APPROVED

Minute of the **Virtual** Meeting of **NHS Grampian Clinical Governance Committee to Grampian NHS Board** on
Friday 14 May 2021 at 10.00 am

Present:	Dr John Tomlinson (Chair)	Non-Executive Board Member
	Amy Anderson (AA)	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
	Jillian Evans (JE)	Head of Health Intelligence
	Prof. Nick Fluck (NF)	Medical Director
	Prof. Caroline Hiscox (CH)	Chief Executive
	Jenny Ingram (JI)	Associate Director - QIA
	Grace Johnston (GJ)	Interim IPC Manager
	Dr Malcolm Metcalfe (MM)	Deputy Medical Director
	Jenny McNicol (JMcN)	Acute Director - Nursing and Midwifery
	Dennis Robertson (DR)	Non-Executive Board Member
	Dr Stephen Stott (SS)	Associate Medical Director - Clinical QIA
	Dr Shonagh Walker (SW)	Associate Medical Director - Performance
Invitees:	Arlene Forbes	Quality Improvement and Assurance Administrator (Minutes Taker)
	Fiona Miele (FM)	Lead Nurse – Child Protection
	Kenneth O'Brien (KOB)	Adult Public Protection Lead
	Janice Rollo	Quality Improvement and Assurance Advisor (Minutes Taker)
	Julia Wells (JW)	Clinical Director

Item Subject

1. **Welcome and Apologies:**
The Chair welcomed members and attendees to the meeting.

Apologies were received from: Dr Bachoo, Prof. Bhattacharya, Dr Fitten, Prof. Lynch, Cllr. Morrison and Susan Webb.

2. **Minute of meeting held on 12 February 2021:**
This minute was approved as an accurate record.

3. **Matters Arising and Action Log**
It was agreed that item 1.2 Brexit led by Mr Alan Gray, Director of Finance, would be stood down from Agenda. If questions arise on the matter this could be brought to Mr Gray's attention.
The item would be removed from the Action Log.

Item 3 Wilson Disease Update provided by Malcolm Metcalfe. MM advised the Service has provided assurance that they have contacted anyone they are able to, however there are a small number of individuals who are uncontactable through relocation, or chose not to reply to correspondence. Of note, no additional cases have been identified.
The item would be removed from the Action Log.

Item 3 Maternity Services at DGH. June Brown advised that the matter was led by Nick Fluck, Simon Bokor-Ingram and Jenny McNicol.
The Action Log would be updated to reflect this.

Item 3 Public Representative. Jenny Ingram advised plan is to collate a pool of Public Representatives to draw in to Meeting's in rotation. The Clinical Governance Committee will pilot Public Representative attendance from determined pool. This will be progressed by Chair/JI/AA and Louise Ballantyne from Public Involvement Team.
The item will remain on the Action Log.

4. **Ovarian Cancer Services**
In absence of Dr Bachoo, Prof. Nick Fluck, Medical Director, provided an update.

NF advised that NHSG provides complex specialist surgery for ovarian cancer for the North region (6 Boards) and continued by highlighting the rate of operations carried out, the staging profile of women and the outcomes for women.

Through North Cancer Alliance and the North Scotland Medical Directors Group there is both an analysis and improvement plan. In addition a regional multidisciplinary team meeting will co-ordinate delivery of care for all women in the North who are identified as having ovarian cancer. Malcolm Metcalfe will Chair MDT on an interim basis.

NF in response to Dennis Robertson, advised profiled women at different staging levels in North may be a pathways issue around slower identification, or regional differences, or staging system in North is different to systems used elsewhere. NF further advised that staging is complex and recognition of symptoms may appear not through un urgent suspected cancer pathway but through diagnostics for other pathways that show up an abnormality related to ovarian cancer. Challenge of early identification can be due to biology of the disease. The reasons around why we have more late stage women that other parts of the Country are unknown, but may be multi-factorial and nuances of differences in staging.

Prof. Caroline Hiscox recognised the huge amount of work taking place in small volume cancer in North, of which ovarian cancer is one. Regional network approach brings governance and accountability challenges, however ovarian cancer leadership sits with NHSG and it would be beneficial to share the improvement plan and other supported documentation with the Committee. NF agreed that this is appropriate and a formal paper will be brought to next Committee.

Chair enquired as to whether there was a broader based cancer services paper for review. NF advised oversight paper could be brought to Committee.

NF, in response to DR on rural population uptake of ovarian cancer referral pathway, advised that a wide range of mixed evidence exists and rurality is an influence, some of which is positive and negative, population behaviour changes with rurality and incidences change with rurality. There is not one definitive answer as it is a wide ranging field and there are different challenges for populations in other Board regions.

The Chair thanked NF for the update and noted that reports will come to the next Committee meeting.

Action: Lead NF – Ovarian Cancer Report Update and Improvement Plan
Action: Lead NF – Cancer (oversight) Report.

5. **Dr Gray's Maternity Service**

Jenny McNicol, Acute Director Nursing and Midwifery, provided an update.

JMcN referred to the four recommendations supported by the NHSG Board. The updated Terms of Reference (ToR) for the Grampian and Highland Maternity, Neonatal and Gynaecology Collaboration had been circulated to the Committee. JMcN also highlighted the remit for the Scottish Government review distributed to committee members which focuses on a regional approach at Dr Gray's Hospital. The review team will include Prof Nick Fluck, Simon Bokor-Ingram, Adam Coldwells and JMcN with a meeting scheduled to undertake preparation work to give a Board perspective.

JMcN highlighted the key risks with continuation of the hybrid model until an appropriate regional pathway for intrapartum transfers is in place; continuing political and public pressures regarding maternity services and their delivery in Moray and deliverability of any recommendations from the review.

JMcN asked the committee to note and support the ongoing work taken by the service, as per brief paper.

DR asked if there was a risk relating to staff morale and in response JMcN advised there are indicators on this issue and prior work was undertaken with the Service team members and we are cognisant of this issue going in to this Government review. In conjunction with Corporate Communications a survey will be issued regularly across team including AMH, with interest shown from Raigmore, covering a North East regional approach. DR enquired as to whether there were additional staff resilience issues around COVID impact in delivering the Service and in response JMcN stated there was an impact on all staff, however maternity services Scotland wide were quick to react to pathways of care both antenatal intrapartum and postnatal for women and with what adaptations could be in place to provide and maintain care. JMcN noted the challenges of maternity staff supporting women who had difficulties of COVID impact such as isolation. Of note, NHSG highlighted as excelling in the actions taken to continue to provide good maternity care throughout COVID. There is a continuity of care team in Moray and is positive in moving forward in challenging times. DR would like to compliment the Team in their continuity of care and service delivery.

Amy Anderson thanked JMcN and Team for the work done, particularly on collaboration. AA enquired as to review outcomes being timed and aligned, taken on board with the direction of the collaboration. JMcN advised that safety model is priority currently, however recognised that current direction may be an interim approach but it was necessary to progress, on premise that review outcomes be addressed.

In response to Chair, JMcN advised she would provide an update at the August Committee meeting. In response to Chair, JMcN stated that differing viewpoints had been resolved and assured, hence updated ToR signed off with an agreed way forward.

Recommendation: The Clinical Governance Committee is requested to note and support the ongoing work being taken by the service.

Recommendation accepted and supported by the Committee.

The Chair asked to note, in response to DR, that the work of the Teams be recognised.

Action: Lead JMcN – DGH Maternity Services Update.

6. **Public Protection Annual Report:**
The report was introduced by Susan Carr, Director of AHPs and Public Protection. SC advised that throughout the pandemic Public Protection has been a protected Service, allowing continued proactive work with multi-agency partners to respond to challenges of lockdown and the risks this has created for vulnerable children, young people and adults. Additional investment in Public Protection had been welcomed and enhanced small widely experienced team.

Fiona Miele, Lead Nurse - Child Protection presented. Of note, FM advised of the risk throughout the pandemic of hidden harm and difficulties in identification and responding to vulnerability. In NHSG, governance approach continued with Protecting Children Groups, Operational and Strategic. Data out of these Groups meetings were scrutinised to identify level of activity. The data demonstrated that initial referrals were down, impact of hidden harm "no eyes on children." Near Me was available for school nurses, health visitors, etc. and Scottish Government guidance was followed for access to children and young people. As universal services locked down, challenges/barriers arose around identification of vulnerability. ID numbers lowered dramatically and hence child protection medicals reduced. As lockdown restrictions eased the measures improved and a spiked increase appeared, as expected and response was prepared and in place. DATIX utilisation continued to identify risk through normal processes. Ensured wider workforce (including multiagency partners) continued with Child Protection mandatory training through MS Teams. Communication with staff continued with introduction of Keeping Connected Child Protection newsletter, positively received.

Kenny O'Brien, Lead - Adult Protection presented and advised Adult Protection covers a group of multiple domains. Key highlight: increases in activity across all domains, except Prevent and Counter Terrorism Prevention. Drew attention to Adult Support and Protection, those more vulnerable to harm and requiring safe-guarding, concerns with hidden harm. Referrals and reports in this area dropped during the lockdown but with increased activity as restrictions eased.

Of note, Adult Support and Protection multi-agency inspection is due with preparation work and NHSG self-evaluation underway across all areas with an improvement action plan in place. Adult Protection training now virtually delivered and sustained, with increased staff training activity from August 2020. Adult Public Protection Training Framework out for consultation. Advised Gender Based Violence has had a significant increase, from research demonstrates a link with COVID and lockdown arrangements, however was an increasing trend prior to pandemic. Advised an increase in referrals in Human Trafficking and work has been done on raising awareness and ensuring training is up-to-date for staff identifying. Further of note, work with sex offenders and multi-agency public protection arrangements has shown an increase of sex offenders in system. A legislative duty of co-operation means there is more NHSG activity in this area with links to public safe-guarding arrangements.

Chair noted thanks to Public Protection Team. AA noted thanks for the report and work undertaken throughout COVID. AA asked during lockdown of universal services if Third Sector, Volunteer Services had opportunities to identify concerns for e.g. around child protection and if there were future opportunities arising out of this. In response FM advised that this sits within the multi-agency context and across the

3 local authorities various Hubs were set up for vulnerable children and were pivotal in ensuring that a degree of protection was afforded to the most vulnerable. In this third sector context there was much more communication around the identification of vulnerability with local authority colleagues. In response KOB advised that within Adult Protection domains this was achieved with slightly different mechanism and local authorities set up helplines to co-ordinate charity access for people housebound during pandemic and lead agency social work colleagues were actively involved in training those individuals who were handling calls. In Third Sector there was identifying adult protection signs and symptoms to pathway referral and report on. In addition, the Violence Against Women and Girls Group, have third sector within their membership with links to ACVO and other third sector networks and raised awareness of using pathways and reporting, particularly social work pathways and NHSG have supported within multi-agency context.

DR enquired of Gender Based Violence aspect had there been any increase in recordings for NHSG own staff during pandemic and what support network was in place. KOB advised no data on this, management of Gender Based Violence held by other agencies. KOB noted that within NHSG there may not be disclosure through employment route and confidentiality aspect. SC advised there are NHSG policies and procedures in place for staff support and further links with current work on NHSG being a Trauma Informed / Trauma Responsive Workforce. Looking to strengthen the work we do in recognising that our own staff can have experience of trauma and how we consider the wellbeing of own staff. SC is a Trauma Champion supporting this recent area of work and CET support in place on how Organisation can improve wellbeing and links in to work of clinical psychologists who supported We Care Programme. DR thanked SC for work in the area of trauma and trauma training and for having a lens in this area on NHSG staff and their delivery of care.

CH wanted to acknowledge the work of the Public Protection Team, KOB and FM, and in particular SC's leadership of the team with expertise and knowledge, further in response during pandemic and looking forward to "upstream" strategic response as an Organisation. The difference in the work of the Team is recognised at every level in the Organisation. **The Chair endorsed the Committee's thanks to the Team and noted that the Committee will continue to be cited on the impact of the Public Protection Team's work.**

The Chair asked if SC was assured in having capacity moving forward with response, development and strategy of Public Protection. SC advised monitoring is required as emerging from the pandemic demand may increase. Will highlight if there is an increased ongoing demand requiring resources. **Committee were assured that at executive level there is an awareness and support to monitor capacity and resource levels.** JI advised of support through the team's attendance at Clinical Risk Management and the Quality and Safety Sub Group for escalation to Senior Leadership Team.

Chair enquired on outcomes and quality of NHSG self-assessment process for upcoming Adult Protection Inspection, of which SC advised is a multi-agency inspection. For NHSG as a key partner, KOB had reviewed the scrutiny body's joint paper quality indicators for a high performing public protection partnership and relevance to NHSG's participation, performance, strategic leadership and oversight of public protection agenda. KOB co-ordinated self-assessment in: AHPs, Acute, RACH and self-evaluation, benchmarking completed on quality indicators to formulate a NHSG wide report card.

Recommendation: The Clinical Governance Committee is requested to note the contents of report.

Recommendation accepted and supported by the Committee.

Committee noted content of comprehensive report and acknowledged wider evidence of leadership on Public Protection agenda. Chair further noted the Public Protection Model highlighted the ambition of NHSG of future strategy around prevention and multi-agency work. Chair asked for this to be reported to Board.

7. **Standing Items:**

7.1.1 Transition from Operation Snowdrop
Remobilisation Plan and the focus for the Committee 2020-2021

NF highlighted context of Clinical Governance where periods of change are times of risk and that structure and focus of agenda is around clinical governance issues pertinent to stage of development Organisation is in. Snowdrop pertained to the tactical objectives to ensure correctly covered areas of clinical risk pertinent to the Board. The paper attempts to now transition from Snowdrop to period of remobilisation, and should we restructure this part of the agenda to cover the 4 key areas of remobilisation which are: Response – maintaining ability to combat COVID and infection control issues associated with COVID; Recovery – large focus on staff recovery to move forward; Remobilisation – switching back on paused services and increasing volume of service delivery in critical areas; and Renewal – focus on transformation. The paper lays out the transition to a remobilisation phase and raises question of standing item on agenda be structured on 4 key elements of remobilisation, in similar manner to Operation Rainbow and Operation Snowdrop.

DR asked if staff had opportunity and management, of a recovery period to recharge and refocus and in response NF advised there has been a deliberate and substantial organisation focus on staff recovery. There is recognition of the impact of pandemic on individuals, family and work and this has been different for people in different ways, hence despite focus and effort naive to say each person in organisation has been through proper rest and recovery process to move forward. Efforts will continue. In response JB agreed pockets of staff feel ready to move forward however, still people in the recovery phase and working to identify this group to offer support they need as part of “We Care” alignment. Chair acknowledged agreement of a tailored approach to individuals/groups.

AA referred to report, page 5, “to consider how core data sets can inform the agenda of committee”, discussing balance between staff recovery and pressures on diagnostic services and how to mitigate those risks for patients and staff. In addition, what the data demonstrates about variation and regular readmission to acute services. Further, enquired to clinical governance linking to performance governance who have aggregate control of remobilisation phase. In response to AA, NF advised clarity of clinical governance lens for what information to scrutinise and assurance. Agree performance governance is looking at the progress of remobilisation however clinical governance pertains to equality, fairness and outcomes for our patients that might be affected by what we do, for e.g. delays in treatment leading to adverse outcomes whereas performance governance will look at numeric progress. Clinical governance lens, framing, looks at personal impact and their measurable outcomes. Chair advised future development session may address this and information could be shared.

Chair enquired what clinical governance looks like for system-wide Portfolios, pathways, etc. pertinent to work/role of this Committee. NF advised clinical governance direction prior to COVID was system-wide and understanding clinical outcomes, assurance metrics, improvement and risk. NF and JB accountable

executives for clinical governance and professional standards to inform NHSG Board Committee and Integration Joint Board Committees of system-wide governance. Throughout pandemic this direction of system-wide approach has proved beneficial and expected to continue.

Recommendation: The role of the Clinical Governance Committee is to have oversight of the implementation of plans, in order to provide independent challenge to the decision making and performance of the remobilisation plan. The Committee is asked to consider these points in relation to the framework set out within this paper in terms of its assurance role.

Recommendation accepted and supported by the Committee.

The Chair noted Committee agreement with the change to the Agenda and that a broader discussion around Clinical Governance will also take place at the development session and returned to Committee. Chair noted his thanks for assurance in Executive Leadership which is agile cross-system.

Action: Lead JI – Clinical Governance Committee Development Session Planning.

7.1.2 Safer Workplaces Programme
June Brown, Director of Nursing, presented report.

JB welcomed the opportunity to provide assurance to the Committee of Safer Workplaces Programme. The report provided detail of the work completed by the Team in the last 3 months. Of particular note:

- funding in place until March 2022;
- IPCN will join team to support work ongoing;
- progress PMO model to business as usual model; and
- ensuring compliance of workforce as we move through civil contingency levels and guidance in place.

The signage work is now complete with ongoing maintenance. Cyclical assurance visits are ongoing, supporting site improvement action plans. There have been approx. 300 visits within clinical environment.

Moving forward the key risks are continued COVID nosocomial outbreaks within healthcare environments and potential complacency of staff in relation to physical distancing and appropriate use/wearing of PPE.

The HIS inspection report (March) at ARI of COVID-19 standards gave 9 areas of good practice highlighted (most of any Board visited) and 3 requirements. The requirements have an action plan nearing completion for sign off. DR thanked the Teams in response to an exceptional report. **DR wanted to recognise the effort and commitment of staff**. **Chair advised Committee endorsed recognition and efforts**.

Chair noted assurance of the progress and further noted the ongoing challenges, likely universal across health service, hence assuring to see the resource continue and monitored against progress and requirements beyond March 2022. JB advised work continues on sustainability moving forward and supporting IPCT, Health and Safety teams, etc. **Chair noted point of assurance in teams adapting behaviours quickly and of the ongoing work of sustainability moving forward.**

Kim Cruttenden, noted the benefits of safer workplaces visits and engagement to inspire staff and keep staff moving forward. KC asked if there was an element of confusion around physical distancing in a clinical setting and if there had been transmissibility due to this in workplace currently. JB advised currently no nosocomial transmission in NHSG however we do witness staff not understanding the rules that apply within the work environment. Messaging will continue and part of the assurance walk-arounds is to build relationships with the Service to have ease of communication to seek clarity if there is confusion in understanding guidance. The IPCNs are linked to each clinical area and are available for support. Psychologist support/input has been available for behaviour change work. Continually monitored for guidance changes.

Recommendation: The Clinical Governance Committee is requested to note the contents of report and update.

Recommendation accepted and supported by the Committee.

Chair thanked the team for the update and noted assurance of progress, which would be included in the Committee assurance to the Board. To remain as an agenda Standing Item.

Action: Lead JB – HIS Improvement Action Plan.

7.2 Public Health Quarterly Report
Jillian Evans, Head of Service Health Intelligence, presented report.

Key points for discussion:
Regarding Public Health team capacity, provided assurance to the Committee that with ongoing recruitment and appointment of locums there is ability to cope with workload during this very busy period of time with COVID and other ongoing public health issues. Hence the Risk around lower capacity earlier in the year is mitigated.

Regarding Cervical Screening recall issues and erroneous exclusions noted this is a Nationally identified issue, and resulted due to quality and completeness of documentation following surgical procedures across Scotland, including NHSG. Improvement efforts are underway and communication of responses, as part of a National effort.

Flu Programme work in progress and the issues around the planning for this year were noted with scenarios of individual flu plan programme, or alongside COVID booster programme. Hence 2 scenarios planning for. Risks include: availability of large venues, availability of National vaccination management tool for invitations. Contingencies in place. Hence work underway for the flu programme and workforce planning and locally enhanced services to meet the Board's endeavour.

In terms of COVID vaccinations, the roll-out has been highly effective and of note addressing the issue of "coldspots" where uptake lower than it needs to be. Very good work to address this in City and Moray with recently introduced walk-in services very well attended across all age groups. This option will be developed, tailored for accessibility. Noted accelerated vaccination programme for Moray due to recent outbreak has been recognised both Nationally and by UK. An effective tool for areas of risk as restrictions continue to ease.

LFD testing uptake has been low for staff (across Boards), with efforts to increase uptake through videos, appeals and efforts continue to address this through staff daily briefs and other methods. Staff were encouraged to think about their individual

and collective responsibility with understanding the possibility of outbreaks, as seen recently in Moray. People will seek testing if they perceive an imminent threat in community, and akin to Moray situation recently may see ripple effect of staff uptake of LFDT.

Contact tracing continues to work effectively and further follow up with "5th" day contact is a welcome intervention for wellbeing check-in and support during self-isolation. One main initiative of contact tracers is their wider work in ascertaining low levels of wellbeing and work continues to develop in this initiative. Further Contact Tracer Team Leaders work in conjunction with health protection response for vulnerable areas, care homes and schools. Hence contact tracers have an important role in wider public health efforts.

DR enquired about people not registered with GPs / Health Services and if they come in to a community can they seek vaccination? JE advised every opportunity is given to be vaccinated and work is ongoing with Employers in communities for engagement. This type of community engagement is established and ongoing. JE advised vaccination accessible through pop-ups (outreach) for people not readily identified through health services.

Kim Cruttenden drew attention to the care-home vaccination figures in the report and JE will revert regarding the figures out with the meeting and clarify. **JE will clarify to Committee post meeting.**

AA asked if there are delays in cervical screening for general uptake population and further if NHSG are progressing self-screening for cervical screening which is being piloted in some NHS Boards. **Regarding the general uptake of cervical screening JE will advise AA out with the Committee meeting**. **NF aware of the scope of the pilot scheme for self-screening and will ascertain position of NHSG Board with regard to this.**

The Chair noted thanks for the developing structure of the Public Health reporting.

JI enquired of Committee should Flu Plan be circulated to Committee before the next meeting date in August. In response, JB advised beneficial to be reviewed before the August date for implementation of the plan. CH agreed with regard to implementation, however the Plan will be reviewed by CET and IJB's as delivery partners, before brought to Committee for assurance. **Committee agreed receipt of Plan prior to August meeting, if appropriately through review processes and approved. Chair noted in principle subject to Executive approval processes**. JI would liaise with Lisa Allerton (Public Health) and Jo Hall (Vaccination Transformation Programme Manager) regarding timing of issue of Flu Plan to Committee.

Recommendation: The Clinical Governance Committee is requested to note the contents of report and the risks presented.

Recommendation accepted and supported by the Committee, noted of risks in paper and accepted.

Action: Lead JE – Care Home Vaccination Data.
Action: Lead JE – Cervical Screening Data.
Action: Lead NF – Position of NHSG Board of Cervical Self-screening.
Action: Lead JE – Timing of Flu Plan issue.

7.3 Healthcare Associated Infection Reporting Framework
Noha El Sakka, Clinical Lead Infection Prevention and Control presented the quarterly report. To inform the Committee of key healthcare associated Infection issues and actions.

Summary National HAI Q3 Report produced by Health Protection Scotland:
The report comprises NHSG Board data and comparisons to other Health Boards and Nationally (with a Q3 year ago time-point comparison).

New graphs provided on Cdiff Infection/ECB/SAB data for 2016 – Q3 2020, demonstrates an assuring direction.

Data produced on the HPS report have been superseded by current HPS reports representing Q4, October – December 2020.

HAI Quarterly Local Report includes data for October – December 2020.

An executive summary provides general percentage overviews of targets and comments on screening programmes and incidents with level of risks. Of note, data pertains to peak of COVID second wave, which has moved on changing levels of risk. Now moving towards remobilisation and other areas of infection also of focus now.

HAI Quarter 4, October – December 2020 report highlights risk areas and progress. Of note, high risk in eye outpatient department with the IPC risk mitigated by relocation of the service with risk downgraded to low which has been reported to Health Protection Scotland. The built environment Risk is complex with various building projects in Foresterhill site, which dictates input from IPC Team (nursing and medical) with high risk relating to pressure of work, staff diverted to COVID work, however now able to support building work projects and scope. National guidance to be reviewed in line with this high profile extensive work in conjunction with stakeholders to keep up-to-date and involvement to meet standards and guidance. Resourcing of staff is an issue and further training of staff to the level required is time consuming however staffing is moving in right direction.

Quarter 4 data for CDiff/SAB/ECB discussed. These three main parameters are measured against national targets and in general figures go up and down, with rise in CDiff infections in the community, marginal rise in SAB in community and hospital setting and ECB generally below figures in previous quarter, community and hospital. Factors in changes to hospital setting (for e.g. Near Me Clinics) has impacted on infections spectrum both hospital and community, not outliers in comparison to National figures, with variations more related to COVID with no alarming figures. Weekly surveillance programme continues, includes medical and nursing staff, with monitoring of infection in these parameters and reporting to HPS when appropriate, investigations and feedback to Clinicians when required. Projects implemented have risk mitigation measures.

IPC work continues at Inverurie community midwife unit. Assessment will take place after Estates works.

Chair enquired re built environment in terms of Risk(s) associated with resource capacity. In response NeS advised requested staff (nursing and medical) resource to expand small staff cohort and with any new project the scope is extensive and requires input from IPC Team. Professional IPC involvement (embedded at start of projects) is essential to eliminate longer term issues in new environment projects. Requires staffing/skill/time and a workforce plan has been submitted in terms of

requirements of nursing, medical and administration staff to support workscope(s). Workscopes cover expanse of time and large areas, affecting patient populations hence critical IPC input. There is current National guidance on ventilation which may be an issue in older building environments.

CH thanked NeS for comprehensive overview and with regard to infrastructure, noted this will be a recurring Board item and CH is assured new commission capital projects will have the financial resources to secure the appropriate expertise. Of note, concerns around maintenance backlog issues and current inbuilt infrastructure in meeting new national set standards. This is not unique to NHSG and Alan Gray Chairs the National Group providing insight to scale of challenge. Assurance at Board level for existing inbuilt infrastructure will not be rapid with a long programme in place and what is required is to demonstrate how risk is mitigated and how this is balanced with Capital refurbishments across large number of areas across estate, of which ventilation is part of.

Recommendation: The Clinical Governance Committee is requested to note the contents of report and the action taken.

Recommendation accepted and supported by the Committee.

Chair thanked for the comprehensive overview for the accessibility of the information in the IPC reports. The reports will go to Board with comments.

Action: Lead CH – Escalation to Board Built Infrastructure Reviews and with oversight from clinical governance aspect, due to impact on patient care.
Chair thanked for assurance in risk mitigation and acknowledgement that Committee has attention on the matter.

7.4 Clinical Quality and Safety Subgroup Quarterly Report
Jenny Ingram, Associate Director Quality Improvement and Assurance, presented report.

Performance – Sharing Intelligence for Health and Care Group (SIHCG):
Co-ordination of 7 National organisations by Healthcare Improvement Scotland provides an annual review of each Board area with data analysis and feedback, published on HIS site, along with a follow-up HIS meeting. HIS have strengthened and revised their process following evaluation and is now a more structured process that will occur on an annual basis. NHSG were reviewed in January and will be again towards the end of the year. The intelligence analysed is wide-ranging and consequently does not just cover quality and safety. It was proposed that NHSG co-ordinated approach to the SIHCG enquiry is via Deputy Chief Executive and PAIR Chair Group. This co-ordinated approach was approved by the PAIR Chair Group and the NHSG approach will be tested on review at year-end. NHSG met with SIHCG in April and appropriate clinical quality and safety information will come via the Quality and Safety Sub group to Committee in August.

Of note, the quality and safety subgroup escalated to SLT the risk of resource required for the Adult Protection multi-agency Inspection discussed by KOB under agenda Item 6.

Assurance – Shared Learning Template:
The operational groups of quality, safety and governance sits with IJB's and sectors. Discussions were undertaken to agree items/topics that should come to the cross system Quality and Safety Subgroup. From these discussions and on review of previous agenda items and meeting papers the group agreed to test a shared

learning template. MHLD Service tested the template to share audit findings through the Governance Leads and within 1 day the information had been escalated and sent to GP's. The shared learning template is in the early stages of development but is seen as a commitment to support data and information flow cross system to support quality and safety.

Improvement – Duty of Candour and COVID-19:
National discussions have demonstrated Duty of Candour has not paused and NHSG continue with compliance and keeping people fully informed and up-to-date during the process. It is recognised that there could be delays in the process due to COVID and staff should ensure individuals are keep fully informed, up-to-date and records are kept.

The Duty of Candour Act still has to be tested in cases where people have come to harm when healthcare services have been reduced or have ceased when this has been out with the control of the NHSG Board.

Improvement – Access QI:
NHSG supported the development of the Access QI Improving planned care pathways toolkits and NHSG will present their experience along with Healthcare Improvement Scotland at NHS Scotland Event In June. The work along with Tayside, the other accelerator site, will progress to Phase 2 for Cardiology physiology, paediatric MRI and radiology. This work sits nicely with Portfolios pathway approach and how we apply skilled QI methodology and project management for change and redesign of pathways.

Risk – Bowtie:
JI advised the Bowtie method of risk assessment is a visualisation (in a single clear picture) with "knot" of bowtie demonstrating where control of hazard is lost. The Hazard (what we are concerned about) is our "failing to maintain the highest standard of Clinical Quality and Safety". The left of the "knot" shows threats that may cause us not to deliver clinical quality and safety. The right of the "knot" shows measures to stop the threat from happening, mitigation. Further demonstrates Lessons Learned processes, currently undetermined with pockets of good practice but requires clarity across whole system of how lessons are learned from adverse events or complaints, with action and flags. The consequences demonstrates if barriers fail, there is for e.g. increased scrutiny and enforcement action, etc. with colour coding for high/medium/low. The Bowtie Methodology allows linking for e.g. to public loss of confidence. JI provided an example of repeated adverse events and complaints if we do not learn, this would be the consequence and mitigations in place including weekly CRM and Clinical Quality and Safety Subgroup, which is developing and with Shared Learning.

The visual plan/report of the Bowtie Methodology is shown, further the software has the ability to build action plan(s) and Mike Sevenoaks suggests use with a risk management action tracker. This will be tested.

The current stage of the Bowtie methodology will be taken to the next Clinical and Quality Subgroup and through a development session for the CET and governance perspective a Bowtie will be built at this stage high level, e.g. access, or cross-system area medicines.

Chair noted this Committee seeks assurance on strategic risk(s) and asked link to bowtie risk(s). NF advised strategic risks are more appropriately described as strategic hazards and work with CET is to draw out strategic hazards and what systems and processes are in place to mitigate, prevent those threats from

realisation. Should an adverse event arise, what are the systems and processes in place to capture and learn from or further mitigate the impact and should we get that right we are describing the governance system for quality and safety of clinical care. NF provided an example whereby this bowtie methodology would be applied to a threat.

NF advised the Bowtie Methodology be further developed with CET and should it be appropriate brought to a NHSG Board Seminar. When appropriate further brought to Clinical Governance Committee development session, and to other assurance sub committees of the Board.

CH asked JI to provide for assurance of Committee a report of the management (resources and capacity) of outstanding and overdue Level 1 Reviews and Complaints, which are indicators of quality and safety. This further provides the Committee with an understanding and transparency of areas where resolution of overdue reviews and complaints are challenging. JI advised that the data is structured for reporting to for e.g. HIS, HSE and SPSO. Further information/data has been incorporated in to CRM with additional periodic updates by Leads, for e.g. Falls Leads, Pressure Ulcer Leads. Data will further arise from Bowtie Methodology and National Audits, etc. and this will strengthen Services/area data for CRM and provide meaningful data for Committee. **Chair noted the request for report of overdue Level 1 Reviews and Complaints, and thanked JI for the report. Of note, Chair advised this aligns with AA request of data for Clinical Governance lens.**

KC stated it would be beneficial to see Medicines Service aligned with this work as a major health intervention it is important to address Medicines at Clinical Governance. KC also felt it would be beneficial to see data around for example falls/pressure ulcers and Scotland wide benchmarking data. JI advised cross-system Fundamentals of Care data will be included in the Care Dashboard which forms part of the Excellence in Care Programme (ECP) for Nursing and in the near future with consistent definitions across Health Boards benchmarking can be undertaken.

Recommendations: The Clinical Governance Committee is requested to support; the approach to risk management being taken to strengthen the clinical and care quality and safety profile; and the development of the subgroup Sharing Information Template to facilitate a process for cross system data flow, mutual learning and escalation.

Chair proposed further recommendation of data for Clinical Governance lens be developed.

Recommendations accepted and supported by the Committee.

Action: Lead JI – Clinical Governance appropriate data / Report of Overdue Level 1 Reviews and Complaints.

7.5 EU Transition Programme Update
Chair acknowledged progress, AG's work on EU Transition and keeping the Committee updated in recent months. **Item to be stood down from agenda**.

8. **Committee Constitution Review and Development Session**
Recommendation to schedule a Clinical Governance Constitution Review and Development Session was accepted by the Committee.

9. **Reports to Board**
   - Minute of Meeting.
   - Dr Gray's Maternity Services Update, acknowledged by Committee.
   - Safer Workplaces Programme, acknowledged by Committee.
   - Clinical Governance Committee Development Session.
   - Public Protection Annual Report.

10. **Date and Time of Next Meeting**
    The next meeting will be held on **20 August 2021, 10.00 – 13.00.**
    Meeting invites will be sent via MS Teams.