Minute of the **Virtual** Meeting of **NHS Grampian Clinical Governance Committee to Grampian NHS Board** on Friday 12th November 2021 at 10.00 am

Present:	Dr John Tomlinson (Chair)	Non-Executive Board Member
	Prof. Siladitya Bhattacharya (SB)	Non-Executive Board Member
	Dr June Brown (JB)	Director of Nursing - HSCPs
	Prof. Susan Carr (SC)	Director of AHPs and Public Protection
	Kim Cruttenden (KC)	Non-Executive Board Member
	Noha el Sakka (NeS)	Clinical Lead - IPC
	Prof. Nick Fluck (NF)	Medical Director
	Jenny Ingram (JI)	Associate Director - QIA
	Grace Johnston (GJ)	Interim IPC Manager
	Cllr Shona Morrison (SM)	Non-Executive Board Member
	Miles Paterson (MP)	Public Representative
	Siddharth Rananaware (SR)	Public Representative
	Dr Shonagh Walker (SW)	Associate Medical Director
Invitees:	Paul Bachoo (PB)	Medical Director - Acute
	Emma Davies (ED)	Public Health Registrar – NHSG Long COVID Lead
	Arlene Forbes	Quality Improvement and Assurance Administrator (Minutes)
	Dawn Getliffe	Management Trainee
	Laura Gunn	Quality Improvement and Assurance Administrator (Minutes)
	Chris Littlejohn (CL)	Deputy Director of Public Health
	Alison McGruther (AM)	Lead Nurse – Aberdeenshire CHP
	Jenny McNicol (JMcN)	Acute Director - Nursing and Midwifery
	Janice Rollo (JR)	Quality Improvement and Assurance Advisor
	Lynne Smith (LS)	UOM – Obstetrics

Item Welcome and Apologies:

1 The Chair welcomed members and attendees to the meeting. Apologies were received from: Amy Anderson, Dr Janet Fitton, Prof. Caroline Hiscox, Dr Malcolm Metcalfe, Cllr Dennis Robertson and Dr Steve Stott. Chair wished to acknowledge the pressures in the System and against that context thanked for the quality reports received for the Committee. Thanks to Leads, report Authors and their Teams and commended all colleagues for their efforts. The Committee able to provide due scrutiny.

2 **Minute of meeting held on 20 August 2021:** The minute was approved as an accurate record with Public Representatives noted as formal attendees.

3 **Matters Arising and Action Log**:

Action Log: agreed, items covered in current agenda and future meetings.

Noted, action at request of Janet Fitton to invite Non-Executives of IJB Clinical and Care Governance Committees to the Development Session and the Chairs were duly invited.

Of note, Joint Case Reviews ongoing and will be brought to Committee via Clinical Risk Management with identified learning. Expected December 2021.

Of note, Nosocomial Clinical Review ongoing and will be brought to Committee on completion at a future date.

4 **Response, Recovery, Remobilisation, Renewal**

4. 1 RMP4, Operation Iris and context for next 6 months

NF provided an update. Advised inter-relationship between RMP4, Operation Iris and G-OPES. In recognition of next 6 months updated Remobilisation Plan with Scottish Government. RMP4 and Operation Iris to Board of NHSG in December.

Highlighted, importance of Service Delivery (in RMP4) and given pressures focuses on how to support ongoing Unscheduled Response, Critical and Supported Services (and residual impact on other Services).

Approach and delivery of RMP4 is contained within Operation Iris. Operation Iris (October 2021 – April 2022) managed by System Leadership approach. G-OPES (Grampian Operational Pressure Escalation System) developed from Winter Planning, Contingency Planning and Business Continuity Planning (and learning from management of COVID). G-OPES provides a single approach to evaluating pressure across entire Health and Care System. Actions within G-OPES goal orientated and gives potential to increase capacity through risk and pressure based derogation of specific standards.

In terms of Clinical Governance Lens, Scope of Service Delivery RMP4 provides and ensures governance arrangements for quality of care patients receive within or out-with Scope. Through Operation Iris ensure governance arrangements formulated and how these sit with existing clinical governance arrangements. In terms of G-OPES and associated Derogations there is potential Risk in compromising quality of care. Advised of 5 domains within Derogations.

Chair thanked for overview and setting context. NF advised in response to SM, in many pressured areas (particularly "front door" services, e.g. ED) for a long period of time standard practice when a department is completely full people brought in to department and may be waiting in corridor outside of assessment area. Endeavoured to remove from standard practice, has impact on quality of care, however common to see practice across the UK. Balanced, if practice is removed potential in ambulance queuing outside of "front door". Hence risk is balanced, someone waiting outside and potential of not releasing ambulance versus quality deficit for someone brought in to corridor. Effectively queuing capacity. NF in response to Chair advised important to be explicit in what derogating from as carries different consequence(s) in terms of risk for both individual and Organisation.

4.2 Derogation of IPC Guidance – Physical Bed Spacing

JB presented Paper issued to Committee. Of note, challenges in providing delivery of Critical and Protected Services and safe "flow" through System and required support. Paper produced for CET to examine key risks identified and benefits of derogation. Paper shared with Ethics Committee for ethical opinion. Of note, IPC colleagues were not in support of the reintroduction of beds. The CET debated risks and it was agreed in current position to re-instate beds and further in future operate within G-OPES and associated derogations, when appropriate to do so. JB advised to date the beds had been introduced in NHSG with governance process to monitor via CRM (Clinical Risk Management) and IPC colleagues who highlight COVID nosocomial outbreaks and potential association with reinstated beds. As required, CRM escalation to CET. Derogation introduced to 23rd November 2021, at which point reviewed.

Chair confirmed the Derogation not for Committee approval. JB advised in response to KC, work continuing to reintroduce all beds. Some beds may have been introduced but not operational due to staffing levels. However, full understanding and clarity of beds estate. KC requested clarity on where beds had been reintroduced and JB advised brought to Weekly Connect on 15th November.

SM advised supportive of derogation and governance arrangements. JB advised in response to SM that anecdotally aware of similar work in other Boards. Due to variance in Estate's, Board's at different starting points.

CL recommended Committee sighted on monitored benefits and potential harms (real time) of derogation and further assured of mitigation. JB agreed and advised CET receive monthly review and this will be brought to Committee. The benefits measure would include continuing with

ESCAT0 and 1 activity, which is impacted on by Unscheduled Care flow. **PB would complement CRM Risk monitoring with summary position on reintroduced beds utilised be ESCAT0 and 1 patients and demonstrated Performance and Productivity Theatre output.**

JB advised in response to Chair, staff cannot be transferred from current Ward base to create a new Ward consequently beds introduced to current Wards/Areas and staff in those Areas supported.

Recommendation
The CGC is asked to support the plan agreed in this paper. The Committee supported the plan.

4.3 Integrated Specialist Care Services Portfolio
4.3.1 Critical and Protected Services / Cancer Services Update
Paul Bachoo. Medical Director – Acute, updated.

Papers put forward to Committee:

- Cancer Effective Plan, response to Scottish Government. For Plan to be met activities within Closing the Gap Paper required. For noting.
- Bowtie to visualise integrations and complexity of cancer pathways, how dependant they are and bottlenecks. For noting.
- For discussions "Influence of Out-patient Resource on Cancer Performance" Paper.

Of note, 62-day Performance remains challenging. No evidence that patients in Cancer Pathways are coming to harm by excess mortality. In terms of Cancer Pathways the Out-patient Area critical and often reason patients breach wait-time(s), demonstrated in thematic graph. Data supports hypothesis Out-patient capacity currently for face-face consultations has 2 competing high priority demands, patients in Cancer Pathway and patients in Urgent (non-cancer) Clinical Pathways. Out-patients department currently at position of "living with COVID". Through that unable to process both Pathways fast enough. Reassuringly, no excess mortality in Pathways and graph demonstrates "health debt" of urgent suspected cancers has largely come to be repaid, currently. Plans and processes coming in to place there is expectation that plans would be beneficial to improving 62-day Cancer Performance.

NF enquired in detecting cancer early are there known changes in profile, stage at which people identified and further efficacy of "living with COVID" treatment regime's which have potentially modified approach to chemotherapy and surgery, impact. In response PB advised these matters required careful consideration of obtaining data. Currently, detailed analysis not available however work progressing in this area. Anecdotal reports from Clinicians on utilising longer operating times, fewer cases, utilising more blood during surgery and length of stay is slightly longer. Formal analysis required to ascertain quality and outcomes. Cancer Oncology Teams analysing any shift from early stage cancer regimes (where intent is curative) to regime of holding the position, and palliative. Reassuring to see data on Cancer Pathway patients does not show an excess mortality however important to note that data on all-cause mortality from cancer a different issue.

Chair noted assumption that backlog of presentations had come forward and hence awareness of overall landscape and action plans with timeframe of 2023. In response PB confirmed timeframe and advised modelling had so far been accurately aligned. The graph discussed referred to urgent cancer referrals. Challenges exist in processing surge in "presentation" quickly enough within KPIs and Frameworks. **Chair confirmed Committee seeking assurance across the frameworks**. PB confirmed this is the approach required and is demonstrated in Cancer Effective Plan, with ambitious timelines. **NF confirmed the data is "Fixed Prediction Conversion Rate" for referrals and noted beneficial to monitor the "Live Conversion Rate",** which may be modified by Society changes and affect timelines, expectation of stabilisation in terms of demand.

In response to KC regarding graph "Death of patients while on the Cancer Pathway", PB confirmed relates to patients on Cancer Pathway, and been treated.

SM noted self-referral screening for women aged 70 and over was paused, Scottish Government directed and **CL would revert with current information available.**

Clinical Governance Committee asked to note and acknowledge:
1. The service have a detailed understanding of the challenge (of note, and continues to have)
2. The work to date through our Cancer plan
3. An excess of mortality has not been identified amongst patients on cancer pathways.

Further Chair requested information on progress with Plan and addressing "challenge". PB confirmed and agreed to return to Committee in February 2022 to update on progress.

Committee noted, acknowledged and assured.

4.3.2 Closing the Gap (Critical and Priority Surgery and Theatre Cancellations)

Paper details a series of projects ongoing over last 3-4 months in and across, Portfolios. Commenced following data on theatre cancellation rates. Route Cause Analysis undertaken on "why" cancellations in System and developed and progressed Programme of Projects, detailed in Paper. Work supported by Derogation(s) of IPC guidance to increase Surgical Beds. Areas of improvement in Pre-operative Assessment, detailed and in place. Good achievement in Pre-operative Assessment (multi-professional clinical) Team located in one fixed area "home". DoSA responsible for 85% of admissions. Hope to bring to Committee reduced cancellation rates. Highlighted, need to synchronise with theatre availability and workforce. Expected impact on 31-day and 62-day Cancer Performance.

Chair noted complemented Plan and provides assurance on detailed work being undertaken.

PB noted in response to Chair, required support in delivering the plan (further to meet National Indicators) with understanding Portfolios (and their inter-relationships) developing and assurance moving in right direction.

The Committee asked to note the detail of paper and contribution from the Portfolio. The Portfolio Lead is seeking assurance from Committee the sub-optimal performance is well understood and feel able to support the Plan.

Committee noted, acknowledged and assured. Support Plan and Programme of Projects. Noted potential for variance in performance indicators.

4.4 Integrated Family Services Portfolio (IFP)
Jenny McNicol, Acute Director - Nursing and Midwifery, provided an overview.

Portfolio involves NHSG and each of the Health and Social Care Partnerships. Focuses on working with and listening to (informed by) communities to support improvements and health outcomes for women, children and families in Grampian. Generational change involving more than Health. Strong focus on children – Child Health Structure 2020 referenced – working, integrating, with HSCPs. Referenced Women's Health Plan and incorporation to Portfolio, delivery plan 2021-2024. Noted activity in Assurance and Governance Structures for IFP, identifying gaps, improvements and maximising achievements by whole System working. Children, Young Persons and Maternity Governance and Assurance Group established and Women's Governance and Assurance Group to be established. IFP Oversight Board (Terms of Reference developed) provide oversight and priorities and reports to CET and NHSG Board / Committees. Referenced need for IFP through examples of, Deprivation and Women in Custody and Prison. IFP seeks inclusion, opinion and learning from across System. SM welcomed whole System approach and projects in place.

4.4.1 DGH External Review and DGH Collaboration Update
J McN updated on progress of Grampian and Highland Maternity, Neonatal and Gynaecological Collaborative. Advised timeline of woman (Intrapartum) able to transfer from DGH to Raigmore and SoP requested for month end. Escalated and supported by CET of NHSG and NHS Highland. JMcN advised in response to SB of achieving SoP that challenges exist with NHS Highland Maternity Services workforce and cultural aspects. Supported by Director of Nursing and CET of NHSG and NHS Highland to progress.

JMcN advised in response to Chair, that External Review would influence progression and "end point". Further deliver on recommendations from External Review for Maternity Services at DGH.

In response to SM, the timeline of External Review was advised. Currently, expected to receive the confidential report w/c 15th Nov and published at near future date once it had gone to Cabinet Secretary. Noted, JMcN currently unaware of related communications and "messaging".

4.4.2 Breast and Gynaecology Services
JMcN introduced Lynne Smith, UOM – Obstetrics, to present Papers:

LS discussed the current challenges facing Breast and Gynaecology Services for In-patients. Referenced paper produced by Tara Fairley Sept 2021 which identified impact and risks as: wait-times, well-being, emergency admission and attendances, level of complaints and adverse events, concerns on tertiary regional services, research income, post-graduate training and consultant technical and competence confidence.

Referenced wait times for confirmed cancer cases very good however, consequently utilising of theatre lists for gynaecology oncology consultants determines reduced capacity for diagnostic or other procedures. Over pandemic reduced to low number theatre lists. Theatres supporting Service with ad-hoc lists. Noted bed capacity challenges. Whole System pressures can result in "boarding" patients. Challenges ensuring procedures go ahead. Not currently in position to run to less urgent capacity patients. Stracathro fully utilised for limited procedures. Albyn utilised for 2 theatre lists and future capacity to be determined.

Breast Services managing well for their cancer patients, potentially 1 to 2 day delay in meeting target. This resulted from Locum delayed commencing in Service. Issues with bed capacity and related to discharges, concerns with lists going ahead. Albyn capacity to be determined.

JMcN advised in response to Chair that Breast and Gynaecology Services sit within IFP and has integration as elective surgery, within PB's remit and ISC Portfolio. Hence, the Cancer Plans to 2023 will include Breast and Gynaecology Services.

SB requested Committee be informed that Aberdeen is a major endometriosis trial centre and leads 2 National trials (£3million funded) with concerns individuals are randomised to surgery versus medical treatment. Many may finish trial before getting surgery due to waitlist.

LS advised in response to SB, Consultants prioritising patients in terms of clinical escalation and discussions ongoing with SED around consultant prioritisation thresholds. An instigated weekly meeting supports process for theatre lists. Cancer Pathway patients prioritised, followed by clinically prioritised patients. JMcN referenced Baird Hospital in 2023 would provide 6 new theatres. JMcN noted need to reflect on impact on women and family.

The Committee noted the information provided, which will continue to be reviewed and utilising all opportunities moving forward. Position (improving or not) will be brought to Committee at future date in 2022. Currently cannot provide assurance due to pressures on whole System.

5 **SLWG Long Covid Update**
Emma Davies, Public Health Registrar, Long COVID Lead – NHSG provided an update on work of SLWG.

SLWG (multi-disciplinary) established at end of August 2021, to agree and oversee implementation of action plan to reduce impacts of Long COVID on communities in North East. Scottish Government funding may become available April 2022. Through work understood to be a clear lack of direction, support for those who had not been hospitalised and this had been agreed by SLWG as a priority pathway. Advised of lived experience input (to shape services) and best use of limited resource. SLWG will report to People and Services Recovery Oversight Board. Updates provided via Clinical Board and connections made with MHLDS, Rehab Steering Group and We Care. Initial benefits include co-ordination, driven by evidence and lived experience and awareness

raising of available resources. Challenges include lack of resource to drive work forward and lack of resource to invest into sustainable service improvements.

Chair thanked ED for update on what is an emerging picture. JB noted benefits of people with lived experience shaping agenda. ED advised through lived experience forums, peer support community emerging through social media. ED advised in response to SR, 2 NHSG staff members with Long Covid are involved on Group and the SLWG has supportive links to We Care Programme. SR noted increased number of NHSG staff involvement would be beneficial. NF advised in response to Chair that Clinical Board hopes to bring together fraternity of treating clinicians to receive an update on therapeutic approaches, which may include Long Covid element.

6 **6.1 Clinical Quality & Safety Subgroup**

Jenny Ingram, Associate Director, Quality Improvement and Assurance, presented report.

Updated on Complaints Prioritisation Framework developed with SPSO guidance.
Noted, Handling and Learning from Feedback Annual Report 2020-21 published. The report does not include comparison of 20/21 with previous timeframes, appears complaints reduced significantly due to pandemic, hence not comparable.

Committee prior requested information on correlation of reduced staffing levels on adverse events. A Paper was submitted to the Chief Executive Team. It was agreed that reduced staffing levels was not the best primary code to identify actual patient/staff safety events and further work had been undertaken to support the correlation of information to provide an overall picture at the weekly Clinical Risk Meeting (CRM).

Advised CET met with HIS (Healthcare Improvement Scotland) and current position described on the challenge of pressure and capacity to address complaints. HIS recognised this and agreed to discuss at National level and feedback.

Advised Duty of Candour Annual Report 2020-21 produced. Key points to highlight, as remobilise services there may be instances of harm linked to delays in care, some of which may trigger DoC. Continue to use national guidance and seek legal opinion.

Advised of Board development session which focussed on Hazard Management and Bowtie methodology. **The Clinical Quality and Safety Subgroup continues to develop Bowtie for quality of safety and care and this would be brought back to Committee in February 2022.**

KC noted accessibility of Feedback Annual Report and queried if the level of complaints in relation to staff was comparable with other Board's and does a robust and timely process exist in System for learning from events. JI advised in response that complaints in relation to staffing at normal levels, however of note staffing is also highest level complimented. In relation to sharing of learning, in Risk Bowtie area is variable and instigated Shared Learning Template, work in progress. Identified as "gap" in our "controls".

NF advised in response to Chair, legal opinion not sought on G-OPES. In areas of derogation, engaged with Regulator's.

NF put forward topic for discussion at future Committee on potential to develop own Risk Register for assurance, risk(s) recorded at Committee level. Relates to uncertainties in assurance set-up, different to operational or corporate risks.

Recommendation
The Clinical Governance Committee is requested to support:

The approach being taken to the management of both complaints and adverse events during this period of enduring pressure;

The development of the risk management visualisation system and reporting from this to the Committee.

The Committee acknowledged and supported.

6.2 Public Health Reports
Chris Littlejohn, Deputy Director Public Health presented reports.

6.2.1 Test and Protect

Quarterly update provided. Of assurance to Committee availability of testing (hospital and community). Continued NHSG provision of testing specifically and ongoing collaboration with UK government testing programme.

Of note, in relation to testing for healthcare staff (specifically high risk settings) very high uptake of PCR testing reported (98%). Risk to NHSG Testing Service related to SG funding being non-recurrent, short term contracts.

CL advised in response to SM, postal test kit system available for those unable to access walk-through facilities. Mobile Testing Units previously deployed to outbreak localities however current challenge as high prevalence across the area. Consequently, difficult to secure and deploy mobile testing units.

JB advised of additional measure for staff who have a household contact to remain at home and undertake a PCR test. CL confirmed policy of isolation and test for cardinal symptoms. Constantly reviewed nationally.

Recommendations
The Committee is requested to note the ongoing work of Test and Protect to deliver against the Test & Protect strategy.
The Committee is asked to note the key risks highlighted within this report and the associated mitigating actions.

The Committee noted and accepted recommendations.

6.2.2 Vaccination Programme

CL advised care home residents at 75% uptake of Booster. This level relates to vaccination teams unable to enter care homes that had COVID cases or outbreaks. Ongoing issue. Further awareness of DNA rate higher for boosters across the population. **Requested DNA rates for care home residents for boosters. JB would raise at Enhanced Care Home Group.**

Recommendations
The Clinical Governance Committee is asked to note the risks presented in Paper and to:
Continue to support the aims of the Vaccination Programme Board and the approach and support the workforce demands required to meet priorities.

The Committee noted and accepted recommendations.

6.2.3 Clinical Governance Arrangements

Developing extensive work plan over a period of time. Director of Public Health noted as a Portfolio Lead for population health.

Recommendations
The Committee is requested to note the ongoing work of the DPH Team and wider Public Health Directorate to address identified weaknesses.
The Committee is requested to support the principles of the Directorate's approach to improving our system of clinical governance.

The Committee noted progress.

6.3 Healthcare Associated Infection

Noha el Sakka, Clinical Lead IPC presented report. Informed the Committee of key HAI issues and actions. Highlighted and discussed the new risks identified.

Of note, built environment remains a risk on IPC Agenda with aging estates and risks with ventilation and water, etc. Shortage of workforce within IPC and Estates for workscopes. Noted as "High" on Risk Register.

In relation to National Surveillance, NHSG in line with national levels and not outliers in measures. Not breached 95% confidence level, provides assurance. Of note, some surveillance work remains paused. Statistical comparative data provided, as per report.

Work continues on local delivery plan targets with actions plans.

NeS requested to note HAIRT Report not available as Report not ratified by HAI Executive Committee. Would be brought to Committee at future date.
NeS provided assurance to Committee on governance and escalation structures, particularly in relation to Derogation(s). Advised Risks monitored and escalated to CRM which occurs weekly. CRM escalate to CET, as required.

Further noted, lack of capacity in IPC Team to support new projects and built environment works. Would continue to support existing projects but would not support new projects. Continue to support main capital projects such as Baird and Anchor. Paper provided to Infrastructure Oversight Board that includes recommendations for system for IPC project/work requests and process for prioritisation. Noted ongoing challenges of guidance and standards that arrives from various sources such as Scottish Government, etc.

Further significant work ongoing for the implementation of clinical Respiratory and Non-Respiratory Pathways.

Advised IPC week held to provide information and awareness of water safety.

JB noted the incidences of water safety across the estates in previous 9 month period and advised working with Scottish Governance colleagues to understand work ongoing in relation to managing these risks, governance arrangements.

JB in response to Chair, in relation to built environment, water safety delegated to Director of Estates and Facilities as Responsible Officer. The Responsible Officer would report to Occupational Health, Safety and Wellbeing Committee. Hence 2 parallel routes to Board including Clinical Governance. **Chair consequently noted for Clinical Governance Committee to notify built environment IPC matters to Board**. Chair would contact Chair of Performance Governance Committee (that receives infrastructure matters) for joined up approach to reporting.

NeS advised in response to Chair, sourcing staff and training is challenging due to specialist and complex input required. Requires training period for new staff. In medical, IPC step by step pathway provided for new Consultants. Continually updating colleagues as guidance changes. GJ confirmed requirement of funding and of sourcing appropriate staff with experience and availability to train to timeframe. Staff were appointed on pre-COVID activity. Training estimated to take approx. 1 year. Workforce development on roles and responsibilities ongoing. JB from national perspective similar difficulties in other Board's. National group working on framework for IPC education, supporting roles moving forward (JB Co-Chair). **Chair requested sight of plan in place for the Committee.**

NF advised in response to Chair that BOWTIE methodology utilised and would mature to understand how to control significant "threats" that all organisation face.

The Committee noted report and actions taken.

7 **Committee Constitution Review and Development Session**

Chair of note, the Clinical Governance development session held to inform, support the Board address future strategy. Committee noted progress and suggestions would inform discussions to be held in 2022.

8 **Reporting to the Board**

- PB requested to put forward noted balanced approach (recognising context) to assurance of risk in Cancer Services. Chair linked PB's request to developing work on Risk.
- Derogation. Related increased surgical productivity and performance measures to be undertaken. NF referenced as competing Risks. Risk 1 of insufficient capacity and meeting time critical interventions. And Risk 2, "threat" of HAI, or nosocomial outbreaks in System. The introduction of beds encompassed in plan to deal with Risk 1 aware that derogation away from "barrier" around Risk 2. Monitoring controls around 2 risks determines if balance approach of intervention is right.
- As a Committee focusing on Portfolio Development and arrangements in Agenda.

9 **Date and Time of Next Meeting**

During period of Operation Iris, complex period of time, it was agreed to hold an additional meeting for clinical governance assurance.

The next meeting would be held on**, 17th December 2021 at 1530 Hours.**
Meeting invites will be sent via MS Teams.