APPROVED

Board Meeting
12.09.24
Open Session
Item 13.3

NHS GRAMPIAN

Minutes of Meeting of The Clinical Governance Committee held in Open Session
14 May 2024 at 1.30pm virtually by MS Teams

Present	Robertson, Dennis	Chair, Non-Executive Board Member
	Bachoo, Paul	Medical Director Acute / Vascular Consultant
	Bhattacharya, Siladitya	Non-Executive Board Member /Honorary Clinical Chair in Obstetrics & Gynaecology
	Burrell, Mark	Non- Executive Board Member /Specialty Doctor/Service Clinical Director ADH/OMFS
	Brown, June	Executive Nurse Director/ Deputy Chief Executive (Item 13)
	Coldwells, Adam	Chief Executive
	El Sakka, Noha	Consultant/ Lead Infection Prevention and Control Doctor (Item 10)
	Evison, Alison	Chair / Non Executive Board Member
	Fairley, Tara	Associate Medical Director - Clinical Assurance and Quality
	Fluck, Nick	Medical Director / Consultant Nephrologist
	Houghton, Emma	Associate Medical Director /General Practitioner
	Johnston, Grace	Infection Prevention & Control Manager
	Little, Rachael	Quality Improvement & Assurance Advisor
	Patwa, Hussein	Non-Executive Board Member
	Paterson, Miles	Public Representative
	Poskitt, Gillian	Associate Director - Quality Improvement & Assurance (Item 9)
	Russell, Dave	Public Representative Lay Member
	Walker, Shonagh	Associate Medical Director
	Webb, Susan	Director of Public Health
Attending	Lindsay, Stephen	Non-Executive Board Member - Employee Director
Invited	Matthews, Jennifer	Corporate Risk Advisor (Item 6)
	McLeod, Lucy	Divisional General Manager - MUSC Portfolio (Item 7)
	Friar, Stephen	Unit Clinical Director for Emergency Pathway /(Item 7) Consultant in Anaesthesia & Critical Care
	Fraser, Geraldine	Integrated Families Executive Portfolio Lead (Item 7)
	Barnard, June	Chief Nurse (Item 8)
	Boker-Ingham, Simon	MHSCP Chief officer (Item 14)
	Duncan, Sonia	Corporate Manager(Item 14)
	Robertson, Fiona	Chief Nurse (Item 14)
	Lawrie, Gerry	Head of Workforce & Development (Item 15)
	Colville, Katie	Associate Director of Midwifery (Item 15)
Minute Takers	Bray, Paula	Quality Improvement & Assurance Administrator
	Salvona, Andrea	Quality Improvement & Assurance Administrator QIAT
Apologies	Houghton, Emma	Associate Medical Director /General Practitioner
	Patwa, Hussein	Non-Executive Board Member

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1 Apologies
Noted as above.

2 Declarations of Interest
No declarations of interest.

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3 Chair's Welcome and Briefing

The chair welcomed members.

4 Minutes of Meeting on 13 February 2024

Approved.

5 Matters Arising

GP thanked colleagues who had helped fine-tune matters arising over the last couple of meetings. The remaining items were discussed at a pre-committee review. Discussions are continuing on the development of the CRM report, which will remain on the committee's agenda with the primary care element added as a new item. The Annual Delivery Plan will be agreed upon this year and all items will return later this year with dates added to the planner**.**

6 Strategic Risk Assurance - Risk 3068. Deviation from recognised service standards of practice and delivery

Jennifer Matthews (JM), Corporate Risk Advisor, presented the report on Strategic Risks number 3068. June Brown is aligned as the risk owner and executive lead. The report's aim is to detail activity surrounding risk numbered 3068 and deviations from the recognised service standards of practice and delivery. The intention is to help the committee scrutinise the activities around the risk, in addition to governance and assurance arrangements.

JB affirmed this was a multidisciplinary document as the risk looked at deviation from standards of practice across the organisation due to patients being seen by more than one individual, which involved wider decision-making throughout the organisation. The recruitment of international recruits to NHS Grampian has been successful. With regard to other recruitment, there was an ongoing chronic issue around the recruitment of registered nurses. Over the last year nursing vacancies were significantly reduced, with an increase of approximately 70 WTE posts. There is ongoing work on the recruitment and retention of nursing and midwifery staff.

In response to Partnership's query concerning the availability and monitoring of beds and the subsequent impact on staff, JB explained the ongoing challenges in obtaining beds in a surgical environment when no non-standard beds or standard beds are available in medical wards. JBa provided assurance to the committee that the Non-Standard Patient Area Monitoring Group is monitoring the frequency of when non-central patient areas are used, noting this was also about the impact on patients and staff. Last month senior leaders across the organisation spoke to patients and staff which yielded important data to support teams implementing any changes required. Given staff are now using corridor care and non-standard patient areas, there was ongoing work to adapt the tool to use as a more effective control measure.

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The implementation of PPT is monitored and when breaches occur, these are used as an opportunity to review practice in that area, learn lessons and share learning.

Recommendations

Assurance - Review and scrutinise the information provided in this paper and confirm that it provides assurance that:

- Processes regarding the management of Strategic Risk 3068 are in place and are working effectively. Any gaps in controls are identified are being addressed

Decision - Determine if the Assurance Level assigned to the management of the risk is appropriate

The Committee agreed and accepted the recommendations.

6.1 **Strategic Risk Update - Risk 3065 Inability to effectively deliver planned and unplanned clinical services**

Jennifer Matthews (JM), Corporate Risk Advisor, provided an overview of the paper on risk 3065. This was presented to the Committee in February 2024 with a request to return to the committee with the next steps on assurance. Following discussions with the Chief Executive Team (CET), it was determined that splitting the risk into unplanned and planned service pathways was the best way to focus efforts given their complexity. The paper outlines the decision-making process and how things will move forward. JM highlighted there was active planning and conversations around the control of these risks. The aim was to ensure these were included in risk reporting to assist with discussions with CET and Board Committee. This was a work in progress.

Recommendations

Assurance: Note the information provided in this paper and confirm that it provides assurance that:

- Improvements are being made to the development and management of Strategic Risk in this area.

The chair noted the definite signs of improvement and the committee agreed and accepted recommendations.

7 Whole System Risks Associated with Unscheduled Care Delivery: Improvement Plan

Lucy McLeod (LM), Senior Responsible Officer for Unscheduled Care Programme Board and Stephen Friar, Unit Clinical Director for Emergency Pathway and Consultant in Anaesthesia and Critical Care presented a single slide visual and paper to the committee detailing the response to long waits at the Emergency Department (ED) and the ongoing improvement work supported through the Unscheduled Care Programme Board. The single slide visual was a reference document for the ongoing front door teams to refer to and was not a working document. The paper shared with the committee provided an overview of the improvement work that highlighted productive opportunities for improving the patient journey,

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as well as outlining the existing standard operating procedures and escalation frameworks already in place.

The chair acknowledged improvements but expressed concern about the inference in the paper that tools were not being utilised effectively and opened the floor to questions.

SF acknowledged the long ambulance waits but stressed this was also about moving patients through the system. Staff were provided the tools through the Safe Transfer of Patients (STOP) and SOPS were set up on how this would be implemented. It was accepted the tools were underutilised in some areas and not always used as intended. When transfers between specialties work more efficiently this will free up capacity within ED. SF stressed there were ongoing conversations with ED physicians about the ED transfer specialty tool which was a different way of working for clinicians. The clinicians were the experts in differentiating patients at the front door, but the tool was new and required time to be embedded into the system.

LM provided assurance that while the presentation showed formal system-wide policies, there were also internal assurance processes, the joint escalation framework with the Scottish Ambulance Service (SAS), in addition to the Ambulance Long Waits improvement work. There were productive opportunities that had been identified as well as ongoing work around this by SF and LM, which the Unscheduled Care Programme Board is keen to optimise. It was acknowledged more could be done, but there were also small incremental gains at the front doors as well as other areas that could achieve a greater return.
As for barriers to equitable boarding, SF is currently working with Health Intelligence for a formula, clinical teams were supportive and this was at an early stage.

LM reported on meetings between clinical leads to explore opportunities for more cross-system pathway working. Examples of these were happening, and there were future opportunities for more pathways. There is an ongoing scope of work to look at a single front door system for a cohort of patients coming through ED and filtering through Acute Medical Initial Assessment (AMIA). This might involve expanding the Rapid Ambulatory Assessment Clinic (RAAC) capacity which is currently limited in scope and clinic space.

GF highlighted ambulance waiting times are currently a high priority. Acknowledged NHSG is an outlier in the 90th percentile of waiting times across boards but is average in terms of the median turnaround time at approximately 50 minutes, which is comparable to most mainland boards. The 90th percentile fluctuates considerably but may be due to high periods of activity combined with high occupancy in the system, as the low figures in April may attest to. This is currently being examined through the data. No single activity will change the current situation, but it is likely that a combination of improvement activity together could. It was reported that some Improvement work streams through the Unscheduled Care Programme Board have not yet started and that data from the Discovery

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Centre for Sustainable Excellence is being used to ensure the correct leverage points and drivers are behind improvement activity.
NHSG has fairly accurate projections of patients arriving at the Emergency Department and through AMIA each day at peak attendance times, although ongoing work around AMIA with potential scheduling could be attempted.
NF recognised that capacity and developing relationships around complex handovers was a key factor in getting the system to work. It was further acknowledged 8-hour waits were remerging, and the group were in agreement there was a responsibility to design the system to reduce the frequency and hopefully eliminate it.

GF provided assurance that the joint agreement with the ambulance service ensures that any deteriorating patients in the ambulances will be fast-tracked through in addition to immediate life-threatening calls in the community, where ambulances and crews respond. The risks are being mitigated as much as possible. It was acknowledged there are lengthy periods in our emergency department and in AMIA and waiting rooms. Patients not seen quickly are at risk of adverse events and this is a concern. The wider risk of people not being in the right place at the right time is covered within the strategic risk part of report.

LM provided assurance on measuring productive opportunities. There are a number of other processes in place and the Discovery Data has led to an output report which covered the leverage points. The productive opportunities were self-populated. A report goes back centrally on a monthly basis and is held by the Unscheduled Care Programme Board, in terms of those deliverables. The first target is likely to be any non-delayed length of stay in excess of 14 days or delayed length of stay in excess of 14 days because smaller incremental productive opportunities at the front door have less of a yield in terms of ambulance waiting time improvements. Productive opportunities will be captured and monitored and LM's role is responsible for these deliverables. Updates will be provided as required to the committee. The handoffs NF referenced are part of work not yet scoped work but are within the delivery plan this year to look at the prevention agenda and redirection, noting a snap audit of 36 handoffs for one patient before they got to the correct person they needed. This is where there is a real gain that has not yet been exploited.

LM provided assurance that escalation protocols are in place for services outside of Aberdeen Royal Infirmary (ARI). A scope of work for mental health this year was carried out through the Unscheduled Care Programme Board who look at most of the system access including HMP Grampian and other partners outside of ARI.

The authors were commended for the amount of ongoing work and thanked for providing an abbreviations table.

Recommendations

Assurance – review and scrutinise the information provided in this paper and confirm that it provides assurance that the policies and processes

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necessary are in place and are robust.

The committee agreed and accepted the recommendations.

8 Clinical Risk Management Report

June Brown, Executive Nurse Director/ Deputy Chief Executive, presented the Clinical Risk Meeting (CRM) paper to the committee, noting the term 'Management' from the previous report title has changed to 'Meeting'. This reflects the fact services manage these risks as the meeting's purpose is to seek assurances about activities around risks, not to manage the risks. The report included all data that was discussed at the weekly CRM. Two highlights of the report were the completion of the STOP work and the continuing work around the Non-Standard Patient Monitoring Group.

Members remarked this was a comprehensive and good paper.

JB clarified that the top 3 concerns are discussed every month and data incoming to CRM are reviewed and the top 3 concerns for the organisation are identified and presented to the Chief Executive. Concerns have changed little over time and were last reviewed at the end of April.

Recommendations

The committee is asked to note the clinical risk profile and associated impact of board level deviations highlighted in this report and support the actions being taken to reduce the risk.

The Committee noted the report and actions.

9 Cross-System Quality, Safety and Assurance Group

Gillian Poskitt, (GP) Associate Director for Quality Improvement, introduced the Cross System Quality, Safety and Assurance Group paper (CSQSAG). GP wanted to bring to life to the committee the enthusiasm in the group meetings, in particular through the portfolio highlights. Clinical colleagues have made connections over the two meetings as the main focus of that group is about learning and connecting within the system. In response to a query on Grampian Guidance, GP provided assurance around ongoing work and that CSQSAG members were asked to feedback to local clinical governance groups in their next meetings on the need to support the review and update specialist guidance by Portfolios in a risk-based approach.

TF reported a new steering group is being set up which would provide a different governance structure for Grampian Guidance. This will involve, clinical and leadership colleagues from primary and secondary care, and will include the Grampian Guidance team. The steering group will report to the Professional Directors Forum. The group will provide more oversight, and a safer, transparent governance structure for the development and

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management of Grampian Guidance. The first meeting is planned for the end of June.
Members commented the report was well laid out and an excellent piece of work. MB requested to be notified of any vacancies within the new steering group.

Recommendations

The Clinical Governance Committee was asked to note this report and the actions taken within it.

The committee noted the report and the actions taken within the report.

10 Healthcare Associated Infection (HAI) IPCT Report (April 2024) and 10.1 Healthcare Associated Infection (HAI) IPCT Report (January 2024)

Noha El Sakka (NES), Consultant in Microbiology, updated on the HAI parameters regularly reported to the Scottish Government. Looked at in the report were C Diff infections and E.coli Bacteraemias of which NHSG are generally below the national average for quarter four of 2023, reported on 9 April.

Staphylococcus Aureus Bacteraemias are slightly above the national average, these are being regularly reviewed and monitored and measures are introduced as required.

Surgical site infection reviews are currently paused while reporting on mainly other parameters, this is in addition to the healthcare built environment and the work being carried out there.

The challenges of ARI being an aging building estate is also contained in the report and NHSG are trying to address the issues to mitigate the accompanying risks.

MB enquired when the SSI reporting would be re-commenced. NES responded that there is currently no indication being stated by Scottish Government but this is being monitored for any change of decision. NES agreed that there needs to be an element of surveillance in the future but this will depend on the priorities of Government.

There was a discussion on the areas that were reviewed in the past around SSI and the focus change due to Covid and other factors and the dates discussed in the reports submitted.

NES and JB confirmed that the reports are first sent to the Strategic Committee then the Executive Committee for assurance and ensure balances and checks are in place before it is brought to the CGC.

DR thanked both for the information and NES for the presentation.

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Recommendations

The Committee were asked to review and scrutinise the information provided in the paper to confirm it provides assurance that the policies and processes necessary are in place and are robust, that any gaps have been identified and are being mitigated effectively, acknowledging the improvements to policies and processes are being made and appropriate evidence of these have been provided to the Committee's satisfaction.

Members are content.

11 Annual Statement to the Board for approval

DR informed the group that the annual statement to the Board was to be reviewed and approved prior to submission to the Board and asked for an approver.
MB responded that he was happy to approve the statement. This can now sent to the Board.

12 Terms of Reference

DR stated that the Terms of Reference for the group were due to be reviewed.
NF commented that the Assurance Framework noted in Appendix 1 would require review and updating for the groups who are part of the reporting network to the Committee. Otherwise, the ToR is appropriate but the Appendix requires some work and this could be an opportunity for a development session for the group looking at the role of meetings like CRM in relation to the Committee and added as a new appendix.
The Chair thanked NF and would be diarised for a future date.
The Committee approved the ToR.

13 Professional Annual Assurance Report – Nurses & Midwives

June Brown, Executive Nurse Director presented the second paper to the Committee which focussed on the Workforce, who they are, how they are regulated and what that looks like as well as education and training, Healthcare Support Workers and their framework and Staffing Legislation will be in the Health and Care Staff in Scotland Act when it is introduced. There are approximately 7,500 Nurses, Midwives and HCSW in the NHGS workforce split over the different Portfolios and the majority of Nurses are in band 5 roles in Integrated Specialist Care Services, there are 113 Midwives in Grampian who work for one year at Band 5 then automatically move on to Band 6 which most are, and presently, there are around 2,000 HCSWs in substantive roles working across the various Portfolios with the majority at Band 3 following the work done by STAC which is ongoing. Nurses and Midwives are registered and managed via the Nursing and Midwifery Council (NMC), but there is no regulatory body for HCSWs.
JB explained the role of Nurse Director and the responsibilities around the Nursing and Midwife staff employed only by NHSG, including GP practices which are managed by the Organisation, to maintain our checks

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on regulatory requirements for the registration of staff and fitness to practice.
Further detailed for the Committee, was the process around recruitment and validation and re-validation for all Nurses, Midwives and Bank staff in these positions. It was noted that there are currently 23 ongoing concerns being reviewed with the NMC for a number of issues.
Presently, future Nurses and Midwives are required to go through a three year Undergraduate program or an equivalent Open University opportunity and the education is regulated by the NMC with scrutiny from NES Education for Scotland. There was a review recently in relation to our role to provide Practice Placements and to support students and this is also completed by the University and NES. There are many NES frameworks that support in providing education and competence which is aligned nationally for different types of staff and roles.
The HCSW framework employs the four Pillars of Practice, Clinical Practice, Facilitating Learning, Leadership and Evidence, Research & Development for education and there is a level of practice according to the Band a HCSW is employed and working in.
The Health Care and Staffing Scotland Act became live on 1 April 2024 and this is currently being reviewed in terms of meeting the requirements for appropriate and safe staffing. This aligns with existing requirements for staff governance, clinical governance and workforce planning but it does not prescribe minimum staffing levels. NHSG presently has a Programme Implementation Team and this reports to the Staff Governance Committee to address areas such as Common Staffing Methods, real time Staffing Assessments, escalation processes and addressing severe and recurrent risks.
DR asked for clarity of the process of identity checks for Agency and Bank Nurses. JB clarified that all identities are rigorously checked following an interview process and checks in accordance with the HR Once for Scotland Policy and this is applied to agency staff through their employer.

There followed extensive discussion from the Committee on the presentation.

Recommendations

The Committee were asked to consider is the CGC assured that the NMAHP Directorate is delivering sufficient controls to support the Professional Assurance Framework for Nursing and Midwifery? Is the CGC assured, that the Nursing Midwifery and Healthcare Support Workers workforce in NHS Grampian are suitably qualified, trained and supported to provide safe and effective clinical care? The Committee agreed that these assurances had been reached.

The Chair thanked JB for her report.

14 Highlighted Portfolio – Moray

Simon Bokor-Ingram, MHSCP Chief Officer, Fiona Robertson, Chief Nurse and Sonia Duncan, Corporate Manager attended to discuss the report for Moray.

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SB-I informed the group that the report was an overview of the activity around Acute process both for the Health and Social Care Partnership in terms of the IJB and DGH reporting lines which are detailed, to give the Committee assurance of the these mechanisms within the Portfolio, and the level of cross checking built into the system for the monitoring and reporting of data to the IJB and is also to CRM.
The portfolio has those two key components, the Health and Social Care Partnership and the acute hospital. It was recognised there is difference in how those two elements report, but there is consistency in terms of our portfolio senior management team, FR as Chief Nurse for the portfolio works between the two and allows for commonalities and shared pathway issues to be quickly identified.
Complaints or incidents are often multifaceted, more so as time goes on, which may be an indicator of the level of integration in the area with Social Work, Health Services, Acute and the Community. This involves a number of different bodies to look at a particular incident.
FR added that processes and systems in terms of Clinical Risk Management meetings have improved and she is Chair of the meetings for Moray and DGH.
This gives consistency across the area for shared learning through those processes.
FR is also currently chair of the Moray Clinical and Care Governance Group, and the processes in terms of the DGH clinical governance chairing presently. There are changes and improvements in terms of our overall Clinical Governance processes across the portfolio.
SD informed that identifying future learning opportunities is presently at the forefront in the Portfolio.

DR asked for an update on the Public Dental Service in the area.
SB-I responded that the urgent care service has been secured and work is ongoing to be preventative by establishing routine appointments and increasing patient registrations. There is a waiting list for this but are offering out of area opportunities to register, and using the Scottish Dental access initiative which is a financial incentive to practices to help them get kind of up and running and started in Moray. There are discussions with our colleagues in NHS Grampian Estates and Capital Planning on using the opportunity around the levelling up funding to create the potential for premises in the centre of Elgin for future dental practices as premises and setting up practices have been a barrier.

DR thanked SB-I, FR and SD for their report.

Recommendations

The Committee was asked to note the update presented by the Moray Portfolio colleagues to provide comment and to seek assurance.

Members noted as content.

15 Integrated Family Portfolio Update

Geraldine Fraser, Integrated Families Executive Portfolio Lead, and Katie Colville, Associate Director of Midwifery, updated the Committee.

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GF highlighted that some of the quality and safety issues and some of the associated improvement activity around about those which would be considered to be our clinical risk areas and some of these draw from the risk register. In terms of the Paediatric Anaesthesia Service which is still in year one, and has been very vulnerable in terms of provision from last year and into the current year. Two new consultant have been appointed and started in March with another two joining in August, and will strengthen the team.
Also highlighted was work within the HDU and Children's Hospital which is recognising higher numbers of children with long term ventilated conditions spending time in the hospital while waiting for care at home packages which takes time to set up. There is a change on how the beds in that area are used. There are few beds in that area and following an adverse event, there is a piece of work in place to review the training skills and ascertaining the correct level required for provision of critical care to children in the NHSG.
There are also details in the report of themes noted in maternity, particularly round adverse events and complaints and feedback linked to the work the Quality, Risk and Governance Team are performing in the area. There is an aim to expand that and look at similar themes for Women's Health and Children's Health around risk management approach and update the Committee following a number of high and very high risks which were out with the tolerance levels.
GF confirmed that all of the very high and tolerable risks now have action plans in place, and there are two outstanding high risks, for which updates are received prior to the meeting. This work is well underway, and needs only to be finalised and signed off.
An external review around The National Embrace Report will be undertaken and a EPA culture survey results for the Children's Hospital is showing positive results, particularly around the nursing cohort who completed the survey two years ago and have completed it again recently. This showed that 84% of nurses felt that there had been an improvement within those two years and the level of engagement has gone up which is positive news.
KC expanded on the National Embrace Report where Neo-natal death rates in NHS Grampian were flagged. In the 2022 data, there is a change from 2 RAG statuses to a red RAG status. There is focus work in place and an MDT team will be undertaking a subsequent review of all cases from 2022 in June 2024. The findings of that review will be brought back to the Committee.
DR was pleased to note the progress in the area and asked if there was a specialist nursing team in theatres to support the new Anaesthetists.
GF confirmed that the theatre nursing team are in a good place at present.

No Recommendations were noted for this item.

The Chair thanked both for the comprehensive update.

16 Any Other Competent Business

None Raised

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17 Date of Next Meeting/Dates of Future Meetings

13 August 2024, 1330 – 1630 Hours, MS Teams
12 November 2024, 1330 – 1630 Hours, MS Teams