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