APPROVED

NHS GRAMPIAN

Minutes of Meeting of **NHS Grampian Clinical Governance Committee** held in Open Session on **Tuesday, 13 August 2024** at 1330hrs virtually by MS Teams

Present	Dennis Robertson (DR)	Chair, Non-Executive Board Member
	Mark Burrell (MB)	Non-Executive Board Member / Specialty Doctor / Service Clinical Director ADH/OMFS
	Dave Russell (DRu)	Public Representative
	John Tomlinson (JT)	Non-Executive Board Member
Attending	June Brown (JB)	Executive Nurse Director / Deputy Chief Executive (Item 6)
	Paul Bachoo (PB)	Acute Services Medical Director (Item 7.1)
	Noha El Sakka (NeS)	Consultant / Lead Infection Prevention and Control Doctor (Item 8)
	Tara Fairley (TF)	Associate Medical Director - Clinical Assurance and Quality
	Nick Fluck (NF)	Medical Director
	Stephen Lindsay (SL)	Non-Executive Board Member / Employee Director
	Kenneth O'Brien (KOB)	Associate Director of Adult Public Protection (Item 9)
	Shonagh Walker (SW)	Associate Medical Director – Professional Performance
Invited	Geraldine Fraser (GF)	Integrated Families Portfolio Executive Lead
	Isla Gray (IG)	Quality Improvement and Assurance Advisor – Feedback (Item 10)
	Sean Harper (SH)	Director of Psychology (Item 11)
	Grace Johnston (GJ)	Infection Prevention & Control Manager (Item 8.1)
	Gerry Lawrie (GL)	Head of Workforce and Development (Item 12)
	Linda Ann Lever (LL)	Team Lead Adverse Events and Feedback
	Rachael Little (RL)	Quality Improvement & Assurance Advisor (Item 5)
	Jennifer Matthews (JM)	Corporate Risk Advisor (Item 7)
	Fiona Miele (FM)	Lead Nurse Child Protection and FNP Lead (Item 9)
	Matthew Toms (MT)	Head of Performance Governance (Item 13)
	Elizabeth Wilson (EW)	Health and Care Staffing Act Implementation Programme Manager
	Andrea Salvona	Quality Improvement & Assurance Administrator (Minutes)
Apologies	Alison Evison (AE)	NHSG Board Chair / Non Executive Board Member
	Emma Houghton (EH)	Associate Medical Director – Primary Care
	Miles Paterson (MP)	Public Representative
	Hussein Patwa (HP)	Non-Executive Board Member
	Gillian Poskitt (GP)	Associate Director - Quality Improvement & Assurance

Item	Subject	Action

1 Apologies

Noted as above. The meeting was quorate.

2 Declarations of Interest

No declarations of interest.

Chair's Welcome and Briefing

The chair welcomed members and introduced John Tomlinson who is joining the Clinical Governance Committee (CGC) as a substantive member of the Committee. Mark Burrell chaired the remainder of the Committee meeting.

3 Minutes of Meeting on 14 May 2024

Agreed as accurate. SL noted he had been missed from distribution of papers and requested designation be listed as Employee Director. Committee support to action.

4 Matters Arising

Three items have been confirmed as returning to Committee on 12 November 2024. The Annual Delivery Objectives and Primary Care GP data items are yet to be agreed when they will be presented to Committee.

5 Cross-System Quality, Safety and Assurance Group Update

Rachael Little, Quality Improvement & Assurance Advisor, outlined the paper which summarised the Cross System, Quality, Safety and Assurance Group meetings. RL clarified the meeting was not intended for escalations, reporting, or performance measures. The purpose of the group was for discussions and sharing of good practice.

RL summarised paper provided. Highlighted the Handling and Learning from Feedback Annual Report from the Complaints and Feedback Team in the Improvement section. Also discussed at Item 10.

Recommendation: The Clinical Governance Committee is asked to note this report and actions taken.

The Committee agreed and accepted the recommendations.

6 Clinical Risk Meeting Report

June Brown, Executive Nurse Director, provided key highlights from the Clinical Risk Meeting (CRM) paper. Paper intended to provide assurance and management of board level deviations and is aligned to Strategic Risk 3068 which focuses on deviations from recognised service standards of practice.

- There have been no escalations from the CRM group to the Chief Executive Team (CET).
- The Safe Transfer of Patient work is complete and due for review in February 2025. The non-standard patient group can review any deviations in care, where work continues on measuring safety and risks and these come to CRM on a monthly basis.
- There were a number of complaints and the rate of complaints have increased. However, the Scottish Public Services Ombudsman (SPSO) cases have decreased.
- The report contains details of any mitigations of risks.

Work was progressing by Tara Fairley, the CRM Chair and Gillian Poskitt, Associate Director – Quality Improvement and Assurance, in relation to clinical governance processes to understand optimum working across the system. Any name change will be notified to the group.

The CRM takes a proactive approach to looking at data and asking questions if there has been a change to ensure this is not going to impact other elements and provide a balance between clinical, financial, and staff governance.

The group is also observing for any change in data about the quality of care being delivered. JT was reassured that the process was fit for purpose.

A disparity was noted in the report. 22% of trainees were less than full-time whereas NHS Education For Scotland suggested this was 10%. SW reported there had been a change in the application process, employees may be selecting part-time as an option to work sustainably and prevent future burnout.

DR clarified there was instruction from Scottish Government to avoid noting papers and take a more proactive approach. This was to ensure papers were reviewed and given appropriate time to identify the assurances.

JB clarified the request to committee was to be assured there is appropriate actions in place to mitigate risks in relation to deviations of standards of care and apologised this had not been communicated effectively in the paper.

It was suggested that the reports should be framed to be directive as opposed to for noting.

Recommendations: The Clinical Governance Committee is asked to note the clinical risk profile and associated impact of board level deviations highlighted in this report and to provide support to the actions being taken to reduce risk.

The chair was assured despite the semantics of the group's name and the committee agreed and accepted recommendations.

7 Strategic Risk Reports

JM introduced the two risk papers and asked the committee to scrutinise the processes of the risks including governance and to consider the overall picture. One risk was split into two which allowed an added level of granularity to enable the required focus from a risk-based perspective as aligned with the requirements of NHS Grampian.

7.1 Risk 3065 'Inability to meet population demand for Planned Care'

Paul Bachoo, Acute Services Medical Director, presented an overview of work in progress to monitor Risk 3065.

The presentation provided an overview of data from the Health Intelligence team, the Portfolio Governance process, and PBs role as Lead for Planned Care on mortality data with the purpose of demonstrating risk in detail thorough analysis of all available local and national data.

National data on deaths within 30 days of a planned surgical procedure for NHSG show deaths within 30 days of a surgical procedure across all specialties have declined. All other NHSG specialities lists have mortality rates within the controls and often below what has been set.

Local data on the number of patients who die while on the waiting list shows an increase in the number of patients on waiting lists with multiple comorbidities.

Trends analysed from patients attending Emergency Department (ED) admissions from the inpatient waiting list over the last three years showed those at the highest risk while on the waiting list are from those who require operations within 30 days (ESCats1). 95% of resource capacity for planned care is directed to this patient group. Reassurance was given this was an area of focus.

ESCatS1 categories data showed a stabilisation of the waiting list for inpatient surgery resulting in a phased reduction in admissions. The numbers were small.

Emergency Outpatient data showed considerable waits and an increasing trend in ED admissions from patients awaiting new outpatient appointments, although the numbers were small. This was affecting a sub- group of specialities (General Surgery, Acute Medicine, Urology, Trauma and Orthopaedics) as patients were readmitted. NHSG numbers of non-elective length of stay are comparable to other hospitals and appear satisfactory but data from individual hospitals is less satisfactory and has time and cost implications.

PB summarised the findings for the paper concluding that the strategic risk remains at an intolerable level. Separating the risk allows a better understanding and more proactive approach to managing or suggesting actions to reduce the risk and ensure access to planned care. There is a focus required on overall capacity.

PB confirmed in response to DRu, there was no correlation between the cause of some patient's death identified in the report and previously identified conditions: deaths of patients in elective inpatient day cases are not a result of surgery or wait, they are often

because they have multiple significant life-limiting critical conditions. Additionally, there was no list of patients who have died on consultant waiting lists who have not been identified as requiring elective surgery or treatment within a hospital surrounding.

DRu sought assurance that delays that may be due to information management and information technology had been addressed.

PB conveyed processes could be faster and better integrated and that ownership of information needed to be part of a wider cultural shift to an integral part of normal day-to-day working and referred to the recent success at the recent transfer of patients to another hospital for breast cancer.

MT gave reassurance that robust processes were in place although in some cases, this was a manual process.

It was confirmed there has been consideration of demographics and increases in elderly and frailty cases but there was no reason to include as the key was timely access to planned care for all. Currently, the balance is towards unplanned and NHSG requires better usage of planned care capacity and bed base. This was linked to modernising surgical pathways and the use of technology and advancing technologies in surgery, particularly when demand goes up.

In terms of research on the length of wait and its impact on patient outcomes, it was reported there was an increasing likelihood of escalation for outpatients, and the readmission risks identified in the paper were referred to. A PhD student within NHSG currently working on this issue.

Recommendations: The Clinical Governance Committee is asked to review and scrutinise the information provided in this paper and confirm that it:

- Provides assurance that improvements are being made regarding the management of strategic risk 3065 and appropriate evidence has been provided of these improvement activities and any gaps in controls or mitigations have been identified and are being addressed.
- Determine if the assurance level assigned to the management of risk 3065 is appropriate at limited.

7.2 Risk 3639 'Significant delays in the delivery of Unscheduled Care'

Geraldine Fraser, Integrated Families Executive Portfolio Lead, highlighted issues from the paper on Unscheduled Care Strategic Risk circulated to the committee.

NHSG had attendances for unscheduled care, the lowest presentations in Scotland per head of population at ED, and the lowest number of ambulance conveyancers to emergency services in Scotland per head of population. Work has been provisioned for alternative provision of care including flow navigation centres and 'call before you convey' with the Scottish Ambulance Services (SAS) resulting in positive outcomes for patients.

Of note, was an increased acuity and complexity in patients admitted which is affecting length of stay. The acute bed base does not meet the demand for medical and unscheduled care. Current data shows NHSG 1.4 acute hospital beds per thousand of population, which is lowest in Scotland. Work ongoing to maximise resource and mitigate risks.

GF explained the consequences of long waiting period in ED and Acute Medical Initial Assessments. Non-standard beds and corridor care were a solution but not a long-term solution.

The report will be submitted to Staff Governance Committee acknowledging the impact on the workforce.

GF provided additional details of ongoing work. Grampian Operational Pressure Escalation System and the Daily System Connect are flagged and the Civil Contingencies

Group are reviewing issues more effectively on a whole system basis. A new tactical group is being established to predict bed availability for better planning, management and to analyse past data for learning.

Further strategic improvement work is ongoing, led by the Unscheduled Care Programme Board and supported by the Scottish Government Unscheduled Care Improvement Team and Centre for Sustainable Delivery, who have requested a focus on targets. While this will result in improvements, it was stressed there will be no significant change in the system unless the bed base needs are addressed. Work is ongoing on the bed-base review and emergency capacity plan. This will go to the Chief Executive Team.

Visits undertaken at other Boards to understand their Unscheduled Care system. Learning will be used and adapted for new NHSG initiatives.

MB was pleased to see continuing work on controls and welcomed questions from Committee.

DRu queried if focus on reducing the length of stay was backed by data and if there was an opportunity to reduce stays in hospital from stays of 6-7 days to 5.

GF confirmed there are separate targets for 7 days, and separate work ongoing for improving patient journeys around delays and reducing delayed discharges with Health and Social Care Partnerships. NHSGs performance on this was positive with good turnaround times. The discharge lounges are not always fully utilised. Discharge champions are currently being considered, they will be monitored and reported on.

GF responded to a question from the report about controls not being consistently applied in peaks of resource constraint. Earmarked funding for Unscheduled Care Performance can be used for increased capacity as opposed to time-limited improvement activity.

In response to comments regarding work undertaken by the Integrated Joint Boards (IJB), GF reported on current work through the Chief Officer on coordinating the Unscheduled Care Team and IJB delayed discharge work to ensure a joined-up approach.

JT was partly assured but will reflect and follow up with other IJB colleagues in Grampian regarding a whole system focus on impact of different works.

DR commended, work to mitigate the risk given existing capacity issues.

GF has been in touch with communications staff and spoke about public messaging around discharges. Further work could also be considered on barriers to discharges and the delayed discharges champion model spanned for a trial. Provision is being reviewed for emergency capacity in Woodend and Rosehill through the bed base review and this could be considered in winter planning. When patients are identified for boarding out, this can add two days to their acute stay and impact on beds for planned care. Situation is complex and needs consideration.

GF noted there were lots of skilled and experienced staff working on this, reviewing every possibility and making good progress.

DR highlighted and commended, joint work with SAS to prevent ambulance stacking.

GF highlighted the potential and willingness to explore a whole system approach referring to engagement from GP and Primary Care colleagues at a recent workshop and keen to work jointly.

Winter planning work underway with no predictions from Public Health this would be different from last year and plan will go to NHSG Board. There is a move away from a seasonal approach and to adopt a flexible approach. The Emergency Capacity Plan will sit alongside the general winter planning.

The chair was reassured everything was being done to mitigate risks.

Recommendations: For assurance the Clinical Governance Committee is asked to:

- Review and scrutinise the information provided in this paper and confirm that it provides assurance that improvements are being made regarding the management of strategic risks 3639 and appropriate evidence has been provided of these improvement activities and that any gaps in controls or mitigations have been identified and are being addressed and for decision.
- Determine if the assurance level assigned to the management of risk 3639 is appropriate at limited.

The chair was reassured everything was being done to mitigate risks and agreed on recommendations.

8 Healthcare Associated Infection (HAI) IPCT Report (April 2024) and 8.1 Healthcare Associated Infection (HAI) IPCT Report (January 2024)

Dr Noha El Sakka (NeS), Lead Infection Prevention and Control Doctor, updated on Healthcare Associated Infection Reports circulated to the Committee to inform of key Healthcare Associated Infection issues and actions.

NeS reported that Staphylococcus aureus Bacteraemia (SAB) is above the national average in Quarter 1, despite being higher than the national average, the figures are within a 95% confidence interval, are not outliers nor above the normal variation in relation to healthcare or community associated SABs that were expected from previous years.

A range of other actions were progressing with environmental health concerns outlined in the paper.

It was clarified during questions that this relates to Risk 3566 the current lab capacity had previously undertaken environmental testing however at present they have limited capacity to do this. There are ongoing explorations between the laboratories and IPCT on how this would be received if required.

MB remarked on the need for further training on peripheral venous cannula (PVC) to keep up with the national standards.

Recommendations: The Clinical Governance Committee is asked to:

- Review and scrutinise information provided in the paper and confirm it provides assurance that the policies and processes necessary are in place and are robust and that any gaps have been identified and assessed and risks are being mitigated effectively.
- Acknowledge that improvements to policies and processes are being made and appropriate evidence of these has been provided to the committee's satisfaction.

The Committee agreed and accepted the recommendations.

8.1 Healthcare Associated Infection (HAI) Reporting Template (HAIRT)

NeS explained the reporting template circulated covering information from October to December 2023 was submitted to the committee after being taken through several layers of other committees as part of a governance and ratification process.

The Committee ratified and approved the document.

9 Public Protection Team

Kenneth O'Brien, Associate Director for Public Protection, and Fiona Miele, Child Protection Lead Nurse, co-presented and highlighted significant developments, activities, and issues from the 2023 Public Protection Annual Report.

Key updates detailed were:

- Appointment of NHSG Adult Public Protection Learning & Development Co-ordinator.
- Contributor to, and early adopter of the national self-evaluation toolkit for NHS Public Protection Accountability and Assurance Framework
- Developed Protecting People public website linking visitors from NHSG website
- Reorganisation of statutory and mandatory level 1 training in the Joint Integrated Child and Adult Protection Online Training programme.
- Evaluation from the Joint Inspection of services for children, young people in need of care and protection report concluded the overall impact of services was adequate, with 3 areas of improvement.
- Learning Reviews - Activity across NHSG child protection committees identified a number of cases of sudden infant deaths where parental substance misuse was a feature, leading to the North East Child Protection Partnership Conference and the creation of video footage of event currently used by NHSG staff and multi-agency workforce across Grampian.
- Development of NHSG Child Protection Policy
- National Bairns' Hoose Development - Preliminary work, contribution to, and impact of supporting children and young people through the Child Protection investigations process in Aberdeen City and Aberdeenshire.
- Launch of, and recruitment of staff for Adult Support and Protection Champions Programme: assessment and evaluation has been positive.
- The Joint inspection of Adult support and protection in the Aberdeenshire Partnership area was positive on a multi-agency basis, health duties and responsibilities and identified areas for improvement now integrated into the improvement action plan.
- Conclusion of work with mental health, psychology, and social work colleagues jointly to delivery of Pathway for Capacity Assessments for Protection Based Decisions
- Gender-Based Violence (GBV) - Appropriate operational procedures and information governance arrangements in place for the management of health, attendance, and participation at Multi-Agency Risk Assessment Conferences (MARAC) for Gender Based Violence for NHSG public protection specialist nurses. Acknowledgement of risk in the early identification of GBV.
- Female Genital Mutilation (FMG) - Staff receive ongoing support and training, particularly from public protection midwives.
- Human trafficking - Ongoing work and continuation of training and support. Acknowledged further instances of human trafficking within the Police Scotland area.
- Ongoing work to meet legal requirements and identification of key risks for Multi-Agency Public Protection Arrangements (MAPPA)

JT queried the governance and improvements in GBV and requested clarity on updates to Committee. KOB clarified there had been success in resolving the issue of Staff attending MARA. Public Protection Committee Quarterly report is brought to the Clinical Governance Committee.

JB clarified that GBV sits with Public Health and was a challenge. Advised, meeting tomorrow with Public Health in relation to this risk. Work ongoing, and JB offered to report back to Committee as conversations progress.

Recommendation: The Clinical Governance Committee is asked to approve the contents of the report.

The committee approved the contents of the report.

10 Handling and Learning from Feedback Annual Report

Isla Gray, Quality Improvement and Assurance Advisor – Feedback, presented key points from the Annual Report to Committee.

Issues of training new staff on the feedback system, how items are escalated, and how compliments are dealt with and other ways of recording patient satisfaction were commented on.

Recommendation: The Clinical Governance Committee is requested to:

- Approve the NHS Grampian Handling and learning from feedback annual report for publication

The Committee commended the report and approved the recommendation.

11 Professional Annual Assurance Report – AHP and Psychologists

Sean Harper, Director of Psychology, presented on Professionals Assurance for Applied Psychology in NHS Grampian which was circulated in the meeting papers.

Points raised in the slides included:

- The development over the last year of a professional structure for assurance and accountability.
- The newly formed forum titled Psychological Therapies Improvement in Governance Board for the overall governance of all psychology and psychological therapies.
- Obtaining and retaining regulation for the Health and Care Professionals Council (HCPC), and the applicability of CEL 23 for all other professionals.
- Clinical Supervision, Turas appraisals and monitoring of, and management of performance by NHSG policies and guidelines and regulatory bodies.
- Involvement in strategic bodies and groups to ensure psychological perspective is considered.
- Ensuring regular appraisals to look at performance, learning needs and goals.
- Engagement with NHSG Programme implementation team to ensure compliance with the Health and Care (Staffing) Scotland Act 2019 including a standing item on the Senior Psychologist Forum and a SOP to cover risk, risk assessment, mitigation, and escalation procedures, including actions and staff training time for leadership.

SH highlighted, major risk was reduced funding for recent psychology posts while being one of the lowest work time equivalents for the workforce in Scotland per 100,000 population. Performance has improved over the last few years however, it will be challenging to maintain current performance to waiting times given reduced funding.

JT asked if item should be submitted more widely to the Health and Social Care Partnerships and the IJBs Clinical Governance Committees. NF advised, there were some complexities but agreed visibility within the Partnerships would be helpful.

Recommendations: The Clinical Governance Committee is asked to review and scrutinise the information provided in this paper and confirm it provides assurance that the psychology service is delivering sufficient controls to support the professional assurance framework, and it is assured that applied psychologists are trained and supported to provide safe and effective clinical care.

The Committee accepted the recommendations.

12 Health and Care Staffing Act and Clinical Governance Implications

Elizabeth Wilson, Health and Care Staffing Act (HCSA) Implementation Programme Manager, and Gerry Lawrie, Head of Workforce & Development, presented to the Clinical Governance implications arising from the Health and Care Staffing Act.

GL noted was first time the matter had been presented to the Committee and briefly went through the background, context, and principles of the act. Work sits with services to fulfil

the duties required while implementation of the Act is supported by EW and another staff member.

EW updated on where the work is sitting currently and expanded on key points of framework and requirements. A range of duties are reported into an annual report. First annual report is to be submitted in April 2025 and is published the same day. First quarterly report on high-cost agency workers for all roles has been submitted. EW outlined the duties and requirements and reported on ongoing work around the duty to have arrangements to address severe and recurrent risk and ensure adequate time given to clinical leaders to ensure the requirements of the act on staffing elements. There are staffing level tools currently in place in nursing, midwifery, and medics in ED. A range of national resources are available for staff and the 2 page quick guides are being actively promoted.

The approach taken has been to build on existing reporting, reporting mechanisms and processes. EW referred to relevant questions to be asked in terms of the shared opportunity with the Clinical Governance Committee:

- How have any of the act's related systems and processes improved outcomes for service users? Would this be a tangible element that could be teased out through any of the reports already being sought?
- Would there be anything around the achievements and outcomes from a positive perspective from the act that is impacting on that safe, high-quality person-centred care as well as from any of the learning and risks identified?

EW hoped these would start conversations.

MB commented, the balance of duty to training, service provision, and clinical leaders getting time always has tension.

In response to a question about the consequences of NHSG failing in any of these duties, EW clarified there were no financial consequences laid out in the act but there would be an impact on public confidence as well as external bodies coming internally to work with NHSG.

GL noted this was a journey and work in progress, compliance would not necessarily be achieved in this year given complexity and size of organisation but is being supported and facilitated by the roles in place.

NF commented on the need to clarify which aspect of the reporting will be most usefully viewed in both the Clinical Governance Committee and Staff Governance Committee.

EW responded to a further query on how outcomes will be measured. It was agreed prior to the programme that the reporting mechanism was through Staff Governance Committee to seek assurance on behalf of the Board. The discussion today was about looking to align questions sought by the CGC from others and incorporate them into the reports required under the act. It was agreed if any clinical concerns arose those would come to the CGC.

EW clarified that some processes are still being identified in terms of risks being escalated but there was input into the Implementation team, from operational teams, professional group representatives and EW and GL. Clinical Professional Directors are also supporting the development of a standard process.

EW clarified aim is to build processes into working practice consistently which will meet the requirements of the act.

Recommendations: The Clinical Governance Committee is requested to note an overview of the Health and Care (Staffing) Scotland Act 2019 and consider implications for the committee.

The Committee thanked EW and GL for the presentation and thought provoking paper and accepted the recommendations.

13 ISCP - Local Access Policy and Out of Area Placements.

Matthew Toms, Head of Performance Governance, provided an update on the changes made to the Local Access Policy following a request from the Committee to review if there had been any unintended consequences following these changes, particularly in relation to patients living within areas of deprivation.

MT reported that the pattern of deprivation linked to DNA (did not attend) and CNAS (could not attend) has not changed, and do not believe there is any detrimental impact on these patient cohorts by the changes made.

MT confirmed that monitoring will continue. DR suggested that regularity of reporting will be discussed at the CGC de-brief meeting.

Recommendations: The Clinical Governance Committee is assured that:

The access policy changes have not had an unintended consequence and the ongoing monitoring to will continue via the Integrated Specialist Care Portfolio Programme Board

The Chair thanked MT for report and accepted the recommendations and reassured that this will be monitored.

14 Any Other Competent Business

SL reiterated request to be included in the distribution list and requested papers in advance as a member of the committee.

15 Date of Next Meeting

12 November 2024, 1330 – 1630 Hours, MS Teams