Borders NHS Board

Meeting Date: 3 December 2020

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

CLINICAL GOVERNANCE COMMITTEE MINUTES 29.07.2020

Purpose of Report:

The purpose of this report is to share the approved minutes of the Clinical Governance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Clinical Governance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Compliant.
Consultation	Not Applicable.
Glossary	-

APPROVED

Minute of a meeting of the **Clinical Governance Committee** held on Wednesday 29 July 2020 at 10am via TEAMS

Present

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

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Head of Clinical Governance & Quality
Mr R Roberts, Chief Executive
Dr C Sharp, Medical Director
Dr A Howell, Associate Medical Director, Acute Services/Clinical Governance & Quality
Dr T Patterson, Joint Director of Public Health
Mrs N Berry, Director of Nursing & Midwifery
Ms S Flower, Associate Director of Nursing/Chief Nurse Primary & Community Services
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Dr E James, Consultant Microbiologist (deputising for item 5.1)
Mrs R Pulman, Nurse Consultant, Public Health
Mrs K Guthrie, Clinical Nurse Manager

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:

Mrs L Pringle, Risk Manager
Mr P Williams, AHP Associate Director
Dr J Bennison, Associate Medical Director, Acute Services
Mr S Whiting, Infection Control Manager
Mrs S Horan, Associate Director of Nursing/Head of Midwifery, Acute Services

The meeting was quorate.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Previous Meeting

The minute of the previous meeting held on the 26 May 2020 was 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 Infection Control Report

Nicky commenced the item by reporting that the last positive COVID 19 case in NHS Borders was 8 June, and the last positive member of staff was the week beginning 3 June. Ed and Nicky invited any questions on the report.

Fiona asked if we should be concerned about missing targets for example the CDI and e-coli targets. Ed reported that national targets were met over the last year. CDI targets have changed and there is some work to do on the new targets. He also reports that e-coli targets were new and a group has been set up to look into this.

Fiona commented that HAI during COVID 19 is clearly going to be subject to some scrutiny and it is important this is documented. She asked if there was a plan for seeing what lessons were learned and their outcomes. Nicky commented that Annabel carried out a detailed review on DME patients, Health Protection Scotland have published data on their website, Ed and Sam have reviewed the patients across DME and Community Hospitals this highlighted the difficulty in pinpointing what learning there might be. There was a reduction in outbreaks when the advice was to treat all patients coming in to hospital as possible COVID 19 cases, triggers changed regularly throughout the country so it was difficult to see where there was sustained transmission. Ed reported that there had been changes since clustered outbreaks; focus has changed from testing patients coming in to hospital to also testing inpatients becoming unwell which was a deviation from National guidance.

Fiona reiterated that from a Governance perspective it was important to document and openly discuss the lessons learned at some level whether it be at the Committee or at the Board. Ralph suggested that the lessons learned are clear but evidencing what has changed as a consequence is something that can certainly be done at this Committee.

There was further discussion regarding learning from other Boards on achieving targets consistently but as targets had changed and were new to all Boards this was going to be difficult.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and was assured by actions being taken.

5.2 Care Home Clinical & Care Governance

As report was late it was acknowledged there may have not been time to scrutinise the report properly and questions were invited outside the meeting should they arise.
Sonya stated she was encouraged by team and recognised that this is a very challenging subject and teams had gone about their business without upsetting the care homes involved. She enquired about the areas of recommendation, and asked if they reviews would be done in an integrated way rather than separately. Nicky gave an overview on the visits already completed and commented that there were only a couple more to take place. Work had taken place in conjunction with Health & Social Care Partnership and a Care Home Managers Group was set up to meet fortnightly. The group will discuss setting up an improvement forum to look at population needs and how we support the care homes to deliver services differently, financial issues will be discussed separately.

To give the committee assurance the Care Inspectorate had visited one of our care homes, the report was positive and they intend on visiting one of our other care homes, Nicky has asked that our representative be present to enable collaborative working.

Fiona enquired how progress will be reviewed and monitored, discussion followed regarding the action plans for each care home which will be managed at fortnightly operational groups. Frequency of visits will be discussed with the homes individually, homes with areas of concern are being visited first. NHS Borders made decision to test visiting staff to ease concerns from the care homes regarding these visits. Tim commented that a discussion needs to take place regarding the committee's role in relation to care homes as the purpose of the committee is to provide assurance to the board that NHS Borders are supporting care homes as requested. The provision of care lies with the care homes directly and does not come under the remit of this committee or the board. Cliff re-emphasised Tim's comments on the role and accountability of NHS Borders to the Care sector stating we are happy helping our colleagues in other areas but we are not responsible or accountable for the quality of care provided. Ralph also echoed that we are clear on the requirements to support the care homes, particularly around infection control support and advice.

Laura and Nicky have prepared a paper for Scottish Government outlining the governance lines in terms of our relationship with the council and the integrated joint board and our role as Clinical Governance Committee. This was also noted in the Board report so they are clear on our scope of responsibilities. The item has been added to the Committee agenda as a standing item.

John noted that he is involved in the work being done by the operational group and because of that he feels assured on what board has taken responsibility for.

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

5.3 Adverse Event Overview

Laura highlighted key issues in report noting a reduction in adverse event reporting in recent months which directly correlates with the reduction in patient presentation through the system but the level is constant even taking into account this reduction. She commented that there was nothing of exception to note.

There are 32 active SAERs working to timescales for these events with the obvious restrictions during COVID 19, these timescales have been altered with lead reviewers being diverted to front line duties. The families involved have been informed of these delays.

Peter commented that there are 13 outstanding reviews for Mental Health and Learning Disabilities six of these are awaiting drug death review group, unfortunately NHS Borders is unable to control the timescale for these reviews. Two are delayed due to lead reviewers being relocated. Peter commented that he anticipates the remaining will be completed before the Committee meets again.

John enquired about the low figures for significant events of aggression and violence given that these are noted as the highest incidents reported. He also asked what the tobacco and illicit substances events were in terms of significance.

Laura agreed that the violence and aggression events reported are high but most are managed well by our PMAV team and are recorded as having minimal impact this is partly due to improved PMAV training and processes therefore there has been a reduction in aggression and violence events causing significant harm. Tobacco/illicit substance events include any event where substance misuse/drug use has been involved which may have caused harm to any patients in our care.

Rachel Pulman joined the meeting

Cliff commented that we as a Committee should be assured that the work done previously to create a culture of reporting events and near misses via our DATIX reporting system has been successful and we have increased awareness of where and when events are occurring, particularly in the areas we are focusing on. The next step however is looking what can be done to address these issues where we can.

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

5.4 Duty of Candour Internal Audit

Laura gave a brief overview of the Duty of Candour internal audit and reported that NHS Borders were actively working on the audit action plan. We were aware of most of the actions highlighted and by the end of the audit many had already been completed. Evidence has been sent to internal auditors and any outstanding issues were being addressed. Laura commented that we were making good progress towards completing the remaining actions. We aim to have our training programme concluded in December this year. The annual report will be brought to Committee as per the Committee's workplan.

Fiona enquired about the number of staff members who require training. Laura commented that there are 370 approvers and final approvers on the DATIX event recording system and explained that our Patient Safety Team are coaching them through any issues triggered through DATIX as being possible duty of candour related events. It was felt this was the best way to address the training given current constraints on delivering classroom based training.

John enquired about the use of Teams to deliver training; Laura commented that it was difficult to even use this method due to time constraints, she did however confirm that the lead reviewers training would be delivered this way.

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

5.5 Public Protection Annual Report

Rachel attended to highlight the key items from the report. She commented that the separate child and adult protection committees have been replaced by a multiagency Scottish Borders Public Protection Committee this was to enable a more family based approach and to strengthen communication and partnership working between child and adult services. She mentioned how important it was to recognise that protection of our more vulnerable individuals in the Borders is everyone's responsibility. There has been an increased focus on training and raising awareness of roles and responsibilities for public protection. Our response to adult protection from a health point of view is also a focus, modelling this on the already well established model for child protection. Scoping is underway to look at the addition of another nurse fitting in with public protection model to increase resilience.

Kirsteen Guthrie joined the meeting

Sonya enquired about the anticipated outcomes of the five delivery groups indicated in the report and how do they measure success. Rachel confirmed that each group has three key deliverables to achieve. Success can be measured by feedback from families and the outcomes of intervention on the identified risks.

Nicky has identified a need for Rachel to liaise with Laura and Clinical Governance to look at measures and data to show improvement and deliverables.

Alison enquired as to the risk if we don't recruit and invest in Adult protection; Nicky commented that this was picked up through Critical Services Oversight Group (CSOG) and Rachel has identified the need for a business case to be put forward for joint funding for a band 7 post to further support adult protection.

Ralph commented that a dashboard is in development to provide assurance to CSOG and it might be possible for Clinical Governance Committee to be cited on this dashboard to provide the committee with assurance.

Peter further commented that in his role as chair of the adult protection delivery group they are developing a data suite looking at relationship between referrals and outcomes which should also provide assurance. The Care Inspectorate highlighted that multiagency audits were another area for development which the adult protection delivery group are now exploring to promote good interagency working.

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

5.6 Screening Services Report

Tim explained the delay in the Screening Services report was partly due to staff absence and partly because of redeployment of staff during pandemic. The screening programmes are reported quarterly to the appropriate clinical governance groups and this bi annual report to the Committee gives an overview of the various screening programmes. Tim explained some of the complexities of the data and various reporting structures which meant that it was difficult to produce and annual report but he did feel that the report gave a flavour of the issues faced not only by NHS Borders but Nationally. He commented that some of the screening programmes had been delayed this year due to COVID 19 and that they were starting to remobilise these programmes. Pregnancy and Newborn screening work was paused due to staff relocation.

Tim will update committee on remobilisation of screening at a next meeting. He will also ask one of their registrars to update the screening report which can be brought back to the committee in 6 months.

Borders perform well in terms of uptake of screening in particular we are seen as a leader for uptake of bowel screening. Tim updated the committee on several of the initiatives which were taking place but on pause at present. There has been discussions nationally on the governance of screening programmes and that there had been recognition that this has been an issue in the past.

Fiona commented that whilst we welcome this report the committee would prefer more up to date data.

ACTION: Remobilisation report for next meeting and update of screening report in 6 months.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and asked for further assurance by way of updates as noted in actions

6. Person Centred

6.1 Claims Update

Report was presented to the Committee to give a sense of claims received, there was nothing to note in terms of trends. Having been asked previously to highlight claims connected to complaints or significant adverse events Laura was able to note that 45% were related to issues we were already aware of through our complaints and adverse event processes.

Sonya enquired as to the reason why some claims have not been identified prior to claim. Laura commented that having just taken on the governance surrounding claims in Clinical Governance that she feels assured the claims we should have known about we did, and the others were more likely to be negligible and therefore would not be considered as a claim by the Central Legal Office (CLO). Cliff supported Laura in this finding.

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

7. Clinical Effectiveness

7.1 Clinical Board Update (Acute Services)

Kirsteen invited questions on the report. There were no questions put forward but Nicky wanted to note the new consent form for elective patients developed by David Love. Cliff commented that consent forms are being updated retrospectively.

Kirsteen updated the committee on the expected remobilisation of outpatients stating that they are expected to be running at 40% from August. Fiona asked if this was face to face only or if virtual out patients were included. Kirsten commented that this was a mixture of both. There was a discussion about virtual consultations and the balanced risk between them and face to face intervention. Nicky reports that they are taking a slow and cautious approach to ensure they are getting the balance right acknowledging that near me and telephone consultations have their limitations.

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

7.2 Clinical Board update (Primary & Community Services)

Susie highlighted how learning from adverse events in the community hospitals was being shared. Aligned with older adults in hospital standards she had undertaken some spot checks within the community hospitals, it was recognised that there was still work to be done. Going forward a more standardised approach will be used throughout the community hospitals utilising Healthcare Improvement Scotland self assessment tools to enable them to evidence the care community hospitals give and highlight where improvements can be made. Patient flow has been an issue ways to encourage partnership working with BGH patient flow to avoid delayed discharges were being explored.

Unannounced visits are expected and Susie hopes to have an update for the Committee once visits completed.

John enquired about the enhanced OT and Physio services for the BGH and if this was having an impact on patients in the community as OT in particular had been previously used extensively to assess patients at home and keep them out of hospital. Susie commented that it was an issue they had recognised and work was underway with integrated services to ensure a whole team approach.

Nicky acknowledged that this was a difficult balance and was a large piece of work aligned with older person's pathway. She cited a recent reduction in delayed discharges both in community hospitals and mental health which is attributed to the hard work that is ongoing.

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

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

Mental Health Services

Peter highlighted the amount of work that had taken place to ensure services were delivered during the recent pandemic, he acknowledged how flexible the staff had been and how willingly they had adapted their practices and methods of delivery of services. Pressure on beds had increased and there some services are not being provided due to restrictions. Mental Health services are anticipating a further increase when lockdown restrictions are lifted due to the impact of COVID 19 and lockdown restrictions.

The CAMHS service will undergo a service review with the initial review date of August 21 2020. This will be coordinated by Clinical Governance and the Mental Health Quad under the instruction of the IJB Chief Executive Rob McCullough Graham and supported by NHS Borders Chief Executive, Ralph Roberts. The review will focus on enabling the service to meet the requirements of the new CAMHS service standards and ensure that all members of the CAMHS team are fully signed up to NHS Borders Values. It will be carried out by the Scottish Government National CAMHS advisor Stephen McLeod with support from his team.

Peter commented on the inclusion of Adult mental health and MHOAS consultations to highlight staff were using and adapting different resources. Due to the demographics of the MHOAS service users applications such as near me consultations have not been picked up which was expected.

Cliff commended mental health for embracing digital strategy where appropriate. He felt that it would be helpful for the next report to see number of referrals per week to the various services to demonstrate the anticipated increase in pressures on the services. Peter agreed but pointed out that the level of acuity of referral has been impacted due to lockdown restrictions and patients are possibly presenting or being referred further down their pathway and required a greater intensity of input from the services.

Learning Disabilities Services

LD services have moved to digital platforms where appropriate. There has been an escalation in Public Protection referrals to LD services recently this will be explored to ensure the increase in referrals had been addressed appropriately.

Peter highlighted that carer stress and carer breakdown had increasingly become an issue and that it was vital that there is the support available for carers and families. There had been a perception of escalating intensity of referrals but numbers had not dramatically increased.

John commented that it was important to recognise that pressures on Mental Health and Learning Disabilities following closure of day services was already an issue pre COVID 19 and we need to continue to be mindful of the impact on patients, their families and carers.

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

The Committee congratulated Mental Health & Learning Disabilities Services staff on their willingness to embrace the new ways of working throughout the pandemic.

8. Items for Noting

Minutes from Acute Services Clinical Governance Group from May and June were presented for noting.

9. Any Other Business

There was no further business of note.

10. Date and Time of next Meeting

The Chair commented that next meeting of the Clinical Governance Committee due on 16 September 2020 may have to change due to availability of Chair. Alternative date and time will be explored and committee informed. It is anticipated that this will be via Teams call.

The meeting concluded at 12:05