future design of ward areas, including bathrooms/shower rooms and toilets. Janet added that we should not try to resolve falls to zero and that there is a level of falls that should be expected in order to rehabilitate people. Nicky added that there is a lot of improvement work ongoing in DME at the moment, including an Excellence in Care nurse looking specifically at falls. The aim is to decrease falls with harm, which is currently looked at with the assistance of the Clinical Governance Team. David Love queried whether we should be looking at falls data alongside data on patient rehabilitation to put falls into context.

ACTION: Ros to ensure two years of data be included and the mean removed from the adverse events report.

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

6. PERSON CENTRED

6.1 Scottish Public Service Ombudsman (SPSO) Update

Ros Gray informed the Committee that only 3 cases were outlined in the SPSO paper, including one very complex case that involved multiple teams and complaints. A thorough complaints investigation was undertaken, however no SAER was required. There is no update from the SPSO on this case yet. The other 2 cases are included on the Adverse Events tracker and no outcome from the SPSO has been received for these. Ros confirmed that Datix numbers will be added to cases in future papers. Ros also added that a tracking system is being developed to extract learning from these cases.

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

7. EFFECTIVENESS

7.1 Clinical Board Update (BGH, Primary & Community Services)

Nicky Berry informed the Committee that the paper is a work in progress and elements of the paper have been discussed with the Chair prior to the meeting. The paper includes a summary of the recent OPAH inspection around Food, Fluid and Nutrition. An action plan has been developed and the report from HIS is expected next week for factual accuracy. Nicky noted that the main areas for concern included MUST documentation and the lack of strategic oversight. It was noted that the cardiac arrest data would no longer be routinely reported as a sustained improvement over time had been demonstrated. It was suggested that good news stories should also be shared.

Nicky added that we have identified a small number of areas that require to be looked at. These include delayed discharges, patients in surge beds and that her General Manager colleagues must be included in this. As Erica Reid is now the Lead Nurse for Community, Erica will prepare a report.

David Davidson queried why there were a number of actions around complaints, adverse events and risks overdue. Nicky noted that the actions showed an improving picture but there are further improvements to be made. Sheila MacDougall noted that the amount of managerial time required for these systems cannot be under estimated and that the Risk, Health and Safety team are providing support. Nicky noted that improvements should be seen by the end of this financial year. The Chair added that it would be useful if a cover paper could be included in the future highlighting the top themes of what is good, what is bad and success stories, similar to that in the performance reports for Strategy & Performance Committee.. Jane Davidson queried whether the statement around delayed discharges having increased since the 72 hour standard was introduced is factual; Nicky confirmed that the data would appear to support this statement.

ACTION: Nicky to develop a cover paper detailing top themes and success stories to be included with the next update

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

7.2 Clinical Board Update (Mental Health)

Peter Lerpiniere informed the Committee of the investigation at Melburn Lodge following the death of a patient who had a pressure ulcer. As the pressure ulcer was highlighted on the death certificate the Procurator Fiscal will take an interest.

He also highlighted the change in the way suicide investigations are reported to HIS. They no longer have the capacity to review investigations and will only disseminate the learning points submitted by Boards. To ensure we continue with robust scrutiny the MH service is engaging with Dumfries and Galloway to deliver a collaborative system of suicide reviews and consider implications for practice.

Peter noted that while the Dementia diagnosis HEAT target remains unmet, work continues with GP colleagues to ensure dementia diagnoses are entered on to the Dementia register.

David Davidson queried whether the issues around SAER learning and the difference between systems and review criteria for Health and Social Work is an issue for the IJB. Peter explained that this relates only to ensuring that significant adverse event reviews involve a clinician who is familiar with suicides due to the sensitivity of the area.

The Psychological Therapies HEAT target also remains unmet, and Peter advised of some work being undertaken by the new Head of Psychological Therapies to address this.

Alison Wilson asked whether anything can be learned and shared with other areas from the Clinical Productivity exercise within Mental Health. Peter agreed to take this back to the teams within and ask for details which can be shared.

ACTION: Peter to discuss lessons learned from the Clinical Productivity exercise within Mental Health.

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

7.3 Clinical Board Update (Learning Disabilities (LD) Services)

Peter noted that there was no Clinical Governance meeting within the LD service held last month. Learning Disabilities is a fully integrated service that works effectively, however they are mindful that they are missing their review target. The committee asked if there are concerns that they should be aware of and Peter commented that our situation is not out with the norm.

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

8 ASSURANCE

8.1 Child Protection Annual Update

Dawn Moss presented the Child Protection Annual Update to the Committee. The paper was written by the Child Protection Committee and includes key highlights around the inspection that took place last year. From an NHS Borders perspective, we have completed the actions or on track to complete. Dawn noted that there has been a significant increase in Child Protection referrals. However, upon looking at the trend with colleagues it appears this is national. The reason for this is an increased awareness of Public Protection and the Child Protection agenda is much wider than it was 5 years ago.

Dawn highlighted that the main priorities:

- Develop an action plan on child sexual exploitation
- Involvement of young people in self evaluations
- Increase awareness of the Committee
- Improve risk assessments
- Monitoring and supporting staff

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

8.2 Children & Young People's Health Strategy Improvement Framework Update

The current strategy runs to 2018 and the improvement framework covers 2016/17. There has been intensive improvement work, which highlights the progress that has been made. Children in the Scottish Borders generally are in good health but there are inequalities and the Health Improvement Team is working with partners to address these. David Davidson asked if there was adequate input from Live Borders to assist with tackling obesity in young people, which is a major issue for the Borders. Allyson stated that we are working in partnership with Education and the active schools programme and also undertaking work on pathways within NHS Borders. The plan for 2017/18 is to scope out issues relating to child healthy weight and raise awareness with partners, developing strong pathways to support. Dawn Moss added that there was increased contact with Health Visitors who can highlight concerns at an early stage. Sheila MacDougall queried how the Child Health Strategy identifies and manages risk and asked how NHS Borders will be aware of any strategic risk. Risk assessments are held within services and reported to Service Leads, it is not for the strategy to hold this detail but to provide a snapshot. Risks should also be included on the risk register.

Cliff added that we need to consider how we bring NHS children's services closer together so that life changing conditions, such as a learning disability are picked up at an early stage. Allyson indicated that this is challenging where there are differences in professional understandings and practice.

David Davidson asked if we should be provided with an annual report on Children's Services, covering highlights and risks. It was agreed that this should go to the Executive Management Team and then to the Community Planning Partnership as governance is through the Children and young People's Leadership Group. Jane & Allyson will ensure this is on the Executive Management Team agenda and will come back to this Committee to provide a verbal update.

ACTION: Jane and Allyson to request the Children & Young People's Health Strategy Improvement Framework be added to the Executive Management Team agenda.

ACTION: Allyson to come back to the next meeting (September) to provide a verbal update.

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

8.3 End of Life Care

Dr Annabel Howell updated the Committee on recent developments within the Palliative Care service, including the appointment of a Nurse Consultant for Palliative Care.

The end of life care facilitator and the specialist team have done

- the use of the end of life care documentation (CREOL)
- spreading CREOL within BGH, Community Hospitals and plans to extend more widely with all areas and Care Homes.

- developed an outline for a piece of work for care home beds for those who need care, but do not require specialist palliative care or hospital care.
- working with Practice Education Facilitators through NES and with PATCH and St Columbus.

Outcome measures are becoming essential in all areas and have been developed within Palliative Care (OACC via the Cicely Saunders Institute) and software and staffing are beginning to be in place to help support the recording of these outcomes. . Palliative care are contributing to the new unitary patient record and a member of the Palliative Care team now attends the 8am daily handover to help identify Palliative Care patients at an earlier stage and to encourage the idea of realistic medicine.

David Davidson queried whether the contract for the End of Life Care Facilitator would be extended as this was due to come to an end. Annabel confirmed that it potentially could be extended as Macmillan funded a full time post and the current post holder has only been working part time, so the current incumbent may be able to remain in post until May 2018 within the current budget allocation. David asked about rolling out Palliative Care at home and Annabel informed the Committee that she and the Nurse Consultant are visiting Strathcarron Hospice shortly where they have a hospice at home service - a more cost effective model that we are keen to adopt. With this there may be an opportunity to explore different funding models for specialist palliative care in the community.

The Chair asked where the role of Medical Education and Realistic Medicine comes in. Annabel explained that part of the role of attending the 8am handover is to query current management of patients and investigations to ensure they are in the best interests of the patient rather than just because we can perform them. We (clinical leaders, the Board and governance committee) need to support clinical colleagues towards a realistic medicine approach and away from “defensive medicine” i.e. doing tests to avoid litigation.

The Committee discussed having honest conversations with the public regarding our health service costs and ensuring the public are aware of the challenges we face on a daily basis. Cliff pointed out that materials and resources highlighting the questions that patients should be asking at appointments are available. The Chair asked if Pharmacy would be able to provide details on costs of medications being offered after an experience elsewhere of a GP practice inadvertently informing patients of costs of drugs resulting in rationalisation of medications. Alison advised areas already receive their ‘top spends’ from the Pharmacy department and as some costs are on a contract these would be confidential but we could look at other ways to share this information. Jane Davidson asked if it would be possible to test this approach with a GP Practice to explore the true benefits to patients.

ACTION: Alison to explore ways of sharing drug costs and look to test with one GP Practice

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

8.4 Staffing Levels

Nicky Berry explained that she had been tasked with looking into staffing levels after a concern was raised in DME during the night. It was also highlighted that current staffing levels were not allowing nursing staff to attend ward rounds. Nicky explained to the Committee that there are national challenges around the recruitment of registered nurses. These challenges are addressed on a daily basis which include being proactive, looking at current skill mix and up-skilling staff. The Nurse Bank still have a number of registered nurses and there have been changes to the way of working on the Nurse Bank to try to encourage more people to join. Nicky noted that we lose on average 2.6 registered nurses per month. Dr Cliff Sharp added that this is a national issue that we have foreseen. David Davidson asked if there was any update to item 5 on the action plan detailed in appendix 54a. Nicky confirmed that she would check with Erica and feed back to the Committee.

ACTION: Nicky to seek an update to item 5 on the action plan

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

9 QUALITY IMPROVEMENT

9.1 Quality Improvement Approach

Ros explained that this paper was based on her assessment since she has been in post and acknowledged that current systems have established great foundations. There is an opportunity for next steps, to bring together improvement thinking and identify a broader vision to become a learning organisation. The paper details broad outcomes and aims, including 'how much, by when'. The paper focused on 4 key areas, which now include Food, Fluid and Nutrition after our recent inspection. A coordinated approach to improvement, taking small improvements to scale and achieving 'Joy at Work' are included in the paper. DME have been the first area to come on board, with Ward 4 and Ward 9 showing a desire to be involved.

Ros highlighted to the Committee that a number of people who would be involved in supporting quality improvement at ward level are also currently involved in the audit activity and there are no staff available to help support the teams. A different approach to auditing is currently being tested. This approach involves the Senior Charge Nurses leading a 'person centred coaching tool' where the SCN works with the nurse looking after the patient to review documentation while using the opportunity to provide coaching. Admin support would be required for the SCNs to allow them to undertake this activity.

David Davidson thanked Ros and received the paper very well. Ros explained that in one Board where they managed to eliminate falls in a high risk DME environment, the SCNs had 30 hours per week dedicated admin support and we are currently exploring this. It was noted that our current admin support is generally a Healthcare Support Worker who gets pulled back in to the numbers to support vacancies. David Davidson asked where the budget sits for this and Ros explained that if SCNs are able to coach and mentor staff, this may have an effect on 1:1 nursing requirements and other associated costs. There is also some funding

allocated for admin support. Ros added that each area will have a measurement plan, including outcome and balancing measures, which would highlight this.

Claire Pearce added her support to this approach and her surprise that the SCNs do not currently audit their own notes. The tool that is being developed will take no longer than 10/15 minutes coaching opportunity per patient and Claire would challenge any SCN who could not find the time to do this. Claire added that she was looking at bringing back the supervisory model, which had previously been used in the BGH, but is very supportive of this approach. Dr Cliff Sharp commented that we expect a lot from our SCNs so we need to be realistic about what we are asking of them. SCNs require support, leadership, structure and guidance, Nicky and the Clinical Nurse Managers can help to provide focus. Jane Davidson added that she welcomed the paper and especially the detail around falls and the ambition for 100% of patients and families to be engaged effectively. She added that it was good to see progress and there are many points in the paper that she would support. Jane felt it would be worthwhile taking the time to work as a unit to agree on the simplest way to facilitate this approach. A discussion with key people on how this can flourish is required and a verbal report will be provided at the next meeting.

ACTION: Ros to provide a verbal update on progress at the next meeting (September).

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

10 ITEMS FOR NOTING

10.1 Minutes

The following minutes for:

- Child Protection Committee Minutes
- BGH Clinical Governance
- Primary and Community Services Clinical Governance
- Learning Disabilities Clinical Governance

10.2 Papers

- Organ Donation Summary Paper
- Mental Health Adverse Event Newsletter

In relation to the Organ Donation Summary paper, Dr Cliff Sharp added that we could do better on organ donation.

Ros Gray pointed out that the Adverse Events newsletter was added at the request of the Committee.

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

11 ANY OTHER BUSINESS

David Davidson queried the role of the Clinical Executive Operational Group and the Joint Executive Team. It was explained that the role of the Clinical Executive Operational Group is to discuss performance management and the Joint Executive Team is effectively a team meeting. The Chair asked if it would be useful for their minutes to be noted by the Committee; however Dr Cliff Sharp felt that more information without any context might not be useful. It was agreed that the minutes would be included for noting at the next meeting and this would be discussed at BET.

ACTION: Amie to include the Clinical Executive Operational Group and Joint Executive Team minutes for noting on the next agenda

12 DATE AND TIME OF NEXT MEETING

The next Clinical Governance Meeting will be held on the 13th September at 2pm in the BGH Committee Room.

The meeting concluded at 16.50