**Minute** **NHS Tayside**

**Tayside NHS Board**
**Care Governance Committee – Open Business**

Minutes of the above meeting held on Thursday, 5 August 2021 at 1000 hours in the Director of Nursing and Midwifery's Office, Level 10, Ninewells Hospital and via the use of Microsoft Teams.

**Present:**
**Non Executives**

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| Mrs J Alexander | Non-Executive member, Tayside NHS Board/Employee Director (MS Teams) (Left at 1040 hours) |
| Mrs A Buchanan | Non-Executive Member, Tayside NHS Board |
| Mrs P Kilpatrick | Vice Chair, Care Governance Committee/ Non-Executive Member, Tayside NHS Board (MS Teams) |
| Professor G Martin | Non-Executive, Tayside NHS Board (MS Teams) |
| Mrs T McLeay | Chair, Care Governance Committee/Non-Executive, Tayside NHS Board |
| Dr N Pratt | Non-Executive, Tayside NHS Board (MS Teams) |

**Executives**

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| Mrs C Pearce | Director of Nursing and Midwifery, NHS Tayside |
| Professor P Stonebridge | Medical Director, NHS Tayside |

**In attendance:**

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| Mrs D Campbell | Associate, Director for Patient Safety, Care Governance and Risk Management |
| Mr G Doherty | Director of Workforce (MS Teams) |

**Attendee:**

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| Ms M Campbell | Committee Support Officer (MS Teams) |
| Dr A Clement | Clinical Director, Angus Health and Social Care Partnership (MS Teams) (Item 7.3) |
| Mrs A Cunningham | Justice Healthcare Manager (MS Teams) (Item 9.1) |
| Mrs P Davidson | Infection Prevention and Control Manager (MS Teams) (Item 7.6) |
| Mr M Dickson | Clinical Governance Co-ordinator, Perth and Kinross Health and Social Care Partnership (MS Teams) (Item 7.2) |
| Dr H Dougall | Clinical Director, Perth and Kinross Health and Social Care Partnership (MS Teams) (Item 7.2) |
| Mrs J Galloway | Head of Heath and Community Care Services (MS Teams) (Item 9.1) |
| Dr S Hilton | Public Health Consultant (MS Teams) (Item 7.9) |
| Miss A McManus | Allied Health Professions Lead, Perth and Kinross Health and Social Care Partnership (MS Teams) (Item 7.2) |
| Mrs A Michie | Communications Manager (on behalf of Mrs J Duncan) (MS Teams) |
| Mrs A Mitchell | Dundee HSCP/Dundee City Council (on behalf of Dr D Shaw) (MS Teams) (Item 7.2) |
| Ms K Melville | Lead Pharmacist (MS Teams) (Item 7.10) |

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| Miss A Nicoll | Clinical Governance and Risk Management Facilitator (MS Teams) (Item 8.3) |
| Mrs K Reynolds | Lead Nurse, Dundee HSCP (on behalf of Dr D Shaw) (MS Teams) (Item 7.2) |
| Mr K Russell | Associate Nurse Director (Item 7.5) |
| Ms H Scott | Director of Performance (MS Teams) (Item 7.11) |
| Mr C Sinclair | Associate Nurse Director (MS Teams) (Items 7.3 and 8.2) |
| Mr B Webster | Management Student, Dundee University<br>Shadowing the Director of Nursing and Midwifery |
| Ms L Wiggin | Chief Officer, Acute Services (MS Teams) (Item 7.4) |

**Apologies:**

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| Mr G Archibald | Chief Executive, NHS Tayside |
| Mrs L Birse-Stewart | Chair, Tayside NHS Board |
| Mrs E Devine | Head of Health, Perth and Kinross Health and Social Care Partnership |
| Mrs J Duncan | Director of Communications and Engagement |
| Mr S Dunn | Associate Director of Nursing, Midwifery and Strategy |
| Mrs M Dunning | Board Secretary |
| Dr E Fletcher | Director of Public Health |
| Reverend A Gibbon | Head of Spiritual Care |
| Dr S Hilton-Christie | Associate Medical Director Patient Safety, Clinical Governance and Risk Management |
| Mr M Kendall | AHP Lead, Dundee Health and Social Care Partnership |
| Mrs T Passway | Interim Head of Clinical Governance and Risk Management |
| Mrs N Richardson | Interim Director of Allied Health Professions |
| Mrs V Irons | Chief Officer, Dundee Health and Social Care Partnership |
| Dr D Shaw | Clinical Director, Dundee Health and Social Care Partnership |

**Mrs Trudy McLeay in the Chair.**

**Action**

1 **WELCOME AND APOLOGIES**

The Chair welcomed all those present to the meeting. No new or leaving members were noted within the Committee membership.

The Chair welcomed Mr Brian Webster, Management Student from Dundee University, who was in attendance, shadowing the Nurse director to enhance his knowledge around nursing leadership.

Apologies were received and noted above.

Test of Change: The Chair advised that the test of change with the Agenda and Minutes for Noting being included as hyperlinks, had proved to be a failure, and would not be repeated for subsequent meetings as access for all members could not be guaranteed. Minutes which are provided to the Committee members for noting will be provided as part of the documentation pack. This test of change had been undertaken as part of a consideration to reduce the considerable number of reports and papers provided within the combined documentation.

**Action**

## 2 DECLARATIONS OF INTEREST

No interests were declared.

## 3 MINUTES AND CHAIR'S ASSURANCE REPORT

### 3.1 Minutes: Care Governance Committee Open Business 3 June 2021

The Minutes of the Care Governance Committee Open Business 3 June 2021 were approved, proposed by Mrs A Buchanan, Non-Executive Member, Tayside NHS Board and seconded by Mrs P Kilpatrick, Vice Chair, Care Governance Committee.

**The Committee:**

- Approved the Minutes of the Care Governance Committee Open Business 3 June 2021.

### 3.2 Chair's Assurance Report

The Chair advised that the Chair's Assurance Report was produced following the Committee on 3 June 2021.

**The Committee:**

- Noted the Chair's Assurance Report of the Care Governance Committee Open Business June 2021.

## 4 ACTION POINTS UPDATE AND MATTERS ARISING

### 4.1 Action Points Update

Mrs Claire Pearce, Director of Nursing and Midwifery provided updates on incomplete actions:

Action Point 3: Completion date of 7 October 2021 for the evaluation to have been undertaken. Confirmation of completion to be noted within the Action Points Update for the Care Governance Committee on 7 October 2021. A full update on the evaluation will be included within the next Assurance Report for Strategic Risk 16; which is scheduled for presentation to the Care Governance Committee at its meeting on 2 December 2021.

Action Point 6: Meeting has been arranged to discuss a process through which information is provided to Health and Social Care Partnerships in relation to recommendations and learning from SPSO reports. Ms Scott will update the meeting further on 7 October 2021.

Action Point 7: Action is marked as complete. The Committee agreed that further action be raised as consideration should be given to how Sage & Thyme or equivalent training could be developed and/or provided within NHS Tayside. Ms H Scott, Director of Performance advised that she had investigated the provision of Sage and Thyme training funding over previous years. Previous funding now not available through the Nursing Directorate budget. Ms Scott considered that a new approach be engaged with in that previously trained staff could share the principles of

learning with others. Mrs J Alexander, Non-Executive Member recalled previous agreement that funding of staff undertaking Sage & Thyme training was the responsibility of individual Services and therefore there would not be a requirement for a central fund to be in place. Mr G Doherty, Director of Workforce indicated that Sage and Thyme training was not core training for the organisation and supported a review of the organisation's training requirements and agreed to discuss this with Mr Scott Dunn, Head of Development and request him to explore further how equivalent training could be undertaken within the organisation. Mr Doherty will also request that Mr Dunn liaise with Ms Scott to bring recommendations back to the Committee on a proposal to provide a cascade model of training for staff, to the Committee on 7 October 2021. GD HS & SD

During the meeting Mr N Pratt, Non-Executive Member provided a link to on-line training to aide Committee members understanding of discussion and training requirements:
http://www.sageandthymetraining.org.uk/online-training

Ms Scott reported that within the NHS Tayside Annual Feedback report which is on the agenda at Item 6.1, there is information that over 200 staff have accessed on line learning sessions on the subject of effective communication, which have been supported by Dr D Armstrong, Lead Advisor to the Scottish Ombudsman.

Action Point 8: Action is marked as complete. Additional questions raised by Mrs P Kilpatrick, Vice Chair, Care Governance Committee:

- Pilot in Paediatrics – Which site? Date of pilot?
- When in 2022 is HEPMA to go live?
- Roll out in Perth Royal Infirmary prior to other site – What is the reason this site has been chosen?

It was agreed that request would be made to Dr P Curry, Chair Area Drug and Therapeutics Committee to present a short update report, inclusive of queries above, to the Care Governance Committee at its meeting on 7 October 2021.

Action Point 9: Noted that a meeting has been arranged to discuss a process through which information is provided to the Equality and Diversity Governance Group in relation to recommendations and learning from SPSO reports. Ms Scott will update the meeting further on 7 October 2021.

**The Committee:**

- Noted the updates provided.

4.2 **Matters Arising**

There were no other matters arising.

5 **COMMITTEE ASSURANCE AND WORKPLAN**

5.1 **Committee Assurance Plan and Workplan 2021/2022**

**Action**

Mrs Pearce advised that the documents provided set out the work for the year 2021/2022 and gave assurance to Committee members that all matters have been undertaken timeously.

**The Committee:**

- Reviewed and noted the updated Committee Assurance Plan and Workplan for the year 2021/2022.

5.2 **Record of Attendance**

The Chair wished to commend all members of the Care Governance Committee for their continued commitment to attending the Committee during this third wave of the COVID-19 pandemic, this has allowed key discussions to be undertaken and decisions made ensuring the remit of the Committee has been fulfilled to date.

**The Committee:**

- Noted the Record of Attendance.

6.1 **NHS Tayside Feedback Annual Report 2020/2021**

Ms Scott presented the NHS Tayside Feedback Annual Report for the year 2020/2021 for Committee member's awareness and invited any comment on the content. Following presentation to the Care Governance Committee, the Annual Report will be presented firstly to the Executive Leadership Team, and then to Tayside NHS Board on 26 August 2021 for approval and publication thereafter, with submission to the Scottish Government, Healthcare Improvement Scotland, the Scottish Public Services Ombudsman, and the Patient Advice and Support Service by 30 September 2021.

Ms Scott advised that the Annual Report provided feedback around the experiences of NHS Tayside's patients, carers, family members and members of the public; and this information is reviewed to inform learning, actions and improvements to improve the services provided by the organisation.

The Annual Report demonstrates how NHS Tayside encourages and gathers feedback, handles complaints, supports learning and provides examples of improvements made as a result of feedback received. The report also captures how the organisation continues to develop and support a culture which encourages feedback in a clear and understandable manner.

The report provides examples of improvements and/or successes which have been achieved during the year 2020/2021, for example:

- There has been a 40% increase in stories through Care Opinion
- A Person Centred Network has been developed, which will support the work of four network groups to improve the care experience for staff, patients, families and carers; transform person-centred leadership and care cultures; develop community engagement including patient and public involvement; and develop person centred practice through

shared decision making.
- Aligned with work to improve the Complaints Handling Process, there has been training and education to staff to assist and build confidence to undertake early resolution and to support staff wellbeing.

Ms Scott indicated that key priorities for the year 2021/2022 will include:
- Continue to promote the use of Care Opinion: introducing the system within Health and Social Care Partnerships; collaborating with Interpretation and Translation Services and Care Opinion to improve the accessibility of the system; and continue to increase the usage and engagements of the system with both public and staff in areas which already utilise the system.
- Complete with the Complaints Handling Improvement Programme initiated within the year 2020/2021.
- Develop further resource and training for staff to build skills for early resolution and staff wellbeing.
- Embed the whole system Person Centred Network.

The Chair thanked Ms Scott for presenting the very informative report.

Mrs Buchanan made a suggestion that Ms Scott review the examples of Care Opinion stories cited to ensure that there is a more balanced view of patient experiences contained within the Report, with no bias to favour NHS Tayside. Ms Scott agreed to review the examples prior to presentation to the Executive Leadership Team. HS

Mrs Kilpatrick queried whether in respect of the number of Prison Healthcare Service complaints under Performance Indicator Four, the total prison population that NHS Tayside serves could be indicated to give an indication of the scale of complaints received. Ms Scott agreed to review this table and provide a total prison population for Tayside.

Ms Scott also agreed to review narrative relating to the “Themes from Complaints” table to clarify that this information includes Prison Healthcare data.

The Committee members provided no further feedback to Ms Scott and accepted the report subject to the above amendments.

**The Committee:**
- Reviewed and accepted the NHS Tayside Feedback Annual Report, subject to amendment, which had been provided for review and comment.

7.1 **Dundee Health and Social Care Partnership: Assurance Report**

Mrs A Mitchell, Locality Manager, Dundee Health & Social Care Partnership and Mrs K Reynolds, Lead Nurse, Dundee Health and Social Care Partnership presented the Assurance Report on behalf of Dr D Shaw, Clinical Director.

**Action**

Mrs Mitchell highlighted to the Committee:

- The top five clinical, care and professional governance risks within Dundee HSCP:
  - Increasing demand in excess of resources, Dundee Drug and Alcohol Recovery Service (DDARS)
  - Insufficient Numbers of DDARS staff with prescribing competencies.
  - Current funding insufficient to undertake the service redesign, DDARS
  - Covid-19 Maintaining safe DDARS
  - Clinical Treatment of Patients – Mental Health Service (946)
- Outstanding adverse event management reviews continue, with the number reducing as teams focus on balancing time between ensuring new adverse events are comprehensively reviewed and dedicating time to review legacy adverse events. However, there is recognition that the number of overdue adverse event management reviews and overdue actions is higher than the Partnership would wish.

The Chair thanked Mrs Mitchell for her brief overview of the report circulated.

In response to query from the Chair, Mrs Reynolds confirmed that following agreement to reduce the number of new patients entering the DDARS (reduction from four access assessment clinics per week to two) the patients are placed on a waiting list which is reviewed regularly to place patients in to treatment. Mrs Reynolds advised that there are currently two General Practices in Dundee which offer enhanced drug and alcohol services, with an additional General Practitioner having been appointment, raising that number of Practices to three.

Discussion took place around NHS Tayside's payment to General Practitioners who are contracted to provide enhanced drug and alcohol recovery service to patients which is not equitable with payments across NHS Scotland. Mr Doherty cautioned against arbitrarily enhancing NHS Tayside's payment thereby putting local General Practitioners and the Health Board at a disadvantage against the rest of NHS Scotland. Mr Doherty suggested that this topic would be a discussion for the national Chief Officers Group to agree a single position which is then applied across NHS Scotland, and is not for the Care Governance Committee. GP payments is being raised at senior level within the partnership and appropriate action is being taken.

Responding to query from Dr Pratt, Mrs Mitchell advised that the introduction of the multi-agency non-fatal overdose pathway within Dundee; along with the take home naloxone programme and same day prescribing have shown an improvement on the number of fatalities within Dundee.

Dr P Stonebridge, Medical Director queried how many General Practitioner sessions were available per 100,000 of population within Dundee, compared to Glasgow. Mrs Reynolds advised that she would — AM DS

take this query back to Dr Shaw and include this information within the next assurance report.

Mrs Mitchell advised that the level of assurance offered within the assurance report was one of ***"Moderate":*** Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence on noncompliance.

The Chair thanked Mrs Mitchell and Mrs Reynolds for presenting the assurance report which provided assurance that systems are developing well across the HSCP, although the Primary Care Groups and associated reporting needs to further develop to provide comprehensive reporting across all aspects of all services.

**Level of Assurance**

- The Committee accepted that the level of assurance offered from the assurance report was one of "***Moderate"***.

**The Committee:**

- Considered and accepted the report from Dundee HSCP which was provided for assurance.

7.2 **Assurance Report: Perth and Kinross Health and Social Care Partnership**

Dr H Dougall, Associate Medical Director; assisted by Mr M Dickson, Clinical Governance Coordinator and Miss A McManus, Allied Health Professional (AHP) Lead presented the Assurance Report for consideration by the Committee.

Dr Dougall advised that the increased scrutiny which is being undertaken through the Care Governance Committee is being reflected within the Perth and Kinross Care and Professional Governance Forum, focusing on risk management and mitigation.

The report provides information on the Partnership Risks, with more detail on Risk Scores and grading contained within Appendix 2 of the Assurance Report. There has been an increase in the number of risks within the Partnership to 23 risks, due to the inclusion of the Mental Health Service Risks. Discussions are still ongoing around ownership of the Prescribing Risk. Risk 735 relating to clinical psychology access has been removed following discussion and the successful recruitment to post.

Dr Dougall advised that greater assurance to the Forum is received through more regular reporting from Services within the Partnership, and this is evidenced within Appendix 3 of the Assurance Report.

Dr Dougall gave a summary of the top risks:

- Risk 657 General Practice Unit within Pitlochry, graded Red with a score of 20. Tests of change have been undertaken through the move to 12 hour shifts for staff and this has proved to be a positive move in the retention of existing staff and recruitment to vacant posts. Staff do

tend not to live in the rural area of Pitlochry and the flexibility of the 12 hours shifts has benefitted staff with less commuting time, better work/life balance, and improved working activity. It is hoped that the improvements which are cited will reduce the risk score.

- Risk 886 Staff challenges within the Occupational Therapy Service within Perth Royal Infirmary, graded Red with a score of 20, again successful recruitment is expected to reduce the risk score.
- Risk 982 Workforce, graded Red with a score of 20. Whilst this is a significant risk, new models of care are being explored with a reconfigured workforce model put in place to ensure that the safe delivery of service is maintained. This work is ongoing in collaboration with the Mental Health Service Associate Medical and Nurse Directors.
- Risk 829 Accommodation for staff, graded Red with a score of 20. Exploration of alternative accommodation option continues.

Dr Dougall advised:

- Clinical and care governance arrangements were summarised within Appendix 3 of the Assurance Report and that work had now resumed following the delay due to COVID-19 on developing governance and performance dashboards supporting care assurance across agreed professional standards; with the additional work of improving locality performance data to services.
- The top five themes for adverse events with harm remains the same as within the last report to the Care Governance Committee:
  1. Violence & Aggression
  2. Pressure Ulcers
  3. Slips, Trips and Falls
  4. Accident (mostly minor moving and handling issues; staff burns from handling hot drinks; other relatively minor knocks and bumps)
  5. Fatality (the vast majority of these relate to unexpected deaths of patients in the community who were known to an HSCP service)
- Progress has continued in reviewing the number of outstanding red adverse events, with 13 outstanding events at the time of the report. Delays in completion of these outstanding red events are due to complexity of events; delays due in part to the ongoing COVID-19 response of the Services involved; and co-ordination of multiple agencies and services responding to the event.
- Complaints received aligned to Perth and Kinross HSCP are similar in number to those cited within the previous report with no change to top three themes.
- A COVID-19 specific inspection visit, by Healthcare Improvement Scotland (HIS), to HMP Castle Huntly in January 2021 commended the prison establishment citing 13 areas of good practice, whilst also identifying a few areas of further action.
- A Clinical Care and Professional Governance Group for Mental Health is now in place and meets monthly to review performance against Mental Health Key Performance Indicators; monitor and progress actions for service risks; and monitor progress against the Listen, Learn, Change and HIS improvement plans. A deep dive has been undertaken relating to the key performance indicator “patients followed up by the Community Mental Health Team within 7 days of discharge”

as it was noted that information entered/extracted was not accurate. A further deep dive is planned to understand the key performance indicator for readmissions. Data cleaning on Trackcare is also continuing.

- Site assurance visits have not yet been resumed following the reduction in COVID-19 restrictions, but it is hoped that these visits will resumed in the near future.

Mr Mark Dickson, Clinical Governance Coordinator advised that since the report was submitted for provision to the Care Governance Committee a new process had been introduced to review all Extreme/Major adverse events at the weekly Senior Management Team Huddle to identify if the event is appropriate for a Significant Adverse Event Review.

Mrs Anne Buchanan, Non-Executive Member referred to the update on care activity planning for those patients with dementia, being undertaken in Older Peoples Mental Health In-patient Teams, and would be interested to see further updates and evidence of incident reduction in the future.

Mr Dickson, responding to query from Mrs Buchanan, advised that once the Tissue Viability Nurse was recruited and in post, they would be involved in all investigations for pressure ulcers of Grade 3 and 4.

Dr Dougall, responding to query from Mrs Pearce, advised the Chief Officer was developing a proposal for consideration on how the Assurance Report from Perth and Kinross Health and Social Care Partnership would be shared across the Integrated Joint Board; acknowledging that the Assurance Report was within the public domain being available through the NHS Tayside website. Mrs Pearce indicated that whilst the Assurance Reports were available on NHS Tayside website as part of a larger document, it was important that the Integration Joint Boards had a process through which the reports were shared across the three partnerships to ensure that there is shared intelligence across the whole system of HSCPs and Mental Health and Learning Disability Services within Tayside and therefore a joint approach would have to be agreed. Mrs Kilpatrick requested that Dr Dougall consider with the Chief Officer an indicative date of implementation for a process to be in place for the sharing of Assurance Reports across the Integration Joint Boards within Tayside, and provide an update to the Care Governance Committee. HD

Dr Dougall advised that the level of assurance offered within the assurance report was one of ***"Moderate":*** Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence on noncompliance.

The Chair thanked Dr Dougall and Mr Dickson for presenting the Assurance Report which provided focused information on the clinical and care governance activities and arrangements across the Partnership.

**Level of Assurance**

- The Committee accepted that the level of assurance offered from the assurance report was one of "***Moderate"***.

**The Committee:**

- Considered and accepted the report from Perth and Kinross HSCP which was provided for assurance.

7.3 **Assurance Report: Angus Health and Social Care Partnership**

Dr Alison Clement, Associate Medical Director, presented the Assurance Report for the Angus HSCP advising that the report offers a ***"Moderate"*** level of assurance providing evidence of mitigation of service risk management; ongoing improvements in adverse event management; reporting on further cycles and the maturing of assurance reporting from services.

Dr Clement gave a summary of the top risks:

- Risk 353 Sustainability of Primary Care Services: graded Red with a score of 25 despite extensive mitigation actions in place to improve the situation. A refreshed approach to this risk is being proposed, which would incorporate both in and out of hours General Practice, and with wider stakeholders including the requirement for recruitment across the wider multi-disciplinary team.
- Risk 578 Financial Management: graded red with a score of 20.
- Risk 591 Workforce Optimisation: graded red with a score of 20. A new Angus HSCP Workforce Steering Group has had its first meeting 13 July 2021, and a workforce plan is being developed. Contribution is being sought to the NHS Tayside workforce plan, with contributions by 5 August 2021. Senior Leadership Team have been asked to complete a workforce questionnaire. Staff Partnership Forum is seeking an engagement process. All these pieces of work will contribute to the development of a detailed picture of workforce challenges, emerging need and accurate risk to the Partnership.

Dr Clement also wished to highlight areas around risk management and care governance to the Committee:

- The Adult Protection Committee continue to meet and a report submitted to the Committee on 16 June 2021 by the Adult Protection Officer offering an increasing picture of activity in all areas of adult protection. Steps are being taken to increase resources available within the adult protection teams.
- The decision around Datix Cloud IQ is ongoing with the tendering exercise being undertaken through NHS Greater Glasgow and Clyde.
- Actions relating to the incorrect patient contact details on Adastra system have been undertaken locally as required, however, this issue continues to be raised at national level, with no resolution.
- Strategic Planning Group continues to meet following relaxation of COVID-19 restrictions, with a new strategic risk around the need to focus on prevention rather than responding to COVID-19 in development.
- Commissioned provider failure, while graded as a yellow risk, is raising concerns around the care homes and the number of vacancies; the

possibility of less beds being commissioned; and the added stress being transferred to the services which provide care at home.

- In respect of Mental Health and Learning Disability Services, six of the eight agreed system wide risks have been added to Datix; with the final two risks being currently added to the system.
- Work continues to be undertaken to support services to complete and learn from adverse events and is showing an improving situation through the management of Local Adverse Event Review timescales and sharing learning across the three Tayside Partnerships.
- The Anticoagulation Service continues to have excellent performance with a positive annual assurance report. Dr Clement highlighted that while less people are now being commenced on warfarin with a resultant reduction in numbers of patients being managed within the service, there will always be a requirement for a high quality service for those for whom it is most appropriate to be managed with warfarin.
- Work is ongoing to support the Angus 2C Practices to participate in the annual assurance reporting utilising the agreed framework, using the learning from the Primary Care Out of Hours Service.
- Complaints continue to be received but a large amount of work is being undertaken to complete complaints within the standards, and at an early resolution stage. Learning from complaints is shared at operational level, and the Partnership.
- Compliments are also seen as important to the HSCP and a process is being developed to review all compliments received through all mediums, including Care Opinion and social media. These will be shared across the Partnership.

The Chair thanked Dr Clement for providing a comprehensive report.

The Chair would wish, on behalf of the Care Governance Committee, to congratulate Ms Gail Smith on gaining the substantive post of Chief Officer of Angus Health and Social Care Partnership.

In response to query from the Chair, Dr Clement advised that Risk 1005 Stakeholder and Partnership Engagement has been inconsistent due to the restrictions which have been in place through the COVID-19 pandemic.

In response to question around the involvement of the third sector in mental health care in the partnership, Dr Clement clarified that due to the COVID-19 pandemic restrictions that there has been reduced access for patients, carers and staff to engage in face-to-face meetings, with third sector involvement usually restricted to telephone appointments to manage mental health conditions. With the reduction in pandemic restrictions patients, carers and staff are keen to re examine how the access to choices of treatments can be optimised across mental health services. Peer support in General Practice is available in all practices. Near Me technology has been utilised, however there are access issues for some patients, and face to face appointments are being increasingly accommodated where required. Dr Clement advised that peer support is accessed through Penumbra and Hillcrest, highlighting the importance of

the tendering process ensuring that the NHS was not dependent on single organisations which supports resilience of service provision. MS Teams meetings are used to support workshops for anxiety, sleep problems, and other specific needs which encourage locality improvement focussing on mental health wellbeing and physical health.

Dr Clement responding to query on escalation within 2C practices from Mrs D Campbell, Associate Director Patient Safety, Clinical Governance and Risk Management confirmed that she and the Senior Leads within Angus HSCP are providing considerable support to the 2C Practices on a day to day basis. Any operational or strategic issues raised are escalated to the Chief Officer as appropriate with regular meetings in place.

Dr Clement advised that while there is lack of clarity around where accountability sits across NHS Tayside and the three Health and Social Care Partnerships under the current hosting arrangements, this is overcome by good partnership working arrangements and a clear practice management escalation process in place.

As previously indicated, Dr Clement offered ***"Moderate"*** assurance for the assurance report presented to the Committee: Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence of non-compliance.

**Level of Assurance**

- The Committee accepted that the level of assurance offered from the assurance report was one of "***Moderate"***.

**The Committee:**

- Considered and accepted the report from Angus HSCP which was provided for assurance.

7.4 **Acute Services Division Quality and Performance Review Report**

Ms L Wiggin, Chief Officer Acute Services Division presented the Quality and Performance Review Report covering the period April to June 2021 for consideration by the Committee.

Ms Wiggin highlighted to the Committee that:

- All nine of the Clinical Care Groups have undertaken a review within the reporting period; some of the national reporting has remained paused; and the organisation continues to be operating within Wave 3 of the COVID-19 pandemic which commenced in June 2021. Remobilisation plans for planned care and treatment time guarantees are in place through agreed Remobilisation Plan 3.
- A new group has been established to provide assurance on the quality of care at an Acute Services Operational level through the establishment of an Operational Unit Clinical Governance Committee, enabling more focused discussion on clinical governance to be undertaken. The first meeting was held on 14 June 2021 with a draft data set of key measures and data being discussed to agree the information required to support the Committee and provide assurance in relation to identified priorities, and identify opportunities for learning

and improvement. Terms of Reference will set out how the Operational Unit Clinical Governance Committee will complement the existing Quality and Performance meetings and avoid duplication.

- The ratio of adverse events with harm against adverse events with no harm for the reporting period is 1:4.
- The number of Extreme/Major/Moderate events reported has remained broadly consistent across the reporting period.
- The number of commissioned significant adverse event reviews from the nine Clinical Care Groups was nine, with 13 local adverse event reviews commissioned.
- Completed adverse event review reports are reviewed and signed off and can be shared across the organisation; and in terms of significant learning can be shared nationally having been signed off by the Nurse and Medical Directors.
- Top five adverse event management events remain consistent: clinically challenging behaviour; slip trip or fall (inpatients only); medication adverse event; violence and aggression; and surgery/theatre. The top event of clinical challenging behaviour has been reviewed and a large number continue to be related to a small number of patients within the Child and Adolescent Mental Health Service Young People's Unit. Work continues to reduce the number of events for this cohort of patients. Currently a review against the number of similar incidents within the other two Young People's Units in Scotland is being undertaken to understand the level of incidence against national data.
- The number of outstanding events demonstrates a reduction (168 events in March 2021 to 138 events May 2021). Support continues to be provided to Clinical Care Groups by the Clinical Governance and Risk Management Team to complete outstanding events.
- Crude mortality levels have shown fluctuation, with reductions in line with the COVID-19 pandemic and decreased patient activity; and increases reflecting the high level of activity and acuity over the winter period and Wave 2 of the COVID-19 pandemic. Since March 2021 there has been a decrease in the crude mortality level to below the median. NHS Tayside's crude mortality rate and the number of COVID-19 deaths occurring in hospital for the reporting period have been below the national average at 14.6/100,00 population and 7.8/100,000 population respectively.
- Pressure ulcer cases has seen a slight increase over April and May 2021, with the increase related to COVID-19 patients admitted to Intensive Care Unit. This information has been shared with the Tissue Viability Network for further review. Tissue Viability Specialist Nursing Service recruitment is underway. Each Clinical Care Group reviews every pressure ulcer presentation to identify where there may be a trend, improvement or learning which is then shared across the clinical care groups through the Tissue Viability Network.
- In depth analysis is being undertaken around falls data as an increase in the incidence rate had been noted over time. Significant reconfiguration of wards, increased activity, complexity and acuity of patient cohorts during the three Waves of COVID-19 pandemic may have had a bearing on the increase in numbers. While Clinical Care

Groups review all falls to identify themes and learning, the Acute Services Falls Forum has been established to refocus and refresh the system wide approach to falls prevention and their management.

- The Clinical Governance and Risk Management Team continue to support clinical care groups with their adverse event management processes. Clinical care groups continue to review current and overdue risks and have actions captured within the reporting system to ensuring risks are accurate.
- The Clinical Care Groups are focusing on sharing learning through the quality and performance reviews. Learning is taken from adverse events, complaints, patient stories as well as from reviewing data and making improvements to practice.
- Work continues to increase the number of complaints which are dealt with at Stage 1, by training of staff in early resolution techniques. Work continues in reducing the number of complaints which have not been responded to within the national time standards. The number of complaints has been consistent, with the number of complaints received in May 2021 at 66.
- Ongoing work around absence levels, establishment data, core training compliance and TURAS have been used to triangulate workforce data.
- Work continues, in collaboration with the Estates Department, to improve the estate environment across the organisation, with a number of prioritised improvements agreed during the COVID-19 pandemic through the Gold Command pathway.

Responding to query from Mrs Kilpatrick, Ms Wiggin advised that the presentation of patients presenting through unscheduled care pathways during Waves 1 and 2 of the COVID-19 pandemic had increased, with greater complexity of patient presentation. However, analysis has not formally been undertaken to consider if the rate of cardiac arrest was greater or less than expected during the COVID-19 pandemic. Mrs Campbell advised that the Cardio Pulmonary Resuscitation Committee will have a breakdown of the emergency and 2222 calls and reviews of these events is undertaken and learning is shared. Mrs Campbell advised that a brief update on the number of cardiac arrest, learning and national benchmarking would be included in the next Acute Services Quality and Performance Review Report on 7 October 2021. LW DC

Professor Stonebridge suggested that where the report narrative requires to be supported by data, the data could be provided within an appendix to the report. Ms Wiggin and Mrs Campbell were happy to support this suggestion.

The Chair thanked Ms Wiggin for providing the report and highlighting key areas for the Committee.

Ms Wiggin offered ***"Moderate"*** assurance for the assurance report presented to the Committee: Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence of non-compliance.

**Level of Assurance**

- The Committee accepted that the level of assurance offered from the assurance report was one of "***Moderate"***.

**The Committee:**

- Considered and accepted the report relating to the Acute Services Quality and Performance Reviews which was provided for assurance.

1136 hours the Committee took a 10 minute comfort break. Mrs Jenny Alexander, Non-Executive Member left the meeting.

7.5 **Mental Health and Learning Disability Services Quality and Performance Review Report**

Mr Keith Russell, Associate Nurse Director presented the Quality and Performance Review (QPR) Report covering the meeting which took place on 25 June 2021, for consideration by the Committee.

Mr Russell advised that:

- The Quality and Performance Review was undertaken through two component parts:
  - In-Patient, Regional In-Patient and Crisis Resolution and Home Treatment Services.
  - Mental Health 'system wide review' which focuses on performance and shared learning across HSCP integrated community services.
- The three HSCPs reported individually on areas of performance which enables system wide information sharing, connection and opportunities for shared learning across key themes such as adverse event reporting, quality indicators, verified incomplete adverse events and the risk management process.
- The harm to no harm ratio across all three HSCPs for adverse events is 1:1. It is considered that reporting of events is low and work is being led by the HSCPs to understand and improve this and increase reporting of all events (with/no harm/near miss).
- HSCPs are working to incorporate the mental health service wide risks into their risk registers, and provide risk scoring appropriately. This will ensure system wide connections, shared learning, and understanding of strengths and weaknesses of risk management across whole system.
- Child and Adolescent Mental Health and the Young People's Unit are currently reported through the Acute Services QPR Report.
- Within Secure Care Services work is being undertaken to further develop the positive safety culture, and this is being led by the Service Leadership Team.
- A Staff Wellbeing Survey has been undertaken across the Secure Care Services which has provided staff the opportunity to share feedback and views on issues associated with safety, wellbeing and collaborative working with the Service Leadership Team. Mr Russell advised that he had spent two very productive days within Secure Care Services across all wards talking to and understanding staff's concerns around the sustainability of safe staffing, as well as their

pride in the work that they do in care for their patients. Staff were able to identify positive role models within the Service, and the Service will work with staff to develop an improvement plan.

- Inpatient General Adult Psychiatry and Learning Disability Services have identified that the top five categories of adverse events are:
  - Violence and Aggression
  - Self Harm
  - Clinical Challenging Behaviour
  - Security
  - Staff
- The Senior Charge Nurse team have a good understanding of the factors influencing and contributing to these events and are working with the multi-disciplinary team to reduce the number of events and improve the key outcomes and measures.
- The harm to non-harm ratio has remained at 1:4 within inpatient General Adult Psychiatry and Learning Disability Services.
- There is an increase in adverse event reporting being noted, as evidenced by the increase in reporting of minor events which is at its highest level and this is felt to be a feature of a positive reporting culture.
- Bed occupancy within General Adult Psychiatry has been under significant pressure with the average bed occupancy median at 92.8% (the Royal College of Psychiatry recommendation for safe occupancy levels 85%). The rolling programme of Ligature Anchor Point Removal has impacted on the number of beds available (reduction of 10-12 beds) and, on occasion, patients have been admitted to non-bedroom areas for a short period of time. Mental Health Services have responded to this significant challenge by rephasing the Ligature Anchor Point Removal programme and ensuring all available beds are open.
- Surge activity is monitored on a daily basis through capacity and flow huddles to gain understanding at an early stage the peaks and troughs of capacity. Assurance was given to the Committee that the current practice in Tayside does not include the admission of patients to non-bedroom areas.
- A review of the Child and Adolescent Mental Health Service (CAMHS) Out of Hours Admission pathway is underway to ensure that young people are admitted to the environment best equipped to meet their needs. As part of this work an audit of General Adult Psychiatry Wards against the standards set out in the Scottish Government Guidelines for the Admission to Adult Mental Health Wards of under 18s is being completed. The Director of Nursing and Midwifery has been provided with current admission rates and can discuss this directly with Committee members as required.
- Mental Health and Learning Disability Services and the three HSCPs are working closely together to reduce the number of delayed discharges within inpatient services.

In response to a query from Mrs Kilpatrick, Mr Russell advised that during the programme for ligature anchor point reduction, all options regarding decanting patients from one area to another were reviewed to ensure

capacity was as flexible as possible. Mr Russell advised that the recent significant demand for inpatient admission, high level acuity and clinical need had resulted in a position where non-bedded areas were utilised for the admission of patients for a very short period of time. Mr Russell and Mrs Pearce, along with the Senior Leadership Team, continue to monitor surge activity.

Responding to a query from the Chair around Improving Observation Practice (IOP), Mr Russell confirmed that the introduction of the new protocol is the biggest culture change in inpatient settings within mental health nursing practice and requires staff to work with individuals in a different way. The pilot of IOP highlighted a number of benefits to the approach and opportunities for learning. The Senior Nurse for Practice Development is supporting the roll out to all other areas across Mental health and Learning Disabilities. Mr Russell agreed to include within the next Quality and Performance Review Report, to the Committee 7 October 2021, a short update on the implementation and use of the Improving Observation Practice Protocol. KR

Mr Russell confirmed that the complaint which has a response time over 200 days has not been referred for external review. The complaint involves a number of services and individuals and this has been the main reason for the delay in completion of the complaint. The Chair wished to reiterate that a patient or family members are at the heart of all complaints and would commend the Service to work toward conclusion of all outstanding complaint responses.

Responding to Dr Pratt's query, Mr Russell advised that the Mental Health and Learning Disability Service has made positive progress in terms of the recommendations from The Independent Inquiry into Mental Health Services in Tayside: Trust and Respect report. Staff have shown great focus and determination to develop services whilst working within a global pandemic. Mr Russell advised that there is constructive and positive relationships in place within the Integrated Leadership Team which is working collaboratively on key issues. While there are still challenges ahead, in particular workforce availability, he would assure the Committee that Mental Health Services have a committed, creative and passionate workforce that is working hard to deliver services.

Professor Stonebridge advised the Committee that recent appointments include an Operational Medical Director for Mental Health and Learning Disability Services, two General Managers and a Lead Nurse, with the Director of Nursing and Midwifery taking the leadership role on an interim basis. This reflects Tayside NHS Board's commitment to progress Mental Health and Learning Disability Services and support staff to deliver safe and effective patient care.

Mr Russell advised that the level of assurance offered within the assurance report was one of ***"Limited":*** Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives, controls are applied but with

some significant lapses.

The Chair thanked Mr Russell for the report, however, would wish to recommend that the Committee record an assurance level of moderate recognising that the Service has acknowledged that there are areas where further work is required, that there are recommendations identified and actions in place and being undertaken. The Committee members agreed that an assurance level of ***"Moderate"*** be recorded.

**Level of Assurance**

- The Committee recorded the level of assurance of "***Moderate"*** for the Mental Health and Learning Disability Services Quality and Performance Review Report.

**The Committee:**

- Considered and accepted the report from Dundee HSCP which was provided for assurance.

7.6 **Assurance Report: Strategic Risk 16 Infection Prevention and Control**

Mrs Pamela Davidson, Infection Prevention and Control Manager presented the assurance report for consideration to the Committee, advising:

- The risk score remained at 20 following review in May 2021.
- Recruitment to the vacancy for Lead Infection Prevention Control Doctor is ongoing with the job description having been completed. A further locum post is being advertised following the Local Infection Prevention Control Doctor post contract ceasing in June 2021. This vacancy impacts significantly on the Team's leadership, decision making, ability to provide advice and input regarding infection prevention and control into projects.
- Hand hygiene data has been included within the assurance report following a deep dive into data undertaken in January 2021, which highlighted reporting challenges from clinical and non-clinical teams, and work is underway with the Business Unit to improve submission of data.
- Key Performance Indicator data has been included within the assurance report; being a national reporting requirement in relation to patient screening for multi-drug resistant organisms (MDRO) methicillin resistant Staphylococcus aureus (MRSA) and carbapenemase-producing Enterobacteriaceae (CPE) on admission to hospital. A review of data collection is being undertaken to improve the process.

Mrs Davidson advised that the publication of national data by Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland for Quarter 1 (Jan to Mar) was released on 6 July 2021; with data for Quarter 2 (Apr – Jun) being local data which is not validated at present and will be subject to change, this validated data will be published

in October 2021.

- Healthcare Associated *E. coli* bacteraemia infection rate for Quarter 1 2021 has slightly increased from 42.1 per 100,000 bed days in Quarter 4 2020 (Oct-Dec) to 42.7 per 100,000 Total Occupied Bed Days (TOBDs) in Quarter 1 2021 (Jan-Mar) and is above the national average. Projected rates for NHS Tayside in Quarter 2 2021 (Apr – Jun) using the same TOBDs as Quarter 1 2021 per 100,000 is projecting the rate will further increase to 43.6.
  Community Associated *E. coli* bacteraemia infection rate in Quarter 1 2021 (Jan-Mar) has decreased significantly from 44.8 per 100,000 population in Quarter 4 2020 (Oct-Dec) to 35.9 per 100,000 population but remains above the national average. Projected rates for NHS Tayside in Quarter 2 2021 (Apr – Jun) per 100,000 population is projecting an increase to 41.2
- Healthcare Associated *Staphylococcus aureus* bacteraemia infection rate for Quarter 1 2021 has increased from 19.1 per 100,000 Total Occupied Bed Days in Quarter 4 2020 (Oct-Dec) to 23.3 per 100,000 TOBDs in Quarter 1 2021 and is above the national average. Projected rates for Quarter 2 2021 (Apr-Jun) using the same TOBDs as Quarter 1 2021 per 100,000 is projecting a decrease to 22.3.
  Community Associated *Staphylococcus aureus* bacteraemia rate for Quarter 1 2021 (Jan-Mar) has increased from 9.5 per 100,000 population in Quarter 4 2020 (Oct-Dec) to 12.6 per 100,000 population and is above the national average. Projected rates for NHS Tayside in Quarter 2 2021 (Apr-Jun) per 100,000 population is projecting the rate will increase to 15.3.
- Healthcare Associated *Clostridioides difficile* Infection (CDI) rate for Quarter 1 2021 (Jan-Mar) has significantly decreased from 14.3 per 100,000 bed days in Quarter 4 2020 (Oct-Dec) to 5.8 per 100,000 TOBDs and is significantly below the national average. Projected rates for NHS Tayside in Quarter 2 2021 (Apr-Jun) using the same TOBDs as Quarter 1 2021 per 100,000 is projecting an increase to 7.8 in Quarter 2 2021 (Apr-Jun).
  Community Associated rates CDI rate in Quarter 1 2021 (Jan-Mar) has significantly decreased from 4.8 per 100,000 population to 1.9 per 100,000 population and is below the national average. Projected rates for NHS Tayside in Quarter 2 2021 (Apr-Jun) per 100,000 population is projecting an increase to 4.8.

Note:
Risk exposure no controls – 25
Current risk exposure – 20 (June 2021)
Planned risk exposure – 16
Risk Owner – Medical Director
Risk Manager – Infection Prevention and Control Manager
Level of Assurance Offered: Limited

The Chair thanked Mrs Davidson for the very detailed Assurance Report.

The Chair raised that the Lead Infection Prevention Control Doctor post had featured in a number of reports and requested an update on the

progress of recruitment. Mr Doherty advised that he would check on the status of this role recruitment.

Post Meeting Note: Mr Doherty has advised that there has been no formal request to advertise the Lead Infection Prevention Control Consultant Post, there are therefore no delays within recruitment. When request submitted, this post will be escalated and advertised as a matter of urgency. Mr Doherty has requested that the matter be formally raised with the relevant Clinical Group to understand why this appears outstanding given the Board concerns.

Responding to Mrs Buchanan, Mrs Davidson advised that a watching brief is being kept on the rates of *Staphylococcus aureus* bacteraemia infection and the interventions and improvement that have been identified are a work in progress; and an understanding of why there is an increase can be gained from the review of cases.

Responding to query from Mrs Kilpatrick on the projected increase in healthcare associated Clostridioides difficile Infection (CDI) rate for Quarter 2, Mrs Davidson advised that while she is aware that other Health Boards may also see an increase in the rate of incidence in Quarter 2, she could not comment definitively as the data used to project is non-validated. Mrs Davidson could confirm that NHS Tayside are currently significantly below the Scottish national average rate; and an increase in Quarter 2 would not raise the organisation's rate to such a level.

Mrs Davidson advised that the level of assurance offered within the assurance report was one of ***"Limited"***: Satisfactory framework of key controls but with significant weaknesses evident which are likely to undermine the achievement of objectives.

**Level of Assurance:**

- The Committee accepted that the level of assurance offered from the report was one of ***"Limited"*** acknowledging that, while there is a wide range of established controls in place, application of and compliance with these is dependent on a large number of variances across the organisation.

**The Committee:**

- Considered and accepted the report on Strategic Risk 14 Infection Prevention and Control provided to give assurance of compliance with national guidance in relation to infection prevention and control.

7.7 **Assurance Report: Strategic Risk 16 Clinical Governance**

Mrs Campbell presented the assurance report for consideration to the Committee, advising that:

- Whilst there had been slippage at the outset of the COVID-19 pandemic, business continuity arrangements were put in place and the business of providing robust clinical governance and risk management continues alongside the COVID-19 response. This will result in the expected reduction of the planned risk exposure rating of 9 to be

achieved by 31 August 2021.

- An Operational Unit Clinical Governance Group has been established to gain assurance from the Operational Unit medical, nursing and management leaderships. The first meeting was held on 14 June 2021, and a terms of reference, workplan and reporting template have been developed.
- To support assurance reporting, improved standardised report templates have been produced and utilised by the three Health and Social Care Partnerships and Acute and Mental Health and Learning Disability Services to provide assurance reports to the Care Governance Committee.
- The Clinical Policy Governance Group has met on two occasions and have provided approved policies for adoption at the Care Governance Committee.
- The Significant Adverse Event Review (SAER) process has undergone a revision and was presented to the Operational Leadership Team on 4 June 2021 with positive feedback gained. Commissioning and sign off processes are being tested over a transition period, with an expectation that all clinical areas will take responsibility for commissioning and sign off of SAERs by end September 2021.

Note:
Risk exposure no controls – 25
Current risk exposure – 12 (July 2021)
Planned risk exposure – 9
Risk Owner – Medical Director
Risk Manager – Associate Director for Patient Safety, Clinical Governance and Risk Management
Level of Assurance Offered: Moderate

Professor Stonebridge advised that given the planned controls which are central to the strategic risk mitigation, Internal Audit colleagues have incorporated Strategic Risk 16 as part of their workplan this year, earlier than as planned in 2022. This is a significant achievement for the organisation.

Professor Stonebridge also advised that the Chief Executive had held a meeting with the Executive Leads for Care Governance Committee, Executive Directors and Clinical Governance and Risk Management Team colleagues to review the Care Governance Committee Annual Report gaining assurance that the Committee is responding to organisational concerns and feedback from Internal Audit Reports. The Chief Executive has provided positive feedback to the Executive Leads on the work having been undertaken by and has provided advice on areas to be taken forward by the Committee.

The Committee were requested to approve the application that the Strategic Risk 16: Clinical Governance Current Risk Exposure Rating be reduced to the Planned Risk Exposure rating of 9, supported by the evidence that was provided within the Assurance Report, reinforced by

the Care Governance Committee Annual Report. The Committee were in agreement that the Strategic Risk exposure rating be reduced to a score of 9.

Following query from the Chair, Mrs Campbell advised that staff training in Datix Cloud IQ, if this was the system which the organisation pursued to procurement, would be embedded in the implementation plan for the purchase. Mrs Campbell advised that one benefit of Datix Cloud IQ is that it is less complex than the current system utilised.

Mrs Campbell clarified for Dr Pratt that the Clinical Policy Governance Group was established with a remit to scrutinise, approve and recommend for adoption Clinical (including Infection Prevention and Control); and Nursing and Midwifery policies, a role previously undertaken by the Clinical Quality Forum. The establishment of the Operational Unit Clinical Governance Committee does not replace any function of the Clinical Quality Forum, this new Committee will improve the robustness of clinical governance arrangements within the clinical services in the Acute Operational Unit, and link in with the Quality and Performance Review processes already in place.

Mrs Campbell advised that the level of assurance offered within the assurance report was one of "***Moderate***": Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence of noncompliance.

**Level of Assurance:**
The Committee agreed that the level of assurance gained from the report was one of ***"Moderate"*** acknowledging that Clinical Governance and Risk Management Team had introduced business continuity plans which had worked in parallel with the organisation's response providing robust clinical governance and risk management arrangements.

**The Committee:**
- Considered and accepted the report on Strategic Risk 16 Clinical Governance which had been provided to present the strategic context and actions that have and will be implemented to continue to address the clinical governance strategic risk.
- Agreed the recommendation that the risk exposure rating be reduced to a score of 9.

7.8 **Assurance Report: Strategic Risk 736 Public Protection**
Mrs Pearce presented the assurance report for consideration to the Committee which provided an update on the progress of the Public Protection Framework for NHS Tayside since its approval in January 2021.

Mrs Pearce advised that:
- Two Adult Protection Advisors have been orientated into post, as part of Phase 1 of the framework.
- The Public Protection Executive Group have met on two occasions

30 March and 2 June 2021, with the minutes provided to the Committee for information; and Terms of Reference and Membership have been agreed.
- Phases 2 and 3 of the framework have commenced and recruitment to the Adult Protection Team is progressing.
- The risk rating, which had been reduced from a score of 20 to 16 at the last report to the Committee in April 2021, has remained the same despite progress being made.
- Scottish Government monies released through the continued commitment to oversee care homes is being utilised to temporarily fund Adult Protection Advisor resource to support work within care homes as part of the multi-agency partnership. The Adult Protection Advisor resource will provide a range of benefit to reduce risk, support early recognition of and prevention of risk.

Mrs Pearce advised that as a whole strategic risk of public protection there still remains work to be undertaken to ensure a cohesive shared infrastructure, however, it is acknowledged that the Child Protection element provides a higher degree of assurance, having been embedded in organisational practice for a number of years, than the Adult Protection element which is still under development.

Note:
Risk exposure no controls – 25
Current risk exposure – 16 (July 2021)
Planned risk exposure – 12
Risk Owner – Director of Nursing and Midwifery
Risk Manager – Associate Director of Nursing, Midwifery and Strategy
Level of Assurance Offered: Limited

Mrs Pearce offered an assurance level of ***"Limited"***: Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence of noncompliance.

**Level of Assurance:**
The Committee accepted that the level of assurance offered from the assurance report was one of ***"Limited"*** acknowledging that Phase 1 Recruitment of the framework is complete and Phase 2 has been initiated with clear direction on shared Public Protection functions.

**The Committee:**
- Considered and accepted the report on Strategic Risk 736 Public Protection which had been provided to give an update on the progress on the Public Protection Framework for NHS Tayside since its approval in January 2021.

7.9 **Assurance Report: Strategic Risk 798 Corporate Parenting**
Dr Simon Hilton, Consultant in Public Health Medicine attended the Committee to give a verbal update on Strategic Risk 798 Corporate Parenting.

**Action**

Dr Hilton advised that since he commencement his post of Consultant in Public Health Medicine in April 2021 and accepted the management of the strategic risk there has been limited progress made since the last report to the Committee, primarily due to capacity issues deriving from the ongoing COVID-19 response. Dr Hilton advised that he is currently still assuming the responsibility for the Child Health Commissioner role within NHS Tayside until a substantive individual is in post.

Dr Hilton advised that the NHS Tayside Corporate Parenting Group had been established with its first meeting scheduled for the end of May 2021, however, due to the emergent COVID Delta variant and the Public Health commitment, this meeting was subsequently cancelled. Dr Hilton advised that he had remained engaged with members of the Group so as not to lose the dynamic and momentum that had been built up. The rescheduling of the NHS Tayside Corporate Parenting Group is now a priority, with Dr Hilton indicating to the Director of Public Health that dedicated time be set aside for this, irrespective of the ongoing COVID-19 response. A focus of this Group will be to evidence progress against the Corporate Parenting Plan which has been agreed by the organisation and consider all corporate parenting issues which arise within NHS Tayside.

Dr Hilton advised the Committee that the Care Inspectorate is undertaking a joint inspection of services for children at risk of harm and the inspection within Dundee is ongoing currently, completing end of November 2021. Published report will be available in early January 2022.

A Sub Group of the Tayside Regional Improvement Collaborative (TRIC) Priority Group (PG) 4 is currently reviewing an action plan for partners; and Dr Hilton has advised this group to avoid duplication and/or too many actions in order that tangible progress can be made against outcomes of actions contained within the Corporate Parenting Plans which NHS Tayside and the three Local Authorities have in place.

Dr Hilton advised that having reviewed the controls in place and those planned there had been no firm actions taken since the last report to the Committee on 22 April 2021 which would directly reduce the risk.

Note:
Risk exposure no controls – 20
Current risk exposure –15 (August 2021)
Planned risk exposure – 6
Risk Owner – Director of Nursing and Midwifery
Risk Manager – Director of Public Health
Level of Assurance Offered: Moderate

Dr Hilton offered a ***"Moderate"*** level of assurance from his verbal report: Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence of noncompliance.

**Action**

**Level of Assurance:**
The Committee accepted the level of ***"Moderate"*** acknowledging that, whilst there had been no firm progress on the actions within the risk since the last report, there were firm plans to progress the NHS Tayside Corporate Parenting Group which will review progress against the approved Corporate Parenting Plan; and the recruitment of the substantive Child Health Commissioner is being progressed.

**The Committee:**
- Accepted the verbal report on Strategic Risk 798 Corporate Parenting.

7.10 **Safe and Effective Management and Use of Controlled Drugs across Tayside**

Ms Karen Melville, Lead Pharmacist Controlled Drug Governance presented the report to provide assurance that there are process in place within NHS Tayside to ensure the safe and effective management and use of controlled drugs.

Ms Melville highlighted:
- The Director of Pharmacy is appointed as the Controlled Drug Accountable Officer, supported by a small team of Lead Pharmacist, Inspection Officer and Administrative Assistance.
- The NHS Tayside Safe and Secure Handling of Medicines comprises of a suite of principles and specific guidance, one section of which is dedicated to Controlled Drugs. Following feedback this Controlled Drug section was updated and approved through the NHS Tayside Medicines Policy Group and presented to the NHS Tayside Local Intelligence Network in March 2021. The Controlled Drug Governance Team will be working with Associate Nurse Directors to roll out the new documentation across NHS Tayside. Delivery, whilst being significantly delayed due to the COVID-19 pandemic, has now been planned for September 2021, following which there will be a programme of peer audit undertaken to review compliance.
- The rolling programme of self-assessments within General Practices have been significantly delayed due to the COVID-19 pandemic, however, to date seven Practices have been inspected by the Controlled Drug Governance Team, with the Team anticipating that this work will continue as restrictions ease.
- There are appropriate processes in place within NHS Tayside for the disposal of controlled drugs, witnessed by pharmacy staff or an individual formally authorised by the Controlled Drug Accountable Officer.
- Controlled drug incidents, near misses and/or concerns are reported to the Controlled Drug Team and are reviewed on a daily basis, ensuring that the events have been appropriately investigated, actions and learning identified. The Controlled Drug Team can also provide advice to Services where appropriate. In depth review of incidents has allowed the Controlled Drug Team to identify broader organisational issues which have required changes in systems, policy or procedures; and which have resulted in amendments to the Controlled Drug governance section of the Safe and Secure Handling of Medicines.

Ms Melville offered a ***"Moderate"*** level of assurance from her verbal report: Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence of noncompliance.

**Level of Assurance:**
The Committee accepted that the level of assurance offered from the report was one of "***Moderate"*** as the processes which are in place currently meet the standards expected; incidents are continually reviewed and learning from incidents are shared, and the launch of the updated Controlled Drug section of the Safe and Secure Handling of Medicines will help NHS Tayside towards more consistent and robust handling of controlled drugs across all services.

**The Committee:**
- Considered and accepted the report on the Safe and Effective Management and Use of Controlled Drugs across Tayside.

7.11 **Scottish Public Services Ombudsman (SPSO) Reports**
Ms Hazel Scott, Director of Performance presented the Assurance Report providing an update on the information submitted to the Ombudsman by NHS Tayside and an update on the decisions published during the period May and June 2021.

Ms Scott highlighted:
- Three cases were investigated by the Ombudsman and decision reports published on their findings:
  - o One case upheld (with recommendations)
  - o One case partially upheld (with no recommendations)
  - o One case not upheld.

  Appendix 1 provides a summary of the decision letter findings.
- Appendix 2 provides an update on the actions which were outstanding in respect of cases previously reported to the Committee. All four cases have now been closed by the Ombudsman as recommendations have been met.
- With regard to SPSO Ref 201900199: staff training is ongoing in relation to Interpretation and Translation Policy and effective implementation of same by staff when required. The particular complaint and the learning has been widely shared across clinical services, and with Equality and Diversity Champions to cascade appropriately.

The Chair thanked Ms Scott for the report giving the Committee assurance that the processes in place for reviewing and responding to recommendations made by the Scottish Public Services Ombudsman are effective.

The Chair raised with Ms Scott the change to the report whereby the detail of each case reported by the Ombudsman had been removed and queried the reason for this. Ms Scott advised that the detail previously

**Action**

included within the report had been removed at the request of the Medical Director (Caldecott Guardian for NHS Tayside). The Chair thanked Ms Scott for her response and asked that she raise the level of detail included within the SPSO report with the Medical Director and request that perhaps themes could be provided within the report to give context to the recommendations. HS

Ms Scott advised that the level of assurance provided within the report was one of ***"Moderate"***: Adequate framework of key controls with minor weaknesses present, controls are applied frequently but with evidence on noncompliance.

**Level of Assurance**
The Committee accepted that the level of assurance offered from the report was one of "Moderate" as assurance is provided on completion of recommendations, however wider organisational learning from SPSO recommendations remains an area which could be improved.

**The Committee:**
- Considered and accepted the SPSO Report which was provided for assurance and which updated the Committee on the Ombudsman's decision reports for the period May and June 2021.

## 8 ITEMS FOR DECISION

### 8.1 Care Governance Committee Annual Report 2020/2021

Professor Stonebridge presented the Annual Report for approval to the Committee highlighting:
- The dissolution of the Clinical Quality Forum in November 2021 had led to leaner processes of clinical and care governance and risk management processes.
- The Clinical Governance Strategy is a key aspect of the delivery of safe and effective clinical care, and while this has been suspended in part during the COVID-19 pandemic clinical governance activity has continued in relation to adverse event and risk management.
- The appointment of the Associate Medical Director for Patient Safety, Clinical Governance and Risk Management will support the clinical teams to prioritise clinical governance issues.
- The reporting of the Health and Social Care Partnerships directly in to the Care Governance Committee has provided more assurance to the Committee and, through the Chair's Assurance Reports, Tayside NHS Board. The evidence provided within the reports in support of the assurance offered continues to improve and evolve.
- Equality and diversity is central to our activities as a healthcare organisation, and the appointment of an Associate Medical Director for Workforce who will be a central lead for diversity will focus our thinking in this area.

The Chair thanked Professor Stonebridge for bringing the Annual Report to the Committee, acknowledging that the document had been circulated for comment to Committee members and feedback incorporated as

appropriate.

The Committee considered the Care Governance Committee Annual Report 2020/2021 and were satisfied that the Committee had fulfilled its remit as detailed within NHS Tayside's Code of Corporate Governance. The Annual Report was proposed for approval by Mrs Kilpatrick, Vice Chair, Care Governance Committee and seconded by Dr Pratt, Non-Executive Member, Tayside NHS Board.

**Level of Assurance:**
The Care Governance Committee recorded a level of Comprehensive Assurance in relation to the Care Governance Committee Annual Report 2020/2021.

**The Committee**

- Considered and approved the Care Governance Committee Annual Report 2020/2021.

8.2 **Clinical Policy Governance Group Report**

Mr Charles Sinclair, Associate Nurse Director/Co-Chair Clinical Policy Governance Group presented the report to the Committee advising:

- Two development sessions had been held for Group members who may provide support where required to authors in the updating or writing of new policies for NHS Tayside. These sessions were well attended and received.
- The group had met for the second time on 30 June 2021 at which time it had approved one policy, which was presented to the Care Governance Committee for adoption:
  - Disposal of fetal remains less than 24 weeks gestation.

The Chair thanked Mr Sinclair for his concise update, indicating that the updated policy had been circulated for members review prior to the meeting.

**The Committee:**

- Approved for adoption the policy which had been submitted by the Clinical Policy Governance Group:
  - Disposal of fetal remains less than 24 weeks gestation.

8.3 **Duty of Candour Annual Report**

Mrs Campbell presented the third Duty of Candour Annual Report for approval by the Committee.

Mrs Campbell highlighted:

- The Annual Report, covering the period of 1 April 2020 to 31 March 2021, provides detail on the adverse events (15) which occurred within NHS Tayside that triggered the duty of candour process.
- The focus on the duty of candour process is not singularly the reporting of events, but is around the lessons learned from events and how these can be shared across all services within the organisation.

The Chair thanked Mrs Campbell for presenting the Annual Report to the Committee for approval and thereafter for publication.

The Chair noted the information contained within the report demonstrating the number of patient/relevant person accepting/declining a copy of the final review report, and queried whether there was any explanation of why they declined. Mrs Campbell advised that the Service complete entry into the Datix system and would evidence why the patient/relevant person does not wish to receive a copy of the final review report and it was agreed that this information will be provided in future annual reports to the Committee. DC

Mrs Buchanan, Non-Executive Member proposed the Duty of Candour Annual Report for approval, and this was seconded by Mrs Kilpatrick, Vice Chair, Care Governance Committee.

**The Committee:**

- The Committee approved the Duty of Candour Annual Report for publication.

## 9 ITEMS FOR AWARENESS

### 9.1 Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill Update Report

Mrs Jillian Galloway, Head of Health and Community Care Services and Mrs Angela Cunningham, Justice Healthcare Manager presented the report to the Committee for awareness and assurance on the implementation of the Forensic Medical Services (Victims of Sexual Assault) (Scotland) Act. The Act provides the legalisation to support the improvements to the forensic medical service and implementation of a self-referral service across Scotland so that an individual can access healthcare and request forensic medical services without having to make a report to Police Scotland. Currently, NHS Tayside provides this Service on behalf of Police Scotland, the change will lead to this Service now becoming a responsibility of NHS Tayside. Implementation date of April 2022.

The report gave a progress update on the Health Board Readiness Assessment, which outlines the actions to implement the self-referral service and identifies any further work to be undertaken prior to “going live”. The Committee was assured that Tayside NHS Board are in a good position, and any delays that are affecting implementation are those that are occurring nationally (example; access to services within NHS24).

Once these delays are resolved Tayside NHS Board will work to implement services locally. Whilst the report was due to be presented for awareness, Mrs Galloway and Mrs Cunningham offered and the Committee accepted **Moderate** assurance on the progress of actions to implement the Forensic Medical Services (Victims of Sexual Assault) (Scotland) Act within Tayside.

**The Committee:**

- Considered the report and noted the progress as evidenced in the implementation plan which had been provided to the Committee for awareness and assurance.

9.2 **Internal Audit Report – T08/21 Internal Control Evaluation 2020/21**

NHS Tayside Internal Control Evaluation 2020/2021 Report No T08/21 was provided to the Committee for awareness, all recommendations contained within the report are contained within Strategic Risk 16 Clinical Governance as mitigating controls.

An update on the outstanding action from ICE Report 2019/20 Action Point 4 Development of Standard Operating Procedure for External Inspection Visits had been received from Ms Dunning, Board Secretary: Internal Audit advised on 23 June 2021 that as NHS Scotland was on an emergency footing until at least 30 September 2021, this action had a revised completion date of 31 March 2022.

**The Committee:**

- Received and noted the NHS Tayside Internal Control Evaluation 2020/2021 Report No T08/21 which had been provided for awareness.

**Items for Noting**

9.3-9.6 **The Committee:**

- Care Governance Committee members noted the previously circulated minutes from the following meetings:
  - Area Drug and Therapeutics Committee Minute 22 April 2021 (approved)
  - Public Protection Executive Group Minute 2 June 2021 (approved)
  - Spiritual Healthcare Committee Minute 8 June 2021 (unapproved)
  - Equality and Diversity Governance Group Minute 13 May 2021 (unapproved)

10 **RESERVED BUSINESS**

The Committee moved into Reserved Business at 1320 hours.

10.1 **Minutes: Care Governance Committee Reserved Business 3 June 2021**

The Minutes of the Care Governance Committee Reserved Business 3 June 2021 were approved, proposed by Mrs A Buchanan, Non-Executive Member, Tayside NHS Board and seconded by Mrs P Kilpatrick, Vice Chair, Care Governance Committee.

**The Committee:**

- Approved the Minutes of the Care Governance Committee Open Business 3 June 2021.

10.2 **Action Points Update**

**Action**

**The Committee:**

- Noted the Action Points Update where all actions were complete.

11 **DATE OF NEXT MEETING**

The next meeting will take place at 1000 hours on 7 October 2021, and will be undertaken through MS Teams.

Subject to any amendments recorded in the Minute of the subsequent meeting of the Committee, the foregoing Minute is a correct record of the business proceedings of the meeting of Tayside NHS Board Care Governance Committee held on 5 August 2021, and approved by the Committee at its meeting held on 7 October 2021.

7 October 2021

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CHAIR DATE