CLINICAL GOVERNANCE COMMITTEE	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Textphone users can contact us via Typetalk: Tel 0800 959598 www.nhshighland.scot.nhs.uk/
DRAFT MINUTE	**1 July 2021 – 9.00am (via MS Teams)**

Present
Dr Gaener Rodger, Non-Executive Board Director and Chair
Elspeth Caithness, Staffside Representative
Robert Donkin, Lay Representative
Graham Hardie, Non-Executive Board Director
Heidi May, Board Nurse Director
Gerard O'Brien, Non-Executive Board Director
Dr Boyd Peters, Medical Director
Emily Woolard, Lay Representative

In attendance
Mary Burnside, Head of Midwifery
Louise Bussell, Chief Officer
Fiona Campbell, Clinical Governance Manager (Argyll and Bute)
Dr Paul Davidson, Associate Medical Director
Carolynn Forsyth, Emergency Practitioner for Accident and Emergency (Item 4)
Fiona Hogg, Director of Human Resources and Organisational Development
Stephanie Govenden, Consultant Community Paediatrician (Children's Services)
Rebecca Helliwell, Associate Medical Director
Brian Mitchell, Board Committee Administrator
Mirian Morrison, Clinical Governance Development Manager
Ian Rudd, Director of Pharmacy
Hazel Smith, Unscheduled Care Project Manager (Item 4)
Leah Smith, Complaints Manager
Simon Steer, Director of Adult Social Care (from 10.20am)
Rashmi Srivastava, Consultant (Obstetrics and Gynaecology) (from 10.20am)
Katherine Sutton, Chief Officer (Acute)
Dr Jenny Wares, Consultant in Public Health Medicine
Claire Wood, Deputy Director of Allied Health Professions

1 WELCOME AND APOLOGIES

Apologies were received from Dr T Allison, A Christie, J Docherty, M Moss, A Palmer and Dr E Watson.

The Chair took the opportunity to welcome Robert Donkin and Emily Woolard to their first meeting of the Committee in their role as Lay Representatives. It was advised they would receive HIS "Voices" training as part of the Induction process. Each were invited to introduce themselves to the Committee and took the opportunity outline a little of their respective background and experience.

1.1 Declarations of Conflict of Interest

There were no Declarations of Interest.

2 MINUTE OF MEETING ON 29 APRIL 2021

The Minute of Meeting held on 29 April 2021 was **Approved,** subject to the inclusion of F Campbell in the List of those Present and an update of the job title for E Higgins .

Associated Actions were then considered as follows:

- **Actions 14, 16, 17 and 23** – Included on agenda. Actions to be closed.
- **Actions 1 and 2** – Actions to remain outstanding.
- **Actions 5, 11, 13, 22, 24 and 25** - The Chair advised she would seek updates in relation to these Items out with the meeting.
- **Action 16** – HSE Report (Raigmore) circulated. Action to be closed.

The Committee otherwise:

- **Approved** the Minute.
- **Noted and/or agreed** the actions, as discussed.
- **Agreed** further discussion on outstanding actions be taken out with the meeting and the relevant Action Plan be updated accordingly prior to the next meeting.

2.1 MATTERS ARISING

- **NHS Highland Remobilisation Plan 2021 Risk Register** – Noting the relevant Risk Register had not been submitted for this meeting, the Chair sought an update on who would provide this. H May undertook to follow up on this matter with EDG.
- **Committee Self Evaluation Exercise Feedback** - The Chair advised a short Committee Development Session would be held, on a date to be confirmed, to consider the relevant feedback received. The exercise would be repeated early in 2022.

The Committee so Noted.

3 PATIENT EXPERIENCE AND FEEDBACK

The Chair introduced the circulated Case Study documents, documenting both positive and negative patient experience, which had been produced by the Clinical Governance Team Complaints Manager who in turn advised as to the history behind bringing these to Committee for shared learning purposes. E Woolard emphasised the importance of being able to consider aspects relating to 'what happened next' in terms of realising positive outcomes, particularly for patients, from relevant Case Study exercises and welcomed the opportunity to participate in this activity. She welcomed the reporting of direct patient feedback. L Smith stated the key outcome aspect for the NHS Board was in relation to whether the initial complaint was upheld or not, and where it was upheld what the learning points were and what action was subsequently taken.

There followed discussion, during which there were a number of calls for increased direct data collection from patients, in addition to the current two yearly Inpatient Surveys and other feedback. M Morrison advised NHS Highland was looking to pilot greater direct patient feedback. It was emphasised that effective management and use of such data would be as important as collection, given the large number of patient contacts across the NHS Highland area even on a daily basis. On the question raised in relation to patient feedback on food in hospital, H May advised NHS Boards were governed by a series of regulations relating to food provision, including the need to be aware of the nutritional content of all meals provided. Nationally, greater consideration was now being given as to introducing a standardised menu across all hospital sites in Scotland.

After discussion, the Committee:

- **Noted** the circulated reports.
- **Agreed** future report iterations include detail on what happened next.
- **Agreed** to inclusion of a future agenda Item on increasing direct patient feedback.

4 HIGHLAND IMPLEMENTATION OF FLOW NAVIGATION CENTRE

P Davidson spoke to the Committee and advised that in December 2020, the Scottish Government had indicated a desire to improve the flow of patients on 'minor' care pathways, and working with others had established the idea of introducing the concept of Flow Navigation Centres within NHS Boards. There had been a soft launch in relation to the same. There had been greater public awareness raising activity of late, of the availability of the relevant 24 hour telephone advice line, which in turn sought to avoid unnecessary Emergency Department admissions, and direct patients to the most appropriate local care route following relevant triage via the local Flow Navigation Centre by a senior decision maker. Provision of advice and support was central to the concept, likewise ensuring the right care was provided in the right place. On the question being raised in relation to associated age thresholds for children, it was advised Child Services had not been included at the launch stage, with that particular element being formally re-assessed. Further information would be provided in due course.

H Smith then gave a short presentation to the Committee on the Urgent Care and the Flow Navigation Centre in Highland (Right Care, Right Place, Right Time – First Time), based on the Covid model which was perceived to have been a success. The aims associated with redesigning Urgent Care were outlined, along with an illustration of the organisational structure introduced in Highland. The Highland Hub was unique in terms of number of NHS Boards, geographical spread, the number of individual sites involved, and the level of strong collaboration required and involved. The Centre went live on 1 December 2020 and additional staff had been employed and trained. The relevant patient pathway was shown. An indication was given as to the benefits accrued by both patients and NHS Highland Services by introducing this approach, and on the point raised it was advised the step change from prior arrangements was the availability of an In Hours service as well as an enhancement of the same Out of Hours. Activity and performance levels to end April 2021 were shown, indicating a steady increase in usage and it was noted that in addition to current local communication activity, national communication activity had begun in late June 2021. It was noted most feedback received had been positive in nature, with patients appreciating the ability to speak direct to a senior clinician although some aspects of the service remaining a work in progress. Positive examples of individual case handling activity to date were provided, illustrating the difference in service provision from that prior to the Flow Navigation Centre being introduced. The question was asked and it was confirmed the service had been introduced within Argyll and Bute, again with a soft launch. Whilst not all associated elements had been fully implemented to date, especially within smaller units and Services, this was close to being completed. In terms of moving forward with the Flow Navigation Centre it was stated this would involve looking to increase relevant uptake through public and staff awareness; stabilise the current structure; and ensure appropriate Clinical Governance consistency. Elements relating to adding further value were also indicated, including increased joint working with Island Boards on Redesigning Urgent Care.

During discussion, the need for patients to repeat their stories to multiple clinicians was raised as a potential issue with this system and in response it was stated if the process worked correctly, with multiple outcomes available, then there would be fewer stages where this would happen as the patient would be referred to the right place more efficiently. In relation to ensuring Senior Decision Makers were in possession of all relevant local service information it was advised this was ensured through a centrally held extensive database, constantly updated at a local level, and available over Microsoft Teams. Decision makers can also make direct contact with local services and clinicians where appropriate. Out of Hours Mental Health support, through the Children's Unit remains in place.

After discussion, the Committee:

- **Noted** the update and presentation content.
- **Noted** a future update on performance would be provided to the Committee in twelve months.

C Forsyth and H Smith left the meeting at 10.20am

5 NHS HIGHLAND INTEGRATED PERFORMANCE REPORT (IPQR)

The Chair advised the circulated report had only been issued the morning of the meeting. M Morrison advised that discussion was underway in relation to revising the current Clinical Governance measures within the IPQR document then took members through performance data relating to Complaints (Stage two - 20 day target) and Freedom of Information requests. Work was ongoing, in association with the Complaints Manager, to develop a plan to improve Complaint performance levels. It was noted that Freedom of Information request performance had improved markedly since being assumed by the Clinical Governance Support Team.

H May took the opportunity to advise, in relation to Tissue Viability activity, current data was being assessed with a view to inclusion within the next iteration of the IPQR. On Falls, there had been contact with NHS Boards by Scottish Government, to advise as to a new Adult Acute Collaborative from 1 September 2021, in line with Scottish Patient Safety Programme activity, and which would involve measures relating to reducing the number of Falls by 20% by September 2023 and reduce Falls with Harm by 30% over the same period. It was anticipated this target may be extended in to Care Homes. Historically, NHS Highland had performed well in relation to Falls prevention activity. There would also be a target in relation to Early Recognition of the Deteriorating Patient and both would be challenging to achieve.

B Peters recognised the need for the IPQR document to be further updated to better reflect the requirements of Governance Committees and others. In relation to activity regarding Falls within Care Homes, he stated it would be of interest to understand the level of input NHS Boards may have in this area moving forward. Any requirement for increased support activity, by NHS Boards would be challenging. At present, NHS Boards had no overarching governance role in relation to private Care Homes. On this point, S Steer confirmed that Care Homes were currently regulated by the Care Inspectorate, with the existing NHS responsibility and input being on an emergency basis only, subject to Temporary Direction by Scottish Government. He emphasised Care Home staff are regulated and subject to Social Care Registration Standards as well as relevant contractual standards where applicable. Current assurance was given through the national Care Home Assurance Group.

The Committee otherwise:

- **Noted** the reported position.
- **Agreed** there were no major areas of concern at this time in relation to Clinical Governance.

6 INFECTION PREVENTION AND CONTROL REPORT

H May spoke to the circulated report which detailed NHS Highland's position against local and national key performance indicators to end March 2021. She advised NHS Highland continued to improve and remained on track to meet relevant targets other than for EColi, despite strong performance in that area. Associated issues relating to hydration in Care Homes were being taken forward and there was strong performance in relation Hand Washing activity. There had been an Unannounced Inspection by Health Improvement Scotland (HIS) on 15 and 16 June 2021, in relation to which Senior Charge Nurses had indicated they had felt well supported through the

process, and on which both the initial and follow up responses had been positive and had resulted in three associated Requirements. These Requirements had related to organisational fabric, appropriate use of PPE, and safe distancing of patients (screens).

During discussion, and on the specific point raised, it was confirmed that there had been cases of Covid having been contracted within an NHS Highland hospital setting. There had been outbreaks within Raigmore and RNI, Inverness.

B Peters emphasised that during the pandemic period many staff members had to quickly learn to become familiar with the correct usage of PPE in relatively short order, many of whom had not been regular users previously, and during a very anxious time overall for staff. There was a recognition that staff providing patient care were exhausted at this time and it was further noted that the impact of Covid continued with regard to effect on available staffing levels. This was an issue being faced by all NHS Boards. Dr Peters, as Board Medical Director, took the opportunity to recognise and pay credit to all relevant NHS Highland staff who had performed both professionally and with extraordinary commitment during the pandemic to date, and continued to do so, as evidenced by the recent positive HIS Report. All agreed, those clinical staff members involved in the Inspection process deserved enormous credit for achieving such a positive result during the most challenging of circumstances.

The Committee:

- **Noted** the update on the current status of Healthcare Associated Infections (HCAI) and Infection Control measures in NHS Highland.
- **Agreed** to circulate the HIS Formal Report, when released into the public domain.

7 HEALTH PROTECTION ACTIVITY

7.1 Covid-19 Update

J Wares gave a brief presentation to members advising as to the current position in terms of the number of confirmed cases in Highland, confirming the recent spike arising from the impact of the Delta variant and noting that approximately 20% of Highland cases having been identified in June 2021 alone. The progression in terms of geographical spread was indicated, with case rates increasing across the entire NHS Board area and becoming much more prevalent in younger age groups than before following the rollout of the vaccination programme. This was particularly noticeable among the young adult male population. Hospitalisation rates across Scotland remained relatively low. In terms of daily activity within the NHS Highland area, there were over 100 cases per day being identified on a consistent basis (apprx.7%), with testing numbers at a high level. In terms of general impact, nine Care Homes were closed to admission and outbreaks were being addressed within a small number of these. Schools, businesses and healthcare services were all being impacted, with most cases identified within schools and hospitality settings. With regard to management of demand there had been number of changes introduced including to the Contact Tracing process and a stepping up of relevant surge capacity. Various awareness raising activities were being undertaken, vaccination rollout continued and NHS Highland sought to influence national decisions where appropriate. B Peters referenced self-isolation as one of a number of critical management tools that had to be maintained despite the difficulty of keeping that message at the forefront of public thinking as lockdown measures were being relaxed. Vigilance was required in order to reduce current case number levels.

H May stated the impact of contract tracing activity and self-isolation requirements on NHS Highland front line staffing levels was becoming more of a significant issue and this was likely to deteriorate before improvement would be evident. Staff with a clinical background, engaged in activity elsewhere at this time such as Contact Tracing, were being remobilised into front line positions where possible. I Rudd advised three Community Pharmacies were currently closed due to staffing issues, with the impact on GP Practices likely to be similar. R Helliwell went on to give

examples of the impact of self-isolation requirements on staffing within Argyll and Bute, with smaller teams taking a significant impact. She stated that Care at Home services in some areas had been severely impacted, with the knock on effect being felt within NHS services and by available NHS staff as a result. It was stated each of the three Covid-19 waves encountered to date had impacted on services in different ways. This wave had generated greater staffing issues. The Chair stated this should be escalated to the NHS Board as an issue of concern. J Wares emphasised that as society opened up the number of people coming into contact with a positive case would increase, placing an increased burden on Contact Tracing Teams as a result. NHS Highland continued to participate in and seek to influence relevant discussion of these issues at a national level.

During discussion, it was stated that any shortage medicines currently being experienced would likely be as a result of increased demand due to Covid-19 rather than the impact of Brexit. It was confirmed that staff testing, to enable return to work was only a pilot scheme at this time. There were no plans to extend Test to Release arrangements at that time. P Davidson paid tribute to the work of those NHS Highland staff and others in ensuring the successful rollout of vaccination activity, noting the very high level of vaccine uptake to date across the area. He emphasised the importance of maintaining existing mitigating strategies. On the issue being raised in relation to local communication, where an outbreak is evident, J Wares confirmed this was undertaken although it was recognised others can also issue their own communication messages, such as local politicians. Feedback was always welcomed. B Peters took the opportunity to advise that local politicians were provided with updates and emphasised the level of personal responsibility people should have to ensure they know what to do in the event of a local outbreak etc. It was acknowledged that local politicians can be seen as the first point of contact for members of the public, even in relation to healthcare matters, and the impact of that had been recognised.

After discussion, the Committee:

- **Noted** the presentation content.
- **Agreed** to extend their thanks to all involved in the vaccination programme rollout.

8 EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

8.1 NHS Highland Response to Ockenden Report

M Burnside spoke to the circulated NHS Highland Gap Analysis against the recommendations contained within the report of the Shrewsbury and Telford Investigation (Ockenden Report), these having been shared with NHS bodies across the UK. She went on to state that in relation to "Hearing the Voice of Women and Families", further work was required to ensure processes for engagement with Service users were in place and appropriate learning was taken and applied. The Highland Maternity Voices Partnership had been launched in April 2021, the membership of which was outlined, with constructive feedback starting to emerge from women and families in relation to the future development of Highland Maternity Services. In relation to the requirement for training to be undertaken on a team basis, it was reported that in Scotland this was the subject of a National Directive and Multi-Disciplinary Training Programme. A number of challenges existed in relation to delivering a training programme over the previous year. A number of improvement initiatives continued to be taken forward, such as the National Maternity Strategy and Best Start and which would seek to address a number of issues raised by the Ockenden Report findings.

The Committee otherwise Noted the circulated gap analysis document.

8.2 Review of Non-Medicine Related Clinical Policy/Guidelines

I Rudd spoke the circulated report and advised the matter had now been satisfactorily resolved.

The Committee so Noted.

9 OPERATIONAL UNIT REPORTS BY EXCEPTION AND EMERGING ISSUES WITH MINUTES FROM PATIENT QUALITY AND SAFETY GROUPS/ARGYLL AND BUTE CLINICAL AND CARE GOVERNANCE GROUP

R Donkin raised the matter of clinical decision making structures and was advised that the key element to ensure was that individuals worked 'within their respective licence' and competency. This applied across all areas and to all levels of clinical operation. This type of question was asked when looking back on an individual incident of care, for whatever reason including formal Reviews.

In relation to revisions to the Quality and Patient Safety structure at Operational level, P Davidson advised that reports had been submitted to the Committee from all relevant areas. Minutes had not been circulated as relevant matters were addressed through the Exception Reports.

9.1 Argyll & Bute Clinical and Care Governance Committee (Health and Social Care) Exception Report

There had been circulated an Argyll and Bute Exception Report providing detail in relation to Significant Events Reviews (including Duty of Candour Adverse Events), Complaints activity, the local Quality and Patient Safety Dashboard, Clinical Risks, Children's Services and issues of concern to escalate and/or best practice to share.

9.2 Highland Health and Social Care Partnership Exception Report

There had been circulated an Exception Report in relation to the Highland Health and Social Care Partnership Area, providing detail in relation to Significant Events Reviews (including Duty of Candour Adverse Events), associated Learning and Improvement activity, Complaints activity, the local Quality and Patient Safety Dashboard, Clinical Risks, Children's Services and issues of concern to escalate and/or best practice to share.

9.3 Raigmore Hospital Exception Report

There had been circulated an Exception Report in relation to Raigmore Hospital, providing detail in relation to Significant Events Reviews (including Duty of Candour Adverse Events), associated Learning and Improvement activity, Complaints activity, the local Quality and Patient Safety Dashboard, Clinical Risks, Children's Services and issues of concern to escalate and/or best practice to share.

9.4 Infants, Children & Young People's Clinical Governance Group

There had been circulated an Exception Report for June 2021 highlighting activity relating to Significant and Initial Case Reviews for Child Protection; Risk Register Items; Complaints, Mortality and HSMR; issues of concern to escalate and/or best practice to share; and other successes or areas of good practice to share.

The Committee Considered the issues identified and received assurance that appropriate action was being taken/ planned.

10 Community and Care Services Update

The Chair advised this was an item that had been included within the Committee work plan with a view to ensuring visibility in relation to matters of a clinical governance nature out with the Acute Services setting (Community and Care services, Primary Care, Mental Health, Adult Social Care etc). She advised that the processes for providing and taking such assurance would continue to

be discussed further with relevant Officers in line with the Committee Terms of Reference. Relevant Clinical Governance risks should be highlighted to this Committee.

P Davidson advised that current Exception Reports for the Highland Health and Social Care Partnership, as submitted under Item 9 on the agenda, already addressed relevant Community aspects. He suggested further discussion as to the associated data elements that could be included within the Integrated Performance and Quality Report, also circulated to the Committee. In response, the Chair advised that overview reports were required, as opposed to the level of detail contained within Exception Reports, enabling the Committee to take assurance in relation to Clinical Governance processes and systems within the Community setting. Reports would relate to Argyll and Bute, North Highland and Social Care areas. P Davidson stated that an overview of the processes and systems in place could be provided to the Committee although questioned the need for regular updates in relation to the same. The Chair agreed.

S Steer emphasised that Social Care Services were not clinical in nature, and were covered by the Social Work (Scotland) Act and overseen by the Chief Social Work Officer for Scotland who was responsible in law for assurance relating to professional practice. NHS Boards had no locus in relation to providing regulation or oversight other than on Infection Prevention and Control matters during the current pandemic period and providing suitable support arrangements. Assurance was currently provided to the Highland Health and Social Care Committee; Care Home and Care at Home Assurance Groups and others including through Highland Council to the Chief Social Work Officer. It was confirmed that should a matter of Clinical concern relating to Social Care arise then this would be reported to the Clinical Governance Committee as and when that arose. The need for wider discussion in relation to Community/Social Care governance systems was accepted. The Chair emphasised the Committee would be seeking reporting by exception only.

G Hardie took the opportunity raise the matter of reporting in relation to Mental Health Services, with particular reference to Argyll and Bute and was advised updates were regularly received in relation to the CAMHS Service. Relevant issues or concerns are raised via Exception Reports. B Peters advised as to a number of the reporting routes at operational level, where relevant issues can be identified and re-emphasised the role of this Committee was to take and provide assurance to the NHS Board that relevant Clinical Governance processes and systems were in place and operating effectively, and appropriate action taken where an issue of concern was identified. The Chair stated if any Committee member felt the need for a specific update on any relevant subject area, this request should be raised with her or the Committee Administrator for consideration.

The Committee:

- **Noted the stated position.**
- **Agreed** a report providing an overview of Clinical Governance processes and systems within North Highland Community be provided to a future meeting.
- **Agreed** there be further discussion out with the meeting in relation to wider Social Care governance processes and systems.

11 NHS BOARD RISK ASURANCE FRAMEWORK – STRATEGIC RISK REGISTER

11.1 Updated Strategic Risk Register

There had been circulated the current Strategic Risk Register document (May 2021), in relation to which B Peters advised this had been refreshed and associated individual Risks amalgamated into Strategic Risks where appropriate, the specific elements relating to which had been delegated to individual Governance Committees in terms of assurance etc.

On a general point, the Chair stated that the format and content of papers received in relation to the identified Strategic Risks on the agenda did not allow the Committee to take relevant assurance and provide recommendations to the NHS Board based on that assurance.

11.2 Strategic Risk 662 – Clinical Strategy and Redesign
Strategic Risk 715 – Public Health (Covid-19 and Influenza)

B Peters advised that interviews for a Head of Strategic Planning and Performance were to take place the following week and stated the successful candidate would have a key role in further developing the Clinical and Care Strategy through appropriate engagement. A one year Strategy Statement had been developed to accompany the NHSH Remobilisation Plan and the final Strategy was expected to in place for 2022. The Chair stated the one year Strategy Statement would expire at the end of the current financial year and as such this continued to be a major Risk area for the NHS Board.

The Chair stated that assurance could be taken in relation to Risk 715 in the absence of a formal update other than that provided in earlier discussion.

After discussion, the Committee Considered the relevant Strategic Risks and:

- **Agreed** limited assurance could be given to the NHS Board in relation to Risk 662, based on the update provided, and the risk of a final Clinical and Care Strategy not being developed before the interim one year Strategy had elapsed.
- **Agreed** the EDG be recommended to review the current Medium Risk level assigned to Risk 662 within the Strategic Risk Register.
- **Agreed** significant assurance could be given to the NHS Board in relation to Risk 715, based on the updates provided in earlier discussion.
- **Agreed** the EDG be recommended to maintain the High Risk level assigned to Risk 715 within the Strategic Risk Register.

11.3 Strategic Risk 877 (Communications and Engagement Strategy)

F Hogg spoke to the circulated report providing an update on the development of a three year Communications and Engagement Strategy and Annual Action Plan in mitigation of the Risk, which was jointly held by this Committee, Staff Governance Committee and Highland Health and Social Care Committee. There had also been circulated an update on development of an Action Plan for 2021/22. Both documents had been included within the circulated report. F Hogg advised that permanent Community Engagement Manager and Engagement Officer positions had recently been appointed to. Consultancy support was being commissioned in relation to taking forward relevant website design activity. Overall, strong progress was being made in relation to mitigation of this Risk across the organisation.

The Committee Considered the relevant Strategic Risk and:

- **Agreed** Significant assurance could be given to the NHS Board, based on the update provided.
- **Agreed** the EDG be recommended to maintain the current level assigned to Risk 877.

11.4 Updated Clinical Governance Committee Risk Register

The Chair referenced discussion at the last meeting and confirmed a revised Committee Risk Register would be submitted to the next meeting for ratification.

B Peters took the opportunity to confirm that the revised QPS structure was being progressed, following recent organisational restructuring, in relation to which recruitment activity was now substantially complete. On the matter of Committee scrutinisation of assurance information, or lack of the same, this would be a Moderate level Risk that the Committee would require to remain sighted upon.

After discussion, the Committee:

- **Noted** the updates provided.
- **Agreed** the Committee Risk Register be included on all future meeting agendas.

12 ADVERSE EVENTS AND SAERS

M Morrison spoke to the circulated report providing an update on performance with managing SAERs within the Acute Services Division, Highland Health and Social Care Partnership, and Argyll and Bute Integrated Joint Board. It was reported there were 45 open SAERs, with 32 exceeding the national completion target of 26 weeks. The NHS Highland SAER performance report for June 2021 was circulated and it was confirmed that a performance report, based on incidents logged on Datix, was issued to each Operational Division on a monthly basis. It was stated that SAER performance, and the management of adverse events, required closer monitoring and action to be taken by each of the operational units to improve performance and ensure that adverse events are reviewed in a timely manner. All cases, especially all those prior to May 2021, required to be reviewed.

R Donkin requested that future reports include a summary overview of the data being presented and further sought an update in relation to the purpose of, and process for SAER Reporting. At the request of the Chair it was agreed both new Lay Representatives be taken through the relevant process out with the Committee, by the Clinical Governance Support Team. The report previously submitted to the Committee in this regard would also be forwarded.

After discussion, the Committee:

- **Noted** the reported position.
- **Agreed** to support the recommendation that each Division submit plans, through QPS Groups to address outstanding SAERs.
- **Agreed** to support the recommendation that all cases waiting review be assessed to ensure the right level of investigation.
- **Agreed** to support the recommendation that all outstanding actions be subject to review.
- **Agreed** each Operational Division submit progress reports to the next Clinical Governance Committee.
- **Agreed** further relevant performance measures be included within the IPQR, subject to agreement by the Board Medical and Nursing Directors, and Clinical Governance Development Manager.
- **Agreed** Lay Representatives be taken through the SAER and wider Clinical Governance processes.

13 AREA DRUGS AND THERAPEUTICS COMMITTEE – SIX MONTHLY UPDATE/ EXCEPTION REPORT

I Rudd introduced the circulated report providing assurance to the Committee that the Area Drugs and Therapeutics Committee and Sub Groups continue to meet to perform their respective functions as measured against their Terms of Reference. The report also highlighted two areas of risk, in relation to the review of the Highland Immunisation Coordinating Group Terms of Reference and designation of a medical lead for Patient Group Directions, setting out how these issues were being addressed.

The Committee:

- **Noted** the report content and took assurance that the ADTC and its Sub groups continue to function in accordance with respective Terms of Reference to deliver medicines governance.
- **Noted** the mitigating actions taken in relation to the issues identified.

14 ANY OTHER COMPETENT BUSINESS

There were no matters raised in relation to this Item.

15 REPORTING TO THE NHS BOARD

The Chair confirmed there would be discussion with the Board Nurse Director in relation to providing the NHS Board with an update in relation to staffing capacity as a result of self-isolation requirements.

Feedback would also be provided in relation to assurance taken in relation to the three Strategic Risks assigned to the Clinical Governance Committee as per earlier discussion.

18 DATES OF FUTURE MEETINGS

Members **Noted** the remaining meeting schedule for 2021 as follows:

2 September
4 November

14 DATE OF NEXT MEETING

The Chair advised members the next meeting would take place on 2 September 2021 at 9.00am.

The meeting closed at 12.40pm