APPROVED

Minute of the **Virtual** Meeting of **NHS Grampian Clinical Governance Committee to Grampian NHS Board** on
Friday 20 August 2021 at 10.00 am

Present:	Dr John Tomlinson (Chair)	Non-Executive Board Member
	Amy Anderson (AA)	Non-Executive Board Member
	Prof. Siladitya Bhattacharya (SB)	Non-Executive Board Member
	Dr June Brown (JB)	Director of Nursing - HSCPs
	Prof. Susan Carr (SC)	Director of AHPs and Public Protection
	Kim Cruttenden (KC)	Non-Executive Board Member
	Noha el Sakka (NeS)	Clinical Lead - IPC
	Dr Janet Fitton (JF)	Clinical Governance Lead – Aberdeenshire CHP
	Prof. Nick Fluck (NF)	Medical Director
	Jenny Ingram (JI)	Associate Director - QIA
	Grace Johnston (GJ)	Interim IPC Manager
	Dr Malcolm Metcalfe (MM)	Deputy Medical Director
	Cllr Shona Morrison (SM)	Non-Executive Board Member
	Miles Paterson (MP)	Public Representative
	Siddharth Rananaware (SR)	Public Representative
	Cllr Dennis Robertson (DR)	Non-Executive Board Member
Invitees:	Paul Bachoo (PB)	Medical Director - Acute
	Katie Colville (KC)	Consultant Midwife
	Tara Fairley (TF)	Consultant Obstetrician
	Arlene Forbes	Quality Improvement and Assurance Administrator (Minutes)
	Laura Gunn	Quality Improvement and Assurance Administrator (Minutes)
	Chris Littlejohn (CL)	Deputy Director of Public Health
	Jenny McNicol (JMcN)	Acute Director - Nursing and Midwifery
	Lesley Roberts (LR)	Safer Workplace Manager
	Janice Rollo (JR)	Quality Improvement and Assurance Advisor

Item **Welcome and Apologies:**

1 The Chair welcomed members and attendees to the meeting. The Chair extended a warm welcome to 2 new Public Representatives appointed to the Committee, Miles Paterson and Siddharth Rananaware. Apologies were received from: Simon Bokor-Ingram, Prof. Caroline Hiscox and Dr Shonagh Walker.

The Chair acknowledged the pressures on the System and put forward the thanks of the Committee for the range of papers brought and responses to requests for information in order for the Committee to provide assurance in times of acute pressure. Thanks to paper Authors and requested thanks relayed to their Team members.

2 **Minute of meeting held on 14 May 2021:** This minute was approved as an accurate record.

3 **Matters Arising and Action Log**:

Agreed, items covered in current agenda and future meetings.

Public Representatives – Item to remain for the ongoing work exploring a pool of representatives. Two newly appointed Public Representative are supportive of this.

4 **4. 1 Dr Gray's Maternity Services – External Review Update**
Jenny McNicol, Acute Director Nursing and Midwifery, provided an update on the external review.

The expectation was for external review report (to Scottish Government) to be published at the end of September. Of note, this was the current status of external review and there had been full engagement from Staff of NHS Grampian and NHS Highland and further with public engagement.

Chair thanked J McN for the update provided on the external review. NF advised facilitation of submission information to Chair and Chair can initiate further dissemination as appropriate, with option available for Non-Executives.

Action: Lead NF – Dissemination of External Review Submission.

The Chair thanked JMcN for the update and noted the position, timeline of the review and the Item of DGH Maternity Services External Review would be raised at November meeting with NHSG Board alignment.

4.2 DGH Report
Tara Fairley, Consultant Obstetrician, provided an overview of the report.

Up to date Terms of Reference will be circulated to the Committee.

In response to Prof. Siladitya Bhattacharya, KC advised in terms of the Grampian and Highland Collaboration a recommendation being developed was that all intrapartum transfers would go to Raigmore. This work stream being worked through currently. However, of note both physical and staff capacity at Raigmore had made this challenging for their Service currently. To mitigate the risk, second stage transfers would go to Raigmore and first stage transfers to AMH (unless there is a degree of maternal or foetal urgency).

Chair noted the timings, agreements with Highland are implemented within 1 year and enquired of current plan in relation to starting date. In response JMcN advised the timeline of 1 year exists however, aiming for sooner than the 1 year timeframe. Reliant on NHS Highland and the positive work undertaking jointly through collaboration. A meeting on 30th August would take place to ascertain current position of work streams. **An update on timelines would be provided at next Committee meeting. Chair noted this would be beneficial along with External Review information.** JMcN advised for both NHS Grampian and NHS Highland a clear destination point would give clarity and direction. NHS Highland working on a business case which requires certainty on Service Model Delivery. Dennis Robertson noted the positive aspects of Collaboration due to endeavours of those involved and enquired of pressures on Scottish Ambulance Service in terms of co-ordination, as to whether they are going to Raigmore or Aberdeen, logistical problems. JMcN advised the Ambulance Service are included in work streams and Collaborative, taking account of their view points.

The Committee noted and supported the ongoing work and with noted thanks to the Management and Teams involved.

5 **Response, Recovery, Remobilisation and Renewal**
5.1 Response and 5.1.2 Unscheduled Care Update
Prof. Nick Fluck reflected on transition from Operation Rainbow to Snowdrop and structuring the Agenda around the Remobilisation Plan.

Operational Workbook focused around 2 objectives and commenced on 1st July 2021 and had run for a period of approx. 6 weeks. Formally stepping out of this on 16th August 2021 to a more standard operating process. Hence the Operational Workbook in a sense historical but provides information and documentation of the processes undertaken. Moving forward from this process (whilst facing the same issues experienced) necessary to move to a footing of normal business approach. Frequently, known to have experienced “black” alert status in terms of acute hospital led to setting up an extensive collaborative across the System to rewrite a normal Operational Pressure Escalation System which sets out the actions we would take to growing pressure from each part of the System.

Further, regarding ambulance congestion a number of actions were taken. Firstly, joint case reviews with Ambulance Service undertaken for individual cases where there were concerns of

delay in turnaround for ambulance crew that led to an event in the community. **Review work underway and would be brought to Committee on completion.** Secondly, working collaboratively with Ambulance Service on the developing Operational Pressure Escalation System and how the Ambulance Service's Escalation System (when they reach thresholds of critical service delivery) aligns and a conclusion should be reached in the coming weeks. Thirdly, improvement plans developed on reducing ambulance congestion.

NF requested JI to provide update on G-OPES. There are 4 levels of G-OPES (escalation), with identifiable thresholds for each area and actions to be taken. Recent discussions have been held with Health and Social Care Partnerships, due to cross System thresholds and similarities.

Chair thanked NF and JI for the overview. Chair enquired of NF to comment on National picture, based on NHS Grampian comparison. NF advised on broad terms the pressures are being recognised in every part of Scotland. In specific terms, ambulance delays in 5 larger Boards, an endemic issue and all challenged with issue.

Amy Anderson, thanked for helpful update and enquired of Government view and in absence of Prof. Hiscox, NF advised member in a Group representing NHS Grampian who met with Cabinet Secretary found this helpful with candid discussions on the pressures the Systems are under, this was well received and given positive support.

Dennis Robertson enquired of core capacity and pressures further being related to staffing issues and recruitment. NF noted workforce is a primary driver for capacity, further structural capacity related to COVID measures and infrastructure across Scotland, some of which unable to "turn back on".

JI referenced escalation system related to Unscheduled Care Plan, two areas of work ongoing. First area working with Ambulance Service on pressures and, second adopting a 90-day plan, improvement methodology cycle, with clinical leads from Primary Care, Secondary Care, NHSG and Ambulance Service. In reference to DR's question, transport is included which should relieve pressure on ambulance staff. To note, work ongoing.

Chair thanked NF and JI for updates. **Chair noted practical plan of action and on basis of updates from NF and JI, Committee assured of the agile approach, plans and processes being put in place and taken forward.**

5.1.3 Safer Workplaces

June Brown, Director of Nursing, thanked Chair and Committee for opportunity to provide update on activity undertaken in relation to ensuring we have safe workplaces within NHSG.

JB advised the work had been developed as part of programme model at beginning of pandemic and work underway to ensure we have continuing robust programme working with IPC, Health and Safety, Occupational Health Services to ensure this is embedded moving forward. JB introduced Lesley Roberts, Safer Workplace Programme Manager, to provide an assurance update and also for the Committee to consider this alongside the Infection Prevention Control update to follow and the number of nosocomial COVID third wave outbreaks. JB noted the Safer Workplaces Programme had contributed to the reduction of outbreaks. Further Committee to note, the HIS inspection of March 2021 and Action Plan which followed completed and returned to HIS.

Lesley Roberts presented The Grampian Safer Workplaces Update.

Dennis Robertson thanked the Team for their extensive work. DR enquired of staff behaviour in non-patient areas and in response JB advised from a health protection test and protect perspective it was noted nosocomial outbreaks would likely arise from these environments and would suggest behaviour relaxed, however there has been very low nosocomial outbreaks since start of third wave.

Amy Anderson thanked the work of the Team and admired the Kind to Remind initiative which is about encouragement and working with people. Referenced capacity, system and team pressures and enquired if the Safer Workplace Teams were supported in their role of embedding measures

and further noted potential disproportionate rules for non-clinical settings around FRSM use and staff fatigue in following stringent measures for the environment they are in. In response LR advised overall stringent measures had been encouraged in the correct approach to ensure guidance followed. A value based training approach. The COVID brief had been instrumental in keeping staff aware of current guidance. JB in response to disproportionate measures advised following evidence based current guidance from Scottish Government. AA advised for clarity this was not a personal viewpoint of stringent measures.

Chair provided an update of background to Safer Workplaces Programme to new Public Representatives.

Recommendation: The Clinical Governance Committee asked to note the progress update. Chair further recommended Committee's assurance of robust processes in place.

The Committee noted and supported the ongoing work, assurance of processes and with noted thanks to the Management and Teams involved.

5.2 Response, Recovery, Remobilisation and Renewal
5.2.1 Critical and Protected Services and 5.2.2 Cancer Services
Paul Bachoo. Medical Director – Acute, presented:
PB noted thanks to Teams for producing comprehensive papers, including special thanks to The Cancer Performance Team. Noted specific paper on access to theatre and theatre cancellations would be brought to subsequent meeting.

Of note period covers January to June 2021. The papers brought pertain to performance, current issues, challenges, risks, actions and action tracker. Data utilised comes from number of sources, local Grampian data, NCA, meetings, Medical Directors and territorial Board Directors.

Cancer Oversight Report
Cancer Performance Jan 21 – Jun 21 – Overall Grampian Performance, comparative with North Cancer Alliance (Highland and Tayside) and Scottish running average, 2 major performance index markers.

31-day performance measure is stable on positive trajectory, comparisons marginal.
62-day performance measure compares less favourably with others in the region and nationally.

Backlog January 20 – Jun 21:
The graph demonstrates cancer performance, protected services, unscheduled care, all interrelated. From March to December 2020, generally improving however as pressure rises in System (through whichever surge is driving the pressure) cancer performance and treatment backlog responds very rapidly. This suggests resilience, flexibility and the ability to continue delivering performance is compromised.

NHSG Cancer Oversight:
Issues with surgical capacity and the baseline for capacity and workforce, support services are potentially not set at the appropriate levels with the appropriate confidence. Systemic anti-cancer therapy system had been challenged recently with a loss of workforce. There is an action that maintains the business, maintains the performance and this may become preferred model going forward. Pathology Services vital in Cancer for precision medicine and selecting patients appropriately for correct levels and types of intervention. Noted ability to maintain and increase pathology services currently through various additional waiting lists and utilisation of independent sector.

Further challenges in workforce and radiology, and how we address to prioritise and by utilising independent sector. Endoscopy is an area where funding approved for increasing service through independent sector. Workforce issues in Breast Services partially resolved. Colorectal and Urology Cancer, in 62-day measure, requires attention and change.

NHSG Ovarian Action Plan:
Noted key actions undertaken this year around moving this Service which is part of regional complex surgical services hosted in NHSG. A number of risks identified and recommendations in place and occurring to demonstrate improved outputs moving forward.

Recommendation to Clinical Governance Committee:
Of note, 31 day cancer performance remains consistently improved and approaching national averages. 62 day performance is area where significant work being undertaken in Grampian, across region and in collaboration with Scottish Government Cancer Teams.

The Clinical Governance Committee is asked to note the work and support the actions plans. Further update would be presented at Clinical Governance Committee to update progress and advise progress of action plans for the 31 day performance- Theatre access and 62 day performance-action plans.

Prof. Bhattacharya noted current status and enquired of next 6-12 month anticipations taking in to account measures being taken to mitigate challenges. In response PB advised performance related to standardising pathways and acceptable practices would be in place, work underway. Greater standardisation of how we initiate cancer pathways for this particular group and work being undertaken with South and West, would assist. The recruitment of staff in key areas, vital to avoid bottleneck, is an area which would help with the 62-day pathway. The approach with Portfolio system and working alongside other Portfolios would help to focus on where key areas are which each Portfolio contributes to. The relationship developed with Scottish Government and their support and understanding allows carrying out transformational work. An important effect would come from the review on utilising current resources in theatre, improving steps around pre-operative assessment, day of admission surgery unit. Ensuring processes linked to one another, currently patients could be on an operation pathway but not ready for surgery. Integration of those steps, key parts are of focus. Prof. SB in reference to harmonising pathways noted importance of this harmonisation and integration, not addressing surgery in isolation, combined pathway.

Kim Cruttenden enquired of staffing in Cancer Services. In response PB advised current mitigation ensures there are no delays in chemotherapy prior and post-surgery, or as a primary intervention. JB advised that from recruitment perspective undergraduates come out of University once a year and on completion of their programmes shortly would be available for employment. For assurance NHSG continue to utilise agency and bank to support areas as required. Bank staff had been requested where appropriate to uptake fixed term roles in a substantive way. In response to KC advised the vacancy number is not pertinent to this particular area and pockets of vacancies occur across the System.

Amy Anderson noted the Ovarian Cancer Report states the regional approach brings governance and accountability challenges and enquired how difficulties were being overcome to improve outcomes for women in the North. PB advised a number of activities being undertaken at different levels, CET level, territorial Board Medical Directors and North Cancer Alliance. Malcolm Metcalfe brings level of independent scrutiny to the Pathway from 3 Health Boards that come together at the pre-operative level.

PB noted in response to Siddharth Rananaware that exit interviews are standard practice for understanding and learning opportunities.

Dennis Robertson enquired of succession planning / programme at Consultant level and PB advised as an Organisation becoming better at succession planning. NF noted there is good work in succession planning however wider challenges.

The Chair and Committee noted the work and supported the action plans, seek further update/reporting, for assurance at next Committee meeting as Committee seeking appropriate focus and attention on matters. DR further recognition given to pressures in System.

Chair referenced Audit Report on theatre utilisation and be raised on the action log.

6 **6. 1 Clinical Quality & Safety Subgroup**

Jenny Ingram, Associate Director, Quality Improvement and Assurance, presented report:

Performance and Assurance

JI advised of a meeting with Healthcare Improvement Scotland to review the first year of national reporting of Level 1 Category 1 Adverse Events. Discussions were supportive acknowledging introduction of the structure during pandemic was challenging and worthy to note first year of observations had highlighted variations between Boards in determining definitions for what constitutes a Level 1 Adverse Event. Working with HIS and other Boards through a National Network to ascertain consistency in approach/definitions with a SLWG working on reporting outcomes codes and updated NHSG template. Training package for adverse events in final trial and takes form of standalone modules. The subgroup continue to finalise the template which is currently Acute focused and the HSCPs and MHLDS continue with template development however of note, outcomes are available for current reporting purposes. Further addressing consistency in involving family's and patients from initial contact through to advising of any actions and outcomes. Acknowledgement that benchmarks (level 1 review commissioned within 10 days) may be set differently and potentially a difficult timescale for certain family circumstances. Aligned with Duty of Candour legislation which frames what families want out of reviews.

Improvement

Annual Quality and Safety in Healthcare Event (Be Civil, Be Safe) to be held on 26th October 2021. The call for poster abstracts had been issued with responses currently being received.
The Scottish Patient Safety Programme relaunched next phase of Acute Adult collaborative, commencing September 2021.

Risk Management

CET sessions held for critical thinking of BOWTIE methodology. Viewed BOWTIE methodology from a strategic level to provide assurance, and clinical governance committee assurance, which highlighted threat prevention through mitigation and barriers. Threat prevention categorised, National, Operational and Governance (oversight groups).

Progress on BOWTIE methodology shared with CET and Risk Report (from Illuminate, DATIX) which demonstrates the impact of risk across System which could lead to "harm or injury". Further sessions would be held with CET to develop organisational level risks and BOWTIES which are of high level and review to be brought to Board Seminar in October 2021. Subgroup developing Risk Management Plan.

Janet Fitton enquired of independent contractor threat and does threat/risk belong to IJB's who are generally providers of Primary Care. Longer term how risks are distributed between layers of clinical governance system as responsibility may sit with IJB Clinical Governance Committees rather than an overall System Risk however, recognises need for integrated system for awareness of risks being managed in System. JI advised in terms of terminology consideration given to Threat becoming Cause and consequently Cause, Effect and Consequence terminology. NF advised work from Quality and Safety Group to have a System focus and BOWTIE methodology at system level provides a description of how we have set our system up to become aware of uncertainty and risk in Organisation further to reliably deal with it. This provides assurance of gaps and how we deal with problems across all organisations including independent contractors, IJB's and the Health Board.

Amy Anderson noted "Threats" framed as very specific, acute based and enquired of bigger picture. Further the language appeared counter intuitive to culture we would like to encourage and how the methodology would be shared with staff. JI thanked AA for the comments on terminology and consideration would be given to Cause, Event and Consequence. So far the discussions in clinical groups had not detected any antipathy around language. However, would not want the language to be a barrier and would be reflected upon.

The Chair advised that they further Chair the Risk Audit and Performance Committee for City IJB and noted ownership important and recognising interface between different bodies and currently not entirely clear however noted developments in this area. Highlighted discussions that should be held at seminar to clarify how we work across the different bodies of the System and

acknowledging where accountability sits. The role of this Committee is to be assured that systems in place and accountability exercised and Quality and Safety system-wide processes "pulls" issues out. In reference to language a briefing and engagement of terminology required.

Dennis Robertson welcomed the BOWTIE approach and its development as a standardised approach through to potentially including primary care settings.

Feedback and Complaints
Discussion at the Clinical Governance Committee meeting in May wished to consider the summary data from CRM differently, particularly in relation to performance, assurance, improvement and risk. Summarised the data in a different way in current report to ascertain usefulness of data.

Of concern the number of open complaints were increasing along with the percentage of overdues. For last Quarter at pre-pandemic levels of complaints within the System. Capacity is challenged and level of complaints returned to normal. Work developing with Engagement and Participation Committee to address non-clinical aspects of complaints such as accessing information, etc.

Janet Fitton responded to number of open HMP complaints advising these sit with Aberdeenshire HSCP and to note complaints are of a different level and Prison relatively new to DATIX. Aberdeenshire HSCP aware and working with Prison Teams to achieve better system and processes to resolve.

Dennis Russell welcomes new way of reporting and presentation format gives clarity required.

For the next Clinical Governance Committee it is proposed to focus in detail on adverse events in relation to: Level 1 Reviews including those that are overdue, outcomes from the reviews and learning. Reported staffing events where fundamentals of care are documented as being delayed or compromised. Supported by Committee.

Recommendation: The Clinical Governance Committee is requested to support the approach to risk management being taken to strengthen the clinical and care quality and safety profile and the proposal to provide a more detailed focus of specific metrics from the weekly CRM in rotation at each Committee meeting. Supported by Committee.

6.1.1 Public Health Reports
Chris Littlejohn, Deputy Director Public Health presented reports.

Update on No Cervix Exclusion Incident.
Recommendation: The Clinical Governance Committee asked to note the update. This incident is ongoing and continuing to work with the National Cervical Screening Programme to implement the nationally coordinated response locally. Approved.

Cervical Screening Uptake
The uptake rates dropped during the pandemic year and mirrored trend across Scotland. Expectation that rates would increase with remobilisation of services. Nationally, reviewing a new way of undertaking cervical cancer screening utilising molecular testing for the causal virus.
Recommendation: The Clinical Governance Committee requested to note the update on cervical screening uptake rates and potential future work on self-sampling. Approved.

Test and Protect
Noted ongoing provision of integrated system and resources. Key issue highlighted, uptake of asymptomatic LFD testing by NHS Grampian. Issues with reporting statistics, key denominator and the way the denominator is calculated across Boards in Scotland, for comparison purposes. Understanding in NHSG the denominator is the overall workforce number however, question arisen on appropriateness of denominator. Further question of awareness of need to record negative LFDT result. Consequently, the actual rate may be higher due to staff not recording negative result.

Contact Tracing
Of note, as restrictions ease across the population the role of contact tracing becomes more complex. The rules in relation to isolation depends on many factors. Complex matrix of possibilities that contact tracers work through with members of the public identified as a case, or contact. 37 contact tracers recruited recently and maintaining requisite number required on shift. June Brown noted PCR testing process continues for staff working in care of elderly, cancer services and MHLDS. Response rates are sent to the Government on a weekly basis and staff engagement remains high. **Chair requested PCR testing be included in future reporting. Chair enquired that appropriate actions are taken for positive results and CL advised there is robust response/processes in place.**

Recommendation: The Committee is requested to note the ongoing work of Test and Protect to deliver against the Test & Protect strategy. The Committee is asked to note the key risks highlighted within this report and the associated mitigating actions. **Approved and assured**.

Vaccination Programme
Highlighted, question raised at previous Committee meeting on vaccination rates in care home sector and the significant logistical effort of winter flu planning with preparatory work of expected COVID Booster vaccination.

With regard to winter flu planning, awaiting JCVI guidance on COVID boosters. To assure Committee detailed arrangements are underway.

In response to Kim Cruttenden, CL clarified that identified for first vaccination as care home staff, may not be the totality of care home staff as some vaccinated may not have been identified as care home staff on system, potentially identified in another category, for e.g. age cohort, social care staff. The grounds for this narrative is based on the group of care home staff identified in first vaccination round some 25% were subsequently identified as healthcare staff at second vaccination. There is the possibility that those care home staff had left their care home job and taken up employment in healthcare in period of time between two vaccinations however the high percentage would be unusual. Could potentially suggest incorrect recording in System that some of those at 2nd vaccination were care home staff. Highlighted an electronic data system established and utilised by Users without clear instruction from outset of what the accuracy, importance of data entry should be. **KC enquired of solution identified for process moving towards Booster Programme, etc. CL would raise this as the data from the system requires to be viable. Chair advised links to accountability e.g. Care Homes with IJB and receiving assurance.**

Dennis Robertson commented that the data potentially demonstrates a significant number of people in the care home sector were vaccinated. Important to note, that people were redeployed from other sectors to care homes. Can assurance be taken from the overall percentage of people vaccinated, regardless of status. June Brown agreed with DR on this position. For first tranche of vaccinations in care homes the electronic recording tool was not in place and come laterally for second round. Discrepancies would have existed in recording when the recording tool was not available.

Recommendations: The Committee asked to note the risks presented in paper and continue to support the aims and approach of the Vaccination Programme Board in relation to the delivery of the programme; and note the delivery plan for the forthcoming autumn/ winter programme and the associated risks. Committee noted and supported.

6.1.2 Clinical Governance

CL advised of formation of new Public Health Clinical Governance Group within the Directorate, through which all issues of Clinical Governance would flow.

Amy Anderson noted work developing on relationship between this new Group and other governance structures, including EPC cognisant of their role in assurance for population health in future. Further links to community Public Health teams in HSCPs in their improvement work. CL advised the relationship between new Group and the Directorate's contribution to internal and external partnership governance structures would be developed, noting complexities.

Chair welcomed the formation of this new Group and appreciated context of work being undertaking in a busy and challenging period. Supports assurance. **AA requested an update on progress.**

Recommendations: The Committee is requested to note the ongoing work of the DPH Team and wider Public Health Directorate to address identified weaknesses. The Committee is requested to support the principles of the Directorate's approach to improving our system of clinical governance. Committee noted and supported.

6.2 Healthcare Associated Infection

Noha el Sakka, Clinical Lead IPC presented reports.

To inform the Committee of key HAI issues and actions. Workstreams had progressed well. Noted of report no further areas of concern. Good reviews by Health Protection Scotland and colleagues in other Health Boards who approached NHSG for Lessons Learned based on NHSG metrics on national platforms.

NeS commented on prior discussions relating to nosocomial infections in recent period. Nosocomial infections recorded nationally and Health Protection Scotland provides live data. Graphics demonstrate alignment to various waves of the COVID pandemic.
Due to staffing no national graphical data available from April/May 2021. However, communicated that HAI COVID from April 2021 were 10 cases and 2 clusters. Of note, currently no open clusters on NHSG HAI Dashboard. Continue to investigate any COVID case and open a PAG/IMT for potential cluster incidence. Systems and processes in place and NHSG continually below national levels and we progress in right direction.

June Brown provided rationale for the SABs data in more detail. From Board, two requests further to Clinical Governance Report. One in relation to how data is framed and parameters and control measures in place. JB noted Noha el Sakka and Grace Johnston had clearly summarised in HAIRT Report. It had appeared a fluctuating level in relation to SABs / ECBs, etc. and SBARs clarify for Clinical Governance to provide assurance to Board. Chair thanked for accessible reports.

The Clinical Governance Committee is requested to note that the review had been undertaken and requested to support the actions identified. Committee noted and supported.

Janet Fitton referenced SBAR community acquired ECB, for 1 Qtr period reached level of concern. May be statistical variation. During COVID signposting for management of unscheduled care symptoms published. Offered caution in SBARs to evidence results of findings. NeS commented on utilising "lite surveillance" and required to derive theories and hypothesis to best of knowledge and understanding in order to tackle, address and investigate further when able to do so.

Recommendation: The Committee is requested to note the content of the reports and actions taken. The Committee requested to note the ongoing work around built infrastructure and Board assured of ongoing work. Committee noted and supported.

7 **Committee Constitution Review and Development Session**
Chair thanked Jenny Ingram for drafting paper and setting out proposed agenda with colleagues. The work of the session would require alignment to wider governance review for the NHSG Board. Janet Fitton requested an invitation be extended to Non-Executives of the 3 IJB Clinical Governance Committees.
The Committee approved the paper and agenda for the development session on 7th September 2021.

8 **Reports to Board, would be appropriately selected for Board agenda.**

9 **Date and Time of Next Meeting**
The next meeting will be held on **12 November 2021, 10.00 – 13.00.**
Meeting invites will be sent via MS Teams.