APPROVED

Minutes of a meeting of the **Clinical Governance Committee** held on 13th September 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	Christine Proudfoot
	Dr Allyson McCollam	Fiona Doig
	Mrs Victoria Dobie	Irene Bonnar

1. APOLOGIES AND ANNOUNCEMENTS

The Chair noted apologies had been received from Jane Davidson, Simon Burt, Ros Gray, Dr Janet Bennison, Sheila MacDougall and Dr Tim Patterson. The Chair confirmed the meeting was quorate.

The Chair welcomed Dr Keith Allan who was in attendance on behalf of Dr Tim Patterson and Malcolm Dickson, a newly appointed Non-Executive Director and member of the Clinical Governance Committee. 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 19th July 2017 were approved as a true record.

4. MATTERS ARISING

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

7.2 Clinical Board Update (Mental Health)

Peter Lerpinere informed the Committee that an action plan has been developed on the back of the recent Older People in Acute Hospital (OPAH) inspection which includes actions

around dementia heat standards and diagnosis. Peter added that the report has not yet been published but we have had sight of the draft. Plans are in place to address the areas where we need to improve and the action plan should be formalised by the end of September 2017. Peter highlighted positive areas of good practice to the Committee which included a recently implemented safety huddle in Mental Health, modelled on BGH safety brief. Peter also noted that he has nominated one of the Operational Managers within Mental Health for a leadership award. Stephen Mather asked for assurance around the Psychological Therapies HEAT target and Peter stated that efficiency work around appointments is currently underway which should address the issue. Stephen also noted that the CAMHS is performing well and wished to pass on his congratulations to those involved.

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

7.3 Clinical Board Update (Learning Disabilities Services)

Peter highlighted an accessibility issue when dealing with incidents that have taken place in the BGH and recorded in Datix. These incidents are flagged to BGH managers; however Peter has dealt with these issues. Peter informed the Committee that Streets Ahead is a commissioned service that provides carer support to people who have Mental Health problems or a Learning Disability. Peter explained that Streets Ahead were seen as providing a weak service so some focussed improvement work and staffing resource has been provided to support the service. Peter offered to provide an update on this at a future meeting.

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

8.2 Adult Protection Annual Update

There were no questions from the Committee on the Adult Protection Annual Report.

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

5.1 Infection Control

Sam Whiting informed the Committee that in June the Infection Control team moved from a paper based system to an electronic system that provides an automatic flagging function for historic MRSA positive patients which enables the team to be more proactive around managing these patients. Sam now has access to data on Discovery and when he looked back over last 4 quarters it shows that NHS Borders has the lowest healthcare acquired SAB rate across Scotland. For community acquired SABs, numbers are small but fluctuate. In the first 6 months we had the highest rate of community SABs, however in the last 6 months we have had the lowest in mainland Scotland. Sam also wished to highlight the cleanliness standard to the Committee with recent data showing the BGH as having the 2nd highest cleanliness score within comparable Boards. David Davidson felt that praise should be given to staff to recognise the work that has been done. David also asked whether the statistics showing the community as high for the first 6 months warrants some investigation around why this is and whether there are any lessons that could be learned from this. Sam replied that as the numbers are so small it is seen as a coincidence therefore there is no obvious area to

tackle. Stephen Mather queried whether there was a needle exchange in the Borders, Sam confirmed that there was and that some positive work has been undertaken in Dumfries and Galloway to actively promote needle free initiatives. Sam has acquired some information from them to see if we can try and support this in the Borders. Keith Allan added that he assumed that this was also being looked at within the remit of Public Health.

Hand hygiene was discussed and why it would appear that doctors have poorer compliance than nurses. Cliff Sharp felt that this had improved with regularly reminding doctors of the importance of hand hygiene. Alison Wilson queried the dates for the Infection Control compliance monitoring, Sam explained that the team are now working differently but have plans to address this to get back on track. David Davidson asked whether we receive any statistics on the number of patients using needle exchange programmes. Alison added that there is a system in place that records numbers only. Alison noted that we have needle exchanges in 6 pharmacies within the Borders. It was agreed that some liaison with Public Health around opportunities for education, including when drug users come into contact with Police could be explored. Keith Allan offered to take this suggestion back to the Strategic Lead for the Alcohol and Drug Partnership.

5.2 Hospital Standard Mortality Rate (HSMR) Update

David Love updated the Committee on the Healthcare Improvement Scotland (HIS) visit that took place on the 23rd August 2017 to look at our HSMR and what may be behind current performance. NHS Borders has been asked to provide HIS with a specific improvement plan including details of improvements, timescales and persons responsible by the end of this month. David added that he felt there would be a big focus on deteriorating patients and the infrastructure required. HIS also felt that our coding would benefit with more scrutiny and a team from Information Statistics Division (ISD) will work with us on this. It was also highlighted to HIS that palliative care is different in the Borders in that we admit patients to die in the Margaret Kerr Unit. HIS are unwilling to remove these patients from the system but they have agreed to continue to provide us with a private split (non palliative care HSMR) and this may help us to get a better idea of the direction. Cliff Sharp added that it should encourage us to improve palliative care in the community and manage death outside of the hospital. Cliff queried whether it would be possible to have a footnote included on our reports instead of removing them. David explained to the Committee that our data is artificially lifted as we have 25% of our deaths in palliative care and they will always increase our HSMR rate. This artificially inflates our death rates and when these are removed Borders are the 2nd lowest across Scotland. Stephen Mather felt it was important that Scottish Government and the public are clear on the reasons behind our HSMR figures. David Davidson asked whether our Communications department should be more proactive around messages relating to HSMR but David Love felt it was important that we continue to work with HIS and not take our own private actions that may upset them. Any negative press can be dealt with when it arises. David Love added that a meeting to discuss who should take this forward and agree what we will continue to measure to demonstrate our improvement is required. Stephen Mather commented that we cannot ignore the harm but we need to know what the harm is and the capacity needs to come from reducing other measures.

Nicky Berry informed the Committee that testing of a new Person Centred Coaching Tool has been introduced and rolled out to other wards within the BGH. This is used by Senior Charge

Nurses (SCNs) and nurses as an education tool when reviewing documentation. Nicky asked the Committee if they would support a proposal that for the month of September we cease the OPAH audit and use the resource more effectively to address the basics. Claire Pearce agreed with Nicky and added that we need to target our energy into tasks that are meaningful but we would not stop auditing. Christine Proudfoot agreed and commented that this would free up resource within the Clinical Governance & Quality team to support other areas. It was agreed that we need to stop measuring everything and improving knowledge, morale and skills is a better use of resource. Stephen said it was not the Committee's role to tell Nicky what to do but the Committee accepted her comments and would support whatever is considered to be most appropriate. Claire explained that there are many areas to improve on and it will be 6-12 months before we start to see change. Cliff added that there is an action plan detailing crucial workstreams and the 5 things we must concentrate on. David Davidson asked for regular feedback on each of the 5 sections. It was noted that Cliff and Claire will be taking a paper to BET detailing this approach on Tuesday 19th September.

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

9.1 Quality Improvement

Christine Proudfoot noted that the previous discussion covered much of the Quality Improvement update. Christine added that so much data was being collected that when we looked at the quality it was giving us inaccurate information and this is the reason for looking at other opportunities. The amount of work that went into preparing for the HIS visit was also noted by the Committee.

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

5.3 Adverse Event Overview and Thematic Reports

Christine Proudfoot presented the Adverse Event paper and informed the Committee that this does not paint a positive picture. Numbers are similar from 2016-17 to previous year however there has been an increase in category 3, severe adverse events. Christine added that there is a limited bank of lead reviewers and those that do undertake this role do so in addition to their own workloads. Ownership of events is currently being looked into to guarantee assurance around actions and recommendations. Cliff Sharp added that sight and scrutiny of these, must be core business. Claire agreed that someone must have an oversight for the Board, particularly around learning and themes. David Davidson queried the potential duplication in reporting of pressure damage detailed in the report and Christine clarified that this means patients that move between areas get reported twice. Christine also added that more assurance to try and explain the increase in the total number of developed pressure damage incidents is required. Claire explained that NHS Borders did have a tissue viability nurse but the post did not continue. Staff need to be given education to be able to spot and treat pressure damage. If a tissue viability nurse were to be appointed they would also provide support to nursing homes. Nicky informed the group that concerns she had over a patient that was admitted with a grade 4 pressure ulcer required escalation to the Community Nurse Manager and as a result, District Nurses are now coming in to provide support. It was noted that we haven't had a great process around reporting of pressure ulcers but having a lead for tissue viability and champions within the wards would help to address this. Stephen

noted that pressure damage has increased by 50% and this showed that the decision to remove the tissue viability nurse post does not seem to have worked. Alison Wilson pointed out that this was not a nurse post but a facilitator role. Claire noted that Erica Reid is now leading on tissue viability within NHS Borders and conversations are taking place with NHS Lothian around potentially funding some support. The Chief Executive is happy to go ahead and hopefully someone will be in post within 3 months with Lothian providing support in the meantime.

Stephen asked for more detail in the next paper on the 'progress on work' column in the adverse events table as this currently doesn't tell us much. Discussion took place around the 12 week process for SAERs and the concerns around the number of adverse events and deadline breaches. Christine Proudfoot informed the Committee that a paper is currently being prepared highlighting areas for improvement. Stephen felt that the Executive team must take note of our concerns and asked that this paper go to BET. Nicky noted issues within Maternity around sourcing external reviewers and that every board is experiencing difficulties with this. There are very few people in the organisation with the knowledge and skill set to undertake this resource intensive role. A verbal update has been requested for the next meeting. Alison Wilson noted a typo – 2015/16 should be changed.

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

6.1 Scottish Public Service Ombudsman (SPSO) Update

Christine Proudfoot provided a summary of the report and asked for any comments or questions. Stephen Mather noted that it would be helpful to have more detail around the seriousness of the complaints. Malcolm Dickson agreed and asked if we know if any of these complaints were investigated internally first. Christine explained that all Ombudsman cases have already gone through our complaints process first. Cliff provided some background on the first case and confirmed a chaperone policy will be created on the back of the recommendation and noted that this was not a matter of patient safety or serious concern to us.

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

8.3 Medical Appraisal Annual Update

Mrs Victoria Dobie presented the paper and noted that of the 281 doctors eligible for appraisal in the previous year, 271 doctors had been appraised. Those that had missed the deadline have been asked to set a date within 3 months by the end of the year. Mrs Dobie explained that there is an increasing demand as the number of locum doctors and juniors in locum posts are increasing. Cliff noted the excellent work undertaken by Mrs Dobie and added that we need to encourage people to undertake appraiser training as there is not an even contribution throughout the organisation. Cliff is trying to address these anomalies by looking at capacity with job planning or whether funding would be required as it is in primary care. Malcolm asked what happened to appraisals after they had been completed and Mrs Dobie confirmed that these are stored on a secure site and outcomes available to the Lead Appraiser, Responsible Officer and for doctor's revalidation.

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

8.4 Health Promoting Health Service Programme Update

Dr Allyson McCollam and Fiona Doig attended the Committee to inform of progress in NHS Borders and highlight challenges. The Public Health team facilitate the process of completing the annual report but rely on Clinical Boards to contribute to the content. The current priorities are to reinforce accountability and responsibility and increase emphasis on inequalities and poor health outcomes. Allyson noted that the Lifestyle Advisor service sees less than 10% referrals from BGH which highlights this as an area where further progress could be made. The team are looking into how we can support mental health service users as this has been a difficult area to make progress on and there may be a request by Scottish Government for NHS Borders to look further into this critical area. Allyson added that she was looking for the support of the Clinical Governance Committee and ideas on how we can embed this further. David Davidson noted that he thought this was excellent report and asked Allyson how negotiations with Live Borders were progressing and if there was any opportunity to expand this relationship. Allyson said that the relationship with Live Borders was improving and Fiona Doig added that they have bought into an initiative to support a decrease in Type 2 Diabetes and are looking at new ways of working and partnerships.

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

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

There was an action from last meeting to take a discussion to Executive Management Team. Allyson confirmed that this update was taken to the group but unfortunately there was no opportunity to discuss, however it is part of a continuing discussion with the Integrated Joint Board.

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

8.6 Occupational Health Annual Update

Irene Bonnar presented the update which details the service activity. Irene noted that there are still ongoing issues with non-attendance at appointments, training and pre-screening. David Davidson asked how we get people to attend. Irene commented that there are variable reasons including staff being released and people not communicating that they are unable to attend. It was noted that we have a duty to look after our staff and there should be no circumstances where staff cannot be released. Nicky added that she has never cancelled any training this year. Issues around why people are not attending are being dealt with and Nicky is not accepting 'couldn't be released' as a reason for non attendance. Claire Pearce is now sending letters to those who do not turn up to training to ascertain why. Stephen Mather queried the needle stick injury data as there was a suggestion in the Public Health report that there had been a 33% fall in needle sticks. Irene highlighted the implementation of safer devices and that these are used but not always correctly. There is some poor practice and work to do but progress has been made. Irene confirmed that the Occupational Health team are removing old equipment when they come across it during training and risk assessing non

safe equipment still in use while continuing to look for safer options. Cliff advised that we discourage staff from using devices that make their way into organisation through reps. Irene also highlighted that the approach to moving and handling training had changed to train people on site. There have been some slight teething problems but this has made a difference.

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

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

Nicky informed the Committee that there have been two inherited and two developed pressure ulcers. Study days on compression and tissue viability have taken place and further study days are planned for champions, not link nurses as they were known as previously. Nicky also noted that sickness absence is currently above the national average of 4.76 but work is taking place to try to address this. The use of agency Healthcare Support Workers (HCSWs) has ceased to the point it was a regular occurrence, work is also underway to reduce the usage of agency registered nurses. It was noted that 60 HCSWs have joined the nurse bank. David Davidson asked Nicky why we are behind on the sickness absence target. Nicky stated that she is working with the Clinical Nurse Mangers, SCNs and General Managers to look at rosters and be more proactive when vacancies arise. Nicky also highlighted that all agency requests now come to her for approval but she noted that we still have a challenge around registered nurses. Stephen Mather asked how we can be sure our staff are taking notice of what has been learned on study days, Nicky said that we now have clear descriptions for the champion roles which states you must be passionate around the topic and staff are being asked why they want to undertake this role. Nicky also highlighted to the Committee that every Wednesday along with the Clinical Nurse Managers she is on the wards providing support to staff. It was noted that some leadership had been taken away from the SCNs and there is a need to reinvigorate the responsibility in their roles. Nicky was asked if it was possible to use the reduction on agency spends to release people to attend good quality training. Nicky advised that she was working with Janice Cockburn on costs in the first instance.

Stephen noted that 14 of the 25 SAERs are now overdue and queried what actions are being taken to address this. Nicky related back to the previous discussion that took around the Adverse Events paper and said that the paper and discussion at BET is required. Stephen asked if there was anything the Committee could do to assist and Nicky requested that the Committee continue to keep an eye on this and they will look at themes and improvement plans.

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

7.4 Research Governance

Christine Proudfoot presented this report but noted that she did not write it. Alison Wilson added that she chairs the Research Governance Committee so can answer any questions. The main challenge is around the timely approval of studies, which is currently being looked into. Stephen Mather asked if there was a research lead among the Consultants. Alison advised that there are a number of Consultants that sit on the group and attend meetings but

there is no nominated lead. David Love added that historically, the other part of his Clinical Governance and Quality role provided support to Research. It was suggested that having a lead consultant showing enthusiasm around research could increase the amount of studies being undertaken and that this person could have an overall view and provide support to trainees. Alison noted that we have a nurse advocate who supports teams to take on research studies however usually requests for research are driven from out with the organisation, mostly from the Chief Scientist Office. It was noted that participation in research provides the organisation with kudos and that commercial studies can be lucrative. Alison agreed to ask at the next Research Governance Committee if anyone would be interested in being clinical champion for research.

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

8.1 Pharmacy Annual Update

Alison Wilson presented the Pharmacy Annual Update and asked the Committee for feedback on how they would like to see this report evolve in the future. David Davidson queried whether faults in dispensing and medicines handling should be included in this report but Alison advised that there are 2 separate reports, one for the Pharmacy department and a separate annual review report which includes Datix incidents and trends. The inclusion of costs in the report was discussed and David Davidson queried whether this information is supplied elsewhere. Alison advised that the Board receives this detail on a regular basis. David Love queried the chart on page 6 relating to drug history showing a drop of 13%. Alison advised that this is picked up by the Clinical Pharmacist but she will follow up on what is happening and the reason for the decrease. Alison also noted that data is now being collected on whether prescriptions are correct on discharge as well as whether they are correct within 24hrs of admission.

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

10 ITEMS FOR NOTING

10.1 Minutes

The following minutes and papers for:

- Adult Protection Committee Minutes
- Public Governance Committee Minutes
- Primary and Community Services Clinical Governance
- Mental Health Clinical Governance Minutes
- Joint Executive Team Minutes
- Regulatory Agency Medical Device Alert (metal on metal hip replacements) letter and NHS Borders response

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

11 ANY OTHER BUSINESS

There was no other business noted.

12 DATE AND TIME OF NEXT MEETING

The next Clinical Governance Meeting will be held on the 29th November at 2pm in the BGH Committee Room.

The meeting concluded at 16.30