Minutes of a meeting of the **Clinical Governance Committee** held on 13th July 2016 at 2pm in the Committee Room, BGH

Present:	Stephen Mather (Chair)	Doreen Steele
	David Davidson	
In Attendance:	Evelyn Rodger	Laura Jones
	Simon Burt	Dr David Love
	Sam Whiting	Phillip Lunts
	Jane Davidson	Dr Annabel Howell
	Charlie Sinclair	Dr Andrew Riley
	Lynne Morgan Hastie	Dr Andrew Murray

1. Apologies and Announcements

The Chair noted that apologies had been received from Cliff Sharp, Susan Manion, David Thomson, Sheila MacDougall, Hamish McRitchie, Karen McNicol, Tim Patterson and Nicky Berry.

Andrew Riley is attending on behalf of Tim Patterson.

It was noted that Karen McNicol is leaving NHS Borders.

2. Declarations of Interest

None.

3. Minutes of the Previous Meeting

Doreen Steele noted that on page 5 – Patient Feedback Report it should say 'compliments' and not 'complaints'.

The minutes of the previous meeting held on the 25th of May were then approved.

4. Matters Arising

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

5. Patient Safety

5.1 Infection Control Report

Sam Whiting (SW) presented his report.

David Davidson (DD) asked about the risk associated when isolation is not possible. SW responded that the risk is difficult to quantify. The evidence of cross transmission is very rare. DD asked about visitors and infection control. SW answered that as visitors tend not to go from bed to bed and do not perform invasive procedures, the risk of cross infection associated with visitors is lower than staff.

There was prolonged discussion around infection control measures in six-bedded bays. Jane Davidson (JD) asked if are we are content that systems are operating as intended. SW responded that monitoring does confirm that systems and processes are operating as intended with generally good compliance.

With regard to hospital cleanliness monitoring, SW explained that resources for cleaning clinical areas are prioritised over non-clinical area. This would have the effect of reducing the overall compliance score at times where non-clinical areas are included in monitoring checks. SW was asked in the next report to show a split in cleanliness scores between clinical and non-clinical areas.

DS asked regarding page 9 reasons for the hand hygiene audit not being submitted or completed and was concerned that this did not support a zero tolerance approach to hand hygiene. SW answered that failure to submit an audit tended to be associated with changes in staff who had been allocated to complete audits or were on leave. In these cases, the relevant Senior Charge Nurses had confirmed that this task had now been allocated to alternative staff.

DL asked about cleaning of blood spillages and described what he had observed recently in the Emergency Department. SW advised that the spot checking process includes periodic observations of cleaning processes as they happen. The recurring theme in audits relating staff knowledge on cleaning was being addressed by training accompanying the rollout of a new cleaning agent that is easier for staff to use and will support better compliance. SW explained that in response to the feedback by DL, he would ensure that the Emergency Department is prioritised for early adoption of the new cleaning agent.

SW summarised the incident on page 7. SW explained that an outbreak report is being drafted along with a significant adverse review. No further cases have been identified.

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

5.2 Adverse Event Overview and Prevention and Management of Aggression and Violence (PMAV) Thematic Report

Laura Jones (LJ) presented the Adverse Event Overview containing information on trends over the last 3.5 years since the introduction of the adverse event management policy.

Evelyn Rodger (ER) noted that graphs 1, 2, 3 showed normal variation in the numbers of adverse events reported and queried whether we should be expecting to see a reduction in these numbers based on the improvement work underway. LJ advised it is important to promote a positive culture around the reporting of errors and we would not necessarily aim to see a reduction in reporting of incidents. We should however be monitoring outcomes and seeing reductions against these based on the focused improvement work.

LJ highlighted that individual cases and learning is discussion at clinical board governance groups and can be highlighted to the committee in reports from clinical boards. JD said that it was a helpful report but not an assurance report. JD suggested that this would be positive from an assurance perspective for the committee to ensure learning and action follow significant adverse events.

Thematic Report - PMAV

Sue Keean was unable to attend the meeting so DS suggested a further discussion be scheduled for the September meeting. At the next meeting the committee would like to discuss the areas experiencing high levels of aggression and violence and training uptake in these area.

ER advised that she has been in discussion with the PMAV team to look at how training can be provided differently within clinical areas.

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

5.3 Significant Adverse Event Review's (SAERs)

JD asked the committees views on making SAER reports available to the public through the NHS Borders internet site. It was suggested that this is already done in NHS Ayrshire and Arran. LJ highlighted that a lot of work has been done to involve patients and families throughout the SAER process to provide an open and transparent approach.

There was a debate around this and the need to ask permission from patients. The chair suggested that the Board be consulted on this to make a decision. AM agreed to take this for a discussion at the Board development session.

SM suggested that some detail of individual SAERs be shared through clinical board governance reports to ensure the committee can be assured that learning and actions are being addressed. JD suggested this would be useful from an assurance perspective to link the learning from SAERs to a change in outcomes over time. LJ and AM agreed to consider this for the next report to the committee.

5.4 Very High IT Risks

Jackie Stephens (JS) came to the meeting to discuss the very high IT risks that were facing NHS Borders. She gave a presentation on the following risks:

- Windows XP Desktop
- Radiology Hardware (RIS)

JS is also attending the board in September to discuss the issues further with a view to considering a plan for the resources required to address this. The committee were keen to see a phased plan to address this.

JS was asked to review the risk levels with June Smyth on the basis of the work that has been done to date.

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

6. Person Centred

6.1 Scottish Patient Service Ombudsman (SPSO) Reports

Philip Lunts (PL) talked to a paper summarising progress against the 5 SPSO improvement action plans. For two cases all actions are now completed and closed. The other three are ongoing and PL provided an update on the actions complete and those remaining with timescales for completion.

The Chair asked how the committee can be assured that actions have been completed where staff have been required to undertake personal reflection and practice change. Andrew Murray (AM) advised that they are ensuring that the conversation is taking place by checking the log of appraisals and monitoring feedback about individuals thereafter. ER advised that this would also apply to nursing and would be linked to their appraisal and revalidation process.

JD agreed that this is assuring for the committee and noted that some measures continue to be tracked from the SPSO cases. JD highlighted that this is about culture change and will take time and a continued focus.

JD highlighted that during a recent meeting with a family they had discussed their confidence in raising concerns whilst you are a patient in the hospital. As a result testing work is going to take place in Women's and Children's of a bedside sign advising patients and families about how to raise concerns and who they can contact outwith the ward.

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

7. Clinical Effectiveness

7.1 Clinical Board Update (Borders General Hospital, Primary and Community Services)

Charlie Sinclair (CS) advised that the BGH and PCS will now use the reporting format on front of the committee at the meeting. CS has enhanced the report by adding a summary at the beginning providing an assurance position across each directorate.

CS outlined that daily monitoring of compliance with Older People in Acute Hospitals (OPAH) process measures is continuing. Some areas are now seeing sustained compliance. CS indicated that the audit processes is being reviewed to assess if a sampling process would be effective. JD will consider this with CS.

CS indicated that the SPSO cases relating to the BGH and PCS had been covered in the earlier agenda item.

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

7.2 Clinical Board Update (Mental Health)

Simon Burt (SB) advised that he was happy to take questions in David Thomson's absence.

DD asked for examples of medication errors and noted that he would be happy to receive an email with this information. SB agreed to provide this.

DD enquired about what was happening with the Borders Addiction Service (BAS) in relation to IT issues they were experiencing. SB told DD that the issue holding this up is due to BAS having a preferred system which the clinical board accepted. Information Governance needs to be reviewed and this is currently happening.

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

7.3 Clinical Board Update (Learning Disabilities)

SB advised the committee that he would be moving the LD report over to the format being used by the BGH and PCS for the next meeting.

SB highlighted the ongoing issues around the provision of residential units for clients with autism and challenging behaviour across the UK. At present places are sourced from England and Wales. This requires local staff to make regular visits and impacts on the service. This has been raised by Cliff Sharp at the South, East Scotland and Tayside regional planning group. and SEAT. SB advised that he was managing the risk associated with this issue and is in discussion with Lothian about future provision.

SB highlighted that this is risk which spans the integrated service. DS said that this would be appropriate to go to the IJB for future commissioning consideration.

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

8. Assurance

8.1 Occupational Health Annual Report

Irene Bonnar (IB) gave a summary of occupation health activity from 201515/16. There has been a good use of the service from the staff.

It was noted that just under 25% of referrals to Occupational Health are for MSK. JD highlighted that she has asked for a drop in service to be developed for staff experiencing MSK problems. IB was asked to bring information on how this is progressing to a future meeting.

There was a discussion around uptake for classroom based training. Concern was expressed at the uptake rates and rate of cancellations but individuals and training providers. The committee requested assurance that this issue was being tackled by the group reviewing training provision. IB agreed to raise the points with John McLaren and bring an update back in the next report to the committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and supports this.

8.2 Child Protection Annual Update

ER advised that this was a historical Report from last year from the Child Protection Committee. Moving forward from the recent Joint Inspection of Children's Services the work plan for the next year will be more focused on outcomes rather than processes.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and supports this.

8.3 Care of Older Adults in Hospital (OPAH) Annual Update

Deferred until September.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and supports this.

9. Items For Noting

9.1 Minutes

The following minutes for:

- Child Protection Committee
- Adult Protection Committee
- Public Governance Committee – no minutes
- BGH Clinical Governance
- Primary and Community Services Clinical Governance
- Learning Disabilities Clinical Governance
- Mental Health Clinical Governance
- Public Health Clinical Governance

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

10. Any Other Business

SB told the committee that the Joint Adult Health and Social Care inspection to be carried out by the Care Inspectorate will take place soon. It is anticipated that this will start in January 2017.

11. Date and Time of Next Meeting

The Chair confirmed that the next meeting of the Clinical Governance Committee would be held on Wednesday 28th September 2016 at 10am – 1pm in the BGH Committee Room. **Please note the change of time.**

The meeting concluded at 4.20pm