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