Minutes of NHS Shetland Clinical Governance Committee (CGC) Held on Tuesday 08th March 2022 via TEAMS

Members Present

Jane Haswell	Chair
Colin Campbell	Non-Executive Director, Chair of Audit Committee
Amanda McDermott	Chair of Area Clinical Forum (ACF)
Ian Sandilands	Chair of Area Partnership Forum (APF)
Lincoln Carroll	Non-Executive Director

In attendance

Kirsty Brightwell	Medical Director and Joint Executive Lead
Kathleen Carolan	Director of Nursing and Acute Services and Joint Executive Lead
Michael Dickson	Chief Executive of the Health Board
Brian Chittick	Chief Officer of the Integrated Joint Board
Colin Marsland	Director of Finance
Edna Mary Watson	Chief Nurse (Corporate)
Emma Garside	Clinical Governance Manager
Mary Marsland	Committee Administrator

Contribution to Agenda

Carolyn Hand	Feedback and Complaints Officer (Agenda Item 11 Only)
Karen Smith	Joint Head of Mental Health (Agenda Item 13 Only)

The Chair welcomed Kathy Hubbard to the meeting in her new role as a Health Board Non-Executive Director. It was noted Kathy would be in attendance at a number of meetings within her new role, to gain an understanding of the structure and how it operates.

It was noted a break would be factored into the meeting, if needed.

1 **Apologies**

Apologies for absence were received on behalf of Susan Laidlaw, Interim Director of Public Health.

2 **Declaration(s) of Interest**

There were no declarations of interest to note, however the committee were advised, any declarations of interest could be raised at any point throughout the agenda.

3 **Development Session – Outcomes from Development Workshop 02nd March 2022**

Kirsty Brightwell noted there had been good engagement within the workshop and provided a summary on the outcomes and learning.

Although short, it was hoped people had found it helpful and once all feedback had been received and complied into a sensible order, it would be distributed to the committee.

One of the main highlights from the workshop where colleagues felt what was already being undertaken, was suitable.

It was felt learning needed to be shared, particularly around patient's stories so people across the organisation have more confidence. A process around how to showcase such stories is needed. Reflection had been given as to how these would present themselves to the committee, then onto Board. Having them presented at this committee for discussion, would allow for questions which may not be asked in a more public forum, this would then allow for a more rounded view.

Exactly how does this committee iterate what it is doing well was questioned. It was thought the Quality Score Card is a really helpful presentation which includes narrative and quantitative data. How then, does this committee produce more information within that format which includes both types of data, in order for people to understand the wider picture of what is happening, as opposed to just numbers?

The journey of papers, and how they get to Board was reflected, as was the purpose of this committee, in terms of it providing assurance and scrutiny, as opposed to getting into too much detail. It was felt it was helpful to get clarification of how this committee shapes the way in which it receives papers and assurance, to then be able to pass that onto Board.

The committee were informed, time will be spent on compiling all comments received, into a format that can be shared.

It was noted the Jam Board would remain open until the end of the week for any additional comments/thoughts.

4 **Action Tracker**

The Chair noted a brief conversation had taken place with the Executive Lead in regards to Alcohol Brief Interventions, which would be picked up later within the meeting, as it relates to the understanding of data.

5 **Minutes of the Clinical Governance Committee meeting held on 07th December 2021**

It was noted there was a point of accuracy in regards to Lincoln Carroll's surname within the apologies **– ACTION MM amend.**

The committee approved the minutes as a true and accurate reflection.

6 **Matters arising from the minutes**

The Chair noted the minutes of this committee are a useful way of capturing discussions, which then go to Board. The committee were asked if they were within a useful format to continue with, and do they fulfil the committee's needs as there is a lot of work that goes into producing them?

Colin Campbell noted that although fantastic, there is an enormous amount of detail which could be scaled down to action items and bullet points, and would be happy with a reduced minute of the meeting.
The Chair welcomed the committee to comment within the Jam Board, should they wish.
It was noted comments from the Workshop and today's meeting would be compiled.
There were no further matters arising to note.

7 **Draft JGG Minutes from 17th February 2022**

Emma Garside confirmed minutes from the previous meeting, held on 11th November 2021, which this committee was sighted on in December, were approved.
It was reported these are the draft minutes of the last meeting as they stand, which will be approved at its next meeting in May.
Kathleen Carolan made an observation in that, the agenda is more balanced and whole system. From the topics discussed, there is more equality in terms of what is being looked at in respect of quality and consistency, governance and risk in the partnership. In the past, the agenda was more orientated towards NHS based services. Good discussions were had around pieces of work that are being reviewed through the Senior Officers Group, work that is being done together, across the system.
It was felt this was a positive affair to note to the committee in terms of how we are starting to see a shift.
Lincoln Carroll echoed this sentiment from an Integrated Joint Board (IJB) perspective, in that more information was being received in what those programmes of work are.
Lincoln highlighted the works within Criminal Justice within Adult and Children's Services, specifically around significant trauma and looking at how they can engage with children's services and the paediatric services to try to lower the risk of young people coming into service at an adult age.
There are good works being undertaken and it is felt the JGG is a good route to have conversations around how these things can combine. It's about how we work across the board to reduce things like offending, and young people falling out of services and not being involved at the right time.
The Chair noted from the minutes you are able to see the assurance process coming together with the right people and is why the JGG is crucial.
Brian Chittick gave feedback on the trauma informed lens works. It was noted there is a general movement towards taking the learning and putting it back into the service, with requests being made to look at other services.
There is a meeting organised to try to start to build on the kind of activity to put trauma informed practice at the heart of everything we do.
The Chair noted the link with the operational group is important for the process as it is relatively new.
Kathleen Carolan eluded to the point made by Lincoln Carroll in that these issues are being talking about within the Shetland Children's Partnership, particularly how the link is made between what is happening within Drug and Alcohol Partnership and what is happening within the Shetland Protection Committee, and the wider delivery of partnership services it is felt it is not quite there yet in terms of pulling everything together. Within the Joint Children's Plan, having a focus and link between harm

reduction and what is being done in various elements and arenas of partnership working.
There is now a Senior Officers Group in place which has been reviewing individual learning outputs, which have been discussed in quite a level of detail and is in the process of discussing how to get lessons learned publicised from the reviews, in a way that is meaningful in terms of service delivery. It was thought this would be something that could be discussed with the joint Chairs of the JGG, should they have a focus and a spotlight on looking at some of the issues around Children's services, given that they are very much a multi-agency business which would work well in a JGG discussion. This would then be fed through to CGC. .
From the detailed discussion had, it was agreed to bring back to the committee as an action these groups having a whole Shetland approach – **ACTION**.
The Chair noted 6b of the minutes – Adult Protection Referrals Involving Staff Audit in that Denise highlighted there were no referrals received from health professionals. Could the JGG give this committee assurance this has been reported and what actions are being taken from that, as it does state there will be some discussion – **ACTION**.
For future consideration, the Chair requested, as the JGG feeds into the CGCs assurance, an Escalation or an Assurance "section" be added to the minutes, which state where any assurances are attaining to - **ACTION**.
The committee noted the report.

8 **Clinical Effectiveness Quarterly Report from Joint Governance Group (JGG) – Q3 01st October 2021 – 31st December 2021**

Emma Garside noted this report has been drafted to provide the CGC with an update on Clinical Effectiveness Activity that has taken place across NHS Shetland from October to December 2021.
It was noted the draft report was presented to JGG at its meeting on 17th February with no updates or changes being made.
Work being undertaken in relation to the National Audit Programmes was highlighted within 2.3.3 of the report, which is a positive piece of work along with the review of the Patient Focused Audit. It was noted, key results are highlighted within the report.
The Chair noted the front cover was very good at signposting the entirety of the report, and asked for a brief account to be given on where the audits originate from, for the benefit of new members.
The Chair thanked EG for the brief account, placing the importance of understanding the process of where local audits are.
Kathleen Carolan considered the content of the report and that of the Quality Score Card, in respective of how, whole system the report is with a lot of the activity focused within the hospital setting. The committee were asked for thoughts on where some of the other data exists and how it may be brought together, how to bring in some of the care assurance work, and how to understand what is happening around quality clusters.
Brian Chittick agreed it was part of the thought process and wondered if it could be taken away, giving thought as to how to interject into a lot of the work, particularly within partnership and GP Clusters, highlighting some of the work and actually bringing it forward.

It was noted Acute are good at showcasing audit work with a good example given within the preoperative assessment for GA and is something he will be taking back to his Team via the Learning Board to put forward, what audits are being undertaking, were learning is found and how it is showcased, and provide assurance around the audit works being done. Happy to take this away and discuss with the team via the OPS meeting around how we link into the quality report.

Edna Mary noted there is work that could be done to better support the partnership in getting some of their information into the reports. It is thought a lot of the development work being done around the JGG will help get a more balanced picture, however it is work in progress and accepts the points that the report is quite acute focussed.

The Chair noted the assurance for those processes are there

Kathleen Carolan noted the Leadership Walk around's had recommenced and questioned where highlights from those walk rounds would be seen? Are JGG or the Operational Governance Group (OGG) in a position to start planning 22/23 for that programme? If so, would be keen to get involved and support areas that maybe haven't been involved with Leadership Walk around's before. It's thought there has been one to date, possibly more, and is about getting a sense of what is coming out of that, given they have been paused for two years and that staff have been through a pandemic, what sort of issues are emerging?

EM confirmed there has been one walk around to date which was challenging trying to use the process that had been created. This was also highlighted within the Jam Board, that there is a need to take a step back and relook at it.

An explanation as to why was given and it was noted there are issues to be looked at in terms of the process and documentation. It was however agreed there are other areas to be looked at which include Mental Health, Maternity and Scalloway Health Centre in terms of Primary Care, and are keen to be able to move forward and get people supporting the visits.

Discussion took place around aspect of the Walk round programme.

Colin Campbell noted as a non-executive, found the patient survey particularly powerful and had tried to draw assurance in terms of processes, however wondered if there is a programme to do this kind of a survey across the Board, as it could easily link into non clinical, non-acute areas also?

The Chair noted it is within the Terms of Reference for this committee that these are seen at each committee meeting however invited overviews of where/who plans, across the health board.

KC noted she is unaware of a strategy for doing it in a particular way however, all departments are asked to undertake some form of patient information gathering which is appropriate to their department. There is no systematic approach on how this type of data gathering is seen as important as national audits. It is patchy across the organisation around what and how we get back. In terms of that action plan as well as things that come from lessons learned is work in progress and something to focus on going into 22/23.

Discussion focused around feedback.

The committee are looking to develop this and to look across ages, as well as how it reports back what changes have been made, however is it time well spent? This is the question being explored, with care opinion collating some of that work to some extent, which is anonymous.
The committee noted the report.

9 **Quality Scorecard**

Kathleen Carolan informed the committee this was the usual quality score card this committee receives
At its December meeting, the committee asked for some understanding, possibly an additional column, around what a local measure is and what a national measure is. However due to a pause within some governance arrangements in order to manage Omicron, it has not been possible to incorporate that into the scorecard and apologies were conveyed. It was noted this will transpire as the report starts to be developed.
In line with the discussion around other reports, how the score card can be populated with information from other parts of the organisation and not just by some of the national patient safety initiatives is to be explored.
In respect of conversations had around gathering patient experience stories, and information for assurance, not being shown well within the report is showcasing data being collated through excellence in care. However it was noted there are some measure at the end of the report which are within the community setting. There is a lot of rich data which sits behind that, whilst continuing to do real time care assurance in a number of settings where patients are being asked, whilst still having a car experience, what that experience was like, in order for corrective action to be taken.
It was noted data and consequences of findings are being discussed within the joint senior charge nurse and team leader meetings, however not being achieved as well as it could be, is making that visible in other parts of the governance system, particularly in respect of shared learning. These are things being looked at, which will be brought back for consideration in terms of the report, going forward.
In response to committee feedback, measure being deviated from in respect of pressure ulcers and falls, which are nurse sensitive measures, are being taken and shown from ward to board so there are individual outcomes for patients where there was an adverse event and whether or not there are any lessons to be learned from that individual investigation. The report is trying to expand on some of that information so other community settings can be looked at when it comes to falls and pressure care, it's how to bring that data together that exists in other places which will show a more cohesive report.
It was noted Amanda McDermott leads on a lot of the Excellence in Care work perspective and is happy to speak around the work happening with teams, in order to give more of a sense behind the basic narrative provided within the report.
It was noted there is reference to a date when someone had a cardiac arrest which will be redacted as it is felt it is unhelpful and can be patient identifiable. Apologies were conveyed for this oversight.
The Chair noted this has always provided a useful format, with the new summary sheet at the front pointing the committee in certain directions.

It was noted it is for this committee to provide assurance to the Board, progress is being made in terms of ulcers.
Amanda McDermott reported within the report there is a level of detail that gives direction of travel and within the last three months there has been a drop in acquired pressure ulcers, however, the data does not reflect this in enough detail. It also does not give other streams of work that are supporting the goal of pressure ulcer reduction.
Walk around pressure ulcer reduction was conveyed and it was stated it was easy to get drawn into the numbers and not see what is behind it.
The Chair highlighted, this is the forum to have those discussions for the committee to then produce assurance on the direction of travel across the community.
AM confirmed the same educational resources within the acute teams, enter the care home teams also, to try to harmonise the way in which acquired pressure ulcers are investigated, and how lessons learned are shared.
Within the comments of the chat forum, Kirsty Brightwell commented would a "deep dive" on pressure ulcers would be helpful?
Edna Mary Watson informed the committee it had been suggested to look at pressure ulcers across the three sectors, developing a joint approach, and a better understanding if there is indeed, a significant issue with pressure ulcers, and if so, where is it emerging from and to see if there is a need for additional training support within areas.
It was agreed the committee are assured and can therefore provide that to Board

10 **Adverse Event Report – Q3 01st October 2021 – 31st December 2021**

Emma Garside noted this is the quarter three report from October to December. The information is detailed in a draft report which was presented to JGG at its meeting on 17th February with no updates or changes being made.
It was noted the report is for awareness however key issues added to the report, are highlighted within the front cover of the report.
It was agreed the report would provide the committee with an update in regards to the number of Duty of Candour's (DoC) reported within the quarter, it was confirmed there had been no DoCs to report within the quarter.
In relation to the National Child Death Review System which came into place in October, it was reported there had been one death which is being reviewed by another Board. There is to be a meeting to look at the review and identify any learning within the next couple of weeks. That learning will then be shared.
The committee were informed, lessons learned within areas of work, will be brought through to committee, via its reports.
The Chair noted the intentions for additions moving forward.
The committee noted the report.

11 **NHS Complaints & Feedback Monitoring Report**

Carolyn Hand informed the committee this was the quarter 3 feedback and complaints monitoring report which was presented to Board in February.
It was noted stage one complaint numbers are steady, and are being completed within the five working day turn around.

Stage two complaints are not being completed within the 20 working day turn around. It is thought this is due to the Pandemic, however the 20 days target has always been an unrealistic target to achieve due to the complexities involved, which can span different Health Boards and Sectors.
It is supposed there are no particular themes emerging, however small numbers make it harder to spot trends emerging.
It is assumed there have been no complaints forwarded to the Ombudsman in the last quarter, so there are no outstanding complaint with them at present.
The committee were invited to ask any questions.
The Chair indicated it had been noted on many occasions when complaints take longer, it is seen as a positive, as it indicates the complaint is being fully investigated, and is not seen as a negative.
The Chair remarked a lot of data is received from the complaints, which is good for this committee's assurance.
The committee noted the report.

The committee took a short recess

12 **Strategic Risk Report**

Emma Garside introduced the strategic risk register which are this committees strategic risk responsibilities.
It was noted all strategic risks are reported through the risk management group, then onto the Audit Committee and then to Board, twice yearly.
It was noted the majority of the strategic risks are relevant to this committee.
Highlights of works being undertaken were brought to the committee's attention, along with a clear rational around changes in format to the report, which will give clarity to the committee and Board, and is work in progress.
Also transitioning within the next couple of reports, will be the new risk appetite.
As the full strategic risk report comes twice yearly to the committee, it was requested, a shared list of relevant risks for the committee be presented at each meeting.
The Chair noted it was important to receive the committee's responsible risks at each meeting.
Amanda McDermott noted she has been using the new template which is much more intuitive than the previous version.
The Chair noted the assurance on the process.

13 **Approval of the Approved Medical Practitioners (AMP) List**

Karen Smith introduced the approved Medical Practitioners List.
It was noted historically, an updated list was presented to Board on an annual basis where they would accept the named individuals who were the approved Medical Practitioners for NHS Shetland.
During COVID this did not transpire and now the Scottish Government are requesting a standardised approach to the approval of AMPs, with the list being brought quarterly to the CGC and for the Health Board keep the list administrated an up to date. This also

includes making sure the practitioners undertake the mandatory training that is required, ever five years.
For Shetland there are Adult Psychiatrists and one within Child and Adolescent Mental Health Service (CAMHS) who is an AMP when on Island, and not when they are off Island.
It was noted, approval is being sought for the list, clarity for the administration of the list and that the committee are happy it is presented at each quarter as an update.
Kathleen Carolan noted what is being asked is entirely clear, however how do we deal with the emergent changes that are within models? An example was given of a Consultant Psychiatrist who gives support from England and is not on Island, therefore do they meet the definition of an AMP although providing consultant psychiatry input to children and families in Shetland but is not working under the Section 22 Act as they are not detaining any children or providing emergency powers or input, therefore it may not be this list but may be something that needs to be annotated, in terms of governance so other practitioners can be seen within the governance structure, as it is felt this will become more frequent going forward.
KS gave insight as to why it would be beneficial to have an extra conversation out with the meeting.
The Chair enquired if the training evidence was able to be presented to the committee or dates of when training is due so the committee has sight of this.
KS confirmed she would be happy to be the administrator around which doctors need to be on the list and incorporate where they are at with training, with Mary Marsland then keeping it centrally for the committee.
Kirsty Brightwell indicated this would come through an individual doctors Continuing Professional Development (CPD) and thought would be needed around how this would be linked together. There are a few thresholds to be concerned about which would need to be discussed with Karen Smith and Mary Marsland to make sure this is made as easy as possible - **ACTION**.
The Chair confirmed the committee receive the list every quarter.

14 **Self-Assessment for Annual Report**

The Chair stated agenda items 14 and 15 would be a combined report. Both being in relation to the governance of the committee.
As this is a new committee the Chair asked if the committee were happy if information received from the workshop along with returned surveys, be amalgamated to form the self-assessment which the Cahir will then produce and return by the required date?
The Chair informed the committee the Business Plan for 2023/2024 will factor in a Workshop, which will form the basis of next year's self-assessment rather than using the surveys which are onerous and does not capture the richness the workshop captured.
It was noted there are no concerns to be raised to the Board from the CGC.
Any persons wishing to add any content to the report, were welcomed to contact the Chair.
The committee agreed for the Chair to produce the report from the information received.

15 **Governance Assurance 2021 – 2022 - Final Sign Off**
As above

16 **Whistleblowing Report 2021 – 2022**
Kirsty Brightwell informed the committee this was the first report to be produced since Whistleblowing Standards were brought in, in April 2021.
It was noted the committee will receive a quarterly report whilst the Board and Staff Governance will receive an annual report.
It was confirmed there have been no Whistleblowing concerns raised to date through the new process. It was thought, as this is the first year, there may not be enough awareness across the organisation or it may be nobody has anything to raise. There is a Steering Group that will continue to meet, making sure processes are met and are in place.
Consideration is being given into selecting a random sample of staff to see whether the right awareness is in place, as it is not clear if this is the case. It was noted, this is work in progress.
The committee were informed there are six fully trained confidential contacts who are the first point of contact for members of staff or any persons working with the NHS services who want to raise something.
There is a Datix form in place for trained contacts to use which will enable data gathering. Data will also be gathered around issues that have been raised but are not taken through the Whistleblowing channel, and will provide a wider context. It is hoped things can be put into business as usual if appropriate, and that individuals will be protects in terms of their confidentiality, should they choose to go down the Whistleblowing route.
All processes are in place, however awareness needs to be continually driven, as it is not always in the forefront of people's minds.
It was noted a longer report will be brought to the committee after April, which will include some of the support, the process requires from organisational development as there are gaps within OD.
Discussion ensued around awareness raising with emphasis focusing around exit interviews.
Ian Sandilands noted there are lots of avenues before you get to Whistleblowing, therefore it's around getting the balance.
KB confirmed Whistleblowing is for volunteers and university students, and for anybody who works alongside NHS including social care, home care and care home staff.
University Leads have been asked to include this within the on boarding for students so they are aware Whistleblowing exists.
Before leaving post, Shona Manson was to speak to Voluntary Actions Shetland around Whistleblowing, however unsure if this transpired – **ACTION KB** to follow up with SM.
It was noted independent contractors use their own processes, use NHS Shetlands, or use both.
From discussions it was understood, confidential contacts have a key role.
The committee noted the report.

17 **List of Ongoing Planned Service Redesign**

The Chair gave a brief introduction around the paper.
Kirsty Brightwell reported at the recent workshop the committee explored its role in terms of new service design, new models of care and how the committee sees its role within these areas. It was determined it wasn't the role of this committee, and that its role is to look at assurance from these pieces of redesign.
It was noted, examples of ongoing works are provided within the paper. The table, although now out of date, gives a bigger picture overview of what, at an executive level are priorities, and included is the improvement plan with the service redesign with IJB Delegated Services.
It was thought this may not be required as things had moved on.
Kathleen Carolan noted it would be helpful to understand the ASK around seeing service redesign, is there a sense of what "good" would look like from the committee?
A set of examples of what already exists has been provided, however is there something that would be helpful for the committee to see in a given format to be able to determine where some of the major redesign work is happening, what the outputs of that are, and how well aligned they are to the clinical care strategy?
The Chair clarified as to how this had emerged, and questioned if it was this committees responsibility to have governance overview of where strategic redesign is happening, and if not, then where would that sit?
KB supposed it is what this new committee's role is, in terms of assurance around new projects and new pieces of work, and if they should be presented to this committee, then in what format?
Much discussion ensued.
The Chair recapped, moving forward, the committee would like to explore how it can incorporate this into its remit and how it would then translate, in terms of what it would look like. There is apprehension around the understanding of what the committee would do with the information, and would need to be clear in its role, at a strategic level.
It is felt that there should be something else that is responsible for it, before it comes to this committee. It is felt perhaps, this committee does not have the agility to look at the projects and get the assurance required – **ACTION** the committee agreed to take away and consider how this can be taken forward.

18 **Date of next Meeting**

It was confirmed the date of the next meeting would be June

Brian Chittick brought to the committees attention, a potential Governance issue. From discussions, the committee were assured the appropriate Governance body was involved, and any developments would be brought back to committee for an update, if required.

Brian Chittick further informed the committee he will be taking forward a paper to the IJB at its meeting on 24th March, setting out the interim clinical and care governance arrangements for IJB moving forward, following the disbandment of Clinical Care and Professional Governance Committee (CCPGC), and the establishment of committees like CGC.

BC informed the committee there is a review of all governance structures being undertaken, which is in the process of being produced
The usefulness of partnership working was conveyed, with all structures now in place.
Given the absence of CCPGC, the escalation route will now be through the IJB Audit Committee, which will be an inclusion within the paper. It is felt this is a natural linkage for this committee as Lincoln Carroll is the Cahir of that committee also.
Service links to this meeting were noted and it was thought these links are tighter now than they have been before.

The Chair noted the positive and productive discussion and thanked the committee for their presence and forwarded reports.