HEALTHCARE QUALITY ASSURANCE & IMPROVEMENT GOVERNANCE COMMITTEE: DR LESLEY THOMSON, CHAIR

NHS Lanarkshire

Meeting on 11th March 2021

Key Issues Considered

1. HQAIC Exception meeting held on 26th January 2021) - Dr J Burns provided an update regarding the Care Homes review and Dr L Thomson took the Committee through the action log from the exception meeting. The Committee heard that a Consultant in Public Health is working on the mapped timeline and further work is required regarding admission, discharge and testing data. Dr J Burns advised that a master database will be created and shared with HQAIC to request their feedback regarding the narrative to be developed. It was agreed this will come back to the July 2021 HQAIC meeting for further discussion.

2. Quality Planning & Professional Governance Highlight Report – Dr J Burns advised the Committee that the meeting scheduled for February 2021 was cancelled as it would not be quorate. A decision was taken to circulate the papers electronically and request feedback from group members regarding each, particularly those requiring approval. Several returns were received, however it was acknowledged that not all members provided a response. Committee members advised they did not have assurance therefore Dr J Burns, Mr E Docherty and Mrs K Cormack will review the February items requiring additional assurance and ensure these are given due consideration at the April 2021 meeting of the group.

3. Internal Audit - The Committee considered the update given by Mrs K Cormack regarding recent Internal Audit reports and noted that there are no actions.

4. University Hospital Wishaw SAER – Mrs K Cormack presented an update of the SAER relating to the Covid outbreaks in UHW. She explained that due to requiring data from ARHAI and NHSL hospital systems, the review group have been unable to complete the investigation at the time of the meeting. However, she stated that she hoped to have it with the commissioner within the next week. The presentation covered the topics explored within the report and

highlighted the main factors that were thought to have contributed to the outbreaks. These included;

- high community prevalence (including staff)
- high hospital occupancy rates, many patients moving wards during the course of an admission
- large numbers of frail, elderly patients in Orthopaedic wards who were immobile needing close personal care
- High numbers of Orthopaedic patients boarding in other wards leading to increased throughput of medical, nursing and other staff on these wards
- Contained staff rooms and toilets heavily used & lacking adequate air changes Other factors also thought to influence were
- Cleaning regimens were examined although there were issues, these were unlikely majorly contribute
- There is a lack of single rooms on the site
- Staff testing was not introduced until 21st Dec. 2021
- Staff tracing was difficult
- Staff came to work with mild symptoms before discovering they were positive
- Patients were reluctant to wear masks
- Challenging patients difficult to enforce compliance

The Committee discussed why the cleaning issues were not thought to be a major contributor. Dr John Keaney explained that the cleaning issues were in Covid 19 care areas, however the outbreaks occurred in non-Covid wards. Mrs K Cormack explained that learning was implemented as it was discovered and highlighted a number of actions that had taken place to reduce and contain the infection. The Committee heard that there are currently no closed wards in the acute sites and only one community ward is closed.

5. Lanarkshire Hepatitis A Outbreak 2017 Report – Dr G Docherty provided an overview of the report and stated that he anticipates civil action, however he is confident that the organisation acted appropriately. A further update will come to the Committee when available.

6. Feedback from the Sharing Intelligence for Health & Care Group – NHS Lanarkshire – The Committee noted the report and commented on the very positive feedback regarding NHS Lanarkshire.

7. Quality & Safety Dashboard – Mrs L Drummond advised that the data has been impacted by Covid 19, e.g. crude mortality astronomical point in April 2020 (1st wave) and a higher rate in November 2020 (peak of the 2nd wave). The Committee reviewed data regarding SEPSIS, Cardiac Arrest and Falls with harm. Dr J Burn advised that the system is not yet stable, however an action has been agreed to re-establish the data and feedback from sites to help identify immediate issues and the need to reflect on how we report going forward, understanding that there are ongoing, operational issues that directly impact on the measures used, e.g. ward closures, patients not getting access. The Committee heard that further case-note reviews were planned in the coming months, the detail of which will be shared at future meetings of this Committee.

8. Quality Strategy Implementation Plan 2020-2021 – Mrs K Cormack presented the highlight report, advising that some of the incomplete actions will be carried forward to the 2021-2022 plan, some will be reframed and some will be removed as no longer viable. The Committee heard that work is well underway to draft the 2021-2022 plan and this will be shared at the meeting in May 2021.

9. Corporate Risk Register – Committee members reviewed the paper and Mrs N Mahal enquired regarding the NMAHPs contribution to governance risk, asking for this to be clarified, including more detail regarding the mitigating factors. Mr E Docherty will progress this action.

10. Adverse Events Highlight Report – Mrs K Cormack presented the report, highlighting the breakdown by area and causation codes, noting this helps decide on whether an adverse event meets the Duty of Candour criteria. The Committee heard that the 3rd Learning Bulletin is in draft and will combine not only adverse events but also learning from complaints.

11. Information Governance Highlight Report – Dr R McKenzie presented the report, noting that two meetings of the Information Governance Committee were cancelled, however they met last week and shared good data regarding training. Work continues to finalise the Information Sharing framework and this will help with the GMS rollout and improve quality of care between primary and

secondary care. Cyber security audit data will be presented to the Committee in May 2021.

Information Governance SBAR: The Committee reviewed the SBAR presented by Dr R MacKenzie which detailed a breach of personal information by a NHS Lanarkshire staff member employed via the staff bank who was working with SALUS on the vaccination programme. The investigation is ongoing and a SAER will be commissioned.

12. Clinical Policies Endorsement process – Mrs A Minns presented the twice yearly report to the Committee, noting one change, i.e. the Director of Quality now has oversight of Corporate Policies.

13. Independent Sector Governance Group (Previously Contract Monitoring Group) Annual Report – The Committee reviewed the Annual Report presented by Mr E Docherty, noting that the group has met twice this year. It continues to work well, however some concerns regarding the ability to monitor external agencies.

14. SPSO report – Mrs L Drummond presented the report, highlighting there have been 25 SPSO determinations and 16 upheld (10 since the last Committee meeting in November 2020). Themes include poor record keeping, communication, complaint handling, clinical treatment issues and medication and referral issues. Recommendations were highlighted in the report.

15. Report on Feedback, Comments, Concerns & Complaints – The Committee reviewed the report and noted the different format using the Power BI system. Over 3,000 contacts to patient affairs, these peaked in October 2020 due to the vaccination programme.

16. Bereavement Care Annual Report – Mr E Docherty advised the Committee that the Bereavement Care group has not met and no report was available, however a report would be provided for the May 2021 meeting. The Committee acknowledged that the staff who would normally produce this are at capacity supporting staff through Covid 19.

17. Committee Work-plan – Dr L Thomson requested a development session is arranged to review the items requiring to be covered at HQAIC.

18. Fatal Accident Inquiry – The Committee were given formal notice regarding the case proceeding to a Fatal Accident Inquiry (FAI) and noted that this has been rescheduled to July 2021.

19. Hand Hygiene SBAR – Mr E Docherty presented the SBAR, noting the challenges and common variation therefore urgent actions have been agreed. The Committee heard this work will form part of the Infection Prevention and Control Breakthrough Collaborative and will feature in the Safe Care Plan and be a priority for the Lanarkshire Infection Control Committee.
Any Decisions / Approvals taken to highlight
1. 2.
Any risks identified that need to be highlighted
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