Agenda Item 3

Minute

Falkirk
Health and Social Care
Partnership

Minute of meeting of the Integration Joint Board Clinical and Care Governance Committee held within the Boardroom, Denny Town House on Friday 28 February 2020 at 9.00 a.m.

Voting Members: Fiona Collie (Vice-Chair)

Non –voting Members:
Margo Biggs, Service User Representative
Jen Kerr, Third Sector Interface
Roger Ridley, Staff Representative, Falkirk Council

Also Attending:
Lynda Bennie, Head of Clinical Governance
Patricia Cassidy, Chief Officer, Integration Joint Board
James Foley, Service Manager
Jack Frawley, Team Leader - Committee Services
Ellen Hudson, Deputy Nurse Director
Elaine Kettings, Head of Person Centred Care
Sara Lacey, Chief Social Work Officer
Louise McKay, Nurse Consultant – Older People
Tricia Miller, Lead Nurse Infection Control
Andrew Murray, Medical Director
Gemma Ritchie, Lead Officer for Adult Support & Protection
Martin Thom, Head of Integration
Suzanne Thomson, Senior Service Manager

CCG33. Apologies

An apology was intimated on behalf of Angela Wallace.

The Vice Chair welcomed Jen Kerr to her first meeting.

CCG34. Declarations of Interest

There were no declarations of interest.

CCG35. Minute

Decision

The minute of meeting of the Clinical and Care Governance Committee held on 7 November 2019 was approved.

CCG36. Action Log

An action log detailing ongoing and closed actions following the previous meeting on 7 November 2019 was provided.

Decision

The committee noted the action log.

CCG41. Healthcare Associated Infection – Winter Performance Report

The committee considered a report by the Lead Nurse, Infection Prevention and Control, NHS Forth Valley which provided information on all Healthcare Associated Infection (HAI) related activity across Falkirk and Bo'ness Community Hospitals from October to December 2019. The report provided details of all Staph aureus-bacteraemias Clostridioides difficile Infections, Escherichia coli bacteraemia and Device Associated Bacteraemias with a summary of the investigations carried out. The report style had been updated to provide more graphs to give a clearer understanding of the data.

Incidence and outbreaks across Forth Valley were identified through ICNet, microbiology or from the ward. The identification of outbreaks was determined following discussion with the Microbiologist. In the event of a declared outbreak a Problem Assessment Group or Incident Management Team meeting was held with staff from the area concerned and actions implemented to control further infection and transmission. All outbreaks were notified to Health Protection Scotland and Scottish Government.

The influenza season in Scotland started at the end of November. So far the season had been quieter than in previous years with fewer patients testing positive for flu. There had been no influenza cases in Falkirk Community Hospital or Bo'ness Community Hospital.

Decision

The committee noted the report.

CCG37. National Interim Framework for Adult Protection Committees for conducting a Significant Case Review

The committee was provided with a presentation by the Adult Protection Led Officer which covered:-

- the key functions of the Adult Protection Committee
- the national framework for conducting a significant case review

- governance arrangements
- inter-related investigations, reviews and other processes
- on-going liaison with the Committee.

The committee considered a report by the Adult Protection Lead Officer which provided an overview of one of the first actions from the Scottish Governments' Adult Support and Protection Improvement Plan, the plan would continue to be implemented over the subsequent two years.

The national framework outlined that Adult Protection Committee's should develop their own local operating protocol for handling including identifying who had delegated authority to receive an ICR notification, instruct further information gathering and make a decision on whether to proceed to SCR.

The key elements of the local protocol proposal for the Chief Officers Group's overall consideration, comment and approval were:-

- Adult Protection Lead Officer (LO) had delegated authority to receive ICR notifications
- ICR notifications were considered by LO and APC Independent Chair to consider whether criteria was met
- LO requested and received single agency ICR reports
- LO would share single agency ICR reports and LO constructed multiagency chronology with SCR Panel prior to panel date
- APC Independent Chair would advise COG of SCR Panel decisions made and rationale.

It was suggested that SCR Panel membership was discussed and agreed at notification stage. It was recommended that this was a flexible group taking account of the facts of the case. This would both ensure the right people were involved and would create a greater diversity of involvement and commitment to the process across Falkirk. The APC Independent Chair would not be part of the multidisciplinary SCR Panel to allow for an independent casting vote when the panel could not agree whether or not to progress to SCR.

Decision

The committee noted the report and that the key elements of the proposal would be considered by the Chief Officer Group.

CCG38. Mental Welfare Commission Visits

The committee considered a report by the General Manager which provided information on the recent Mental Welfare Commission (MWC) visits to Forth Valley Mental Health Facilities. There were two visits covered within the report. There was an announced visit to Wards 2 and 3, Forth Valley Royal Hospital (FVRH) which took place on the 22nd October 2019 and an unannounced visit to Ward 1(IPCU) FVRH which took place on 21st November 2019.

Announced visit to Wards 2 & 3 FVRH.

There were 5 recommendations to be addressed by the service:-

(1) Managers should ensure that nursing documentation complied with the Nursing and Midwifery Council Code, professional standards of practice and behaviour for nurses, midwives and nursing associates.

(2) Managers should review their audit processes to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

(3) Managers should ensure that patients and their visitors are aware of the options available to them in relation to visiting arrangements.

(4) Managers should ensure that activities provided were age appropriate and that participation was recorded, evaluated and linked to the patient care plan.

(5) Managers should ensure that there were adequate numbers of suitably qualified staff available to allow patients flexible access to the gym.

Unannounced visit to Ward 1 FVRH.

There were 3 recommendations to be taken forward by the service:-

(1) Managers should ensure nursing care plans were person-centred, contained individualised information, reflected the holistic care needs of each person and identified clear interventions and care goals.

(2) Managers should review the provision of OT to the ward to ensure it was adequate to meet the needs of patients.

(3) Managers should ensure specified persons procedures were implemented for patients where required and that the relevant paperwork was completed and reviewed.

Decision

The committee noted the report.

CCG39. Quality & Safety of Care in Bo'ness Community Hospital

The committee considered a report by the Deputy Nurse Director, NHS Forth Valley which provided an update of the actions and improvement activities being undertaken across the 2 Units/Wards of Bo'ness Community Hospital.

The data within the report illustrated performance against key care indicators which determined the focus for ongoing improvement activities. The report sought to provide evidence and assurance on the safety and quality of care across the two Units as part of governance reporting mechanisms. The Quality and Safety report was provided as an appendix.

Bo'ness Community Hospital had 2 Units/Wards. Unit 1 was a 20 bedded Unit for older adults requiring on-going and palliative care. Unit 2 was a 16 bedded Specialist Dementia Unit. Data for the Quality and Safety report was derived from the Nursing & Midwifery Dashboard and Assuring Better Care (ABC) scorecard which outlined care performance data in relation to quality and safety indicators. The data within the report was verified by the independent unannounced Senior Nurse Led Care Assurance Visits.

Decision

The committee noted the report.

CCG40. Reducing the Risk of Falls and Falls with Harm

The committee considered a report by the Deputy Nurse Director which provided a detailed report on the progress of the falls prevention and improvement actions and activities undertaken across Bo'ness and Falkirk Community Hospitals to reduce the risk of falls and falls with harm. It also outlined the monitoring and reporting systems and processes in place.

Falls data for Bo'ness and Falkirk Community Hospitals demonstrated a reduction in falls with harm over the last year, however the overall fall rate had risen slightly. A Falls Leadership Group had been established to review and monitor the falls and falls with harm data. This was shared across the ward areas to the senior charge nurses and the nominated falls champions. Improvement work continued to be shaped using data to empower change and annotate potential intrinsic and extrinsic contributing factors.

Decision

The committee noted the report.

CCG42. Complaints, How they are Dealt with and Experiences

The committee considered Complaints Performance for April to December 2019 for the Falkirk Health & Social Care Partnership. During the period April to December 2019, a total of 20 complaints (excluding complaints transferred/withdrawn/consent not received) were received by the Patient Relations Team relating to the delegated functions for Falkirk Health & Social Care Partnership.

If a complainant remained unhappy with the response received from NHS Forth Valley, they had the right to contact the Scottish Public Services Ombudsman (SPSO) to request an investigation into their complaint. The SPSO was the final opportunity for the complainant in the complaint process and offered an independent view on whether the complaint was reasonably responded to. The SPSO received 4 cases relating to the Falkirk Health & Social Care Partnership during April – December 2019. It was noted that no investigation would be conducted by the SPSO for the case received in December 2019.

Decision

The committee noted the report.

CCG43. The Mental Welfare Commission - Themed Visit Report to people with autism and complex needs

The committee considered a report by the Head of Integration which provided an update on the Mental Welfare Commission themed visit report looking at support for people with Autism and Complex Needs. The report highlighted the need for specialist support to be provided via Health, Social Care and other partners for people with Autism and Complex Needs.

The report recommendations were considered by the Leadership Group at its meeting of 28 November 2019. There were ten recommendations from the report with implications for Falkirk HSCP across 5 themed areas:-

- Assessment and Diagnosis
- Treatment Support/Treatment
- Responding to Crisis
- Environmental Issues
- Crisis.

The Leadership Group agreed that the multi-disciplinary group would develop a SMART action plan and terms of reference.

Decision

The committee noted:-

(1) the ongoing work through a multi disciplinary group, who had begun to develop an action plan based on the recommendations of the report and who would be responsible for monitoring and implementing any changes, and

(2) that the plan would be reported to the next Leadership Group who would monitor progress and report to the committee on a 6 monthly basis.

CC44. Mental Welfare Commission Scotland Investigation

The committee considered a report by the Head of Integration which provided information on the Mental Welfare Commission for Scotland (MWCS) Investigation report. MWCS published their findings in relation to an investigation into the care and treatment of a woman with learning disability, whose discharge from an acute orthopaedic ward was delayed by 18 months.

A report was submitted to the Partnership Leadership Group's meeting of 3 October 2019. At that time the group recommended the establishment of a Task and Finish Group to consider the recommendations and assure around the Adults with Incapacity (AWI) processes.

The investigation considered several areas including:-

- communication between professionals and the service user and her family;
- risk assessment, risk management and care and support planning,
- legal aspects;
- implementation of self-directed support and the related policy framework, and
- decision making.

MWCS found failings in all the above areas. The report cited systemic issues with Social Work capacity in relation to delay in appointing a care manager and a lengthy delay in allocating a Mental Health Officer (MHO); delays in the guardianship process and the position taken by the HSPC in relation to the suitability of a family member for some of the powers sought.

MWCS concluded that "Had a genuinely open and collaborative planning process taken place, there might not have been a need for guardianship if a return home had been agreed". It was their view "that discharge could have been achieved within a few weeks, rather than the almost 18 months of delay she and her family experienced".

Four key recommendations for Health and Social Care Partnerships were identified:-

(1) Put in place governance measures to ensure that assessment and support planning:-

- Is carried out in line with national and local guidance;
- Has the rights, will and preferences of the person central to the process; and
- That where there were significant difference of opinion this is clearly documented and provided to decision makers.

(2) Ensure that where there is a significant level of dispute, impacting on a discharge from hospital, there are formal mechanisms to address issues and agree a way forward.

(3) Where the relationship between assessors and the individual and their family has broken down, to consider measures such as reallocation where possible, or mediation.

(4) Ensure that high level scrutiny mechanisms monitoring delayed discharge do not allow cases to be put on hold due to awaiting court processes and activity to progress discharge continues, in line with the new Scottish Government guidance on discharging Adults with Incapacity.

There were a number of recommendations in respect of Local Authorities relating to MHO practice to ensure there are clear procedures in place which ensure:-

- There is a system for referral that prioritises people delayed in hospital
- The MHO independent role is respected and supported
- MHOs are always invited to AWI Case Conferences
- Disagreement with a Care Plan is not an indicator of unsuitability of an applicant for guardianship.

Decision

The committee noted the:-

(1) contents of the investigation report;

(2) progress of the Delayed Transfers of Care for AWI cases, Task and Finish Group, and

(3) outcome of the case reviews for those in a hospital setting within an AWI process.