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Minutes of NHS Shetland Clinical Governance Committee (CGC) Held on Tuesday 06th June 2023 via TEAMS

Members Present

Joe Higgins	Interim Chair
Colin Campbell	Non-Executive Director & Chair of Audit Committee
Kathy Hubbard	Non-Executive Director
Bruce McCulloch	Chair of Area Partnership Forum (APF)

In attendance

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

Contribution to Agenda

Lawrence Green,	Health & Safety Lead (Agenda Items 8 & 9)
Stephen Lamming	Maintenance Manager, Estates (Agenda Item 10 only)
Kim Anderson	Chief Nurse (Community & Mental Health), Community Nursing (Agenda Item 11 only)
Carolyn Hand	Corporate Services Manager (Agenda Items 25 & 26)
Melanie Hawkins	Health Improvement Team Leader (Agenda Item 28 only)

1 **Apologies**

Apologies for absence were received on behalf of Lincoln Carroll, Non-Executive Director & IJB Representative, Susan Laidlaw, Director of Public Health and Brian Chittick, Chief Officer of the IJB.

It was noted due to the previous Chair having left the organisation, Joe Higgins had taken up position of Chair, at this present time.

2 **Declaration(s) of Interest**

It was noted any declarations of interest could be taken at any point throughout the meeting, should they arise.

3 **Approve the draft minutes of the meeting held on 07th March 2023**

Kathleen Carolan raised a point of accuracy and asked if the conversation around "Patient Recall" within page seven of the minutes could be reframed.

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The discussion was understood to be in regards to re-admissions to hospital, with re-admission rate data; sitting within the Performance Report for Board and not typically within the CGC report.
Ms Carolan highlighted recent work had been undertaken examining re-admission rates, the data of which could be shared separately with the committee.
The committee approved the draft minutes.

4 **Matters arising from the minutes**
Ms Carolan noted at the committee's previous meeting, there had been a discussion around Care Assurance and seeing Care Assurance Data as a part of the Quality Score Card Report.
Subsequently, at the end of May a workshop with team leaders in care home settings had taken place, where it was asked what would they find helpful to implement the My-Health, My Care, My Home Healthcare Framework for adults living in care homes, which will be developed and brought back to reassure the committee that work is moving forward.
The Chair thanked Ms Carolan, emphasising the hugely important work, and enquired as to an appropriate timescale the committee could expect to receive the information.
Ms Carolan informed the committee the new Care Assurance Group would be meeting in July, therefore information would be presented to the committee at its next meeting in September.

5 **Review of Action Tracker**
Agenda Item 4 – Edna Mary Watson informed the committee this had been an action from the former Clinical Care & Professional Governance Committee (CCPGC) which had been taken forward to the newly formed CGC, relating to a discussion to determine if there was an opportunity to share between the other island boards, and within the specific independent contractor part of the other island boards, an opportunity to have some kind of independent review/discussion if there was every any kind of difficulty locally.
Ms Watson indicated this could be closed off as it was more for noting that this may be a suitable model, if an independent view was to be required.
The Chair noted the general point around gaps and learning cycle's remains relevant, and should be reflected upon within the upcoming workshop - **ACTION**.
It was agreed to close this off from the action tracker.
Agenda Item 7 – Ms Watson noted this was in regards to Health Professionals notifying when there was an adult support and protection concern, which had been referred back to the Adult support and Protection Committee, therefore this action could now be closed.
In regards to adding an assurance level to the Joint Governance Group (JGG) minutes, a verbal view on the assurance of the minutes is provided to the committee, however, this can be added as a written comment to future JGG minutes.
The Chair requested the inclusion of the JGGs proposed views of suitable assurance within future JGG minutes.
Action remains open.

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Agenda Item 20 – Kirsty Brightwell confirmed the Hospital Transfusion Committee (HTC) did take place on 30th May, with no concerns identified, however the team needs support to ensure it has sufficient resources.
The Chair queried if lab results rejected rates being 6.5% and not under the expected 5% was still an issue?
Ms Brightwell informed the committee this was very variable due to it being a small system, with numbers acquiring a huge variability of the percentages. The team have changed the way in which it reports errors to try to draw out the rational, enabling them to provide more information to senior manages within clinical areas, to do a closer look, as opposed to it being human error.
The committee were informed the issue is being reviewed.
It was agreed to close this off from the action tracker.
Agenda Item 12 – The Chair noted the Workforce Risk is being led by Staff Governance. The CGC and Staff Governance will receive updates in regards to the Health and Care Staffing programme and can therefore be closed.
Agenda Item 14 – Ms Carolan informed the committee the post of the Resuscitation Officer had been successfully appointed to, with the new member of staff joining the organisation imminently. Once in post, they will work with the Resuscitation Committee to re-establish some of the data collection, and support the Mobile Skills Unit due in September. It is hoped there will be data underpinning some of those measure within future Quality Score Card reports.
It was agreed to close this off from the action tracker.
Agenda Item 8 – The Chair noted when considering the clinical governance teams quarterly report, the question of where the right questions being asked in terms of Patient Feedback had been raised, as the results were either 100 or very close too. It was further noted **Agenda Item 10 –** having an offline discussion looking to develop a report or appendices around Care Experience, that these two points be carried forward to the scheduled Workshop - **ACTION**.
Agenda Item 9 – Ms Watson apologised for not circulating the dates sooner, and confirmed the incident date was 29th December 2022 making it a Q3, but the actual Clinical Risk Advisory Team (CRAT) meeting where discussion takes place to determine if there is reason to investigate, was held on 11th January 2023 and so would be a Q4 report.
It was agreed to close this off from the action tracker.
Agenda Item 9 – The Chair noted when looking at the number of adverse events at the previous meeting, and the number of documented lessons learned being low, it had been queried if this was a misrepresentation of the picture with more being completed, and was it just a case of the datix item not being closed out, making the report true to an extent, however this needed to be highlighted to RMG.
Ms Watson confirmed a discussion was held at RMG, however was conscious there was no hard factual evidence to provide to the committee.
Ms Watson proposed to have a “look back” at the end of June to determine the current position, reporting back to the committee at its next meeting.

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The Chair agreed to the proposal and noted the figures within the current report hadn't moved much and stated it would be good to know the messages are understood around the importance of closing these items off - **ACTION EMW.**
Agenda Item 13 – The Chair noted this action could be closed off as dates had been circulated.
Agenda Item 16 – The Chair noted the Strategic Risk Report presented at today's meeting had the new format laid out which was much clearer.
Michelle Hankin informed the committee positive feedback had been received in support of the new format, however was open for any further comments or suggestions.
It was noted risks are being reviewed, with all review dates being assigned to the end of the month, in line with the new strategy, making reviewing the risks easier whilst encouraging staff to review the actions to mitigate the risks.
The Chair suggested actions underway to address control gaps be added to the report as there was no evidence of this. It was felt this would be helpful when trying to lower the net risk score – **ACTION MH**.
AOCB – The Chair noted the amended CGC Terms of Reference were presented to the April Board meeting, therefore the action could be closed.

6 **Joint Governance Group (JGG) Approved Minutes 22nd February 2023**
Ms Watson informed the committee this had been a short meeting, however good attendance was had from staff across the acute sector and partnership.
Business conducted at the meeting was highlighted to the committee and a Moderate Level of assurance was recommended from the issues discussed and level of interaction had.
The Chair noted the JGG met again on 18th May and enquired if there were any issues to highlight to the committee from that meeting.
Ms Watson informed the committee most items discussed at the meeting on 18 May meeting were captured within today's agenda and provided a brief summary of key issues and activities currently being undertaken by the Clinical Governance Team.
Colin Campbell requested, the implementation of the Health and Care Staffing Act coming into effect next year is going to have a negative financial impact or a positive impact in terms of increasing staff numbers. Whilst not the appropriate time or place to hold a discussion, would appreciate an update in terms of the reality and the outcome of the implementation of the act, and how it will look in practice verses what is currently being used as staff numbers.
Ms Watson suggested a development session could be held to explore further.
The committee were reassured in terms of the Act, the Board is mandated to use the speciality tools where these exist within practise, some of which are already being used within the organisation and have been for a period of time, as such there are no major surprises expected from the outcome of the tools, however there is the potential some of those may indicate the organisation is understaffed in some areas.
The committee agreed to a Moderate Level of assurance.

7 **Operational Clinical Governance (OGG) 02nd May 2023 - Matters for noting**

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Ms Brightwell gave an in-depth overview of discussions held.
It was noted Flash Cards are a good way of getting a lot of information out quickly, whilst giving a view of completed work, ongoing work and planned works.
It was thought in the spirit of continuous improvement, these should be extended further making them particularly useful.
Ms Brightwell noted the committee was still learning how it operates with people learning what its relevance is. It was thought the depth of discussions could be deeper.
Ms Carolan thought it helpful to note the committee had focused in detail, on the recent Systemic Anti-Cancer Therapy Audit, where the organisation had performed well, however since then guidance for chemotherapy administration guidance had been updated and the committee looked at the Boards service, in line with the updated guidance, noting it meets all requirements.
The Chair noted this was good to hear and puts the Board in a good place which is important.
The committee agreed to a Moderate Level of assurance.

The Chair noted the following policies and procedures were for the committee to approve. The policies had been wildly socialised and circulated amongst other groups, and had, had a good amount of operational and clinical input.

8 **Management of Ligature Risk Procedure**

Kathy Hubbard commented the policy was very thorough and gives food for thought in terms of the design of the new hospital at some point in the future. There is a room specifically designed for this within the Balfour
Ms Carolan informed the committee she had written a lot of the technical detail within the policy, making it clear it is about risk minimisation and not risk elimination as there will be patients within any setting where there will be ligature risks. It is not about bespoke rooms, it is minimising risks across a gradient of risks within any setting. Within the narrative of the document, it is noted this is a policy document, as there are a number of procedures that sit below that, including the Clinical Risk Assessment, however the document itself is called the Ligature Procedure, therefore requires an amendment to distinguish this is a Policy and not a Procedure.
The committee approved the policy (subject to it being clear this is a Policy and not a Procedure).

9 **Red Flag Patient Alert Procedure**

Lawrence Green informed the committee there was still a small amount of work to be undertaken on the procedure in terms of getting it through the Quality and Diversity Full Assessment. Work is ongoing with Information Governance to make sure it is covered correctly to get it through.
It was noted the teams access to the required clinical systems was problematic, however Monique Hunter, Information Services Manager suggested both teams work together to be able to put alerts onto various patient tracking systems, as they already have access into some of the required clinical systems, which would need to be reflected within the procedure.

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It was thought the procedure would be ready, once this had been completed.
Ms Carolan conveyed her thanks for the production of the policy, noting it was quite compliance driven rather than trauma informed driven and asked had guidance been given in terms of how to frame some of the information within the policy?
Mr Green noted there had not, as he was not aware there was a Trauma Informed Team.
Ms Carolan noted she had previously sent the details of Sarah Henry through, who is leading on trauma informed practice across NHS Shetland, the Council and the Partnership, however would resend them.
Colin Campbell noted the policies made sense, and where reasonable and proportionate, however questioned the Declaration of Interest, as working for an Ophthalmic Practice they also have problems with Red Flag Patients.
Mr Campbell noted within page 82 of the pack (page 19 of the procedure) the Patient Behavioural Contract which is proposed the patient signs, mentions "This can result in the withdrawal of my rights as a patient and I can lose my right to receive mainstream NHS Acute and Primary healthcare services" Can a person's access to Healthcare be removed?
Mr Green informed the committee this had been taken from other Boards, however if incorrect, could easily be changed.
Michael Dickson confirmed you cannot refuse to provide emergency care and would need to find a way for the person to receive appropriate care.
Colin Marsland highlighted the Board does have an escalation processes which would also apply to independent contractors.
The Chair enquired what would an individual receive if they were to escalate a Data Subject Information Request (DSIR)?
Mr Green noted this is to be determined with Information Governance as part of the full assessment and is work in progress.
The Chair noted the interesting discussions around both policies, however it was felt there are points that need to be fine-tuned. Notwithstanding the approvals already received from other groups the Red Flag Policy be brought back to the next committee meeting for approval.
Ms Carolan noted there were a number of things within the Red Flag Policy that need to be revisited, in light of the conversations had.
The Chair asked Mr Green to take on board all points raised and return to the committee for approval.

10 **Water Safety Plan**

Stephen Lamming informed the committee this was the governance policy for water safety which sits within the water safety plan which is a larger document. It has been produced by himself, along with the authorising engineer who is an independent body appointed by NHS Shetland, who are experts in the field of water safety, giving independent advise and support.

. It was noted the policy outlines the roles and responsibilities of most of the Water Safety Group, along with the process and procedures carried out in the event of any adverse events or outbreaks.

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It was noted the policy has previously been approved by the Water Safety Group, the Health and Safety Wellbeing Group, the Infection Control Group and the Staff Governance Group.
The committee were informed this is not a new document, but a review which is periodically carried out and is in conjunction with Scottish Health Technical Memorandum 04 (SHTM)
The Chair welcomed any questions or comments.
Ms Watson asked for point of clarity in that reference had been made to the Infection Prevention and Control Officer, however there is a gap within the document presented and asked if this was a vacant position or did the policy need to be updated.
Mr Lamming confirmed he was aware, however it should be removed as responsibility should reside with him as the responsible person for water as there isn't anyone in place who is an Infection Control Water Officer specifically. It was noted there is an Infection Control Lead and a Consultant Microbiologist.
The Chair thanked Mr Lamming and confirmed subject to the minor adjustment, the committee approved the policy.

11 **Confirmation of Death Policy**

Kim Anderson informed the committee the policy and guidance for confirmation of death by registered healthcare professionals was a new policy for NHS Shetland however the procedure itself is not new and was previously recognised as verification of death.
It was noted this had been a National piece of work with all Boards setting out their own policies and guidance.
The policy is straightforward with appendices at the end helping with the practical and training aspects that are required.
The policy had previously been seen at ANMAC and the Joint Governance Group.
The Chair welcomed any questions or comments.
Ms Carolan noted a point for consideration in regards to the statement about operational nursing leads holding a register. This may want to be reframed to say the professional lead will ensure there is a review, as part of the appraisal process. If you have practitioners who are confirming death, they complete an Intention to Practice form, otherwise you maybe creating a cumbersome process that might not necessarily fit uniquely with nursing either
Ms Carolan also noted there was reference within the policy in regards to advanced paramedic practitioners, which is understandable however, they are not employed by NHS Shetland. It was suggested this be changed to e.g. these are the type of practitioners in Shetland who will confirm death.
Ms Anderson thanked Ms Carolan for her reasonable points and noted there does need to be some form of structure in place to manage people who are undertaking this.
A short discussion ensued around who confirms death and the reasoning behind the policy and guidance.
The Chair thanked Ms Anderson and confirmed approval.

12 **Redirection Policy – Emergency Department**

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Amanda McDermott informed the committee the policy is based on National guidance from the Scottish Governments Centre for Sustainable Delivery team and supported by the Royal College of Emergency Medicine.
The policy is not new to NHS Shetland, patients have been redirected for some time, particularly within the Pandemic.
What wasn't happening which the policy helps to do, is to record the activity around redirect which enables any auditing, and to look at the quality of the decision making around redirect. The policy is to ensure consistency and to help monitor activity.
The Chair welcomed any questions or comments.
Ms Hubbard noted this is the right thing to do and enquired if it was still an issue within A&E in that people presenting, should be going elsewhere?
Ms McDermott confirmed there is huge amount of activity that is not appropriate for an emergency department. Work is being undertaken to improve conversations, ensuring the emergency department practitioner has an appropriate triage with the patient presenting, directing them to the appropriate place, whilst providing reassurance to the patient they are where they are supposed to be, making the triage process more robust.
Mr Campbell commented this was a clear well written policy, with clear guidelines and was very comfortable in supporting it.
The Chair echoed Mr Campbell's comment and confirmed approval of the policy.

13 **Draft Hospital Transfusion Committee 2022 – 2023 Annual Report**
The Chair noted this item was included within the committees Terms or Reference (TOR).
Ms Brightwell noted, as mentioned within the action tracker, there was no report to present as the committee had not met, and therefore remains outstanding.
It was reported this will be brought for this committee to be sighted on, once produced, but at present, was not available.

14 **Draft Duty of Candour 2022 – 2023 Annual Report**
Ms Watson confirmed this was the second Duty of Candour Report to be produced.
It was noted through the adverse events process, situations are identified where duty of candour may apply. These are then highlighted to the Medical Director where a formal assessment process is used to determine whether an organisational duty of candour applies.
The report states 102 cases were reviewed, 4 of which were considered to be under the organisational duty of candour.
The type of significant events is shown within page 156 of the pack (page 3 of the report), along with a summary of the status of the 4 cases subject to duty of candour requirements over the year. The summary shows all due processes were followed, in terms of offering an apology, whilst inviting the person and their relatives to participate in the process as much or as little as they wished. Most people did participate, with just one case declining to participate in the process.
It was noted the duty of candour requirements have now been closed off however one or two reports were still outstanding at the time this report was written. It was confirmed these have now been received in relation to three of the cases.

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The committee were sighted on a number of changes to clinical management which had occurred as a result of lessons learned.
It was felt the only challenge was the time frame on getting through some of the processes, however it was felt the importance is about doing a thorough and appropriate review with the active involvement of the patient and family as required.
Ms Watson noted the report provides a Moderate Level of assurance to the committee.
The Chair noted diligence was clear within the organisation in regards to duty of candour protocols and lessons learned which was important.
It was noted the report suggested a Comprehensive level of assurance, however Ms Watson had stated a Moderate level.
Ms Watson noted she was happy with a Comprehensive level, however in view of the timeframes the committee may of felt a Moderate level was more appropriate.
Ms Brightwell confirmed the timeframes within duty of candour are advisory and are not standards the Board is held to. Things may take longer due to capacity and making sure the right decision has been made, however there is oversight of the procedures.
Ms Brightwell was happy for a Comprehensive level of assurance.
The Chair noted it was important to take time to get things right, with the committee agreeing to a Comprehensive level of assurance.

15 **Draft Whistleblowing Annual Report 2022 – 2023**
Ms Watson informed the committee the report provides information about the entire structure.
It was noted there is a governance structure in place. The Steering Group meets on a quarterly basis through the year and a new Whistleblowing Champion was appointed in December 2022.
The relationship with NHS Orkney has continued and strengthened in terms of the Joint Steering Group and a Confidential Contacts joint meeting, the view is this will provide extra professional advice and support.
In terms of the investigation, process and recording there are timeframes that need to be adhered to. Time has been spent within the last quarter firming up a more formal process around how this information is implemented and captured.
Training for Confidential Contacts, Independent National Whistleblowing Officer (INWO), have released a number of training resources. It was agreed to use the Peer Support Network as a place to use those case studies to support learning and to help with practicing skills.
Within the last year work across the organisation was undertaken to raise awareness and promote the “Speak Up” safety culture. There was a Speak Up week held in October 2022 with a number of open sessions held within the canteen at the Gilbert Bain Hospital (GBH) as well as on line sessions, which had been positively received. This provided an opportunity for people to speak through things which may have been bothering them as opposed to it being a whistleblowing issue.
It was noted there are training modules within Turas which people are encouraged to undertake. These are quite significant in comparison to some other Turas modules, therefore uptake has been slow. However progress can be demonstrated over the course of the year.

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A Confidential Contacts TEAMS Channel has been established where information can be shared.
Information on annual figures is provided within the report which shows one case that has been ongoing for a period of time. The case is exceptionally complex and it is hoped this will be concluded shortly.
In summary, over the last year, progress has been demonstrated. Processes have improved as a result of going through the experience of the Stage 2 issue.
It was noted the report offers a Moderate assurance level.
It was further noted after writing this report and taking it to Staff Governance, INWO had released Good Practice Guidance on what should be included with the Annual Report.
As a result Ms Watson proposed the Board version of this report be aligned to the new INWO Guidance, making sure any extra content is captured before submitting it nationally, and letting Staff Governance know of any changes made.
The Chair noted this will be picked up for the June Board.
Questions or comments were welcomed from the committee.
Bruce McCulloch enquired if there were any thoughts to editing the training, staff not having to undertake every module as this could increase staff numbers.
The Chair noted not all three Turas modules needed to be undertake however, it is important people who have particular responsibility for the execution of the policy are adequately trained. Not everyone needs to be trained but they do need to have an awareness.
The available INWO material makes for a more digestible piece of learning, and is an alternative to the Turas modules, especially for management where it is acknowledged they have competing pressures.
It was noted there was something within the April Staff Bulleting that directed managers to a reference guide and checklist which is something a little more straightforward and shorter if presented with a whistleblowing issue.
The Chair noted when at other Champion Meetings NHS Shetland is not unique in terms of training completion rates, with all the right things being done within the space.
It was thought the IMATTER Survey results will be interesting, given the two optional questions around taking concerns forward and if they would be acted upon. Once the information is received a view can be taken within this space in terms of approach and planning.
Mr McCulloch stated when attending National meetings and listening to discussion around Whistleblowing process, it is clearly not well understood. This is not based on training but the numbers of people completing the training and understanding what the process is.
The Chair thanked Mr McCulloch for his helpful input.
The committee agreed to a Moderate level of assurance.

16 **Clinical Effectiveness Quarterly Report as shared with Joint Governance Group (JGG) – Q4 01st January – 31st March 2023**

Ms Hankin reported this was the Clinical Effectiveness report which provides an overview of activities supported by the Clinical Governance Team and includes creating

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the Guidance and Learning Bulletin which is published monthly through the corporate newsletter.
It was noted, the audit service improvement grid is presented in a simplified presentation, reflecting suggested changes whilst reducing the visual. Data has been reviewed and audit start dates incorporated, creating a feedback loop.
The grid includes columns of proposed audits, monthly repeated audits and audits currently being undertaken, whilst providing feedback and results.
Comments on the new presentation are welcomed and improvements, including quality are encouraged to be included within the grid.
It was noted a more targeted departmental approach was used to obtain feedback and updates for audits which resulted in 37% of respondents supplying updates within five working days, and 89% within ten working days. This new approach triggered invites to a number of departments to discuss Clinical Governance, their Clinical Governance needs and how the Clinical Governance Team can support them.
The report provides an overview of the Clinical Governance Afternoons which were provided by Medical, Surgical and Anaesthetics. Positive feedback was received with teams appreciating the time to have multidisciplinary learning.
The report also provides updates in relation to the Scottish Patient Safety Programmes, including acute audit collaborative, quality improvement work around Falls, focussing on Ward 3 quality improvement work to reduce the number of inpatient falls reflected within that Datix data.
It was noted there is a lot of activity ongoing throughout the organisation, with examples of practitioner feedback included within the report. The Clinical Governance Team particularly liked the children's feedback from Child Physiotherapy, examples of how that is being captured is also provided within the report.
It was noted the March Anaesthetics governance meeting was cancelled due to work demand, however Aprils meeting went ahead as scheduled.
The committee were informed attached to the report (appendix 5) is an explanation around the research process. Although a research process is in place within the organisation, it was felt there was not enough awareness around it. It was noted, there is a regular meeting between the Medical Director and Clinical Governance Team where national requests for research participation are viewed. A list of current active research projects will be will be available within the next quarter.
The Chair noted the update stating it was striking the breadth of clinical activity being undertaken across multiple specialities.
It was noted the previous assurance level was agreed as Moderate, however with the feedback received, it was suggested it was a Comprehensive level of assurance.
The committee agreed to a Comprehensive level of assurance.

17 Adverse Event Report – Q4 01st January – 31st March 2023

Michelle Hankins gave a summary of the report.
It was noted there were 139 adverse events reported within the quarter. The top 5 areas included slip, trips and falls, medications including vaccinations, confidentialities, investigation's including x-rays and scans, and infection control.

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There was a reduction in the number of datix with minor harm, which were not considered to be reportable under Duty of Candour or RIDDOR.
There were no new Duty of Candour, Child Deaths or RIDDOR reportable adverse events within this quarter.
There was one Clinical Risk Advisory Team (CRAT) meeting held in January which related to consent and wrong site surgery with the investigation and report in progress.
The committee were informed going forward, there is to be a review around the presentation and context of the report as it is felt there is a lot of information which can be difficult to digest.
It was suggested the report provided a Moderate level of assurance, until the review of presentation and deeper dive around lesson learned.
Mr Dickson sought clarity over assurance scoring, and it being made clear if scoring was around process or information being provided. It was felt discussions thus far had been in regards to process, whilst the information within this report being very comprehensive. It maybe aspects of the reporting are refined, however it does not detract from the comprehensive nature of the information being provided.
Not wanting to lose sight of the important work being undertaken, if building a "dash type" approach, there is a danger of heading to a broader "framework" approach. Assuming that to be the case, is it about information or assurance being received, rather than process?
Ms Brightwell confirmed it is about information being received, to enable the committee to provide assurance of clinical governance activity to the Board.
There is an assurance framework provided within the meeting agenda which describes how assurance levels are determined.
It was felt Mr Dickson's point was well made however, it is about information provided as opposed to process, as the process needs to be there in order to provide the information.
The Chair noted the nature of discussions is broad, with many different speciality aspects. If an overall assurance rating is to be assigned, ultimately there will need to be a pragmatic view as the committee is trying to get to a position of a level of comfort, combining a number of different aspects.
Mr Dickson commented, if it is around assurance, which agreed it is, then the reflection of information provided within the report is very comprehensive and a great piece of work. The fact there is an aspiration to improve further is to be applauded, however the committee should not lose sight on the information already being provided is very comprehensive.
The Chair noted the comments made and the committee agreed to a Moderate level of assurance.

18 **Quality Score Card incorporating the QMPLE Report**

Ms Carolan noted due credit was attained to Ms Hankin for the production of the report.
It was noted the report was self-explanatory with a helpful cover sheet drawing attention to areas of improvement, and to areas of decline.
It was reported ongoing measure in regards to the identification of patient's who's clinical condition is deteriorating, still has variable compliance when recording

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observations. A separate audit was undertaken in May, looking at six patients in more detail, to ascertain if clinicians were making appropriate escalations and clinical interventions if the patient was deteriorating. Out of the six patients being reviewed, all six had accurate observations, with escalations in place which were appropriately actioned. This gives additional information around assurance within that particular quality metric.

The committee were informed a lot of the report content is subject to external scrutiny which is one of the higher levels of assurance, with a lot of the data being shared with national programmes.

It was noted the Board are also subject to a number of external reviews from Healthcare Improvement Scotland which have been touched upon, with improvement work happening in regards to Falls, particularly on Ward Three, an overview of which was received at the Clinical Governance Group. Whilst there were no falls recorded on Ward Three for the month of May, it was noted this requires an intensity of staffing in order to support people, to observe, and to prevent them from falling. As a result, promoting volunteering, how to help people coming into that setting, and providing support for people whilst in hospital will be discussed at a multidisciplinary conversation off line

Previous discussion around this report noted the balance of measures are orientated towards acute and quality assurance measures from national programmes. However it was understood a quality assurance overview from the partnership will be presented at the upcoming workshop from Brian Chittick which may help the committee to see whole system in terms of quality assurance.

The routine outturn of debriefs is included within the report, particularly where more significant adverse events have occurred. As reflected within other reports, thematic analysis is being undertaken, looking at where a clinical risk action team has been called, where a risk or an incident has been rated highly so advice can be provided in terms of the level of investigation needing to be undertaken. Work will focus around improving the emergency psychiatric plan response, as having viewed recent significant adverse events, they have related to patients who have been accessing emergency psychiatric care.

The Chair thanked Ms Carolan for her update and noted the same as earlier received reports, it was heartening to see good quantitative results being posted, whilst noting staff challenges along with a real commitment to thematic learning, embedding it within the organisation/

Ms Carolan suggested on the basis of information presented, an adequate to comprehensive level of assurance be given, noting the imminent discussion to be held at the workshop in regards to quality assurance within the partnership, which will give the committee a whole system outlook in terms of quality assurance.

The committee agreed to a Comprehensive level of assurance.

19 **Whistleblowing Quarterly Report Q4 01st January – 31st March 2023**

Ms Brightwell informed the committee the concern raised within Quarter 3 was still progressing.

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There were two Level 1 concerns raised within Quarter 4, and which did not need to progress to Whistleblowing status. Both concerns had received good support from confidential contacts and it was thought having access to someone who is not an immediate Line Manage or part of the individuals service has been enormously helpful to those individuals.
It was noted timelines are not always met as it is difficult to get back to people within the prescribed period which is to respond to the concern within 72 hours, and completing a Stage 1 within a 5 day period. People often need more time and so it may take two or three meetings with individuals, which exceeds timeframes.
It was reported the Procedure with all the documentation was still outstanding, therefore a Low assurance rating was proposed, however given the information provided it maybe the rating is too harsh.
The Chair agreed the rating was harsh, adding work was required within this area however good progress had been made, therefore suggesting a Moderate level of assurance.
The committee therefore agreed to upgrade the report to a Moderate level of assurance.

20 **Approval of the Approved Medical Practitioners (AMP) List Mental Health Act**
Ms Brightwell informed the committee the report was still not quite there in terms of process. Advice has been sought from Scottish Government as it had been highlighted information received was incorrect.
It was felt helpful for the committee to note, three consultants are Section 22 approved and are up to date on the register.
The Chair noted a Moderate assurance level was presented at the previous meeting as there were concerns in regards to the documentation of process along with training issues and enquired if there was any update around the issues.
Ms Brightwell confirmed due to a member of staffs extended absence, processes had not progressed with a bit of tacit knowledge being lost.
It was noted the committee can be reassured there is safety practice and therefore a Moderate assurance level was suggested.
The committee agreed to a Moderate assurance level.

21 **CGC Workshop Update**
Ms Watson informed the committee the plan for the subsequent workshop is to review the past year, getting the committees reflections on whether the right things have been discussed and thought about. If there are any concerns or if there are things agreed at the previous workshop that may not have progressed.
It was noted the action plan produced at the previous workshop will be analysed. Most actions had been closed off, however there are a number of areas still open for discussion that was suggested be taken to the workshop.
The intent is to relinquish the second half of the workshop to Mr Chittick to update the committee on information from the partnership, enabling conversations in regards to what would be deemed relevant to be reported through this committee going forward.
It was noted the programme had not yet been circulated and would be distributed following this meeting.

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The committee were reminded the workshop was taking place between 10:00 and 12:00 tomorrow, within Room 9 at Islesburgh.
The Chair noted previously, the update was awarded a Comprehensive assurance rating on the basis the committee had a plan, was working through the highest priority actions and that it was duty bound to review them. It was felt the assurance level was in line with the previous rating.
Ms Watson agreed, noting the only outstanding actions from the previous plan was the committee hadn't reached the timeframe for or that there was already a plan for, to address.
The committee therefore agreed to a Comprehensive level of assurance.

22 **CGC Aligned Strategic Risk Report**

Ms Watson noted this was the standard report, however outlines more detail of risks, specifically under the control of this committee. Highlighting issues or changes
It was noted the SR14 Estates risk, had recently been updated by the Head of Estates from a medium risk at Level 4 to a higher risk at Level 12. The rational for the increase was highlighted to the committee.
It was reported SR13, Access to Services had increased slightly over the last year due to the partnership having to work under business continuity arrangements on an increasing basis.
SR16, COVID Outbreak saw a slight increase over the past year, and remains on a high level due the fragility of the service in terms of workforce and the capacity to manage situations.
There is a decrease with SR02, Finance risk which was reviewed by the Director of Finance and reduced to Level 12.
It was noted there have been no changes to most risks the committee are responsible for, with none being closed in any case.
It was highlighted some National Standard concerns were raised around service level gaps within the service level agreement with NHS Grampian due to issues out with their control around workforce which are recognised.
It was noted there are concerns being raised in regards to SR17, IT failure due to cyber-attack, and the challenge of keeping on top of a cyber risk. It was noted there is some mitigation in place, however the ability to completely eliminate the risk of an attack is out of complete control. Concerns were also raised in regards to the IT staffing resource, and their ability to keep abreast of deployment and development of systems, making sure systems are as safe as possible.
Other issue of concern were information governance policies being out of date, and their limited staff compliance with mandatory training, both of which were raised through the Finance and Performance Committee who have an oversight of the two particular issues.
The Chair noted the good work being undertaken, noting it is often difficult and tricky to both document and get right. The progress and amount of effort is apparent which is beneficial to the committee.

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The Chair requested he would like to see actions that are being taken to close gaps that are documented as existing, especially for the risks where the net risk score can be seen still going upwards.
The Chair stated the report is now presented in a way that makes is more accessible, and it is hope people will now refer to it and use it.
In terms of an assurance rating Ms Watson suggested Moderate.
The Chair noted given the fact it is such a broad nature and there are gaps with some of them going upwards a Moderate assurance level felt appropriate.
Mr Campbell stated he was very comfortable, noting a risk could never be a Comprehensive assurance rate, agreeing Moderate was more realistic.
The committee therefore agreed to a Moderate assurance level.

23 **NCA Systemic Anti-Cancer Therapy Audit Overview**
The Chair noted the audit reflected well for NHS Shetland which was referenced to earlier by Ms Carolan.
It was noted it shows the diligence and the professionalism show across the organisation.
Ms Carolan reported the SACT Audit is undertaken every three years with the last one being just before COVID in 2020 and is a two part process.
Both parts of the process were highlighted to the committee and it was noted there is an expectation the regional team will visit Shetland to look at services and to speak to other practitioners and patients but as yet, no date has been set.
It was noted there were concerns in 2020 around the fragility of the multidisciplinary team providing chemotherapy services, however the report shows no areas of concern or improvement which reflects the work undertaken between 2020 and 2023 to grow the team, which is reflected within the report.
It was noted the Pharmacy team had contributed towards the audit, with no recommendations within the report for any areas for improvement around pharmacy practises and logistics.
Ms Carolan noted the report is self-explanatory, however it was felt it was important for the committee to note as it evidenced sustained improvement over the last three years since the previous review.
The Chair noted the report was a good read and very reassuring all round.

24 **Health & Care Staffing Programme Update**
Ms Watson noted the report provided an update since the committee last met, with Workforce Tools being the main focus. An overview of the Workforce Tools was presented to the committee. It was noted as this is a national run, it will be undertaken twice, once in June and again in September. The report outlines timelines for other tools being undertaken.
An update on real time staffing resources was received, again with developments of new tools at national level. It was noted tools in use and being used locally are Adult in Patient and Maternity.

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A generic real time staffing resource is in the process of being developed, however there are challenges in providing a generic tool that would cover a broad range of areas both within primary care and other fields.
The Allied Healthcare Professional (AHP) staffing tool is currently in development and is expected to be launched sometime in June. Once launched and if possible to produce a generic real time staffing resource, this would provide a real time staffing resource for most of the professionals to be able to use and would help the Board to meet one of the duties within the Act.
It was noted NHS Shetland had volunteered to participate in a programme for testing specific guidance chapters. It was agreed to test Chapter 6, having adequate time for clinical leaders to lead, in terms of leading their team and leading patient care within their environment, which would be undertaken within October through to December.
It was also agreed to test Chapter 9, staff training, which would be undertaken between July to September.
It was noted there have been concerns raised nationally, in terms of the timeframe for testing which will have an impact on the Boards timeframes.
It was noted Guidance Chapters are now in final draft and should go out for public consultation by the end of June, however an exact launch date is to be finalised. Good engagement and consultation has been forthcoming throughout the whole process with the NHS services so there may not be much that emerges from a three month public consultation. It was noted it is difficult to plan for implementation with draught guidance which may yet still change.
The Healthcare Act Implementation Team have asked all Boards to provide a quarterly update on progress towards full implementation of the Act. The first report was provided in April and as yet are awaiting feedback. With the next report due mid-July it is hoped feedback is received soon, enabling reports to be in line with what is expected as whilst there was a template provided, there was no formal guidance.
It was reported NHS Education for Scotland have developed a Knowledge and Skills Framework which suggests different levels of training for different levels of management within the organisation. A paper will be presented to the Healthcare and Staffing Programme Board at the beginning of July to formally agree that as an organisation it will have this stepped approach to the implementation of the training.
The Chair stated this was an important piece of work with lots of moving parts.
Ms Hubbard noted the increasing number of complaints in regards to access to Dental Care and enquired if this area was under the Community Health Directorate.
Ms Watson noted Dental does sit within the partnership but the legislation applies to all professional groups across Health Board provided services or within the partnership for things delegated to the Integrated Joint Board (IJB). The expectation is they will also follow in line with the legislation.
Ms Watson noted some people may be aware of eRostering and Safe Care which is a National system the Board are required to implement. Since the report was written, there have been discussions held with RL Datix, who are the company running the programme, and a project team has been established to take forward and roll out the implementation of the system, the governance of which would be tied into the Healthcare Staffing Board.

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Mr Marsland noted this was part of a National process moving towards eRostering, informing the committee of the benefits. It was noted the system will produce information the Board is required to report to Scottish Government.
The Chair stated the report gives an objective assessment of staffing numbers which will feed back up to assurance levels for this group and others, and noted the hugely invaluable work.
It was noted the previous assurance level was Moderate on the basis of outstanding testing, therefore the committee agreed to once again set a Moderate assurance level.

Ms Carolan noted in regards to Healthcare Legislation, as part of the training being undertaken, it is being made clear to staff this is not about numbers, it is about having the skill mix required within a multi professional team to manage the acuity and dependency of patient care. Front and centre of the training and orientation is to detract staff from fixating on numbers within the workload tools so they can be used effectively. It's around creating a skill mix to support the team and the professional judgement that goes with it.

25 **NHS Complaints & Feedback Monitoring Report Q4 01st January – 31st March 2023**
Carolyn Hand stated it was her understanding the committee were looking for a level of assurance in regards to Complaints and Feedback, noting it is unchanged since the previous report and proposed a Moderate level of assurance.
It was noted feedback has been received from the Ombudsman, adding additional scrutiny. There was nothing to be picked up from recent complaint handling, therefore there were no concerns about the way in which complaints are being handled, however in terms of performance around Stage 2s and the ability to answer them within 20 working days remains. This is due to people being under pressure and the fragility within the service. As a result progress in regards to broadening out the numbers of staff working within Complaints administration has not progressed, but is work in progress.
The Chair thanked Ms Hand for her report with the committee agreeing to a Moderate level of assurance.

26 **Draft 2022 – 2023 Complaints & Feedback Annual Report**
Ms Hand reported before the Pandemic, the Feedback and Annual Complaints report was presented to this committee at this point in time, and then to Board at its June meeting, however this has been moved for the past three years by the Scottish Government to the end of September, in recognition of the fact a lot of complaints are taking longer to close out, which is the position across all territorial Boards, resulting in statistical reporting, which is included within the Annual Report is as close to "Fact" as possible as complaints will be closed, and if not, they can't be included which give a false picture of what has been happening. It was noted the statistical report is used as a Benchmark against other Boards.
Current guidelines state the report needs to be with Government and the Ombudsman by the end of September, which means the reporting will be written in time for the August Board and will not be in-line with the next CGC meeting in September. As such

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it was proposed to circulate future Complaints and Feedback Annual Reports by email before being submitted to Board, giving the opportunity for comments to be factored in. The Chair stated under the circumstance this seemed a reasonable way forward and thanked MS Hand for her report.

27 **Leadership Walkrounds**

Ms Hankin noted this was a new report, which provided an overview of the Leadership Walkround activity within Q4.
Thanks were conveyed to those who were able to participate and an overview of each of the three walk rounds was presented to the committee.
The Chair thanks Ms Hankin for her delivery of the report and invited questions or comments from the committee.
Ms Hubbard noted she was pleased to hear staff are being reassured in regards to the purposes of the Walk Rounds/Visits. Having been involved with the Maternity walk round, she hoped staff had gained something from it, as, as a committee member herself, had gained a massive amount from it.
Ms Hubbard looked forward to future involvement noting they are a good idea.
Mr McCulloch echoed Ms Hubbard's thoughts, finding the walk rounds particularly useful and engaging, noting the process, interviews and structures gave enough flexibility to go off in appropriate directions and thanked Ms Hankin for organising the sessions.
Mr McCulloch noted as a Board Member it gave a perspective as one of the things it highlighted for improvement was board visibility and hoped engaging with this process would be taking steps towards that. Mr McCulloch also noted he looked forward to being involved in future walk rounds, giving real recognition Ms Hankin as organiser.
The Chair noted now he walk rounds have been re-established they feel like to right thing to be doing. Hearing what has been said whilst taking into account it is a real central pillar of governance for this committee
Ms Brightwell noted there is a balance in setting out the purpose of the visits, wanting a free flow of conversation. It is getting the balance right around preparing without scripting the visit. Ms Brightwell felt the Managers within her visit of Maternity, stepped away appropriately which was good, making staff feel they didn't just have to say good things.
The Chair thanked Ms Hankin for her report.

28 **National Cervical Screening "No Cervix" Audit Report**

Melanie Hawkins noted she was attending in place of Susan Laidlaw who is the Boards screening co-ordinator. She herself supports Ms Laidlaw around all national screening programmes.
The report is shared for awareness and information around the audit currently being undertaken.
Ms Hawkins gave an in-depth overview of the screening programme which had been ongoing for some time, along with the audit process.
It was noted all is going well and the team were thankful they have great colleagues who are happy to undertake extra work during this period.

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It was noted there had been no additional funding for clinics which is causing huge problems within bigger Boards, however it was thought this is manageable within the small amount of funding already allocated.
The team have tried to mitigate against any form of risks to patients.
It was noted there could be reputational risk to the screening programme and to individual boards as this audit progresses. All Communications are being dealt with through the nationally team, with Jo's Cervical Cancer Trust available to patients should they need to access it.
It was reported things will move on rapidly over the next few weeks and outcomes can be updated upon, if required.
The Chair thanked Ms Hawkins for the update stating it had been clearly thought through in terms of patient aspects, which was good to hear. It was suggested an update report as the audit progresses would be welcomed.

29 **Significant Adverse Event Report (SAER) Internal Audit Report**
Ms Brightwell noted Internal Audit had inspected the SAER process within clinical governance. A clean bill of health was received with no recommendations made, therefore it was reported to be a positive report. The full report is included for the committee to note.
It was stated the report highlights a good reflection of the team. Ms Brightwell conveyed congratulations to the clinical governance team as this was evident within the reporting received within the meeting.
The Chair echoed this sentiment.

30 **Date of Next Meeting**
It was noted the date of the next meeting is Tuesday 05th September 2023 at 09:30, virtually via TEAMS at 09:30.

Subsequent to the meeting the next meeting date was reset to be Tuesday 12th September 2023.

The Chair looked forward to welcoming members who are able to attend the Workshop which will focus around continuing improvement.
The committee were thanked for their time.