APPROVED

Minutes of a meeting of the **Clinical Governance Committee** held on Wednesday 25 November 2020 at 10:00 am via Teams

Present

Mrs F Sandford, Non Executive Director (Chair)
Mrs A Wilson, Non Executive Director
Mrs 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
Mrs N Berry, Director of Nursing, Midwifery and Acute Services
Mrs S Horan, Associate Director of Nursing/Head of Midwifery
Mrs S Flower, Associate Director of Nursing /Chief Nurse PACS
Mr P Lerpiniere, Associate Director of Nursing for MH, LD & Older People
Mrs S Keean, Physical Safety Lead
Mrs L Pringle, Risk Manager
Mr R Roberts, Chief Executive

1. Announcements & Apologies

The Chair noted that apologies had been received from:
Dr O Herlihy, Associate Medical Director Acute Services/CGQ
Dr J Bennison, Associate Medical Director Acute Services
Mr J McLaren, Non Executive Director

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 2 October 2020 were approved.

4. Matters Arising & Action Tracker

Sonya enquired about the physicians associates being part of workforce, Lynn commented that this was a matter for HR and Dr Herlihy had moved this forward.

The action tracker was updated accordingly.

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

5. Patient Safety

5.1 Infection Control Update

Sam gave an update on positive COVID cases across NHS Borders, current figures indicate that there was an increase at the beginning of November but the figures are decreasing again.

He also updated the Committee on the recommencement of infection control spot check audits; these have been unable to recommence these largely due to increase in clinical workload. There have been recent discussion regarding this issues and it has been agreed that they will be prioritising the full infection control audits over the spot checks due to the amount of extra detail they provide, this will also provide extra assurance. Ways to get any additional capacity into the infection control team have being investigated to enable the team to resume rapid spot checks. A key issue is giving ownership and responsibility to the Clinical Nurse Manager for revisiting the Ward and reviewing compliance with any issues identified during the initial audit.

The team have come up with a slightly different approach to hand hygiene audits, which have been an area of concern for some time, these are conducted by the wards themselves and at week three of the month any non submission is highlighted to the quadumverates giving them time to address the issues rather than waiting until it is too late. This approach has been implemented this month and will be reported to the committee in next update.

Fiona enquired about the progression of the recruiting to the team, Sam reported the recruitment process is ongoing. Unfortunately all three shortlisted candidates withdrew prior to interview, the post has been re-advertised. One of the permanent members of the team finishes for maternity leave so it is going to be a difficult period ahead. Sam also reports that this situation is not unusual to NHS Borders and other Boards are experiencing similar challenges. Sarah commented that this is a national issue which has become more challenging largely due to the increase in work due to COVID and the National Infection Control Committee are taking steps to address this.

Sonya asked for clarification reporting to the ICC and if this was different to the report for BET. Sam confirmed that they were asked to give an update to the ICC in terms of risks to ensure that they were cited on NHS Borders prioritising the high risks in relation to increased activity due to COVID.

Fiona enquired if there was cause for concern regarding Ecoli figures as they appear to have doubled and although not outlying are significantly above the Scottish average. Sam responded that it is a concern given it is a Scottish Government target to reduce Ecoli bacteraemia; the main cause of Ecoli is catheter associated urinary tract infections and the t CAUTI group will address, unfortunately they have been unable to meet but it is hoped they

will reconvene in December. Sam provided context in relation to the numbers citing that although there was a marked increase the numbers remain small.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report but not fully assured due to issues with workforce.

Sam Whiting left the meeting.

5.2 Quarterly HMSR

Laura gave update on HMSR position following detailed overview at the last committee. Crude mortality is slightly elevated, which mirrors the position January to March and April to June, consistent with the rest of Scotland. Crude Mortality is not adjusted for any demographics such as age this shows NHS Borders slightly above the Scottish average which is probably reflective of NHS Borders elderly demographic and our palliative care deaths. However the figures remain within the funnel plot. Extra scrutiny has been applied in this area with every COVID death in the first period investigated as well as a sample of non COVID deaths for extra rigour. This should enable themes, trends or anything unexpected to be identified. COVID deaths have contributed to an incline but this had been expected.

Sonya enquired about the correlation between increased admissions and crude mortality, Laura gave a little more clarity on the figures and commented that a pattern is noted at times of pressure in the system. Increased length of stay inevitably leads to increased chance of dying when in hospital possibly because of system delays. It is hoped the mortality reviews will reveal if there is any correlation between mortality and system flow issues.

Discussion followed regarding patient flow being a whole system process and the need to take this into consideration whilst carrying out the mortality reviews and the importance of knowing if we are causing harm and if systems are contributing to that.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report but is not fully assured. The committee await assurance from the continued reviews.

Following Items taken out of sequence as next presenter not available.

5.4 Adverse Event PMAV Thematic Report

Sue presented paper and commented that was important to remember that aggression and violence is a predictable risk, the actions the board puts in place to mitigate against those risks are really important. There is an overarching risk on the risk register for aggression and violence but Sue would like to see a risk assessment for each individual public and patient facing department on the register. There have been slight improvements since 2018 but there is still work to be done which the PMAV team is addressing.

Adverse events have shown a downward trend, the figures also show an increase in adverse event reporting which demonstrates excellent reporting within the organisation but it is important to view context whilst looking at the numbers.

Training has been an issue in terms of numbers of staff being trained, the team expect to train at least 1000 staff per year. There has been a decline in training recently partly due to organisational response to COVID pandemic and the strict guidelines from the Scottish Government. There has been a venue sourced which will enable the team to increase numbers being trained, this will be available from January 2021. Sue assured the Committee that training has not stopped completely and some smaller groups are being trained on an adhoc basis as appropriate and within national guidelines, staff groups with no training or expired certificates are being prioritised. The organisation is asked to support attendance and promote the importance of reporting any adverse events and near misses.

Alison enquired what the risk level was in terms of numbers of staff trained, Sue commented that the risk is currently very high and recorded on the risk register; she also reports that this is a National issue.

Discussion took place following a question from Sonya about what success looked like and about the importance of reporting all incidents including minor and negligible. Violence and aggression is sadly part of healthcare so it would be more worrying not to see any incidences reported. Laura supported Sue stating that success can be seen even though there is a high level of reporting of minimal or negligible outcomes. There would be more concern if high or extreme outcomes were on the incline.

Sue outlined clear definitions on levels of reporting and the committee asked if this could be included in future reporting to the Committee.

Nicky commented that the PMAV team have been supporting and managing the logistics of delivering PPE across the whole organisation very successfully and it has been invaluable to the organisation. The Committee congratulated and thanked Sue on her commitment and asked that she pass this on to her Team for their support

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the process bit would like to keep an eye on training issues.

6. Person Centred

6.1 Patient Experience Update (including SPSO Position)

Laura gave current position on patient feedback. Formal complaints have returned to a normal level post Covid, most of the patient experience team had been displaced to support Covid response so are working hard to get back to reasonable level of response time. This has been a struggle with the pressures across all of the clinical boards in frontline services in terms of their ability to respond but the team are keeping on top of this.

Sonya enquired about SPSO complaint action plans and how these are incorporated into improvement plans by the organisation. She also asked if there were any trends identified, in particular with the concerns regarding medical and nursing care. Laura confirmed that each of the clinical board's governance groups would have sight of any particular ombudsman findings and compare SPSO outcomes with what we had found. The clinical teams are informed and any outcome or recommendations are enacted. There have not been any

particular themes from ombudsman findings identified but if they were they would be part of any improvement plans.

There was a discussion about celebrating our successes and how we effectively share the commendations we receive to our staff. There were suggestions of public engagement through social media and other effective ways other than email to share our success stories. Laura commented that she had started conversation with the Communications Team regarding some of this innovative work, sadly this was shelved due to Covid but she is happy to take this up again.

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

Lettie Pringle joined the meeting

5.3 Strategic Risk Management Report

Risk management Policy was updated in February 2020 and it was agreed that specific strategic risks would feed into the appropriate governance group. The Clinical Governance Committee now has oversight of strategic risks relating to patients and clinical activities therefore this report only shows these risks. There are currently 4 risks which have remained at the same level since May. As part of internal audit recommendations gap analysis is ongoing this may mean the number of risks reported to the committee will increase. The Committee is asked to note the report and be assured that strategic risks within this report are being managed appropriately and proportionately.

Fiona commented if risk around pandemic influenza should be changed to pandemic risk following the Covid outbreak as this may change the way we prepare.

Laura commented that work is ongoing on the current context of strategic risks and this was presented to BET, they are now going to meet with each of the Directors who own the risks. It was agreed that the influenza pandemic risk should cover a far broader remit given the world we live in so the risk will be updated in line with preparation for any type of pandemic.

Sonya commented that risk relating to unacceptable clinical performance doesn't allow for system failure. Laura responded that this particular risk and the context will also be discussed with the Clinical Directors. She also enquired how the risk relating to destabilisation of BGH and the medical workforce was being addressed and what controls were in place and can we be assured that risks are being addressed. Nicky commented that she is assured that the Governance Process regarding risk management is in place and risks are addressed as appropriate.

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

7. Clinical Effectiveness

7.1 Clinical Board Update (Acute Services)

Sarah drew attention to the moving of the Margaret Kerr/Borders Stroke Unit to Ward 12 to free space for CV1 to ensure a safe environment in terms of ventilation, single patient occupancy and separate entrance amongst other things. It is recognised that Ward 12 environment is not the same as the Margaret Kerr unit for our palliative patients but there is ongoing work to support this cohort and provide the appropriate levels of care. There is no evidence that this move has caused physical harm but it is recognised that patients and families are experiencing emotional difficulties and access for loved ones is limited. Sarah reported that there is now good effective senior decision making in place at all times of day which is an improvement.

Sarah went on to explain the COVID-19 mobilisation and escalation to opening further Covid wards and the impact on elective work. Attention was drawn to the innovative person centred work Dr Palik has been exploring on the use of near me assessment of medium risk Covid patients at home.

A Mock inspection took place to test our procedures for unannounced inspections. This identified that areas of work were needed throughout the process. General cleanliness was lacking and there were other areas identified for improvement. The one thing we can be assured of that the majority of patients reported that they felt well cared for. Ward nine was highlighted as an area where there were little areas of concern, they had very positive feedback which was shared straight away with the Senior Charge Nurse.

Lynn gave further information on the innovation of remote Covid monitoring and the two pathways which are being proposed at Government level and asks that we be mindful of the governance and responsibilities for these innovations from a health board perspective. Sarah added that the proposal was taken to the acute clinical governance board so it could be investigated further and the board was supportive of this proposal as long as the governance surrounding it is robust.

Laura asked if there could be an update on the non Covid workload and associated risks in the next report to the committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the content with caveat that Sarah and Lynn are going to work on this new near me pathway.

7.2 Clinical Board update (Primary & Community Services)

Attention was drawn to the progress being made in respect of resurgence. Susie wanted the committee to note the amazing work the teams have been doing in particular the community nursing and district nursing teams and the impact of flu vaccination. The community hospitals continue to undertake mock inspections; action plans from the last report are shared with the governance group.

Adverse events appear high but again this is because staff are better educated on when to report events and most likely related to length of stay within the Community Hospitals. There is some work ongoing looking at average length of stay in relation to falls, incidence of falls appear high but these have been found to be in relation to one or two longer term patients falling regularly rather than a lot of patients falling. Mobilising the District Nurses quickly to care homes during outbreaks has been a challenge on workforce and ability to continue as normal.

The senior charge nurse continue to be supported through the challenges in making sure audit data submitted in a timely manner and the infection control initiative of early warnings at week three before submission is working well.

Sonya asked if the work Paul Williams is doing on the Falls Strategy could come to the Committee at a future date

Nicky wanted the Committee to know the amount of work Susie has done in the community is phenomenal with the inspections in care homes, inspections in Community Hospitals, processes for delayed discharges and care home out break responses

Fiona echoed the thanks of the Committee to Susie and her teams.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents.

Ralph Roberts joined the meeting

7.3 Clinical Board Update (Mental Health Services)

Peter drew attention to aggression and violence figures falling in recent months. The service is under pressure so there is close scrutiny over these figures to keep this trend going.

The use of near me has been embraced fully there were challenges in accessing space to enable the use of near me and options are being sought on areas that can be reconfigured for near me consultations. The service is looking at getting some feedback on patients on their experience of near me.

From January there will be an update from psychology which has not previously been included in the reporting to the Committee.

Documentation on EMISS has been challenging but this issue was due to lack of understanding of the system but this has been addressed. Recent recommendations from SPSO report highlighted a failure to communicate which again was related to documentation.

Fiona enquired about the acuity of referrals following lockdown, Peter reported that they have seen a slight increase in referrals but the flow has been steady as expected in these circumstances. The service remains under pressure with Huntly Burn being at 100% occupancy much more since July 2020 than it has been in the past. Having large numbers of agitated in patients at one time makes supporting the individuals difficult. Peter paid tribute to

his staff working that environment who have been very diligent on staying on top of this situation

Laura asked if Peter could spotlight any issues around the pathways which we are managing where there may be increased clinical risk on his next report.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents.

7.4 Clinical Board update (Learning Disabilities Services)

Peter previously highlighted a public protection issue related to out of area patient, he reported that arranged visits by social worker had to be cancelled, the team are looking for an alternative placement for this patient, the visit will be re-arranged. The LD escalation process has been updated.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents.

8 Assurance

8.1 Care of Older adults update and standards action summary

Peter presented the annual Care of Older People in Hospitals update. He recognised that through this very challenging year the amount of work to maintain standards and continue to improve should be commended.

Nicky commented that the standards are used as a benchmark throughout the organisation and processes are in place to assist in monitoring and improving care.

Sonya asked how success was measured in terms of the application of those standards. Peter responded that standards are used to benchmark clinical practice for example falls management is measured against standards and is regularly reported on, from reports we can see where improvement has been made. He did concede that not all standards can be measured. Laura commented that the ward audits are also based on the standards. The outcomes are presented to the committee but underpinning that are process measures looking at compliance which have also been aligned with other initiatives like Excellence in Care, Patient Safety Programme and other national deliverables.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents.

10. Any Other Business

2021/22 Meeting dates were noted and will be circulated along with the meeting makers as appropriate

11. The following items were presented for noting:

Minutes from other Committees/Groups

- Acute Services Business/Clinical Governance Board August 2020
- Acute Services Business/Clinical Governance Board September 2020
- Primary & Community Services Clinical Governance Meeting September 2020

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

12. Date and Time of next Meeting

The Chair confirmed that the next meeting of the Clinical Governance Committee is on **20 January 2021 at 10.00am via Teams**

The meeting concluded at 12:03