Minutes of NHS Shetland Clinical Governance Committee (CGC) Held on Tuesday 12th December 2022 via TEAMS

Members Present

Jane Haswell	Chair
Colin Campbell	Non-Executive Director, Chair of Audit Committee
Kathy Hubbard	Non-Executive Director
Amanda McDermott	Chair of Area Clinical Forum (ACF)

In attendance

Kirsty Brightwell	Medical Director and Joint Executive Lead
Kathleen Carolan	Director of Nursing and Acute Services and Joint Executive Lead
Susan Laidlaw	Director of Public Health
Colin Marsland	Director of Finance
Edna Mary Watson	Chief Nurse (Corporate)
Michelle Hankin	Clinical Governance and Risk Team Leader
Mary Marsland	Committee Administrator

Contribution to Agenda

Carolyn Hand	Corporate Services Manager (Agenda Item 14 only)

1 **Apologies**

Apologies for absence were received on behalf of Lincoln Carroll, Member and Non-Executive Director, Michael Dickson, Chief Executive Director and Brian Chittick, Chief Officer of the Integrated Joint Board

2 **Declaration(s) of Interest**

There were no declarations of interest to note. Any declarations of interest could be taken at each agenda item should they arise.

3 **Approve the draft minutes of the meeting held on 12th September 2022**

Edna Mary Watson noted a change to Item 17 *Freedom of Information Policy* (page 12 of the minutes) – where it states *"Edna Mary Watson noted* it *would be helpful to add clarification or have some reference to public health information in terms of making the judgement as there is an expectation that people should know roughly whether it is information provided from their department or if a conversation is required with the SIRO.*

This should read *"there is Public Health Scotland guidance on how to use data more appropriately so as not to get into a position of identifying individuals in areas where small numbers are"*.

The minutes were approved as an accurate reflection.

4 **Matters arising from the minutes**

There were no matters arising from the minutes. However the Chair noted a number of action points:

- The deep dive around cardiac arrests will be addressed within the agenda.
- Page 8 of 13 within the minutes - a lengthy discussion had ensued in regards to Finance and Performance Committee, looking at workforce and what this committee will carry as a risk in terms of workforce. It was noted this Action should be forward onto the action tracker and examined at a later date - **ACTION**
- Resuscitation Policy is already added to the action tracker

5 **Summary of Assurance Levels**

It was noted from the previous workshop, the committee were looking to introduce levels of assurance.

Kirsty Brightwell informed the committee the levels of assurance followed on within the agenda, which were in pictorial, as well as written form with the aim being to complete the column with the level of assurance the committee agrees upon, were any further information is required, or if further work is required in terms of where there maybe weaknesses. This would then be taken forward to Board and reported back through reporting committees, in terms of overall culture of assurance as well as clinical governance through the organisation.

It is hoped this will become easier as it is practiced.

It was noted this would add time to each agenda item, which the committee would need to be mindful of.

Kathleen Carolan questioned if providing context around assurance within the reports where applicable, would be helpful for the Board to understand why risk is being carried within some areas? Kirsty Brightwell was in agreement.

The Chair noted this was a good step the committee were taking.

6 **Joint Governance Group (JGG) Approved Minutes 03rd October 2022**

Edna Mary Watson gave an overview of business conducted within the meeting.

It was noted discussion focused on work across the partnership, reviewing issues raised in regards to quality of care across health and/or social care services which was done in multidisciplinary interagency way. The outcome was to develop a process to guide people to set up a small multidisciplinary group, if there is a particular care issue needing to be reviewed.

Concerns had been raised by the Dental Director in regards to one of the Independent Practices, whilst updating on some of the actions that had been taken.

It was noted there had been short discussions on further hot topics, as at the time, it was still operating under the partnership being in business continuity mode.

Issues raised where the fact the partnership was in business continuity and what this meant.

A conversation had taken place with Robert Gordons on how to maximise workforce over the winter period, encouraging students from Shetland who may be returning home

over winter, to consider working for NHS either in clinical, administrative or support roles across the organisation.
A brief discussion ensued around the fact it was National Speak up Week, with Confidential Contacts holding open sessions across the organisation, to encourage people to raise any concerns.
The Chair noted 16 people had been in attendance at the meeting from across the disciplines, which was good, as the basis of the JGG is to strive to have that alliance.
The Chair noted there was reference to a Clinical Governance Service Review Action Plan and questioned if it would be presented to this committee?
EMW noted it had not been added to the Business Plan but could be, to be presented at the next meeting – **ACTION.**
The Chair noted it would be good for the committee to review this quarterly or annually, whichever the committee deems.
Colin Campbell commented the Speak up Week was an excellent idea and noted interest in the response rate, as he had observed within the two Whistleblowing reports there had been no Whistleblowing actions, and remarked this was in context to Whistleblowing.
Kirsty Brightwell informed the committee there had been an online event, with two people attending. There were a further two sessions held within the hospital canteen which was more interactive as the Whistleblowing Champion and Confidential Contacts were able to pull people in and have quiet conversations, with quite a few taking place.
The committee were informed, Jason the appointed Interim Whistleblowing Champion had attended different areas within the organisation, and felt there is a good understanding of how to speak up. There isn't such an awareness of the Whistleblowing standards themselves, but staff that were spoken to, feel able to speak up to their Line Managers or other Senior Managers within the organisation.
Kirsty Brightwell confirmed there had not been any formal Whistleblowing issues raised through that route at present.
The Chair made clear the committee seeks assurance on reports presented and not minutes.
The committee noted the report.

7 **Operational Clinical Governance (OGG) 08th November 2022 Matters for noting**
Kirsty Brightwell gave a verbal update and noted the meeting had been very well attended and was felt to have been the most functional meeting had to date, due to the range of Flashcard Reports presented.
Mental Health reported a sizeable waiting list (63 people) for Attention Deficit Hyperactivity Disorder (ADHD) diagnosis in adults. Mental Health are to have a Waiting List initiative and use this as a learning process with quality improvement principles alongside the Primary Care Cluster Lead. Additional funding has been secured up until March and is hoped this will bring pre-assessment to the process and make it more streamlined.
Bernadette Dunne spoke around Trauma Risk Management (TRiM) and the use of this within Workforce in terms of prevention of Post-Traumatic Stress, thinking about it in the wider context with violence, bullying and accidents at work. TRiM being aligned to

Occupational Health is seen as helpful but this risks reducing the potential to be seen as a multiagency resource. It was noted there was lots of interesting learning.
Shetland has not had any Yellow Card Reports over the last year which was raised for awareness. It was noted the Yellow Card Report is for any adverse effects of any medication.
Flashcards had been received from the Public Protection Committee, which signalled new guidance around Public Protection. It was noted an online inspection was forthcoming which will take up a large amount of time and resource.
Discussion has taken place in regards to Nursing and Midwifery and Allied Health Professionals (NMAHP) in regards to employing all students during holiday periods, and how to promote that across Shetland.
Annex 21 process, needs to be raised at Staff Governance and Area Partnership Forum (APF), along with the advanced practice modules so more nursing courses can be done remotely, which is more flexible and sustainable for staff.
It was noted the Excellence in Care Awards had taken place on the previous Friday.
A level of empathy was felt for Dental, who are currently firefighting and thinking around how it can bring back the Market Street Practice under NHS, and how does the service become more all-encompassing.
There is a holdup with the General Dental Council (GDC) which is affecting the employment of staff and is causing issues in the rebuilding of staff within Shetland. This is a national issue. As a result Shetland is running at around half of its numbers for dentists at present. A lot of working is being undertaken to manage public and staff expectations.
It was reported Mental Health are looking to change their service, taking the workforce budget and having more personnel but at a wider range of banding. This will allow more flexibility for crisis care whilst maintaining planned care.
It was noted Leadership Workarounds will commence again in the New Year.
Discussion had taken place around the Scottish Patient Safety Programme (SPSP) News2 with work being undertaken within the hospital around the accuracy of the recording of observations.
It was noted this had been a positive meeting with people starting to feel they are getting that cross system learning, hearing what is going on in other areas, and getting that cross connection which has been positive.
The Chair noted it was positive to hear Flashcards were coming through and were being used, as this was something that had come up through this committee.

8 **Clinical Effectiveness Quarterly Report from Joint Governance Group (JGG) – Q2 01st July – 30th September 2022**

Edna Mary Watson gave the committee an in depth overview of the key actions and highlights from the report. It was noted the report gives a true and accurate reflection of how things stand.
The Chair thanked Edna Mary for her review and opened out to committee members for comment and discussion.
The Chair stated, even after a number of years, she still struggled with the service improvement grid however, it is accurate at the point of submission which is a huge step

forward, and good from an assurance point of view. There is a lot to understand which is positive, but wanted to understand where the overview was, and is it asking too much? It is appropriate for the committee to look at the report in more detail and valued committee members' thoughts.
Before getting into discussion, Edna Mary Watson highlighted to the committee, historically the report has been based on a mixture of things individual departments have wished to do, that have had clinical priority, or has been a nationally directed piece of work rather than being a locally defined need/drive from the Board, the organisation or indeed the committee.
Michelle Hankin informed the committee, clarifications had been added to the report in regards to responses received from departments, where time pressures or staffing pressures have been indicated, and where audits are being suspended which is highlighted within the report in black.
Where responses were not received, these are indicated in red blocks at the right hand side of the column.
In regards to assurance measures to the committee, areas identified to be struggling have been prioritised for the clinical governance walk rounds in 2023, to meet with those involved, to see what pressures they are under, and how they can be supported.
It was highlighted to the committee in terms of assurance, the grid is being used to implement change and support pathways.
It was highlighted there are two types of audits within the report: nationally prescribed and local audits/improvement works. The Excellence in Care Awards show cased some of the latter which the clinical governance team were unaware of. The leads have contacted the CG team to ask for help and support which is why some of the projects have been incorporated into the report. It was noted this could be made clearer within the report.
Departments are being encouraged to share results with the clinical governance team so it's not such a big task to chase up what is happening with the audits. This is also the case with any learning, so it can be shared with the wider organisation.
The Chair thanked Michelle for her overview and noted it was helpful context on how work is progressing.
Colin Campbell noted there is a lot green within the documents which indicates there is a lot in progress, and detail within the response column indicates it has all been followed up on, which assures him as a non-executive there is focus and follow up taking place. To make this more complete, a note of targeted completion dates would be helpful; with this caveat he would conclude an excellent document which has the right amount of detail.
Michelle Hankin stated that this is a live document which is being attended to on an ongoing basis. It maybe some of the work is permanently ongoing as that is the nature of what it is, but this needs to be annotated
Kathleen Carolan noted in respect of the question around lots of system pressures and teams needing to focus on areas that have the highest impact in terms of quality and safety, is a question to be taken back to heads of service. If they have a programme of evaluation, what does it look like, and what for them is to be the priority for 23/24? The committee is not in a position to comment on priorities. Also for those programmes

which are mainly continuous data collation, the frequency is outwith our control so is not always detailed. It was noted the report could be more explicit around that.
It is recommended that the CG team in compiling the report for the Committee asks Heads of Service what their priorities are for 23/34 given the range of workforce challenges and system pressures. This will provide intelligence re quality and safety, so we can be assured that we are doing things that have real impact, that we are safely pausing work. This may also inform next year's plan and enable a potentially slimmed down programme.
Kathleen Carolan noted as a technical point, within the Maternity and Obstetrics portfolio, there is a red box and wondered what that indicated to the reader?
Michelle Hankin stated the red box is where no response was received and it was to flag to the clinical governance team. The CG team will contact the department twice and if no response an email is sent form the CG lead asking for information and informing them of the importance of this. Sometimes teams will respond after the deadline and sometimes the projects have been suspended (hence the lack of reply), this was an area where they needed to dig deeper to build the talking around the issues happening within the departments.
Kathleen Carolan suggested not receiving a response by email, may be an indicator that team is under pressure or that they may be depleted, so another mode of communication may be required, possibly a short TEAMS chat in order to have that conversation, as that in itself is a response back.
Michelle Hankin noted the brilliant suggestion and indicated she was also keen to go into the hospital to meet the teams and maintaining a clinical contact.
Kathleen Carolan noted this programme only shows what is being achieved, it does not show what isn't being achieved, and as such, there are number of departments not being represented, and it may be something from a CGC point of view to think about the departments that have very little going on, in terms of evaluation, or that is seen within the report.
Edna Mary Watson noted the clinical governance team will be visiting all departments to have a clinical governance chat which has come from the previous information gathering from the clinical governance service review, which highlighted there were a lot of areas where there were gaps within their clinical governance process or understanding across the service.
It was hoped through individual team conversations, information around their clinical priorities, and focuses for 23/24 will be teased out and can then be included within the template for next time, giving a better feel for what is happening, whilst making sure areas are included that are not currently represented.
The Chair noted from her perspective having that discussion in regards to priorities, as a non-executive, it looks like a lot of work, with comments showing a lot of difficulties.
The Chair noted the Resuscitation Committee stands out as it is all black, down to the resus trolley. It was noted the resus trolley is kept up to date and is looked at. It would be useful for the committee to have some feedback in regards to that line so they can be assured particularly around the resus trolley.
Michelle Hankin informed the committee the resus trolleys are checked by the departments, with schedules to aid with checking which is regularly done. The past

checking process was explained and it was reported due to the post of the Resuscitation Officer being vacant for a long period, there hasn't been the collection of data. The clinical governance team leader is meeting with the Resuscitation committee to look at ways the clinical governance team can support this and get some of the data collection back on track. It was noted clinical governance are happy to collate data however but need reports from the service. They could look at a joint approach, this will be discussed at the next Resuscitation Committee where it is hoped a volunteer can be recruited for the clinical governance team to work with, in order to produce a plan to capture some of the backdated data.

Kathy Hubbard made an observation whilst picking up on the point made earlier by Kathleen Carolan, when looking at the document for the first time and imagining it from a manager's perspective, it must be an added pressure on an already pressurised situation, however understands assurance is a requirement but looking at Kathleen's point in regards to priorities people need to inform us of what we might live without knowing. It was felt, for this committee it is about the difficult line around assurance requirements, and not putting even more pressure on an overloaded workforce.

The Chair noted Care Opinion was to be discussed within the agenda, however patient satisfaction is a whole area that can be looked at, along with different ways of getting that feedback, which might support the pressures on departments.

Kirsty Brightwell felt it was the closing of the loop. If improvement work is to be done, and there is a clear motivator for that improvement, how do you close the loop without putting pressure on the service to prove it has made a difference? It would be helpful to see after a year or 18 months, setting realistic targets, as Colin Campbell mentioned. Could that be designed in with the team to look at their evaluation, what is realistic and how the clinical governance team can help.

The Chair invited Kirsty Brightwell to lead the committee through the assurance level of the report.

Kirsty Brightwell noted questions from the discussions in regards to what does the paper mean, and what does it provide, was helpful as Clinical Effectiveness is a big topic with the report providing a lot of detail.

Whilst the committee felt assured, it was not completely, and felt it was somewhere in the middle. The committee were invited to provide some constructive points around what it would like to see, to make it feel more assured. The earlier point made around timelines, could have more narrative in terms of that overview as it is hard as a committee, due to the amount of information being received. It was thought there could be an increase in the narrative within the section around clinical audit, whilst closing the loop for the committee and clinical governance around next steps. .

It was felt the report's assurance was intermediate to moderate.

The Chair invited members who had not preciously contributed, to the assurance discussions which the paper had steered.

Amanda McDermott noted it was difficult to say there is one level of assurance for everything within the chart, as they are providing very different level of assurance, and was unsure you could have one combined answer. There are aspects you would want more narrative around however, there are others where assurance evidence is clear.

As there are varying degrees of assurance throughout, do you plump for somewhere in the middle, which then does not feel right.
The Chair questioned if the committee were assuring the process of the table, rather than the content.
Kathleen Carolan noted in terms of process, the programme does not reflect every department and/or area of evaluation, and on that basis, the committee are able to give moderate assurance to Board as opposed to comprehensive at this time. It is difficult for the committee to access the internal assurance of each project. If interpreting as an assurance rating for the process and not the projects, then moderate feels defensible.
The Chair noted taking this without explanation to Board may not be useful, and suggested discussions may be required around the context and how it is to be introduced to Board. A Board Development Session may also be required before this can be put forward.
The Chair noted she was aware why the OCGG and JGG Meetings had not taken place, which was completely understandable, however these are quarterly meetings which provide assurance, and only two have taken place. Therefore by default, the committee does not have assurance.
Kathleen Carolan noted the wider context of Health and Social Care is important. If looking across Scotland, they have had to abandon their normal governance framework and move to a more agile approach, which the Board has not had to do. The fact the Board has moved to an agile approach around governance on occasion, and done things differently, does not mean that during that period it has not provided assurances, focussing on the absolute fundamentals of safety and quality. It is around how this is captured, rather than counting omissions and how a more nuanced picture is captured. Looking at the big tertiary centres with which we share care, it is impacting on the quality of care Shetland residents experience as well as access to services. Ideologically how do you capture the fact we are a system under pressure, still operating 50 to 70% of the time, when it comes to clinical and care governance?
It is around that nuance understanding, rather then it being seen as a meeting was cancelled and by default, there were no assurance processes as a result.
It was noted the committee needs to be thoughtful around how it does this in some of its reporting both here and more widely across the organisation. When taking of deficits, the Board has in effect, done things differently rather than not doing them at all. In many respects, there has been more closeness of communication around quality, safety and risk within the huddles which have been held three time a week. It is around capturing that, as well as having the more formal part of the clinical governance structure, up to Board.
The Chair noted form the Board's perspective, it would be useful to have this context detailed and note any areas of concern.
It was noted the committee will not progress the report to Board at this time as the committee are feeling their way.
The Chair noted she had heard collectively, a number of moderate assurances from the context of discussion had, therefore the report will be recorded as moderate assurance. If members feel this is not the correct level of assurance, they are to email the Chair.

9 **Adverse Event Report – Q2 01st July – 30th September 2022**

Edna Mary Watson reported there were no Clinical Risk Advisory Team (CRAT) meetings held during the last quarter July to September; however, there had been one held in October which relates to a number of adverse events linked to Mental Health, the outcome of which will be reported in the quarter 3 report,

There were no Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable adverse events during the reporting period;

There are four Duty of Candours (DoC) adverse events currently open and active, some of which are due to providing care in partnership with Grampian. Once a point of conclusion is reached, these will then be reported through lessons learned and shared appropriately.

Within adverse events, there is a total of 90% that are either at minor or a negligible level of harm. This is a slight improvement on the previous quarter by 2%, however there is a small increase in the risk of harm. Numbers are small and don't make much sense in this particular context. What the committee needs to understand is this is only one or two incidents.

It was felt, most noteworthy was the rate of completion of investigations. A discussion was undertaken within the Hospital Management Team and Joint Governance Group around capacity issues and the impact it is having on people's ability to do investigations within the timeframes set within the National targets. This target is ten days, and as stated within the report, at the end of September quarter, only 34% of the level three reviews were being completed within the timeframe. The understanding of recent ongoing discussion around this has led to an improvement, in terms of people being able to get through them and seems to have given a renewed focus.

It was noted there were no Category 1 Adverse Events to report to Health Improvement Scotland (HIS) within the last quarter.

It was stated that although there are a number of Adverse Events still open, the Team are working through these to get them closed off and are providing a more proactive support approach to individuals, to help alleviate the backlog of outstanding Datix reports.

It was noted there seems to be an increase in openness and transparency within the last quarter in regards to informing patients/appropriate person that an adverse event has occurred. It was thought this could be a number of factors, and it is hoped upcoming visits around all departments should help with peoples understanding.

It was noted lessons learned from closed adverse events, was the poorest area of performance. Capacity within the Clinical Governance Team is being created to support people to do appropriate lessons learned from incidents that have occurred.

It was noted data is still being collated on how user friendly people find the forms, with mixed reviews received. The Clinical Governance and Risk Assistant is currently undertaking a Scottish Improvement Foundation Skills (SIFS) programme, with the area of the project focussing on the Datix Form. It is hoped this will then become simpler and more compact for people as it can appear to be a lengthy form at the outset.

It was noted the top category for adverse events are consistent but with no disruptive or violent episodes within the last quarter which is good news.

National events being undertaken which will impact locally are HIS are reviewing their national framework for learning from adverse events. It is anticipated this will be published before Christmas but no publication date has been disclosed. Once released, the Boards local framework will be reviewed and brought in line with the national framework.
It was noted the national standardisation of adverse event categories work has been ongoing for a period of time and has had extra national impetus recently. The datix support system's lead is well engaged within the programme of work and has been making adjustments to local systems as required.
It was reported a replacement system for datix is being sought nationally, with recent active work being taken forward through NHS Greater Glasgow and Clyde to progress to procurement phase as quickly as possible as Datix is not being supported with any development. It was assumed an options appraisal would be available within December however questions have been raised in regards to that timeframe. This will have an impact if there is a move to a new recommended national system.
The committee were informed the flowchart for Child Death Reviews was attached, which had been a previous piece of outstanding. It was noted there were good clear processes, which had come from discussions held with the Sudden Death Audit Group. Subsequently similar processes will be seen around other Sudden Death Reviews as well as other reviews being undertaken so it will become a familiar process that people within the organisation as well as the Clinical Governance Team, can easily put in place, and activate when required.
Re Datix, the Chair noted the stress for staff if faced with changing a whole system and asked if there was any support or forward planning on assisting Teams on getting accustomed to a new system?
Michelle Hankin reported nationally, they are looking at a support package for organisations to help with the transition which will be for staff and managers who use the system. This will also include IT as they will be the ones to implement the changes. Discussion are ongoing, and it is a case of waiting to hear.
The Chair enquired if that would be proportionate as Shetland in the past has been disadvantaged.
Discussion took place around the implementation, costs and pressures a new system will bring to the organisation.
Kirsty Brightwell noted the report has given information around the number of Datix and DoCs, where there has been progression, and where struggles occur. As such does the committee feel there are any gaps? What, if any, information can be taken back to the Team in order to improve the report?
The Chair noted gaps had been highlighted as stands, which has been helpful for discussion, and shows the interpreting of data from the context.
Colin Campbell noted in terms of process, he was completely assured that it is working, however his biggest concern was the learning from adverse events of 37%. It is not helpful to the organisation if there is no learning from the adverse events, and so, was not completely assured around that aspect, or how improvement is to be managed around the learning process.

Kirsty Brightwell noted the point made, however, not all Datix will have lessons learned. It was suggested this be something for the Clinical Governance Team to do to set that denominator for the numerator. Currently the denominator is all things reported into Datix. If the denominator was changed to all adverse clinical events (or some such) this might give a clearer picture of the problem. It was noted this would be something for the team to take away.
Kathleen Carolan, agreed that if presented in a different way this may help to be clearer around where there were learning opportunities and enable all to be more targeted and focused.
Further discussion took place around the recording of data.
The Chair noted the feedback for the Clinical Governance Team and the committee agreed the report assurance as moderate to comprehensive.

10 **Quality Score Card**

Kathleen Carolan thanked Edna Mary Watson who had produced the main bulk of the report and cover paper.
Within the cover paper, it was noted there is a lot of helpful exposition on what the data means, which is seen as an improvement on the way the report is presented to committee.
The purpose of the Quality Score Card, is to provide the Board and the Clinical Governance Committee with a high level overview of the quality metrics that are gathered and reviewed across the organisation, it is not all encompassing, but giving metrics that would give a sense of quality, more holistically.
It was noted there are lots of good data within the report in terms of what teams are doing, with some areas doing better than the national average.
The Chair noted the good learning coming through from Falls and Ulcers and wondered if this would be disseminated out to community services?
Amanda McDermott informed the committee that the tissue viability nurse does not have the capacity to be out in the community. In order to increase educational resources across the partnership, link nurses are invited to attend tissue viability meetings which are well attended meetings. The tissue viability nurse also shares resources and training sessions. There have been a number of Reps on island providing education sessions, which are available to all, across the partnership.
It was noted the link nurses will take back learning to their teams, and the TVN is always on hand for advice when there is investigating or dealing with a pressure ulcer that needs specialist input.
It was noted from a falls point of view, it is a complex picture at present, given the increased number of people delayed in hospital and is difficult to say if there is learning around falls reductions, as the root cause of a person having multiple falls, is often that they are in the wrong environment.
It was noted it is difficult to achieve falls reductions, other than having one to one care, which is done where possible, however does become challenging at night, as ratios differ. Mitigations in acute are not always that relevant to Care Homes and Care at Home Teams as it is setting-specific.

The Chair noted the helpful response, particularly around the Link Nurses and practices, which would be good to highlight up to Board within the quality card, as it is a positive step forward which the Board may not be aware of.
The Chair stated in regards to Falls, some individuals have personal care assistance. It was questioned how the flow of this learning can be maximised across some personal care assistants who are going into care homes, if appropriate. It is thought discussions are occurring, however it is looking at creativity which the Team are very good at.
Kathleen Carolan informed the committee she had previously observed, although the report is still very acute focussed, due to national initiatives, there is an expectation the hospital collects data on falls and not so much within the community. As such, it would be helpful for the CGC to have a conversation when the Director of Health and Social Care is in attendance to discuss where is that improvement data being collected, are there any gaps, are there any gaps within the infrastructure of the community to undertake some of the work and what is the interface with Social Care? It was reported care delivery is entirely integrated, however in terms of performance, the data is being reported directly in to the Integrated Joint Board (IJB) and/or the Audit Committee and is not being reported into the CGC. It is thought there is other data that could be collated together with the Quality Score Card that gives a whole system picture or it may be there are gaps and it would give the committee more clarity around where these may be.
It was felt important for the committee to be aware the report is compiled of accessible data and may not be a complete picture.
The Chair felt it should be captured within the action tracker if appropriate conversations are to take place within JGG or CGC – **ACTION**.
Kirsty Brightwell questioned in terms of the process and quality of the report, was there enough information to understand what it means in terms of subtlety and nuance, and if the process of scores within the report are providing the level of assurance required? Small numbers will not always have a trend or draw a pattern, however not withstanding that how did the committee feel?
It was noted gaps within the partnership and community being done differently may not detract from the Score Card but as another piece of narrative, as people will ask questions which is then fed back into the system.
Colin Campbell informed the committee work is being undertaken by the Finance and Performance Committee, in terms of integrated performance across the Shetland Island Council (SIC), IJB and NHS so there is work being undertake.
Colin Campbell stated this report is one of the best quality reports within the Board which ticks a lot of boxes, you are able to understand the issue, narrative and action plan. The process and the report, gives the comprehensive assurance there is a handle on the issues of quality.
The Chair noted the process and conversations required, in what the CGC and Performance Governance Committee need to explore, whilst providing the same report to each committee? This was perceived to be achievable, however workload should not be increased due to increasing another committee, as there is a danger of duplication.

The Chair asked if the committee were comfortable this is the right Quality Score Card information being presented from a clinical governance perspective and asked the clinical governance team to respond, as Non Executives would have a different view.
Edna Mary Watson stated in terms of what is being presented, Non Executives can be reassured they are seeing good data, however it is around the Acute sector due to national drives. The question remains who, how and where the rest of the partnership data is being gathered. As highlighted by Colin Campbell, it is how the clinical governance team can engage in that process if it is already underway or if it just starting.
Colin Campbell stated he talks about the principles of reporting this kind of information, however the one principle he seeks is the balance between qualitative and quantitative which he is being presented with, with this report.
What could be expanded on within the report, which was presented at the last meeting within the Patient Survey where patients were surveyed on a particular issue.
This exact report or a similar quality report was presented at the Finance Performance Committee which suggests all are working on the same material, therefore there is a need to ensure it is collectively reported, in an integrated or joined up way. It was noted Gary Robinson and Colin Marsland were looking at the Finance and Performance reports
Kathleen Carolan noted it was helpful to add the content of the Score Card was typical of any other Board or Trust across the UK with the right things being included for this point in time. The ambition as an organisation is to show quality metrics as a whole system. These may not be metrics the Board itself needs to see, but being assured as a CGC, all of the data across the whole system is visible somewhere. When it comes to more community focus settings, the uncertainty is being able to have assurance there is improvement data, and there are patient safety programmes being played into. It is around where is that data, and where is it best placed in terms of assurance which may or may not be the Board. The work the Finance and Performance Committee is undertaking may wish to receive a subset of this information, once it has been assured it is the correct information with an interpretation to go with it.
It is important for the committee to understand, it may not be about this report expanding itself, but the committee receiving complimentary companion reports from other areas so it can amalgamate the two things together.
In terms of this committee's quality oversight, it is only seeking 60% of the ongoing quality improvement work within the organisation.
Kirsty Brightwell stated she was mindful the report was providing the committee of assurance around a cohort of data and not full data and that it is not being construed this is the Quality Score Card for all services the Board provides which is important. However, if that was the aspiration, which is not the thinking, then the committee does not have full assurance.
In regards to the Finance and Performance Committee, caution is needed in regards to what the purpose of discussion for that committee is, which is being made clearer to this committee. It may be helpful to have the Finance and Performance Committee to steer/push this committee on the assurance being provided to Board, and to have that read across the two committees so work is not being duplicated, as the worst thing

would be to provide different levels of assurance on the same report, for the same reason.
Edna Mary noted moving forward in terms of care assurance work within the care home environment, herself and her equivalent, the executive manager within community care resources, will be undertaking qualitative and quantitative information around the care sector, and so is ideally placed to be able to bring some of that forward.
The Chair noted the right members were on the committee for when, and if, it aspires into that area.
The Chair noted, if this was an acute report then its assurance is comprehensive, however, if aspirational then it would be moderate. It was noted the committee are aspirational looking at an integrated whole system approach, which it sees as its remit as a CGC.

11 **Whistleblowing Quarterly Report Q1 01st April – 30th June 22 & Q2 01st July – 30th September 22**
Kirsty Brightwell noted the reports had been touched upon earlier and apologised for the Q1 report not being submitted at the previous meeting, however it had been submitted to the Staff Governance Committee
It was noted there was not a lot between both reports. There had been no formal reports submitted through the Whistleblowing route.
More work has been undertaken around awareness, making sure updated information is available on the website, which is a continuation.
Work continues through the Steering Group as at present, Shetland has a joint Champion with Orkney, however going forward, this may change.
It was noted in terms of a process, there is one, but there is still more work to do.
The Chair noted in terms of the committee's assurance, the report was moderate to comprehensive.
Kathleen Carolan stated it would be more accurate to say the report reflects the HEAT framework rather than acute services as it includes data from other parts of the system. As discussed there isn't the visibility around data that sits within the Health and Social Care partnership, which is not seen within JGG structure either. The focus of conversation should therefore be around how visibility is created.
The Chair asked for clarification as it was her understanding if the HEAT Framework is renamed, then that comprehensive assurance would be appropriate.
Kathleen Carolan noted the report has everything it would expect to include, along the original HEAT definitions, however what it does not have now Clinical Governance focuses on all health related services, which include Primary Care and all those in the partnership that are health driven, is visibility, which is probably no different than any other partnership. This is aspirational work that should be planned for future.
The Chair noted this would be included within the context.

12 **Approval of the Approved Medical Practitioners (AMP) List and Process (CAMHS)**
Kirsty Brightwell informed the committee this was the approval of the approved medical practitioners list which is a requirement from Scottish government to report to up to

Board, those who provide Section 22, which relates to the Mental Health Act and Detention, are being monitored.
It was noted to be an important piece of work, making sure people have a legal basis for undertaking the work, making sure their submissions are renewed.
From its last meeting, the committee had noted gaps within the report, in that the status of the Consultants was not clear. It was noted this also read across Child and Adolescent Mental Health.
On preparation for this committee the question was raised around the Joint Head of Mental Health, Karen Smith, seeking assurance from the Child and Adolescent Mental Health Services (CAMHS) Team Lead, Natasha Clubb or others from CAMHS to make sure there is duel sign off and that this committee are getting that assurance through.
It was noted there is a little bit of work needed in regards to this process - **ACTION**.
Kathleen Carolan noted the recent addition of Dr Iain McClure within the CAMHS Team and wondered if he should be included within the report
Kirsty Brightwell stated he was not Section 22 approved and therefore did not need to be included.
Kathleen Carolan stated this would need to be addressed as a developmental issue.
Kirsty Brightwell agreed this was a question to be taken back to the department to ask if that is what is needed - **ACTION**.
The Chair noted as a committee they are aware the process is not there and does carry a significant risk if appropriate processes are not in place. Therefore given the caveat that this is a new process for this committee, it was proposed to assure the report as low to moderate

13 **Heath & Care Staffing Programme Board Terms of Reference**
Edna Mary informed the committee discussion around the Health and Care Staffing Act had taken place at the recent Board Development Session.
It was noted the Act was received the Royal Assent In June 2019 with a view it would have been enacted in 2020, however the Pandemic impacted on timescales.
The Cabinet Secretary for Health announced in June Minister the enactment would now take place from 01st April 2024. As such, all Board areas are putting arrangements in place to enable them to demonstrate they can meet the duties within the Acts. One being the setting up essentially a Programme Board in each of the Health Board areas to have oversight of this piece of work.
The Terms of Reference (ToR) are for the Programme Board which outlines locally the role and remit and have been based on Greater Glasgow and Clyde's Terms of Reference, which is being held as an exemplar across Scotland.
The Chair noted
This was another Board for staff to attend, however does seem to be very patient focused.
It was noted the ToR did not need to be assured and that it was coming through for the committee's approval.
The committee approved the ToR.

14 **NHS Complaints & Feedback Monitoring Report Q2 01st July – 30th September 2022**

Carolyn Hand hoped the report was self-explanatory and reported the performance in regards to response times to Stage 2 complaints was a slight concern. It looks like a slight improvement had been made, when in fact it is the way in which the indicator is worded. It asks you to look at the response time for things closed. Of the eight Stage 2 complaints noted, it only includes information for three of them, as only three of them had been closed at the time of writing the report, leaving five still open.

It is understood there are system pressures that have not been abated, merging alongside the pandemic, and winter pressures on the horizon, getting any out is seen as good. NHS Shetland is not alone in struggling with Stage 2 response times, this is something being heard consistently from other Complaint Officers from other Boards.

The difficulty is the expectation does not go away from the Ombudsman's Office. A letter had been received, stating the Board had to very much comply with the complaint handling procedure and its statutory responsibilities in that regard. They will continue to monitor this and the Board will do its best.

In terms of the Stage 2 responses it is felt they are better to be delayed and right, rather than getting them out sooner and not being completely right. The amount of time taken to revisit a complaint is quite extraordinary.

The committee were informed, since the report was written, another case has been submitted to the Ombudsman, one that the Board was not aware of.

The Ombudsman has written back to inform them they will not be proceeding with it as they felt the response given from the Board was satisfactory. This will be included within the next literation of the report, however this was felt to be positive that they had felt it had been a good report to have gone back to the complainant.

The Chair noted the committee had been discussing system pressures which had been mentioned within this report, and how it is useful to have it within a report as a sighting of what is happening within other Boards.

It was noted the development of this committee is to assure as reports come through, to look at and record the level of assurance. At this point it is a pilot, it is not being used to report to Board at this stage. It is for the committee to look at and improve its assurance work.

Kirsty Brightwell felt it was important to iterate the process, in that are the committee content with the process of dealing with complaints as opposed to content. – The report was presented as standards are not being met around Stage 2s, however the context of that being the complexity, as well as the small numbers of people and demands on their time.

In that regard, there are the four levels of assurance, comprehensive which is a robust level, moderate which is adequate but with some minor weakness, limited which is satisfactory with some significant weakness or no assurance at all, which is a significant breakdown of controls.

Having heard the context of standards not being met, the committee were asked for their view in regards to assurance.

The committee agreed to set the level of assurance at comprehensive to moderate.

It was noted to be a robust and helpful report which was helpful.

The Chair noted as this way of working was new, is there anything the committee would ask for future, if giving the context of pressure, and what is happening across the system. It was suggested having that as a heading within the report, would be helpful. The Chair noted the committee felt it was good to get things right and were fully supportive of this. It was felt this would form the context of future reports, and is a reminder the committee supports such an approach the desire to get things right and the delay

Carolyn Hand stated, it was good to know the committee understands if there are necessary delays. There needs to be a pragmatic approach when reporting to Scottish Public Services Ombudsman (SPSO) and Government as people are not able to drop everything and focus on complaints, there is so much going on, with a small number of people able to run an investigation, as well as being embroiled in other things at present. It had been disappointing to receive a response from the SPSO indicating that in spite of ongoing pressures, it still expects deadlines to be met.

The Chair noted the committee wanted to convey their support.

Kirsty Brightwell thought it would be helpful to express the pressures to SPSO and Government, and to inform them this committee is accepting of deadlines not being adhered to, and that it is assured by the process of the complaints and feedback.

The committee noted the report

The Chair noted work needs to be undertaken around informing presenters of reports, the remit and expectations of the committee.

15 **Care Opinion**

Edna Mary Watson informed the committee the relationship with Patient Opinion as was then, was formed back in 2011. Within that time resources have been used across the organisation to gather real time feedback, which was the original interest, whilst providing a social media platform for individuals to feedback their experiences of care. Although a social media platform, it does offer other opportunities for people to contribute such as, leaflets that people can write up their experiences and send in and a telephone helpline to call and leave comments. The Patient Opinion people then write these up and place them on their website. This then makes them visible to the organisation they are commenting about, other organisations that have signed up, and individuals who may be interested to see what the experiences are.

In 2017 an attempt was made to widen it out to include the Partnership Services, however this did not materialise due to lack of capacity to explore, and at that time, there was a question of whether partnership services were in it or not.

It was noted this is a journey, and it has advanced and rebadged itself as Care Opinion with the focus now on Health and Care Services.

It was noted this has been Scottish Government funded for Health Services from the outset, however in April of 2022 the Government made its latest commitment to Care Opinion, to fund for a further four years. The Government see this as a real independent way for people in Scotland to be able to provide feedback in regards to treatment received within services, across NHS Scotland.

It was noted when talking about NHS Services, this now includes the Ambulance Service and has the potential to include all Health Care Services.
It was noted Shetland was in a positive position as most local health care services are all local authority provided. This then provides an opportunity to have a single platform for people to provide feedback on local health care services, which are all local authority provided.
The committee were informed, bullet points within the main report are key steps needed in regards to refreshing the current structure, making sure all health and social care partnership places are included within the current subscription so is does not increase costs, and making sure it is all contained within the Government funded resource.
Work needs to focus on promoting Care Opinion as a core way across the organisation and services on providing feedback as at present, there is not a lot of feedback coming through this route.
It was noted Care Opinion have developed resources which could be used for focused work going forward.
The committee were informed 75% of all feedback within Care Opinion is generally very positive. Work will continue to try and move this forward in a much more positive way in getting this across all local services.
The Chair noted her delight as a champion of Care Opinion and wondered if this could be incorporated as part of people's induction.
It was noted within the report Shetland was the highest of the three Island Boards.
The Chair informed Edna Mary Watson, in terms of conversations going forward with Social Care, SCAS provide a service level agreement with social care. Commissioned services would be good to include going forward.
Edna Mary Watson noted she was unsure if the current licence would cover those organisations, however there would be no reason not to explore that with Care Opinion and the organisations themselves.
It was noted this report was presented for awareness so no assurance was required.
Colin Marsland stated Shetland Islands Council exists as Social Care Provider on Care Opinion and have had zero stories thus far.
Edna Mary Watson noted it is identified as Shetland Island Council, however does not identify their services, which is the problem. It was felt it is not been actively promoted at this time.
Colin Marsland explored the link and informed the committee all services are provided, however as suggested, it is not being actively advertised.

16 **Public Engagement in the IA Process**

Edna Mary Watson informed the committee, the paper presented, outlined works currently being undertaken to support the public engagement aspect of the IA process for the refurb or the replacement of the Gilbert Bain, and work done to date.
The committee were briefed in activities to date and future ongoing works.
The Chair noted the comprehensive report.
It was noted due to time constraints any comments from the report presented, are to be sent directly to Edna Mary Watson.

17 **Shetland Public Protection Annual Report 2021 – 2022**
Due to time constraints this report was not discussed. The Chair noted it had been included for information only.

18 **Draft Clinical Governance Committee Annual Report 2022 – 2023**
The Chair noted the draft report had been included for the committee's awareness. Any comments in regards to the report should be emailed to the Chair ahead of the next meeting.
The final report will be presented to the committee at its final meeting in March 2023 for approval – **ACTION**.

19 **Review of Action Tracker**
The action tracker was reviewed by the Chair and Executive Lead Kirsty Brightwell following the meeting, which was then subsequently updated and inserted into the CGC TEAMS for the committee to view and comment on, if necessary.

20 **Even Better If – Self Evaluation**
Due to time constraints this item was not discussed.

21 **Date of Next Meeting**
Tuesday 07th March 2023 at 09:30 virtually via TEAMS

The Chair noted at the last meeting there was not enough time to have the "How was it for you" conversation. Without putting extra burden on the committee it was noted ways to undertake this within TEAMS would be explored - how is the new committee progressing in terms of its meetings – **ACTION**

The Chair thanked the committee for the good discussion had.