APPROVED

Minute of a meeting of the **Clinical Governance Committee** held on Friday 2 October 2020 at 11am via TEAMS

Present

Mrs F Sandford, Non Executive Director (Chair)
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
Dr L McCallum. Medical Director
Dr A Howell, Associate Medical Director, Acute Services/Clinical Governance & Quality
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
Mr S Whiting, Infection Control Manager
Mrs S Horan, Associate Director of Nursing/Head of Midwifery, Acute Services
Mr P Lunts, General Manager (item 5.6)
Dr J O'Donnnell, Chair Blood Transfusion Committee (item 8.1)
Dr O Herlihy, Director of Medical Education (item 8.2)

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 A Wilson, Non Executive Director
Dr J Bennison, Associate Medical Director, Acute Services
Mrs L Pringle, Risk Manager
Dr N Lowdon, Associate Medical Director, Primary & Community Services
Mr R Roberts, Chief Executive
Dr T Patterson, Joint Director of Public Health

The meeting was declared quorate.

Apologies received following meeting:
Mr P Williams, AHP Associate Director

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 29 July 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

Sam presented his report drawing attention to the changes in National Infection Control Guidance. He confirmed that although advice had changed on sessional use of eye protection there were some exceptions when sessional use is appropriate, such as children's nasal vaccination sessions.

Guidance from Health Facilities Scotland on approaches to improve social distancing for patients and staff in different contexts has been a focus and work has taken place on how the guidance can be applied, in particular in the six bedded bays in the BGH. The layout of six bedded bays limits how guidance can be applied due in the main to the fixtures in the room. Measures have been implemented to address this with all patients screened prior to admission thus giving a degree of confidence regarding assessment and decision making relating to patient placement. Patients are supported to wear face masks whilst moving around bay. Even with these measures the risk remains high.

Sam highlighted audits undertaken and confirmed issues identified in DME were recorded on action plan to be completed September, since then an administration error was identified and the action plan is in fact due to be completed in October. Since audit was undertaken a spot check was performed and indentified a repeat and recurrence of issues identified in original audit. Sam has arranged to meet with SCN, CNM, ADoN and Head of Domestic Services to agree an action plan on improvements. Full mock inspections will be reinstated.

Community Hospital audits were performed and a number of issued identified, the Infection Control team have done face to face training in both the Knoll and Kelso Hospital, Sam reports a spot check performed in the Knoll following training showed an improvement and they have now achieved 93% compliance.

Fiona asked for clarity regarding medium risk pathway for co-horting patients and the suggestion of creating sub categories in this group. Sam commented that there is a weekly Infection Control Managers Network meeting with Health Protection Scotland and the Scottish Government later today where he will raise this issue as NHS Borders does not fit easily into any of the suggested cohorts due to the testing measures put in place prior to admitting patients. He mentioned that there are particular issues regarding aerosol procedures in six bedded bays and Sam hopes to have clarity following the Infection Control Network meeting.

Lynn commented that NHS Borders are taking a very cautious approach bearing in mind we cannot change our infrastructure and COVID test does not have best sensitivity.

Sonya enquired about the figures for C-Diff, statistically we are not outliers but the community figures appear high and if there was a trigger for us to do something to address this. Sam commented that it is difficult to know how to deal with community infections as the patients have not generally had prior clinical intervention, to give a better sense of proportion he reported that although the figures look high the numbers are low.

Nicky commented that going by the agreed system of assurance introduced by previous Chair, we cannot be assured by the report particularly with regard to the repeat and recurrence of issues in DME, there is extreme concern that there had been no improvement and suggested a report should go to BET.

Sarah shared Nicky's view she and Sam had a discussion regarding a different approach to resolving the issues and will produce a report for BET and feed back at the next Committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report but was not assured and awaits report showing improvement in DME.

ACTION: Sarah Horan to produce a report on recurring themes in DME and present to BET.

5.2 Care Home Clinical & Care Governance

Nicky reported that inspections in Care homes are complete and improvement plan produced. Nicky happy to share this plan with the Committee. Focus continues on the identification care of deteriorating patients, establishment of multidisciplinary virtual ward rounds, anticipatory care plans and MDT meetings. This plan will sit with the care home operational group and be reported up to the care home oversight group. Processes are embedded and further work on establishing relationships is taking place. Nicky chairs a fortnightly meeting with the care home managers but it is anticipated this will move to a joint operational and strategic meeting bi monthly which will oversee any issues which need addressed. She reports progress is being made. The Scottish Government implemented a safety dashboard for every care home and data has started to come in, Clinical Governance & Quality are supporting Nicky with this data. NHS Borders are working with the Care Inspectorate to address non improvement of recommendations in a Borders private care home.

Fiona suggested discussions should take place regarding the level of detail in the reporting to the Committee and invited any thoughts on this to share them with Nicky or Fiona.

John suggested that as part of the discussion some clarity on Clinical Governance responsibilities and accountability. Nicky agreed that further clarity from Scottish Government is required on her role and responsibilities she commented that although not accountable for the care in the homes she is responsible for monitoring the care and providing guidance on issues such as infection prevention and control and recommendations on qualified nursing staffing levels.

ACTION: Laura agreed to work with Nicky on how to inform the Board and what level of detail they require.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report but were are not assured by its content – await further clarity on appropriate levels of reporting

5.3 Duty of Candour (DOC) Annual Report (deferred from July)

Laura presented the annual report from 2019/20 which we are required as an organisation to publish. Duty of Candour came into force two years ago, and implementation plan put in place. Of the 49 significant adverse events there were 15 identified where the DOC process applied. An internal audit was requested to further assist in the drive to implement DOC in the organisation, extensive work had taken place since January to improve reporting. Adverse event recording system has been adjusted to include mandatory fields and better guidance is available for staff. All issues are recorded on a tracker and the Clinical Governance Team follow up on any actions when DOC is enacted.

There has been good strides made towards improvement on understanding of Duty of Candour and the processes involved and it is hoped that next year we will be able to report full compliance on all aspects.

Sonya enquired what was meant by partial compliance; Laura explained that whilst conversations may well have taken place the evidence to substantiate compliance with the process was not obvious, in particular with documenting refusal of meetings when offered.

John commented that he would like some clarity regarding the intention of the report. Laura explained that the report was specifically relating to Duty of Candour to show that we have carried out the steps required. John added that it would be useful to have comparative tables should these become available nationally.

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

5.4 Quarterly HMSR

Laura pointed out that there was nothing of particular alarm in the report and NHS Borders remained within normal limits. Crude mortality had been slightly elevated for the last two quarters and this was discussed at the Board particularly in relation to the lack of adjustments to crude figures despite having a high elderly population and an onsite palliative care unit. Laura shared a slide which gave better clarity and showed the trends being similar to other Boards once the palliative care deaths had been removed.

Fiona commented that the data was old and wondered if we could have the adjusted data more regularly, she also asked if there had been a discussion regarding removing the MKU figures.

Laura responded that it would be difficult to replicate the adjustments regularly as this would rely on ISD doing this for us. Our own data can be projected if this would help. She confirmed that discussion had taken place with ISD about removing our palliative care deaths from the figures but they were not keen to do this, they did agree to a footnote being added to subsequent reports to acknowledge the provision in the acute hospital unlike other Boards.

Sonya asked if the crude mortality figures are impacted by the palliative care figures, Laura confirmed that they were. Laura shared another slide which showed what our figures would look like with palliative care deaths removed, in comparison with other Boards. The trend doesn't change but the rate is reduced once figures adjusted. Borders do follow the Scottish trend so we can be reassured by that, Laura also commented that the winter months show an increase in the crude mortality. The intention is to look more closely at this over this winter and to see why this may be the case and if it relates to seasonal illnesses.

Laura pointed out to the Committee that the admission rate in the last quarter dropped dramatically as it did in all Boards so that may explain the rise in crude mortality in that quarter. Laura indicated this is likely to be evident in the next quarter where there were increased deaths within 30 days of admission due to COVID, and around half of the normal admissions.

Sonya asked if increased demands on the system meant that crude mortality would be higher, Laura commented that this could be the case if people are staying longer in hospital at end of life due to wider system delays.

John asked why Dumfries and Galloway were used as a comparator; Laura commented that the demographic is similar although Borders has a slightly higher elderly population.

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

5.5 Mortality Review Annual Report

Annabel highlighted that a sample of 20% of deaths had been reviewed through the year. During the first phase of pandemic all deaths were reviewed but this has reverted to 20%. The review team has declined in numbers and although reviewers had been identified at the start of the year training was impacted by COVID and clinical priorities. A new tool has been developed and system to be re-established.

Following a question from Sonya regarding Equality & Diversity compliance in relation to mortality, Annabel explained the cases are picked at random so should mean we have a representative proportion of the population. The indications that COVID deaths were more likely in certain ethnic groups and the Borders population not being as ethnically diverse, the decision to review all the COVID deaths rather than a 20% sample meant we could ensure we were identifying issues within all communities.

Fiona asked if the intention was to review all deaths again since we are experiencing another wave. Annabel recommended that we should do this should COVID deaths become an issue again.

There was a general discussion regarding triggers and how and when we investigate an increase in deaths, Nicky pointed out that we need to be mindful of not following COVID at the expense of picking up on other issues elsewhere. Lynn commented that she is not keen to solely reply on Clinical Governance & Quality and that Consultants should be doing mortality reviews as part of their core Support and Professional Activities (SPA) time.

Lynn thanked Annabel for everything she has done for the organisation in her Associate Medical Director Role and that her input has been massively appreciated.

Laura mentioned that in the past all deaths were reviewed but learning from this was minimal and the decision to sample 20% was made, she assured the Committee that if themes or trends in the data are identified the deaths would be investigated thoroughly.

Annabel thanked Lynn for her kind words and supports Lynn's drive to make this every clinician's role. Fiona commented that she looks forward seeing mortality reviews built into consultant job plans.

Sonya asked how the outcomes of these reviews are being fed into the Committee and if there is an action plan produced. Laura commented that the Annual Patient Safety report provides assurance to the Committee and priorities for the coming year are set into our annual workplan, using mortality review learning to identify annual priority areas.

Fiona thanked Annabel on behalf of the Committee for all the fantastic work she has done during her term as Associate Medical Director for Acute Services and Clinical Governance & Quality.

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

5.6 COVID Recovery/Clinical Prioritisation

Phil Lunts joined the call and summarised the rationale of report citing the extreme challenges in providing resources during COVID and increasingly during remobilisation. Clinical prioritisation process was put in place for three main reasons. Firstly so that scarce resources can be fairly allocated, secondly to ensure clinicians were central to decision making and thirdly to provide support to clinicians who are dealing with decision making and interfacing with patients on a daily basis. He explained the levels of decision making which have been altered significantly due to COVID. An oversight group has been established to support these decisions. Risk matrix has been adapted and testing is ongoing.

Phil asked the committee to note and advise on the process, support the matrix for decision making and agree that the prioritisation group support those on the ground to appropriately make decisions and implement what is required.

Lynn commented that it is important to know that a clinician's role is to advocate for their service and patients, matrix was introduced to help standardise the approach on how care is delivered and assist with objectivity. The matrix has been generally accepted with adaptations in various areas to suit their demographics.

Sonya enquired as to who was involved in using the matrix to make decisions as she is concerned that support services will be excluded. Lynn hoped that there would be a multidisciplinary approach on each individual group but advised that there is a broad MDT approach in the over arching Clinical Prioritisation Group.

John enquired to what extent has the matrix been tested. Lynn replied that tool has not yet been formally validated; it has however been run through several services and has been adjusted to suit the various areas.

Phil agreed that the tool will be tested and adapted appropriately. Most important part is to have oversight and senior clinical interface on any decisions.

Committee were happy to support the process.

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

Philip Lunts left the meeting

6. Person Centred

6.1 Patient Experience Annual Report

Laura reported that the Patient Experience Volunteers had noted really positive patient feedback. Since March it had been necessary to scale back the Volunteers engaging with patients due to COVID. Laura noted that there is a concern regarding the ability to respond to patient feedback within the 20 working days target capacity of the Patient Experience Team. Steps have been taken via Clinical Governance & Quality Service review to address this by moving resources across the Team. Laura reported that the Patient Experience Team area getting back on track and it is anticipated that this will be reflected going forward, although Flu is currently having an impact on capacity due to a high volume of calls.

Sonya enquired about how themes and improvements are reported and who oversees the recommendation. Laura reported that she and Nicky have had discussions on themes and plan further discussions with nurse leads in particular on customer focus; she commented that Peter is doing a bit of work on this subject also, they are looking at how they improve communication with patients as this seems to be a particular subject that comes up in most patient feedback.

Nicky commented that improvement on communication is a focus of the Back to Basics Programme and as she has an overview of all the complaint responses she is able to see where improvements are being made. During the pandemic it has made NHS Borders more aware of how communication impacts on patients and their families, particularly when visiting was suspended and the interaction with families was so much more important. The introduction of easier access to electronic communication for patients was part of the communication strategy during the pandemic and it is hoped that this will continue. Nicky concluded that there is still work to be done but they are making strides on identifying how to make further improvements.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and was assured that we are on the right track.

7. Clinical Effectiveness

7.1 Research Governance Annual Report

Laura reported that there was nothing from an assurance perspective to report, research is developing well in the organisation. There has been a great response to COVID research and team has been redirected to support that. National studies had been on pause but these have been slowing coming back on track. Laura commented that research is a very rich area of work and is constantly growing and developing.

Fiona enquired about any intentions on keeping core studies on track should there be a second wave of COVID. Laura commented that unfortunately previously this issue was complicated by things like shielding of patients, particularly in cancer. The team would be able to support keeping studies open but would very much be guided by National advice as before.

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

7.2 Clinical Board Update (Acute Services)

Sarah highlighted a couple of issues in the report in particular the alarming number facing treatment delays. They are engaging with the Clinical Prioritisation Group around this issue and hope to report progress to the Committee at the next meeting.

Adult Unitary Patient record had been paired down during COVID and they have taken the opportunity to further develop and redesign this paperwork with support from the Quality Improvement Facilitators in Clinical Governance & Quality. There has been a bigger focus on the importance of families and carers in the new paperwork which is hoped will help with better communication and in turn better patient experience. ITU staffing was experiencing a deficit partly due to onward movement of staff. Lothian have agreed to support us while scoping staffing in the future.

Sonya enquired how the implementation and training in the use of NEWS was tying in with mortality reviews and if the lag in terms of implementation was a real issue or just down to timing. Sarah commented that the lag time was mostly due to the Quality Improvement Facilitator who is an ITU nurse being taken off the project and pulled back into ITU during outbreak. She is now back in post and training and implementation of NEWS has recommenced.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and was assured that work is on going with addressing the deficit ITU.

7.3 Clinical Board update (Primary & Community Services)

Services are getting back to normal and work is on going. Healthcare Improvement Scotland inspections have taken place in the Community Hospitals. Focus has been on communication with relatives and anticipatory care planning and improvement has been seen. Staff are frustrated that discharge issues are not improving quickly enough but work is ongoing to address this. Nicky assured the Committee that there is a new team in place which will make a difference. Lynn commented that she was concerned regarding capacity and delayed discharge issues particularly going into the winter months. Greater focus at Board level has been requested and the issue is a standing item on Board agendas.

Sonya enquired about our response was to falls. Nicky commented that we have unfortunately not had a consistent falls lead but is anticipated that now Paul Williams is in post there will be a better focus the falls strategy and this will be reported back to the Committee. Nicky further commented that there is learning available from other boards.

ACTION: Update to be provided to the committee regarding falls strategy.

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

7.4 Clinical Board Update (Mental Health)

Peter reported that there had been an increase in adverse events in particular incidence of aggression and violence. Falls remain an issue in particular in older adults dementia unit Melburn Lodge, he cited that people with dementia are more likely to fall so this is not unexpected, they do seek to keep on top of the falls bundles to ensure appropriate assessment and scrutiny of all patients. There had been a steady increase in digital consultations and an increase in referrals has been noted. They are trying to drill into the increase in referrals to identify any themes.

Peter wanted the Committee to know that he is proud of the fact that there have been no cases of COVID in their in-patient mental health units.

Nicky supported Peter's report and commented that NHS Borders are not experiencing anything different from other mental health units across Scotland. Modelling has shown that the length of stay and bed occupancy has not changed but the acuity has. Acuity is higher than normal which has been noted and has been considered in the remobilisation of mental health services. Support for the team has been recognised and an extra registered nurse has been identified for Huntlyburn to help address the resilience issue.

Nicky congratulated the service on how well they managed the pandemic outbreak with no recorded incidences of COVID. Peter acknowledged and appreciates the support of the organisation at this very trying time.

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

7.5 Clinical Board Update (Learning Disability Services)

Peter highlighted an out of area safeguarding issue which had been reported, and noted that due communication had improved and they have much better oversight than before.

Learning Disabilities services have undertaken their first mortality review, this will be a regular review going forward.

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

Lynn McCallum left the meeting

8. Assurance

8.1 Blood Transfusion Action Plan & Annual Report

John O'Donnell asked that the SNBT Annual report be noted by the Committee. He presented the Blood Transfusion action plan for NHS Borders. The Action Plan report highlights the concerns of the Blood Transfusion Service in the BGH. One of the biggest challenges had been staffing issues and although not completely resolved the risk has been reduced following return of consultant Haematologist from maternity leave.

John commented that following the annual report they received a visit from MHRA, the inspection concentrated mainly on the laboratory aspect of the service. They are working toward solutions to the actions raised. John congratulated the laboratory staff for their great efforts.

Another concern John raised is very poor attendance at the Transfusion Committee; this is mandatory committee which requires clinical attendance. Non attendance poses a significant risk particularly relating to out of date policies. John discussed this with AMD and Clinical Directors as well as Associated Director of Nursing in the hope that this will improve engagement with the Transfusion Committee and therefore reduce the current risk level. He is expecting to introduce an automated system to track blood throughout the hospital, awaiting final 'piece of the jigsaw' which will allow this.

John gave a brief overview of the issues of blood transfusion and blood stock levels due to COVID, this is being addressed nationally and at present the risk to the organisation is low. There is already an emergency blood plan arrangement in NHS Borders.

ACTION: Update on progress against recommendations from MHRA to Committee

The **CLINICAL GOVERNANCE COMMITTEE** noted the SNBTS report and was assured by content and work towards addressing actions from MHRA inspection.

8.2 Medical Education Programme Report

Olive attended to talk to the report, she commented that we had a positive year and although COVID has slowed some things down it has allowed work to be done that may not have been addressed. The GMC Survey had been put on hold due to COVID although a Scottish Training Survey did take place. DME scored below national average. Focus feedback groups were set up to look at issues raised and work is ongoing locally with the trainees to address these issues.

Student accommodation has been refurbished, thanks to input from Julie Schiebe and Estates group.

Medical education events have had to be put on hold including the collaborative work with just cycle which was expected to improve mental wellbeing. IM&T have been prioritising work on dealing with the COVID issues so their focus has not been on improving wifi for the students which causes issues with their learning as there is so much now on line.

Post graduate training will aim to focus on audit priorities along with Clinical Governance & Quality and the Morbidity and Mortality agenda.

Trainers are being asked to prioritise supervision in job planning.

Fiona commented that it is great to hear that the accommodation issues had improved and she is keen for the Committee to support looking at solutions to solving the online learning difficulties.

Nicky mentioned that she is heartened by these improvements and congratulated Olive on her hard work towards making headway in what is a very difficult time.

Sonya asked how supervision capacity for physician associate student will be managed. Olive commented that they will rotate through all the departments. Olive is arranging with the potential supervisors and clinical directors on how this will work but does not expect it to be a huge undertaking. Her concern is the trainees, we have had much fewer this year but potentially there could be much more next year this issue is all down to job planning, Lynne and Olive have had a discussion regarding priorities for clinical supervision. Sonya asked if there was a future workforce plan for Physicians Associates, Olive reports that there isn't at present.

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

9. Items for Noting

Presented for noting:

Pharmacy Annual Report

Screening Services Remobilisation Report

Alison Wilson and Julieann Brennan both commented that if there were any questions regarding the Pharmacy report and Screening Service remobilisation report to direct them to Diane and she will pass these on.

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

Minutes of:

- LD Clinical Governance Minutes & Action Tracker July 2020
- Acute Services Board Note of meeting July 2020
- Public Governance Committee Minutes February 2020
- Public Protection Committee Minutes June 2020
- Mental Health Steering Group June 2020

9. Any Other Business

None noted.

10. Date and Time of next Meeting

Next meeting of the Clinical Governance Committee is on Wednesday 25 November 2020 at 10am via Teams call.

The meeting concluded at 13:16