APPROVED

NHS GRAMPIAN

Minutes of **NHS Grampian Clinical Governance Committee** held in **Open Session** on **Tuesday, 11 February 2025** at 1330hrs virtually by MS Teams

Present

Dennis Robertson (DR)	Chair – Non-Executive Board Member
David Blackbourn (DB)	Non-Executive Board Member
Mark Burrell (MB)	Vice Chair – Non-Executive Board Member / Chair of Grampian Area Clinical Forum / IJB Clinical Governance Representative (Aberdeen City)
Hussein Patwa (HP)	Non-Executive Board Member *(in attendance until 1530hrs)*
Dave Russell (DRu)	Public Representative
John Tomlinson (JT)	Non-Executive Board Member *(in attendance until 1500hrs)*

Attendees

Paul Bachoo (PB)	Acute Services Medical Director / Integrated Specialist Care Portfolio Executive Lead
June Brown (JB)	Executive Nurse Director / Interim Deputy Chief Executive – Item 7
Adam Coldwells (AC)	Interim Chief Executive
Noha El Sakka (NeS)	Infection Prevention and Control Doctor / Clinical Lead – Items 9 & 9.1 *(in attendance until 1500hrs)*
Alison Evison (AE)	Chair of Grampian Board / Non-Executive Board Member
Tara Fairley (TF)	Associate Medical Director – Clinical Assurance and Quality – Item 13
Emma Houghton (EH)	Associate Medical Director – Primary Care and Hosted Services
Grace Johnston (GJ)	Infection Prevention & Control Manager – Items 9 & 9.1
Steven Lindsay (SL)	Non-Executive Board Member / Employee Director / IJB Clinical Governance representative (Aberdeenshire) *(in attendance until 1500hrs)*
Derick Murray (DM)	Non-Executive Board Member / IJB Clinical Governance Representative (Moray)
Kenneth O'Brien (KOB)	Associate Director for Public Protection

Invitees

Mike Brown (MBr)	Director of Dentistry – Item 12
Sarah Duncan (SD)	Board Secretary
Jonathan Iloya (JI)	Consultant in Dental Public Health – Item 12 *(in attendance from 1500hrs)*
Rachael Little (RL)	Quality Improvement & Assurance Advisor – Items 5, 6 & 13
Jennifer Matthews (JM)	Corporate Risk Advisor – Item 8
Shantini Paranjothy (SP)	Deputy Director of Public Health – obo Susan Webb – Item 10
David Pfleger (DP)	Director of Pharmacy – Item 11 *(in attendance from 1500hrs)*
Rachel Soplatila (RS)	Chief Nurse for the Public Health Directorate – Item 10
Laura Gunn	Quality Improvement & Assurance Administrator (minute taker)

1 Apologies

Noted apologies received from: Hugh Bishop, Lynn Morrison, Miles Paterson, Gillian Poskitt, and Susan Webb. The meeting was quorate.

2 Declarations of Interest

There were no declarations of interest.

3 Welcome and Introduction

Chair welcomed members, attendees and invitees to meeting.

4 Minutes of Meeting on 12 November 2024

Agreed as accurate.

5 Matters Arising

JT referenced item 26 on Matters Arising Log in relation to Strategic Risks. Chair advised no update available, would review and update at next Committee meeting.

6 Cross-System Quality, Safety and Assurance Group Update

Rachael Little, Quality Improvement & Assurance Advisor, highlighted key areas of paper circulated of discussion held during Group meeting on 11 December 2024. The first meeting of 2025 was cancelled following an announcement from Chief Executive Team requesting any non-urgent meetings to be postponed due to high level of activity in the system.

Chair thanked RL for update. Commented on Portfolio Highlights item and the number of apologies at the 11 December 2024 meeting. Asked if meeting would have been quorate to ensure appropriate representation across the system. RL explained, the terms of reference (ToR) does not require a quorum. The ToR is due for review and would relay this point to the Co-Chairs of Group.

HP discussed recording staff wellbeing, sharing of learning across the system, and ensuring training and development for staff is available while the system pressures continue. RL thanked HP for comments and would relay these to the Co-Chairs of Group for consideration in future agendas.

MB shared views that the paper holds similar themes to those within the Clinical Risk Meeting Report and suggested combining in one paper. TF responded, both groups have similar functions and membership presently. Intention is to move Cross-System Group towards a focus on organisational learning. Less complex agenda, with a particular focus at the meeting on 1 or 2 topics. Exampled the Critical Thinking Session that took place in November 2024 and had a focus on staff communication as a theme from complaints. CRM and Whole System Clinical Governance Group, both chaired by TF, will have a focus on governance, assurance and performance.

Recommendation: The Committee is asked to review and scrutinise the information provided in this report and confirm that it provides assurance on cross system learning, mitigation of clinical and care risks and identification of areas for improvement activity.

The Committee agreed and accepted the recommendations.

7 Clinical Risk Meeting (CRM) Report

Prof. June Brown, Executive Nurse Director, provided key highlights from the CRM Report circulated to Committee. Paper intended to provide assurance and management of board level deviations and is aligned to Strategic Risk 3068 ‘Deviation from recognised service standards of practice and delivery’.

MB thanked for detailed report and acknowledged the useful summary section. MB expressed interest in joining membership of CRM as Chair of the Area Clinical Forum, JB agreed this would be a useful connection.

Further, MB commented on the handling of complaints and amendment to escalation process for complaints open over 80days. Will welcome a progress report once process embedded.

DRu referenced Bed Base Review and asked for an update on the discussions between CET and Scottish Government. AC informed, discussions ongoing. The required further capacity is understood by SG. Mechanism for addressing is not yet clear. Financial plan to be submitted to SG. JB confirmed in the meantime Bed Base Review business case is progressing. Hope that SG will be able to offer support as NHSG has the lowest number of beds in Scotland.

JT referenced the creation of whole-system urgent and unscheduled care ecosystem map and item 18 on the matters arising log in relation to primary care GP data. Both items impact each

other. Asked if Health and Social Care Partnerships (HSCPs) are part of the ecosystem and if governance is appropriately aligned. TF leading work reviewing clinical governance structures across NHSG and identified that it would not be possible for the acute sector or Integrated Joint Boards (IJBs) to function independently. Whole System Clinical Governance Group has representation from across the system, IJBs, Portfolios, etc. Intention for Group to be a place to work towards whole system solutions to most challenging clinical governance issues. Of note, Group remains in infancy stages, only 2 meetings have occurred however engagement from colleagues has been positive.

Recommendation: The committee is asked to review and scrutinise the information provided in this paper and confirm that it provides assurance that a reasonable and proportionate response is in place to minimise harm to patient and staff.

The Committee agreed and accepted the recommendations.

8 Strategic Risk Report

Jennifer Matthews, Corporate Risk Advisor, provided a summary of paper circulated to Committee. Purpose of paper is to inform Committee of the revised proposals of Board Risk Appetite for consideration and, ask Committee to endorse proposal of Strategic Risk reporting to Board Committees twice per year.

MB positively noted the open invitation to Chairs of Advisory Groups to the Board Seminar that took place in January 2025. Found session to be informative. Require to look at escalation mechanisms. For e.g. all options exhausted as a Board and risk remains in place, what support can be provided by Scottish Government. Chair added, CET continue to review NHSG Strategic Risks regularly and will be discussing escalation.

DRu asked if there has been consideration to groups with different risk appetites collaborating meaningfully together. JM responded, next step in process is putting risk appetite into practice. Require to raise awareness of document across the organisation with learning to aid understanding. Risk appetite statement is benchmarking document and would like consistent application across the organisation. Organisational approach to decision making, risk appetite statement to be used as a consistent tool and align to goals of organisation.

In response to JT, JM agreed, strategic risks should be prioritised across the Board Committees. Understand there has to be a balance and will work with Chairs and Committee support to schedule risk reporting appropriately. AC assured that CET are prioritising risks. Meeting every 6 weeks for 2hrs with dedicated risk session which is working well. Further, JT added, can agree to the proposal with caveat that process will evolve as it embeds into Committees and bring shared experience to Board Committee Chairs meeting.

JB shared support of proposals. Key role of Clinical Governance Committee to scrutinise and seek assurance around NHSG Strategic Risks.

MB discussed implementation of risks across services and tensions of regulators. To bear in mind, in relation to clinical application of risks, conflicts with people that are regulated. JM acknowledged the requirement to recognise and consider tolerance and limits when putting this into practice. Relates to how we get the understanding of colleagues implementing day to day.

Chair thanked JM for update. Noting this will be JMs last Clinical Governance Committee due to an extended period of leave.

Recommendations: The committee is asked to:

- Consider the revised proposals regarding Board Risk Appetite levels, providing comment when required.
- Consider and endorse the following proposals regarding the Strategic Risk Management process: Strategic Risks to be reported to aligned Board Committees twice per year.

The Committee agreed and accepted amended recommendations.

9 Healthcare Associated Infection (HAI) Report

Dr Noha El Sakka, Infection Prevention and Control Doctor / Clinical Lead, updated on Healthcare Associated Infection report circulated to Committee. Key points related to Healthcare Built Environment, National Surveillance Key Performance Indicators, Multi Drug Resistant Organisms (MDRO) Screening, and Risks.

Chair thanked for comprehensive update and detailed report. Asked if system pressures could be a factor of MDRO screening non-compliance. NeS responded, is multifactorial however potential that if staff are under sustained pressured screening may not be prioritised.

MB asked for progress update on Very High Risk 3770 “Apparent Lack of Appropriate Organisational Governance of Ventilation Systems in NHSG.” JB advised, Infection Prevention and Control Team (IPCT) and Facilities and Estates Team working in collaboration to develop a Ventilation Safety Group where concerns and recommendations can be discussed. Ventilation safety is responsibility of Facilities and Estates.

In response to JT, NeS updated on the pausing of environmental testing for IPC purposes by NHSG microbiology laboratory. Requests are considered on individual, case by case basis, and provided where capacity allows. Positively noted, good relationship between IPCT and Lab. A business case is being developed by Lab for an internal lab service which will support this function partially. Due to current financial position of NHSG it is unclear if this will progress.

JT commented, assured by report.

Recommendations: The committee is asked to:

- Review and scrutinise the information provided in this paper and confirm that 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 processes are being made and appropriate evidence of these has been provided to the Committee’s satisfaction.

The Committee agreed and accepted the recommendations.

9.1 HAI Quarterly Report – October 2024

NeS advised Report provided for information. Committee content Report is for noting.

JT commented on ward closures due to enteric and respiratory incidents / outbreaks and asked of impact on system in terms of lost bed days. JB responded, data is collated by service, work led by Head of Performance Governance for the Medicine and Unscheduled Care and Integrated Specialist Care Portfolios. Explained, if ward is closed, patients will be appropriately discharged from ward and bed will remain empty until outbreak is finished and IPCT assured control measures in place are working effectively.

10 Highlighted Portfolio – Public Health

Shantini Paranjothy, Deputy Director of Public Health, highlighted key points from paper circulated to Committee. Purpose of paper, to provide an overview of clinical governance arrangements and work undertaken by the Public Health Directorate.

MB welcomed the layout of paper utilising the seven pillars of clinical governance. Good examples of governance structures within the directorate and looks forward to seeing how this progresses.

In response to JB, SP advised, Public Health deliver some services directly for e.g. Waiting Well Service. An adverse event has occurred in this service and the Public Health Directorate followed appropriate process and undertook a Level 1 Review. However delivery of Vaccination

Programmes for e.g. is via HSCPs and therefore the HSCP would be responsible for any adverse event that occurred while delivering. If required an Incident Management Team and Problem Assessment Group would be set up.

HP queried routes of public engagement and how Public Health Directorate ensure appropriate engagement. SP responded, some groups have partners who engage with public (i.e. Friends of Anchor) and feedback. Used Vaccination Programme as an example. Needs Assessment undertaken to understand how service delivery can be improved in terms of access. Inequalities lens, engaged with public, reviewed barriers and used feedback to inform how to most effectively deliver services.

HP positively noted contents and level of detail within report.

Recommendation: The Committee is asked to review and scrutinise the information provided and confirm it provides assurance that policies and processes are working effectively, any gaps have been identified and assessed, and risks are being mitigated effectively.

The Committee agreed and accepted the recommendations.

11 Grampian Area Drug & Therapeutics Committee Annual Report

David Pfleger, Director of Pharmacy, provided overview of report circulated to Committee. Annual Report covers 2023-2024 and highlights key areas of work undertaken through the Grampian Area Drug & Therapeutics Committee (GADTC) and subgroups.

HP asked if technology could aid interface processes particularly with GPs. DP explained in terms of interface, work to be undertaken around communication and shared access to records and information. Exampled recent discussions in relation to speeding up medicines element of discharge from hospital. To allow community pharmacist access to “Care Portal”, providing them with a wider range of information, and potentially providing better communication around hospital and community teams for discharge.

Further, discussed technology and comparison of NHS to European partners who have a higher spend on technology and devices. Part of innovation discussions moving forward for NHS as a whole and the benefits advanced technology could provide patients.

In response to Chair, EH advised, patients always have access to the drugs they require. However, if a new or complex drug, GPs may be more cautious to prescribe without appropriate training or if there is no shared care agreement. Referenced contractual model GPs have currently and visionary work commenced but advised of difficulties implementing changes as national models. Funding mechanisms and investment to Primary Care, locally and nationally, is a fundamental problem. Percentage of funding has continued to decrease putting pressure on GP practices.

DP advised in response to Chair, there are two factors of concern in relation to sustainability: delivery model and finance. Delivery model does not appropriately fit all areas of care, growing complexity of care required for patients. The cost of new drugs are vastly more expensive than the drugs they are replacing. Referenced “self-care” and the financial implications of illness that can be treated by the public without using NHS resources. Public engagement and education is important.

Chair noted discussions moved away from contents of report but thanked DP for open and honest answers.

Recommendation: The Committee is asked to review and scrutinise the information provided in this paper and confirm that it provides assurance regarding the work of the Grampian Area Therapeutics Committee.

The Committee agreed and accepted the recommendations.

12 Professional Assurance for Dentist Professionals in NHS Grampian

Jonathan Iloya, Consultant in Dental Public Health, provided an overview of paper circulated to Committee. Key points related to: General Dental Council regulator, who is regulated, regulatory requirements, NHSG assurance, fitness to practice, education and training, and staffing legislation.

In response to DRu, JI advised, independent contractors in primary care are employed independently of NHSG but deliver contracted services on behalf of NHSG and the HSCPs. Mandatory joining of the NHSG Dental List. Upon joining, agree to comply and commit to a number of regulations, one of which is clinical audit activities. These are quality assured by NHS Education for Scotland (NES). Audits are designed with regulatory and governance oversight in relation to compliance. NHSG undertakes Combined Practice Inspection, every 3 years, which involves examining and inspecting every aspect of the practice incl. staff registration status and compliance requirements of clinical audit process, etc. Additionally, independent contractors have to complete 100hrs of Continuing Professional Development (CPD) every 5 years. As part of annual renewal process, dentists have to indicate to General Dental Council (GDC) how many hours of CPD undertaken each year. There is a minimum number of hours required to be completed in a 2 year cycle to remain on GDC register.

DRu asked if NHSG have sight of complaints that are raised directly to independent contractors. JI noted, NHSG would only become involved when a patient believes their concerns have not been properly managed by independent contractor / practice and subsequently complain to NHSG or GDC.

In response to EH, MBr advised the Dental Practice Advisor will get in contact with the dentist under investigation by GDC to offer support.

EH asked for more information on the Performance Advisory Group and membership of this. MBr shared, Group meets quarterly with potential for any extraordinary meetings if required. Membership of Group: Director of Dentistry, Consultant in Dental Public Health, Dental Practice Advisor and Primary Care Manager. Group discusses a number of topics incl. GDC referrals.

JB asked for data relating to the number of people in Grampian reported to the GDC each year, themes / rationale for reporting, any learning taken from investigations. JI advised data could be collated by Dental Performance Advisory Group and reported to Committee. In the interim, MBr shared, currently 9 people going through a GDC process or GDC are considering commencing process. Some of which unlikely to progress. Can take a number of years for process to be commenced, or not, earliest of the 9 noted was recorded in 2023.

Chair thanked for report.

Recommendations: The Committee is asked to review and scrutinise the information provided in this paper and confirm it provides assurance:

- That there are sufficient controls to support the Professional Assurance Framework,
- And it is assured that registered dental professionals in NHSG are suitably qualified, trained, and supported to provide safe and effective clinical care.

The Committee agreed and accepted the recommendations.

13 Portfolio Reporting to Clinical Governance Committee

Tara Fairley, Associate Medical Director – Clinical Assurance and Quality, summarised reporting template circulated to Committee.

Template created, following a request from Committee to allow portfolios to report more effectively to Clinical Governance Committee. Template split into 4 sections – quality and safety, risk, clinical governance plan, and internal and external reports. Each area has guidance / signposting as to the information to be provided.

Chair thanked TF and pleased with format of template.

DRu suggested the inclusion of derogations. TF advised, has been considered however derogations of clinical practice (and non-standard patient areas) are reported to Committee via the CRM Report. Committee agreed appropriate.

Recommendation: The Committee is asked to endorse the proposed template for Portfolio reports to be provided at future meetings.

The Committee agreed and accepted the recommendations.

14 Any Other Competent Business

No AOCB raised.

15 Date of Next Meeting

27 May 2025, 1330 – 1630 Hours, MS Teams.

Chair thanked members, attendees and invitees for their contributions and closed the meeting.