APPROVED

Minute of a meeting of the **Clinical Governance Committee** held on Friday 20 March 2020 9am in the New Lecture Theatre, Education Centre, BGH

Present

Dr S Mather, Non Executive Director (Chair)
Mrs F Sandford, Non Executive Director
Mrs A Wilson, Non Executive Director
Mr J McLaren, Non Executive Director
Mrs K Hamilton, Chair NHS Borders

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mr R Roberts, Chief Executive
Dr C Sharp, Medical Director
Mrs L Jones, Head of Clinical Governance & Quality
Dr A Howell, Associate Medical Director, Acute Services
Dr J Bennison, Associate Medical Director, Acute Services
Mrs N Berry, Director of Nursing & Midwifery
Mrs E Reid, Chief Nurse Health & Social Care/Associate Director of Nursing & AHPs
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs S Horan, Associate Director of Nursing/Head of Midwifery
Dr J Aldridge, Consultant Anaesthetics & Intensive Care
Mr S Whiting, Deputy Hospital Manager

1. Announcements & Apologies

The Chair noted that apologies had been received from:

Mrs L Pringle, Risk Manager
Dr T Patterson, Joint Director of Public Health
Mrs D Keddie, Clinical Service Manager Laboratory/Infection Control

2. Declarations of Interest

There were no declarations of interest and the meeting was quorate.

3. Minutes of the Previous Meeting

The minutes of the previous meeting held on the 22 January 2020 were approved.

4. Matters Arising/Action Tracker

There were no matters arising and action tracker updated according.

5. COVID 19 Preparations

Ralph Roberts gave a brief resume of the current situation in NHS Borders. He commented that there was a session held yesterday to give an opportunity across the Clinical Boards to share their progress and identify what still requires to be done. Broadly, good progress has been made on preparedness. NHS Borders Board recognised that how prepared we are will depend on whether the projections will be as expected. NHS Borders are preparing for the worst case scenario and hoping for the best case scenario. There is recognition that this will be a marathon rather than a sprint and our aims and underlying principles are to minimise the impact to the population and maximise the care for the patients whilst also protecting our staff.

Letters of support were sent out following the planning session last night. The letters from Scottish Government, GMC and Nursing & Midwifery Council essentially provide cover to Healthcare staff to allow them to act out with their scope of practice as and when required during this emergency pandemic situation. Each Board will go into more detail about thresholds of treatments as demand increases and support for delivery of care through alternative pathways.

Acute Services

There have been changes made to the physical environment with 3 inpatient areas in readiness with 52 beds for COVID suspected and COVID positive patients. Staffing is available for ¾ of these beds and the rest will be arranged over the coming weekend as required, nursing staff have been identified.

In terms of flow CV1 (MKU) is immediate 8 bed assessment of COVID suspicion or COVID Positive patients. When test results are received and the patient is fit to go home regardless of result they will be discharged home. If not fit to go home the negative patient will be absorbed into the hospital footprint and progress on their normal pathway, if they are positive regardless of specialty they are moved into CV2 (BSU).

In state of readiness ward 17 is being prepared for maternity and paediatric suspected COVID cases. This will be made up of 6 beds for paediatrics and six beds for maternity; there will also be provision for extra adult patients but this will be held as a last line at the moment due to the mix of adult, maternity and paediatric patients.

CV3 (ward 14) is a 30 bed unit for adult patients should this be required.

So far this has been working well but there is an awareness that capacity issues may come. At this point there will be a move to the next stage of the plan. This plan is being prepared; it is expected that BECS will move into the day hospital and an assessment Hub will also be based there. The ED footprint has been increased to involve orthopaedic outpatients dept.

Sarah commented that the staff should be commended on their hard work and dedication in the last seven days to enable these changes to take place.

Discussion with other boards will take place regarding medical and nursing staffing. From the end of next week it is expected that there will be a staffing deployment hub which will be run from the committee room in the BGH. This will be for nursing and medicine initially. If staff is identified as surplus in any area the hub will be notified and staff will be deployed to the areas that need them.

Rota coordinators are working across all areas of the hospital to ensure adequate staffing. They are being asked to roster the minimum staffing in each discipline and surplus staff will be allocated on a daily basis from a pool of staff held by the staffing hub.

Medical staff are all aware now that they may have to work in areas that aren't their normal areas of practice. We have doctors and consultants from other areas coming to shadow consultants next week. Trainee doctors are updating their handbooks which have various guides for ward procedures for those who don't normally work as ward doctors

Evening and over night staffing will be increased including a resident medical consultant over night. Weekend medical staffing will be increased to cover expected number of admissions, presentations to ED and also to cover the additional beds. Initially the acute services are staffed for the next two weeks and issues will be addressed towards the end of these two weeks. The central hub will work the same way for both nursing and medical staff.

Advice has been sought from the Deanery regarding the use of trainee doctors as they will not be moved into their next rotation. The Director of Medical Education and the Deanery are working together to ensure that training is not affected. Medical students have been withdrawn from placement but are being allowed to be here on a voluntary basis. Students have been approached to ask if they are willing to remain in NHS Borders as volunteers. It is expected that they will be deployed as HCSW but will be able to perform the tasks they are trained for. The committee can be assured that Acute Services are as prepared as they can be.

It is important that the message of support regarding clinical staff working out with their normal areas of competence and expertise are disseminated to them so that they are aware that they will be protected. Janet reports that where possible they are trying to keep Medical Staff within or as close to their comfort zone as they can be for now but this may change depending on admissions and capacity. Stephen would like to confirm that as far as trainees are concerned is there a guarantee that their learning is protected. Although face to face teaching has been suspended this situation is being used as an educational opportunity on the job rather than in formal teaching sessions, there is as much of a guarantee as there can be that students will not be disadvantaged by not having done the placements that they would have done. CPD requirements for medical staff from medical college has also been relaxed. Our trainees have been excellent and very supportive of NHS Borders who in turn hope that this situation will be made as educational as possible.

We need to repeat and reinforce directly from NHS Borders the messages from the GMC and NMC with a message from Ralph, Cliff and Nicky saying that this issue has been discussed and supported by NHS Borders Board. Staff also need to be assured that we will ensure that they are working within or as close to their competencies. Inductions will be done in the ward areas by a senior member of staff. The approach will be careful, calibrated and stepped as we go along.

Training programmes are commencing on Monday for registered nurses and health care support workers who are currently not working within ward areas to ensure they are ward ready. Practice facilitators will also be out supporting nurses working out with their scope of practice.

During these unprecedented times, it is absolutely vital that we as a clinical governance committee understand what is going on. It is not our role to interfere with operational matters but to look at quality issues, staff issues and the plans for the next stage.

John enquired as to the AHCPC assurance and support. Nicky confirms that this assurance came directly to her and it has been shared with Sandra Pratt and Erica Reid. This will be circulated to the Committee. This should be included in the communiqué to staff so that there is no confusion.

ITU – Jonathon Aldridge

NHS Borders have been asked to increase ITU capacity. At present NHS Borders are equipped for 5 ITU beds but this could be increased to ten. Work is ongoing to look towards and increase to 18 if all equipment available is utilised. Scottish Government and Scottish Critical Care group are doing their best to access as many pieces of equipment including asking the vets to try and supplement ventilator capacity for Scotland. It is recognised that oxygen may also be an issue and manual ventilation may be required if mechanical ventilator capacity is used up. If capacity becomes an issue then there is a possibility that patients could be moved out with area. The Boards have been asked to work together in different locality teams; plans are being put together for extraction teams to move patients to and from Lothian depending on demand on bed spaces. Guidance is expected on triage of patients should Scotland run out of intensive care beds. This will include making some very difficult decisions and raising threshold criteria on suitability for intensive care intervention. Jonathan informed the Committee that this scenario has never before been invoked. To give board assurance at present all critical care decisions are and will be made by two critical care consultants. Suggestion of a lay person being included in this team was discussed as was the inclusion of liaison psychiatry similar to the transplant unit in Edinburgh who assist with any difficult decisions including discussions regarding ethics surrounding these decisions. It was agreed that although this would be advantageous it may mean delays in treatment and might not be helpful in making quick decisions.

Clear National guidance to assist with decision making is expected, sensitivity is essential to avoid ambiguous reporting. It is important that staff are protected and support given in any decision making processes. Staffing at the level we provide at present is changing rapidly but the committee can be assured that the level of care will continue.

Cancer patients will be involved in decision making process regarding timing of any surgical interventions and it is anticipated that cardiac arrest response will alter in accordance with guidance to include PPE being worn when attempting resuscitation.

The communication of structures being put in place is key. Communication should be timely and consistent with governmental communications. It is important to convey that we are prepared and that we will be taking into account the lessons learned from the situation in Italy. Cliff will speak to the press today and Jon will give him an ITU briefing for this.

Plans must also be communicated with GPs and Community care teams directly.

There is a concern nationally regarding access to PPE, particularly in primary care and the care sectors. Pressures in the supply systems are being monitored and hot spots are being prioritised. The committee commented that it is important not to forget the 'non-critical areas'.

Testing for health and social care staff will be available. Social distancing should be the same for staff as the general public. This could potentially remove a large percentage of staff from duty which is already causing an issue. A self testing protocol is being explored to help resolve this issue. This appears to be causing an ethical dilemma and a balance will need to be considered carefully. Operational issues will be discussed out with the meeting but committee are assured that these issues are being dealt with and that the safety of staff is paramount whilst maintaining services safely. All staff that fall into the 'high risk' groups are known to the organisation and the staff co-ordinators are taking this into consideration.

It is important to note that we have had this discussion around the principles, politics, science, pragmatism and subtleties of the staff /patient safety balance. The reality is that the tests are not yet 100% accurate and we need to be mindful of the risks that go with that.

In summary: Electives and routine operations are ceasing. Tertiary referral access could be difficult going forward. Sam provided slides to be circulated regarding anticipated stages of preparedness to the Committee. In the later stages, the Committee should be aware that some patients may be placed in non clinical areas to help with the increased capacity with safety being a priority. Palliative care patients will be receiving more home based pathways than normally seen. Discussions are ongoing regarding moving patients on from hospital settings using adults with incapacity practice and discharge policies and the flexibility of these policies. Trauma cases are also being dealt with slightly differently to minimise the need for/frequency of travel to and from hospital.

There was some discussion regarding the Scottish Government being keen not to remove the treatment time guarantee (TTG) the committee concluded that it is vital that patients should not be disadvantaged and removed from waiting lists.

The Committee thanked Jonathan Aldridge for his attendance to give update on the critical care plans.

Jonathan left the meeting.

Primary Care

Work is on going in the community setting with cancellation of any non essential work in day units and treatment rooms. Work continues on identifying these groups of patients. Key focus is on vulnerable people and the older population. Community hospitals and social care teams are working on moving patients on appropriately. Identifying the support needs of the Care homes and the thresholds for admission are being considered; this work with Care Homes is ongoing. A member of Erica's team is sitting on daily care home meetings to understand where the beds and pressures are in order to keep this group of patients out of the hospital for the time being. Locality teams are being established in the five localities looking at optimising care for patients whose care spans both health and social care and ensuring carer resilience. There are a few high risk patients in the community that require a huge amount of senior nursing time with hospital admission not being appropriate for this particular group of patients. A Primary care assessment hub is expected to be up and running from Monday. Erica has met with GP colleagues to discuss key primary care resilience issues. The key concern is the issue of thresholds of care. Organisational clarity is required regarding these thresholds. It is anticipated that palliative care at home and in the care homes will increase and the team are looking at how they will provide this. Jason Leitch is working with Scottish Government on a staged primary care admission criteria.

Assurance is sought from senior managers that they will be supported by their colleagues and the wider organisation.

A communication to staff to summarise NHS Borders Board's support will be sent out. Laura will prepare and the Clinical Directors will sign the communication.

The Committee was assured that everything is being considered and measures were being put in place to maintain resilience in the Community.

Timely communication was identified as being of utmost importance particularly where there are any changes in clinical practice. There is concern in the primary care sector that communication is focussed on acute care. The committee agreed that any communication should be appropriate to all services and to ensure that any hospital based decisions are shared with primary care. Erica and Sandra Pratt are working with Communications Team to assure that this is the case. The primary care services are vital in keeping our population safe and out of hospital.

There have been many positives and examples of collaborative working which have emerged in this current crisis and the staff need to be commended on that.

Erica commented that Community Pharmacy changes have been highlighted in the report. In particular that non patient facing time has been built in to allow staff to be prepared for the day and assist in managing workload.

Mental Health & LD

With advice on social distancing the team are looking to balance the risk to people's mental health and the physical safety of patients and staff and to support colleagues to do what they

can. Patients will receive wellbeing telephone call and workloads are being reprioritised. There is recognition that there will be an impact on staffing due to re-prioritising routine appointments.

Community staff are being prepared to support the ward staff. Each case is risk assessed ensuring that everyone is being supported. Work is ongoing with pharmacies to ensure medication is delivered appropriately. Out patients services have been halted at present to free up Cauldshiels, Lindean patients are in the process of being relocated. Admitting thresholds have been altered accordingly for Huntlyburn and discharges are being expedited appropriately. The most appropriate place for COVID 19 positive patients is being sought. There had been discussion about a centrally located unit for COVID positive patients but Peter advises that this is unlikely to materialise. Telephone triage of referrals is taking place. Peter wants to commend the staff for being so adaptive in their way of working and their willingness to do what they can to support the Acute and Primary Care sectors. However, there is a concern about the impact reduction in staff will have on patient safety.

LD service is particularly concerned about their patient cohort due to the nature of support required and the risks they face partly due to the volume of staff required to support them. Cliff asked if it would be useful for the Committee to see the presentation provided by Amanda Cotton so as to have a better understanding of the issues being faced by the Mental Health LD services and to provide assurance that issues are being addressed. Cliff will send to Diane for dissemination to Committee.

Peter asked that the Committee note that the Mental Health bed footprint has been reduced unlike other areas of Scotland where they are expanding. MH services are working with Police Scotland & Scottish Ambulance Service on their crisis support. Peripheral services are all closed at present and others stripped back to a minimum. LD is working on a resilience plan to maintain core function.

Risks have been identified with the Opiod replacement therapy provision. This is not considered a core pharmacy service but rather an enhanced service and many pharmacies have had to withdraw that service. The patients will still be receiving their daily doses but they may be getting them to take away with them rather than having these daily doses supervised. Pharmacies with safer layout are being approached to help with this service should it be required thus helping mitigate some of the risks involved. There have already been some reports of aggression whilst waiting for replacement therapies, the services are aware and how to avoid this situation is being addressed.

Peter would like to acknowledge that mental health staff had adjusted their working to support the acute teams under very challenging circumstances.

Stephen noted that the Clinical Governance Committee are assured that, despite the increase in workload throughout the organisation, due to the willingness and innovation from our staff across the piece there is a phenomenal amount of work on going to support the organisation in delivering safe and appropriate care. The risks are being identified and mitigated as far as we can and future planning is on going on a daily basis.

The Committee would like to note their appreciation to all the staff, volunteers and general public for their support and commitment to NHS Borders.

Peter reported that, from a public protection perspective, there will be no change in the risk thresholds for adults and children who are considered at risk. There has been some work done on change in procedure particularly around child protection to elevate decisions to an earlier stage in the decision making process rather than waiting for a case conference. Although this is going to be difficult there will be processes put in place to ensure that this is maintained.

Stephen would like to have an update meeting possibly in a fortnight to keep some oversight on the Governance of the crisis. All present agreed but this is most likely to be done at Board level. This will be discussed with the Board and conveyed appropriately.

6. Patient Safety

6.1 Infection Control Update

Sam Whiting gave assurance that ward cleaning and inspections are still taking place whilst ongoing COVID 19 outbreak. Spot check audits will continue and if issues are identified then a more in depth audit will take place.

Infection Control Committee met this week and one topic discussed was pseudomonas aeruginosa and a full external pseudomonas audit report will be brought to Committee in May. Although priority is the COVID 19 outbreak the processes and current systems on reporting pseudomonas infection are being maintained.

The team setting up the COVID wards have been deep cleaning as patients have been moved and wards decanted.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report. The Committee are assured actions are being taken on an ongoing basis to improve situation.

Due to current situation normal business was conducted virtually prior to the meeting. There were no issues or questions put forward and the following papers were noted by the Committee.

6.2 HMSR Report
6.3 Maternity Services Mortality Annual Update
6.4 PMAV Thematic Report

7 Person Centred

7.1 Scottish Public Service Ombudsman (SPSO) update

8 Effectiveness

8.1 HPHS Report (deferred from January 2020)

8.2 Clinical Board Update (Acute Services)
8.3 Clinical Board update (Primary & Community Services)
8.4 Clinical Board update (Learning Disabilities Services)
8.5 Clinical Board Update (Mental Health Services)
8.6 IR(ME)R Inspection
8.7 Baby Friendly Initiative (BFI) Annual update

9 Assurance

9.1 Clinical Governance Committee Draft Annual Report
Self Assessment
Terms of Reference
Clinical Governance Committee Workplan Sign off & Review of 2019/20 plan

10. The following items were presented for noting:

- Learning Disabilities Clinical Governance Minute
- Adult Protection Committee Minute
- Child Protections Committee Minute
- PACS Clinical Governance Minute
- Mental Health Clinical Governance Minute
- Public Governance Committee Minute
- BGH Clinical Governance Minute
- Public Health Governance Minute

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

11. Date and Time of next Meeting

Today's meeting is the last that Stephen Mather will be attending as he is moving on to pastures new. The Committee would like to thank him for all his hard work, commitment and diligence to the Committee over his term in office and wish him well in his new endeavours

The Chair confirmed that the next meeting of the Clinical Governance Committee is on **26 May 2020 at 2.30pm in the BGH Committee Room**

The meeting concluded at 10:55

APPROVED

Minute of a meeting of the **Clinical Governance Committee** held on Tuesday 26 May 2020 at 2.30pm via TEAMS

Present

Dr S Mather, Non Executive Director (Chair)
Mrs F Sandford, Non Executive Director
Mrs A Wilson, Non Executive Director
Mr J McLaren, Non Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Head of Clinical Governance & Quality
Dr C Sharp, Medical Director
Dr A Howell, Associate Medical Director, Acute Services/Clinical Governance & Quality
Dr J Bennison, Associate Medical Director, Acute Services
Ms E Dickson, Clinical Nurse Manager
Dr T Patterson, Joint Director of Public Health
Mr S Whiting, Infection Control Manager
Mrs L Pringle, Risk Manager
Mrs N Berry, Director of Nursing & Midwifery
Mr P Williams, AHP Associate Director
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities

1. Announcements & Apologies

The Chair confirmed that the meeting would be recorded, there were no objections.

The Chair noted that apologies had been received from:
Dr N Lowdon, Associate Medical Director, Primary & Community Services
Mr R Roberts, Chief Executive
Mrs S Horan, Associate Director of Nursing/Head of Midwifery
Ms S Flower, Associate Director of Nursing/Chief Nurse Primary & Community Services

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Previous Meeting

The minutes of the previous meeting held on the 20 March 2020 were approved.

4. Matters Arising/Action Tracker

There were no matters arising and the action tracker was updated accordingly.

The **CLINICAL GOVERNANCE COMMITTEE** noted the Action Tracker.

5. Patient Safety

5.1 COVID 19 Ethical Advice Support Group

In response to COVID 19, following a request from the Scottish Government, NHS Borders was required to set up a Group to provide an ethical advisory role through the Chief Executive to the Board and an advisory and support role to clinical teams on clinical decision making during the pandemic. Ultimately all decision making rests with the Board Executive Team.

The paper highlighted the role and remit of the group and the areas discussed so far. Topics considered have been based on planning for worst case scenario in preparation for peak in demand so we were ahead of any issues that may have been encountered. Fortunately some of the issues the group has provided advice and support for have not been enacted, for example a more stringent criteria around admission to hospital and critical care.

Other issues have been discussed and guidance has been required to be put in place including resuscitation guidance. The paper has been presented to the Committee to provide assurance that systems are being considered and put in place.

Fiona asked how the lay members were recruited and why this decision did not come through the Board. She also enquired as to how the group put rigor to decision making and ensured that there was agility within the group making sure that clinicians felt that the balance was right.

Laura explained that following a call for volunteers members of the public approached NHS Borders and members were identified through this route, one of whom is Dr Ross Cameron who is a retired NHS Borders Medical Director and the other Fiona Munro is part of the independent advocacy services who we draw on from time to time for support in this type of role. Because of the pace needed to pull this group together, in particular with Fiona's role in independent advocacy, both were seen as members who could provide a wider reflection in any discussions. She also explained that normally public member recruitment would not go through the Board.

In terms of agility the group has been meeting twice a week to be as agile as possible, the 'red' status indicates the preparedness of the group to instigate an on call service should that be required in respond to clinical services needs. The meeting will continue to take place to allow timely response to any future ethical issues with the ability to meet more frequently to respond on a real time basis should this need arise.

Alison enquired about the areas that had been considered and if these were actual issues or were they just scenarios that were being tested. Laura commented that the Birth Partner issue was a live issue due to our theatre set up and the inability to isolate maternity patients

from the rest of theatre and the ever changing clinical risks therein. This issue however had been resolved organisationally and therefore there is no longer an ethical issue.

Other issues have been more theoretical as there was an appetite to plan ahead in preparation.

Nicky also commented that the Maternity issue had arisen because of a challenge from human rights lawyers; she noted that this had been a very testing time and the ethical support group provided an invaluable impartial view on the situation.

John asked if there was an intention to provide a regular report on the topics and outcomes. Laura commented that any live issues would be escalated should these have a degree of risk to the Board and an update to the Public Board would be provided. There will be a report later in the year to recapitulate the actions taken both locally and nationally. The Committee were assured and happy with this approach.

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

5.2 COVID 19 Resuscitation Approach

This was a more difficult issue and the ethics group have acted in an advisory role to support all the NHS Borders boards. Presented with differing National positions on the risks involved in performing chest compressions during the pandemic NHS Scotland Boards were left with the difficult position of trying to interpret guidance and decide what is the right thing to do from a risk and benefit perspective. The risks to staff and outcomes associated with delays to resuscitation were explored. NHS Borders' view was that they were in agreement with advice from RCUK that chest compressions were an aerosol generating intervention and we should be protecting our staff accordingly. A risk assessment has been registered as a significant risk on the NHS Borders Risk Register. The four pathways explained in the paper were reviewed and agreed as a proportionate and reasonable response.

Cliff thanked Laura and her colleagues involved in pulling the risk assessment together and acknowledged that this had been a difficult issue country wide as not all Boards in Scotland were following the same advice. He commented that we wanted to include the position of our frontline staff including Anaesthetists and ITU colleagues and their professional bodies.

This subject is under constant review and will be reported regularly should the evidence and risks change. The Committee agreed that this item should be kept as a verbal update on the agenda for the time being.

John commented that that during outbreak we have followed Scottish Government advice and guidance and this is the first piece of guidance we have chosen not to follow. He was alarmed that there are differences in approach to resuscitation advice throughout NHS Scotland and asked if there were any National discussions taking place to address this situation as it is such a challenging issue. Annabel assured John that there had been significant dialogue with the Chief Medical Officer and RCUK.

The police and Scottish Ambulance Service are following RCUK advice and other boards are now coming on board, discussions continue to take place nationally on a regular basis.

Sam informed the committee that the infection control network have been informed that the Scottish Government are in process of drafting a letter giving clear instructions that one single point for advice should be through Health Protection Scotland despite conflicting evidence from the various Royal Colleges, not only on the resuscitation advice but other emerging topics. Cliff and Nicky have had several conversations with the Scottish Government and asked that they do not send out this letter as they felt it would not be helpful. There was general agreement amongst the committee that the guidance we are recommending is the best fit for NHS Borders at this current time.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report with the caveat that if National Guidance changes we will re-evaluate as appropriate.

5.3 Infection Control Update

Sam reported a slight update since the paper had been written. On page two it appears NHS Borders had achieved the HEAT target but he pointed out that the target is calculated on occupied bed days. In context of COVID19 he is not aware what our occupied bed days will look like other than that they will be very different to what they would have been without COVID 19. Until official ISD data is available he cannot be sure that we had achieved the target.

Numerous discussions had taken place over the years relating to the challenge of significant community acquired SAB cases and the fact that, even though there may have been no intervention prior to SAB being detected, we are obliged to record these. From the new financial year there will no longer be a target for these cases, the SAB rate will be purely healthcare related. The target will be an individual Health Board target to reduce the rate by 10%. For April 2020 there were no recorded healthcare associated SABS in NHS Borders.

Nicky commented that she is sure that the Committee understand and appreciate the workload the infection control team do particularly as Sam is the single point of contact for NHS borders relating to PPE and it is a massive undertaking. She would like to thank Sam and his team on behalf of the Committee for their continued support and guidance. Stephen echoed that sentiment; figures are very encouraging and a testimony to the efficiency and diligence of the Infection Control team. Fiona also echoed this sentiment and commented that it is very good that NHS Borders have now achieved a zero return on staff testing positive. She also commented on the clarity and ease of reading of the report.

John enquired if there was an issue in care settings and if there needs to be consideration given to the impact this has on NHS Borders as accountability is now to sit with the Director of Nursing, meaning that they sit under our governance structures. Nicky commented that care home accountability, leadership and guidance sits with her, conversations continue to take place as to where this will sit in the wider governance structure. Operationally the management continues to sit with SB Cares. There is a strategic group which spans health and social care and they are beginning to look at the governance and how this sits with both organisations.

Stephen enquired about compliance audits and their suspension during COVID 19 outbreak; he commented that he would like the committee to continue to be assured that NHS Borders remain vigilant. Sam assured Stephen that the spot checks although briefly paused had recommenced although re-focused on high risk cases. There has been improvement in key issues from previous spot checks which implies that there have been changes in practice, the challenge now is in maintaining that. The infection control nurses visited one area in Mental Health which had highlighted some issues, they helped identify the areas which required improvement, the team supported these areas with education and tools for improvement which has helped achieve further improvement.

Anecdotally on as a result of staff anxiety around COVID it is reported that there had been a positive uptake of training and staff were more responsive to education and input from infection control. Maintaining this will be incumbent on the continued high visibility of the team and support from local clinical teams. Sam is keen to move as quickly to normality and resume the full audits as appropriate.

With support from Lothian, particularly in the community, the audit tool had been condensed and areas targeted using local intelligence. This, coupled with telephone support, had begun to show benefits.

Sam commented that we were not experiencing anything different from other boards across Scotland.

Given the difficulties we have experienced during the COVID 19 outbreak the committee can be assured that infection control issues are being dealt with appropriately in NHS Borders. Cliff commented that infection control had never been as important and whilst we cannot be complacent he is content that the importance of infection control is a top priority to staff.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and although Infection Control remains a challenge the Committee was assured by the content.

HYDROP Report & Action Plan

Sam apologised for the lateness of the report to the Committee. The report was commission by NHS Borders, the inspector visited the site in May 2019, and report was received by NHS Borders in September 2019. Water safety group met in December 2019 where the report was considered. It then came to the Infection Control Committee in March 2020 but it was too late for Clinical Governance Committee in March 2020 which is why we are only seeing the report now.

Water Safety group did not meet in March and this had been rescheduled. Infection Control Committee meetings will now be taking place on a six weekly basis. In response to the HYDROP report a short life working group had been convened and an action plan drawn up. Risk assessment now entered onto the risk register. The Excel spread sheet shows the actions, one tab shows actions still to be completed and the other shows the completed actions.

Nicky acknowledged that reporting through our systems needed to be addressed by Sam and herself.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and action plan and was assured by the content.

Sam Whiting Left meeting

5.4 Quarterly HSMR Report

Annabel highlighted that currently we are no longer outlying. There had been a review of the first 11of 35 COVID related deaths. The review of these had highlighted that the right systems are in place to support and deliver good care and that this is reassuring. She wanted to note that one of the deaths in our intensive care unit was sadly a member of staff and we should be reminded that each one of these deaths is an individual and this had an impact on staff which needs to be carefully observed and monitored.

Fiona asked for clarity on the number of deaths particularly in April compared with the same time in 2018 and asked whether would we have expected to have seen more excess deaths than we have seen. Annabel reported that she is not particularly surprised. Patients had not been presenting with significant illness coupled with a mild winter and quiet flu season. The figures are reflective of the acute and community hospitals not overall deaths in the Borders. Preparations had been on going since February to deal with COVID 19 outbreak and thankfully we were not presented with numbers of expected during outbreak so our occupancy had been down. Laura commented that she echoed Annabel's last point, the graph is a count and it is predicted that our HSMR will go up for this quarter but this is expected to be consistent with the rest of Scotland. Annabel reports that the more consistent approach to anticipatory care at the front door, although difficult, had been essential and will remain so going forward.

The Committee will be interested to see what the figures show in 6 months time. We can be assured that up to CV19 all was well but await results at a later date. AH reports that the more consistent approach to anticipatory care at the front door although difficult is essential.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and was assured by the content.

5.5 CV19 Risk Register & Strategic Risk

Risk Register

Lettie commented that the strategic risk register is normally reported on a 6 monthly basis but due to COVID 19 response and in order to capture the associated risks there had been a new risk register established. Ownership of this sits with BET and Senior managers of Clinical Board and Support services, the register feeds into the pandemic committee weekly.

Fiona referred to the point on staff being unable to socially distance themselves. She commented on the number of non clinical staff still working in the hospital and enquired if working from home had been taken as far as it can. Stephen commented that undoubtedly the nature of working and meetings will change but the systems will have to improve greatly for everyone to be able to work in a more distanced way.

Nicky stated that there was a team reviewing how we can work more safely and how and where we work within the social distancing limitations. Equipment needed to be more readily available and working from home rationalised. Tim commented that this is an important part of recovery. A descriptive study on staff related clusters and the relationship to staff social distancing limitations is taking place this information will feed into the review.

There followed a discussion around guidance from the Harvard Business Review on managing remote working and meetings and how this is being considered by the quadumverate.

Alison commented that social distancing and home working presented difficulties and cited a certain amount of complacency amongst staff that the committee should be aware of. Stephen suggested that Staff Governance should be involved. John commented that he hoped the work taking place should at some point come through the Area Partnership Forum.

Peter Lerpiniere joined the meeting.

Strategic Risk

Lettie reported that following approval of risk management policy aspects of risk governance were delegated across the relevant governance committees of the Board. Strategic clinical risks will be brought to the Board Clinical Governance Committee from a scrutiny and assurance perspective as opposed to all risks being considered through the Board Audit Committee.

There are three strategic risks noted on the report and the committee should be assured that these are being managed and monitored appropriately.

Tim commented that the pandemic strategic risk had been noted as a medium risk but this should be recorded as high.

Since the report was produced the Clinical performance risk had be reclassified as a high risk.

The **CLINICAL GOVERNANCE COMMITTEE** noted the reports and was assured by their content.

6. Person Centred

6.1 Patient Feedback & Scottish Public Service Ombudsman (SPSO) Updates

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

7. Clinical Effectiveness

7.1 Clinical Board Update (Acute Services)

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

7.2 Clinical Board update (Primary & Community Services)

Susannah was out visiting one of the care homes and Nicky noted that the visit had gone well.

Stephen enquired as to what is happening with immunisation programmes as these had been paused due to school closures and if these programmes had been taking place in alternative community settings until the schools re-open. Tim reports that immunisations are continuing but there had been a small dip. Discussion took place on how to get the message out that immunisations are continuing and that this is being addressed with GPS. The school programme however has paused but this will be included in the recovery plan. The Board are awaiting guidance from the Scottish Government on when the school programmes will restart, hopefully by September, this will also include the flu immunisation programme.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and was assured by its content.

7.3 Clinical Board Update (Mental Health & Learning Disability Services)

Fiona commented that the reports were very clear and straightforward.

The **CLINICAL GOVERNANCE COMMITTEE** noted the reports and was assured by its' content.

8. Items for Noting

Following suspension of core business due to COVID 10 outbreak. No items were presented for noting.

9. Any Other Business

Cliff commented that we must remain vigilant as normal services are gradually resumed. The balance of risk in recovering services has to take into account the risk of coming into hospital. The risks versus benefits of being admitted to hospital need to be carefully calculated particularly over the coming months. He wanted to assure the committee as we move cautiously towards resuming services there will be a tiered approach and this conversation will be had with the patients for their consent on any foreseen risks involved in care and treatment. Cliff will keep the committee updated on the progress of this to ensure we are recovering in a safe, cautious and planned way.
Peter mentioned that risks will also arise in Mental Health and Learning Disabilities Services, particularly as these services are very often based entirely around the relationship that you form with this cohort of patients and the ability to engage with people. It is not an easily

identified risk and is a complicated one but the inability to engage and interact in this manner may have an effect on the quality of care being given. Peter stated that his reporting going forward will reflect this.

Annabel also commented that there are problems with communication and interaction whilst wearing face masks and some patients have been cited as preferring using systems like near me as you can see the person you are having interaction with. All agreed that medicine will be delivered in the future will be very different.

Stephen thanked everyone for their attendance and contribution to our first virtual Clinical Governance Committee.

10. Date and Time of next Meeting

The Chair confirmed that the next meeting of the Clinical Governance Committee is Wednesday 29July at 10am via Teams call

The meeting concluded at 16:03