APPROVED

NHS GRAMPIAN

Minutes of Meeting of **NHSG Clinical Governance Committee** held in **Open Session** on **13th February 2024** virtually by MS Teams

Present		
	Dennis Robertson (DR)	Non-Executive Board Member/ Deputy Chair (Item 10)
	Paul Bachoo (PB)	Medical Director Acute / Vascular Consultant
	June Brown (JB)	Executive Nurse Director
	June Barnard (JBa)	Nurse Director - Secondary and Tertiary Care (Item 7 & 12)
	Siladitya Bhattacharya (SB)	Non-Executive Board Member/ Honorary Clinical Chair in Obstetrics & Gynaecology
	Mark Burrell (MB)	Non-Executive Board Member/Specialty Doctor/Service Clinical Director ADH/OMFS
	Caroline Clark (CC)	Chief Nurse
	Noha El Sakka (NES)	Consultant / Laboratory Medicine (Item 8)
	Alison Evison (AE)	Chair/Non-Executive Board Member
	Tara Fairley (TF)	Associate Medical Director – Quality & Safety / Consultant Obstetrician
	Nick Fluck (NF)	Medical Director / Consultant Nephrologist (Item 9 & 11)
	Geraldine Fraser (GF)	Integrated Families Executive Portfolio Lead (Item 13)
	Grace Johnston (GJ)	Infection Prevention & Control Manager
	Rachael Little (RL)	Quality Improvement & Assurance Advisor (Item 6)
	Jennifer Matthews (JM)	Corporate Risk Advisor (Item 14)
	Hussein Patwa (HP)	Non-Executive Board Member
	Dave Russell (DRu)	Public Representative Lay Member
Attending	Paula Bray (PBr)	Quality Improvement & Assurance Administrator
	Andrea Salvona (AS)	Quality Improvement & Assurance Administrator
Apologies	Susan Carr	Director of AHPs & Public Protection
	Adam Coldwells	Chief Executive
	Miles Paterson	Public Representative Lay Member
	Shonagh Walker	Associate Medical Director - Performance and Deputy
	Susan Webb	Director of Public Health
	Gillian Poskitt	Associate Director Quality Improvement and Assurance

Item	Subject	Action

1 Apologies

Noted as above.

2 Declarations of Interest

No declarations of interest noted.

3 Chair's Welcome and Briefing

The Chair welcomed members.

4 Minutes of Meeting on 13th February

Agreed as accurate.

5 Matters Arising

No matters arising raised.

6 Cross-System Quality, Safety and Assurance Group

Rachael Little (RL), Quality Improvement & Assurance Advisor Report provided a summary of the Cross System Quality, Safety and Assurance (CSQSA) report.

RL highlighted sections in the report covering ideas discussed at the CSQSA meetings, these were an opportunity to share learning across the portfolio structures. The chair opened the item to questions.
It was confirmed the CSQSA group uses the Health and Social Care System approach for learning across Grampian. This includes services delivered in the Acute Sector, Health and Social Care Partnerships, Care Homes, Mental Health Services, and Doctor Gray's Hospital (DGH).

The Scottish Public Services Ombudsman (SPSO) are clear on the training requirements and therefore the CSQSA group is currently reviewing how to package deliverable training to portfolios and the individuals responsible for delivering and supporting responses to complaints. The Portfolio Executive Leads (PEL) have been contacted and work should be completed soon. The PwC audit of the complaints processes made recommendations looking at this and will be discussed at the Audit Committee.

JB explained the effectiveness of the training is established by staff undertaking the complaints process successfully. Currently, staff have difficulty with both the process and understanding how to respond to complaints. It was envisaged the training will improve numbers of early resolutions to complaints, staff will manage complaints more effectively and this will reduce complaints coming into the system. RL noted comments regarding timescales and measurements for assessing the effectiveness of the training, suggesting there is an opportunity to feed this back to the committee at a later date.

Recommendation: The Clinical Governance Committee is requested to support the development of the cross-system training for complaints and feedback in a way frontline teams find most supportive and effective.

The Committee agreed and accepted the recommendation.

7 Clinical Risk Management Report

June Brown (JB), Executive Nurse Director provided highlights of the Clinical Risk Management Group (CRM) Report circulated to the Committee.

JB explained the groups remit was not to manage risks but provide feedback and support where required and find mitigations where possible to services. The report included a new compliments section based on feedback from the last Clinical Governance Committee. Derogations or deviations to care are included in the report to improve performance and ensure patients receive required care. Work is ongoing to ensure understanding of compliance with the Health and Care (Staffing) (Scotland) Act 2019 and due for completion around

the 31st of January. The Bed Base Review is ongoing and currently moving into phase two.

JB responded to query around the approach to risk management in terms of human and financial resources. Discussions are ongoing to ensure there are no deviations detrimental to care and this will be discussed at the Performance Assurance Finance and Infrastructure Committee (PAFIC). NF stressed the quality element of care should not decrease, despite current constraints and reiterated the CRM reviews strategic risks in relation to delivery or finance. This will be covered in the Clinical Governance Committee Board Development Seminar on Quality and Safety next week.

JB explained top 3 concerns are based on clinical perceptions of risk from data submitted to CRM and the ensuing discussions. Concerns to CRM are highlighted and escalated to Senior Executives and act as a 'temperature gauge' to highlight issues impacting clinical delivery the most.

TF responded to query from a public representative on Section 2.3 of the CRM report. TF clarified that Occupational Health restrictions meant health and wellbeing matters and that Junior Doctors on Levels 1 and 2 with occupational health restrictions unable to work at weekends or night shifts carry a significant cost to the organisation when they have to cover Level 3 Junior Doctors rotas due to their higher remuneration.

DR posed a question on behalf of a Miles Paterson, Public Representative, asking if patient complaints can be submitted directly to the Scottish Public Services Ombudsman (SPSO). JB stated the purpose of the SPSO was for members of the public to request an investigation if their complaints to public sector organisations including NHS, were not handled appropriately as they expected. DR noted the significant resources spent in dealing with SPSO cases and NHSG is currently focusing on dealing with complaints more effectively.

NF responded to query from MB concerning the increase in occupational health service restrictions and if mitigations were available. The Committee could ask the Trainee Development and Wellbeing Service (TDWS) to provide a thematic analysis for advice on appropriate modifications. It was acknowledged there was a substantial percentage increase in the number of trainees seeking additional support.

AE asked if CRM were able to be agile in their responses to situations given the volume of data submitted to group and the current system pressures. NF replied that the CRM's effectiveness was due to the current chair and numerous people in each of the domains who submitted data. The CRM group aim to support individuals to escalate risks within their system or direct to the Chief Executive Team (CET) meeting the day after the CRM meeting if necessary. The CRM team also commission reviews if concerning patterns emerge in the data.

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

The Committee agreed and accepted the recommendations.

8 Healthcare Associated Infection (HAI) IPCT report

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

Noha El Sakka (NES), the Lead Infection Prevention and Control Doctor summarised key points in the Healthcare Associated Infection (HAI) Reporting Template (HAIRT).

NES highlighted HAI infections: Staphylococcus aureus Bacteraemia (SAB), Clostridioides difficile infection (CDI), Escherichia coli bacteraemia (ECB) and surgical site infections for the committee's attention. NES is currently awaiting an update on surveillance of surgical site infections as this was suspended since COVID. Rates on ECB and CDI are below the national average for Quarter 3 July to September 2023 in healthcare and community settings. SAB rates are just above the national average for both community and healthcare settings and are being investigated case-by-case through discussion and surveillance to identify areas for improvement. Of note, NHSG are not outliers nor above the 95% confidence interval upper limit for healthcare or community associated for SAB for Quarter 3.

DRu expressed concerns about some work remaining outside of the scope of Public Health and Health Protection teams. NES explained these projects do not follow the same governance route as NHSG projects since they involve partnerships or third parties. The need for clarity of roles and responsibilities of key stakeholders was raised at the Asset Management Group where the recommendations were endorsed, and they are awaiting feedback from partnership representatives present at this meeting. Further work is required to embed this process. The National IPC workforce strategy is the first stage in acknowledging potential gaps and a gap analysis is being undertaken and shared with the HAI executives once completed.

NES responded to DRu's query on the risk associated with an unannounced visit being initially identified as 'high' and then downgraded to 'medium' after the audit. The 'high' status was the result of the initial report. Due to positive comments, the large volume of work from colleagues across various services, responses to questions, evidence, and action plan the risk was reduced from high to medium. DR remarked the thinking behind DRu's query was that organisations should be ready for inspections at any time.

JB noted NHSG were above the national average and asked if NES expected an increase across Scotland. NES conformed rates are not expected to go below average everywhere, and the NHSG rate was largely due to natural variability. NHSG are not outliers, the 95% confidence interval was not breached and regular surveillance and reviewing with clinicians were all in place.

AE referred to the section on continuing improvements on multi-drug resilient organisms and sought assurance the ongoing and improvement work is continuing at a comfortable pace for the team. NES provided that assurance and stated that processes and systems are in place and staff are able to review all relevant data.

DR asked why there was a decline in hand hygiene in medical staff in comparison to nursing staff. NES explained this was specifically related to an area and due to workload intensity. The audit process is in place to learn lessons and identify areas for improvement for the whole team.

The Chair thanked NES for the report.

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

The committee noted the report and the actions taken.

9 CGC Seminar – Quality and Safety

Professor Nick Fluck (NF), Medical Director / Consultant Nephrologist and June Brown (JB), Executive Nurse Director provided an update on the Clinical Governance Committee Board Development Seminar on Quality and Safety to be held on the 22nd February.

NF and JB stated the seminar is an opportunity for dialogue around professional governance and to explore what information should be reviewed when seeking assurance around clinical governance. The seminar will include various aspects that have previously had limited discussions in addition to discussions around understanding the operational and corporate perspective and how these feeds into the Clinical Governance Committee.

The Committee welcomed the update.

10 Discussion on Annual Statement to the Board

The Committee received last year's statement in the papers. It was proposed to share a draft of this year's statement detailing work to date, the future direction of the committee, plans, and priorities. The paper will be shared at the next meeting for members to acknowledge and if there are no amendments the paper can be accepted at the meeting.

11 Professional Assurance – Doctors

Professor Nick Fluck, Consultant Nephrologist/Medical Director delivered the presentation circulated to the members and noted that this was the first time this item has been brought to the Committee.

Professional Assurance has been discussed for several years in the organisation and is now brought following a change to the Committee's terms of reference to provide a regular update.

The focus of the presentation is Doctors in Grampian who provide NHS clinical care to the population of the area of which, NF is the Accountable Officer. A report has been formatted around the Professional Assurance Framework which was formerly presented to a range of meetings, including Staff Governance and the Audit Committee.

NF explained the structure of the groups that make up this cohort and added there are a vast range of specialisms to consider. NF concluded the presentation by asking the group to consider several questions around the shared presentation and invited discussion to ensure the correct risk, volume sufficient controls and framework were in place.
There ensued a very lengthy discussion and questioning from the group.

The Chair asked if there was a robust system in terms of succession planning and if we have enough appraisers going forward.

NF responded that there are multiple approaches in place and stated that whether there is a robust route that there are a few factors to consider, including the fact that there are differences in those of Secondary and Primary care, of which the latter is less challenging as it is a stand-alone job.

Recommendations:
Assurance
The Committee is asked to review and scrutinise the information provided and confirm it provides assurance that:

- **The Medical Directorate is delivering sufficient controls to support the Professional Assurance Framework.**
- **It is assured that the Doctors in NHS Grampian are suitably qualified, trained and supported to provide safe and effective care.**
- **Note the currents risk associated with Professional Assurance of Medical staff.**

Discussion and Feedback

- **Clinical Governance Committee to consider the approach in the report for seeking assurance and provide comments and feedback.**

The Committee agreed and accepted the recommendations and stated they would like an update to come back to the meeting at a later date.

12 Update on Health Improvement Scotland (HIS) Inspection

June Barnard, Nurse Director - Secondary and Tertiary Care, reminded the Committee there had been an unannounced inspection by HIS on the Safe Delivery of Care. This was done at both ARI and DGH between 9 - 11 October 2023 and released on 1 February 2024.

There was a focus on the 7 domains of Assurance Framework during the inspection which included visual inspections, triangulation of results and questioning and discussions with staff. An improvement action plan was developed and re-released when the report was published.

It was noted by HIS that conversations with staff highlighted staff were committed to delivering safe care in a compassionate manner and the patients spoken to reported good experiences. It was also noted that teams are under operational pressures and by the fact we have employed the use of non-standard patient areas and corridors at times of peak capacity and there was some positive feedback for our teams in terms of having well-managed and organised ward areas.

An internal SBAR, short summary of the requirements, recommendations and areas of good practice, has been developed which is shared widely through all the governance processes. The actions required from the inspection, 66 in total, 30 for ARI and 36 for DGH. HIS Inspectors wrote to NHS Grampian on 2 occasions during the inspection phase, expressing concerns regarding the management of controlled drugs and management of incident reporting. Separate piece of work to be responded to and returned to HIS by 31 March 2024. Work moving at pace across the organisation on all other actions.

The Chair remarked that sign off from HIS is dependent on achieving the highlighted actions and we need to be assured that the actions taken are appropriate and in line with those detailed in the report.
JBa agreed and assured that there is a programme of meetings scheduled with each individual portfolio where there will be scrutiny of the work to ensure they will be compliant with the requirements.

The chair recognised the volume of work involved.

13 Integrated Family Portfolio

Geraldine Fraser, Integrated Families Portfolio Executive Lead reported on the past year around the Portfolio and acknowledged the support and training that has been delivered by JM on raising awareness and education on the Portfolio's risk management approach. It is felt the Service is now able to better identify the nature of the risks and in the response to them.
It is seen that the nature of the risk is different across the Portfolios as there are teams managed through a variety of integrated specialities for example, the Emergency Department is within MUSC, so there is wider involvement in terms of response and the ongoing work in the Portfolio oversight of the risks and there is now quarterly risk management meetings which were set up in the last year.

Going forward, we are to look at whether a specific action plan is linked to the risk register for each of them, so there is work to be done on this and look at the recording in a consistent fashion with senior managers looking at improvement work in relation to the risk management and wider governance arrangements. It is hoped this will allow for the action plans to be in place by the end of March 2024.

The Chair thanked GF for the report. It was acknowledged that there has been an improvement in terms of transparency but noted there is still a large amount of work to be done.

Recommendations: – The Committee is asked to –
The Committee is asked to review scrutinise the information provided in the paper and confirm it provides assurance that improvements are being made to processes regarding Risk Management and Governance arrangements within the Integrated Families Portfolio
There are sufficient controls and/or mitigations in place for the management of intolerable risk within the Integrated Families Portfolio

It was decided that GF would return to the next meeting on 14 May 2024 to gain assurance around the recommendations made.

14 Risks

Jennifer Matthews (JM), Corporate Risk Advisor, advised this is a new item for the Committee, but it is hoped this will be a regular item going forward.

The report focuses on Risk Management and the activities throughout the organisation and is linked to the Board Committee Risk Process. Progress on this has been building over the last year and is split into three sections.
The includes presenting the report to this Committee to give an overview of the risk profile of the organisation to give an overall focus on the type of risk and the amount that is being presented within the entire system presently. There is also a reflection across the partnerships for an overall balanced view to highlight key areas. From this, it is noted that there is an increase and trend in the types of risk related to compliance aspects.

The plan right now is to present one strategic risk per cycle of which there are two aligned risks. For scrutiny, the risk presented is relating to the delivery of planned and unplanned care and our inability to do this in a safe and effective manner. There are several mitigations in place, so we ask the Committee to consider these high rated risks. It should be noted that we expect these types of risk of an operational nature to be managed by the Portfolios or area

directorates, but it is this enhanced level of assurance and oversight that is sought from the Committee.

The Chair acknowledged there has been a lot of progress in terms of where we are on Risk considering resources to meet patient care objectives.

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

- **Identified gaps in the NHS Grampian Risk Management activities are being addressed through improvement work.**
- **Work is ongoing regarding the management of aligned strategic risk. Aligned intolerable risks are being managed appropriately to bring them back within a level of tolerance.**

The Committee is asked to determine the level of assurance that can be provided regarding the management of strategic risk 3065 and whether it aligns with the Chief Executive Team.

- **Determine the level of assurance that can be provided for the management of aligned, intolerable risks.**

The Committee agreed to JM returning to the meeting on 14 May to review next steps on assurance.

15 Items for Noting

No items for noting.

16 Any Other Competent Business

No other competent business raised.

17 Dates of Future Meetings

14 May 2024
13 August 2024
12 November 2024