Approved by Committee on 13 January 2025

Healthcare Governance Committee
Monday 4 November 2024 at 9.30am
Hybrid meeting – Meeting Room 1, Eglinton House and MS Teams

Present:

Non-Executives:
Mrs Joyce White (Interim Chair)
Cllr Marie Burns
Mrs Jean Ford
Dr Tom Hopkins
Mr Neil McAleese

Board Advisor/Ex-Officio:
Ms Linda Semple, Interim Board Chair
Ms Claire Burden, Chief Executive – arrived after item 5.1
Mrs Vicki Campbell, Director of Acute Services – arrived after item 5.1
Mrs Lynne McNiven, Director of Public Health
Ms Jennifer Wilson, Nurse Director

In attendance:
Ms Tracy Baillie, Assistant General Manager, Cancer and Diagnostics item 7.1
Ms Bobbie Coughtrie, Screening Improvement Manager items 8.1+8.2
Ms Jincy Jerry, Director of Infection Prevention and Control item 6.1
Ms Sandra Ferrol, Litigation Manager items 6.5 + 6.6
Mr Darren Fullarton, Associate Nurse Director, Lead Nurse NAHSCP items 6.3+9.4
Ms Alison Hanlon, Lead Scientist Blood Transfusion item 8.4
Ms Geraldine Jordan, Director of Clinical and Care Governance
Ms Ros Morrin, Public Health lead for Primary Care Sexual Health item 6.8
Ms Ruth McMurdo, Deputy Nurse Director item 6.2
Ms Jennifer Reid, Senior Programme Manager, Public Health Mass Vaccination item 8.3
Ms Carly Wylie, Public Inquiries Coordinator item 6.7
Mrs Angela O'Mahony, Committee Secretary (minutes)

1. Welcome/Apologies for absence

1.1 The interim Chair, Mrs Joyce White, welcomed everyone to the meeting. The agenda was re-ordered slightly to allow colleagues providing updates to join the meeting.

1.2 Apologies for absence were noted from Dr Crawford McGuffie.

2. Declaration of any Conflicts of Interest

2.1 Dr Tom Hopkins, Non-Executive Board Member, declared an interest in relation to item 6.4, front door overcrowding, in his role as an ED Consultant at University Hospital Crosshouse (UHC) and left the meeting for this item. Mr Neil McAleese, Non-Executive Board Member, declared a connection in relation to item 6.4, front door

overcrowding, as his partner was currently working in ED at University Hospital Ayr (UHA).

3. Draft Minute of the Meeting held on 9 September 2024

3.1 The Minute of the meeting held on 9 September 2024 was approved as an accurate record of the discussion, subject to the following change being made:

Under those present, for Mrs Jean Ford, to remove "attended part of meeting" and replace with "left the meeting after item 8.4".

4. Matters arising

4.1 The action log had previously been circulated to members and the following update was provided:

- **Item 8.4 (09/09/24), East Ayrshire Health and Social Care Partnership (EA HSCP) annual report** - a report was e-mailed to members on 1 November 2024 to update on the Galston Smart Hub as requested. Action complete.

All other items were either on the agenda for this meeting or a submission date had been scheduled for a future meeting.

4.2 The Committee noted the work plan for 2024-2025.

5. Patient Experience

5.1 **Patient Experience themed report – Clinical Treatment**

The Director of Clinical and Care Governance, Ms Geraldine Jordan, presented the second in the 2023/24 series of papers exploring complaint themes. The report provided a detailed analysis of complaints related to all aspects of clinical treatment from 1 April 2023 to 31 March 2024.

During the reporting period there were 1,618 complaints received, with 1,128 classified as stage 1 and 490 Stage 2, an increase of 409 compared to the previous year. Of these totals, 45% of these complaints related to clinical treatment, an increase from 40% in the previous series.

For complaints received by the Health and Social Care Partnerships (HSCPs), EA HSCP received 300 complaints pertaining to prison healthcare, with over 80% of these related to medication and the remainder about access to doctor and/or hospital services. Most complaints were not upheld as appropriate care had been provided.

Ms Jordan provided an update on Mental Health Services (MHS) complaints, with 62 complaints received, up from 60 in the previous series. The most common themes related to MHS had not changed since the last themed series.

The majority of complaints related to Acute services, with a total of 90 stage 2 complaints about clinical treatment and 120 stage 1 in this category. Stage 1 complaints mainly pertained to delays in accessing treatment or receiving diagnostic test results. Stage 2 complaints were multi-faceted and covered a number of issues. The majority of complaints about clinical treatment related to either nursing or medical input with the most common subthemes set out in the report.

The Nurse Director, Ms Jennifer Wilson, reiterated in response to a comment from a member that while the Board understood the themes and issues identified, it was important for the report to clearly outline actions being taken in response and outcomes achieved. She would consider future assurance reporting with the Director of Clinical and Care Governance outside the meeting. **JW/GJ**

Following a request from members, Ms Wilson advised that an assurance report would be provided at a future meeting on improvement actions being taken for complaints related to CAMHS performance, specifically for children and young people without a diagnosed mental health condition who are no longer able to be seen through the CAMHS pathway. **JW/CC**

Committee members discussed the report and commended teams for the good work being done. Members commented that in terms of proportionality, the report should be considered in the context of the wide range of services being delivered by the Board. Ms Jordan confirmed that this would be reflected in future reporting. **GJ**

Outcome: Committee members received the second in a new series of papers exploring complaint themes and sub themes, on the theme of clinical treatment.

6. Patient Safety

6.1 Healthcare Associated Infection (HCAI) report

The Director of Infection Prevention and Control, Ms Jincy Jerry, presented a report on the Board's performance with the HCAI Standards. Members received an update on incidents and outbreaks dealt with during quarter 2 and key learning and actions taken.

Ms Jerry advised that Clostridioides difficile infection (CDI) rates were slightly higher compared to the previous quarter. Staphylococcus aureus bacteraemia (SAB) rates remained above the national target but within the upper threshold. For Escherichia coli bacteraemias (ECB), the community acquired ECB rate was fairly high and the Board was an outlier for the first time. Hospital acquired ECB remained within the confidence interval upper limit. Improvement work taking place to reduce HCAI rates in Ayrshire and Arran was outlined in the report.

Ms Jerry emphasised that HCAI should be seen in the context of the individual involved and everything possible should be done to prevent infections given the negative impact on patients.

The Nurse Director, Ms Jennifer Wilson, recognised the complex infection prevention and control environment facing all Boards. NHSAA was interrogating data, clinical pathways and treatment being provided to see what could be done differently to enable the Board to deliver the best HCAI performance.

Ms Jerry confirmed in reply to questions from members that the Board had raised the need to set realistic and achievable HCAI targets with ARHAI Scotland on multiple occasions. Discussion was ongoing at ARHAI Scotland about HCAI rates for 2024/25 which had not yet been set.

Ms Jerry clarified that the amber HIIAT noted related to a COVID-19 outbreak managed between July to September 2024 which had previously been reported to the Committee.

In response to a question from a member, the Chief Executive advised that she would ask the Director PH to provide an update to the member on local Tuberculosis infection rates outside the meeting. **CB**

The Nurse Director, Ms Jennifer Wilson, noted that a detailed briefing on the recent Aspergillus outbreak in Ward 3A at University Hospital Crosshouse had been circulated to Board Members on 4 November 2024. Healthcare Governance Committee (HGC) members had consistently been updated through routine HCAI reporting and the outbreak had been managed in line with national requirements. Ms Wilson added that risks related to the ageing hospital estate were not new and continued to be managed on an ongoing basis, similar to other Boards with older hospital buildings.

Committee members considered the detailed update provided and thanked the team involved for the actions taken to manage this outbreak. Members agreed that an assurance report on the outbreak be presented at the next meeting, specifically on improvement work related to infection prevention and control and built environment. **JW/JJ**

Outcome: Committee members noted the report on the Board's performance with the HCAI standards. Members noted the update on incidents and outbreaks dealt with during quarter 2 and key learning and actions taken.

Members requested that an assurance update on the Aspergillus outbreak at UHC be provided at the next meeting on 13 January 2025.

6.2 **Acute sites Pressure Ulcer (PU) position report**

The Deputy Nurse Director, Ms Ruth McMurdo, provided a detailed update on PU rates at both hospital sites.

Ms McMurdo advised that UHC continued to have a higher number of PUs than at UHA which had seen a decrease in prevalence. Datix data indicated that the majority of hospital acquired (HA) PUs were grade 2 and that improved PU management could have resulted in a different outcome for half of these cases.

Ms McMurdo outlined the background to the PU prevention work being done through the PU breakthrough series collaborative launched in January 2022. While this work had resulted in some positive outcomes, there were ongoing challenges due to system and workforce pressures. The PU Improvement Nurse (PUIN) for Acute services seconded role had been extended to end March 2025 to support ongoing improvement work. Ms McMurdo emphasised in response to a question from a member that while this role was key in taking forward investigations and identifying areas for improvement, everyone within the team had a role to pay in relation to PU improvement work.

The collaborative had now concluded and a strategic workshop was held in August 2024, with a number of key actions agreed as set out in the report. Focused improvement work was ongoing targeting the top five areas of concern.

The Nurse Director, Ms Jennifer Wilson, highlighted that a review of the Tissue Viability Team had identified a recommendation for training and education at the bedside for teams to enhance knowledge. Another action involved the Lead Nurse for Emergency Care working with Scottish Ambulance Service to ensure base line skin assessment is carried out at handover given the impact of long waits on patient pressure areas.

Committee members sought clarity around the national reference value data provided for UHA in the report. Ms McMurdo would check the position and provide an update outside the meeting. **RMcM**

Ms Wilson advised that to give context the national PU collaborative had ran some years ago and data was now out of date. There had been an increase in PU prevalence across Scotland for a number of reasons, including increased patient frailty and incapacity. A request had been made by all Boards for national support in terms of improvement methodology to support Boards seeing an increase in PU rates which it was suspected may have started in the community. Ms Wilson would keep the Committee updated of progress.

Outcome: Committee members noted the update on PU prevalence and current plans to reduce incidence of PUs within Acute sites.

6.3 **Quality and Safety report – Mental Health Services (MHS)**

The Associate Nurse Director and Lead Nurse, NA HSCP, Mr Darren Fullarton provided an overview of performance and activity and highlighted progress with core measures of the Scottish Patient Safety Programme (SPSP) and Excellence in Care (EiC) in inpatient Mental Health wards.

For SPSP measures, Mr Fullarton highlighted that rates of incidents of physical violence and restraint remained consistent and stable. Rates of self-harm remained consistently low, with a spike in data attributed to a single patient presenting with significant acute MH needs. As members had previously been advised, these rates were not reported nationally and benchmarking was not possible.

NHSAA was leading development of an unscheduled care hub based at Woodland View Hospital. Following pilot work earlier in the year, the hub was launched in September 2024. The Chief Executive recognised that the new hub was an important area of innovation for the Board in avoiding unnecessary ED attendances, with early positive results. She commended the team involved for the work done to establish the hub using existing estate.

Mr Fullarton highlighted that for EiC measures, there had been a sustained reduction in inpatient fall from April 2022 to May 2023 at Ailsa Hospital. In August 2023, there was a patient with complex needs who had multiple falls. Since that time, the QI team had been supporting the ward with focused improvement work. The report outlined MH falls process measure improvement work being done to ensure this aligned to the Mental Health client group. A review of the falls process audit for use in elderly mental health wards would be tested at Ailsa Hospital before being rolled out to other areas.

In regard to Food Fluid and Nutrition, there had been a review of the mealtime coordinator role and a new audit tool had been implemented across all MH inpatient areas and the wider organisation in June 2024. Since implementation data demonstrated overall 100% compliance.

A stress and distress tool was being developed in the specialist dementia unit to ensure all people have this done within 14 days of admission.

For MH quality management practice learning environment (QMPLE), aggregate scores from University of the West of Scotland students during the reporting period were 75-100% based on 27% submission rate, with work planned to increase submission of feedback.

Mr Fullarton advised in reply to questions from members that early work had commenced to understand what work would be required in NHSAA for the next phase of the SPSP MH programme, with no major concerns to highlight at this point.

Outcome: Members received the assurance report on performance and QI activity in terms of Scottish

Patient Safety Programme Mental Health and Excellence in Care programme within NHSAA.

6.4 **Front door overcrowding concerns**

The Director of Acute Services, Mrs Vicki Campbell, provided an assurance report on current performance and ongoing work to support delivery of sustained improvement to prevent front door overcrowding. This followed concerns raised by ED Consultants at both hospital sites on 17 April 2024 regarding ongoing overcrowding issues and their impact.

The report set out focused actions being taken within ED and across the system in response, and early positive impact. Since the report was written, the Board had continued to see weekly improvements in relation to front door congestion and 12 hour delays had decreased significantly from 153 patients in April 2024 to around 50-70 patients in recent months. However, there could be delays and congestion on some days, particularly at weekends, which could impact on weekly figures. The Board was now pushing towards a November reset and early work had recently commenced, with positive results and improved performance last weekend.

Mrs Campbell advised that in terms of wider quality measures, adverse events had reduced slightly since concerns were raised, stage 2 complaints had reduced and staff sickness absence and vacancy rates remained static. In response to comments from ED staff about challenges for new team members, the team had come up with an initiative to create a supernumerary post which was currently out to advert.

Mrs Campbell clarified in reply to questions from members that actions related to cross divisional discharge priorities, specifically HSCP discharge process mapping workshop sessions and six week recovery plans, would take place later this week. Mrs Campbell advised that two workshops had recently taken place with representation from medical and nursing colleagues. An action plan had been developed to be progressed over the next two weeks in relevant ward areas to cohort patients to reduce length of stay and create flow.

Committee members discussed future reporting arrangements. The Nurse Director, Ms Jennifer Wilson, clarified that quality of care measures related to this work will be reported via HGC and performance measures through the Performance Governance Committee. Members agreed that an assurance report on the progress of the SAFER Bundle being implemented to improve flow and reduce decongestion will be provided at the next meeting on 13 January 2025. ***VC***

Outcome: Members received a report on current performance and ongoing work to support delivery of sustained improvement to prevent front door overcrowding. Members looked

forward to receiving a report on the progress of the SAFER Bundle at the next Committee meeting on 13 January 2025.

6.5 **Litigation**

The Litigation Manager, Ms Sandra Ferrol, provided an overview of litigation activity. The report outlined service improvements arising from litigation cases and assurance that these are being progressed through local quality assurance and clinical governance process. The Board had a total of 85 litigation issues currently active, of which 12 were fatal accident inquiries, one of which had recently had a determination published.

Outcome: Committee members noted the report on Litigation activity.

6.6 **Operation Koper**

The Litigation Manager, Ms Sandra Ferrol, provided an update on ongoing investigations of COVID-19 related deaths in care settings and gave assurance that required systems are in place to respond to and comply with Operation Koper.

Committee members thanked Ms Ferrol and wider teams for the difficult and complex work being done in response to these investigations.

Outcome: Committee members received an update on Operation Koper and assurance that required systems are in place with regard to responding to and complying with Operation Koper.

6.7 **COVID-19 Inquiries**

Ms Carly Wylie, Public Inquiries Coordinator, provided an update on COVID-19 Inquiries and assurance that systems and processes are in place to meet the requirements of both national COVID-19 Inquiries.

Members received a detailed update on the UK Inquiry and the progress of the 10 modules. Modules one and two were now complete. Module three, impact of COVID-19 on healthcare systems, being heard was of particular significance to Boards as there may be findings and recommendations that could directly affect Boards. Timelines for the modules were as set out in the report.

The Scottish Inquiry was taking a human factors approach and the Inquiry was concentrating on impact hearing. Health and Social Care Impact Hearing evidence was heard from patients, families, charities and representative groups. Impact Hearings for Education and Young People; and Finance, Business and Welfare would begin on 4 November 2024 and would run through to the end of the year.

Both Inquiries had agreed to minimise duplication.

Ms Wylie outlined the reporting approach being adopted by NHSAA, with quarterly reporting to Corporate Management Team and six monthly updates to HGC and exception reporting as required.

Outcome: Committee members received an update on COVID-19 Inquiries and assurance that required systems and processes are in place to meet requirements of both national COVID-19 Inquiries. Members thanked the coordination/response team as well as wider staff for the work being done to respond to the COVID-19 Inquiries.

6.8 **National Cervical Screening Exclusion audit outcomes**

Dr Ros Morrin, Board Clinical Lead for the national cervical screening exclusion audit provided an update on outcomes of the national cervical screening exclusion audit in NHSAA which was now largely complete.

Dr Morrin set out the background and context to the national audit. NHSAA had reviewed over 10,000 records, with 90% of patients having been correctly excluded from the screening programme. At least 23 women were incorrectly excluded, however, no women reviewed during the audit had required further colposcopy treatment.

The Cervical Screening Management Team was working on proposals to safeguard processes for managing exclusions from the Cervical Screening Programme going forward. This would include failsafe procedures to prevent any further inappropriate exclusions from the programme and ongoing audit of applied exclusions to provide quality assurance. These processes would be informed by national guidance or recommendations following completion of the audit nationally.

Outcome: The Committee noted the outcomes of the national cervical screening exclusion audit in NHSAA. Members thanked teams involved for the significant work done and were assured of the robust process followed and positive outcome achieved.

7. Quality Improvement

7.1 **Cancer Quality Performance Indicators (QPIs) governance**

Ms Tracy Baillie, Assistant General Manager, Cancer and Diagnostics, provided a report on management and governance of cancer QPIs and cancer waiting times performance.

Ms Baillie highlighted that following changes in the management structure over the last year, Cancer Services had moved from Surgical Services to Diagnostics. This positive change had resulted

in a change in meeting structure and reporting processes, as detailed in the report.

Members received assurance of the robust cancer governance arrangements in place locally, at regional West of Scotland and national level. Locally, monthly meetings took place attended by each tumour type lead, following a rolling programme, covering a range of performance areas to enable whole service review. QPI performance data was used for planning patient outcomes and local services. The action plan gave a snapshot of cancer management, with each service responsible for highlighting areas of challenge and supporting improvement work.

Appendix 3 of the report provided the framework for effective cancer management. Ms Baillie provided assurance that while there were considerable challenges related to some tumour types, overall NHSAA's cancer management was good and compared well to the Scottish average.

Ms Baillie advised in response to a question form a member about the summary of current actions per tumour type/service, that the West of Scotland Cancer network audit cycle set a calendar each year for when data was due, with information for each cancer type provided at a different time in the year. Members requested that where available up-to-date data be provided for these actions.

Outcome: Committee members received the report and acknowledged the process behind management and governance of cancer QPIs and cancer waiting times performance. Members acknowledged that NHSAA's cancer management overall was performing well compared to the Scottish average.

7.2 **Scottish Intercollegiate Guidelines Network (SIGN) guidelines report**

The Director of Clinical and Care Governance, Ms Geraldine Jordan, provided an update on progress to implement SIGN guidelines within NHSAA.

Ms Jordan advised that since November 2021 there were on average five guidelines reviewed each year. SIGN had made a commitment last year to a five year plan, with seven guidelines to be reviewed each year which would have an impact on the team's capacity to manage these as they come through the system.

Members received a detailed update on progress with SIGN guidelines. SIGN 146, Cutaneous Melanoma, had been fully implemented. Of the nine guidelines remaining open, two were in the process of identifying a clinical lead. The current implementation status of the remaining seven guidelines was outlined in table 1 of the report.

Ms Jordan highlighted that for SIGN 166, stroke guideline, there were 527 recommendations for Boards which was unprecedented. This guideline had been part-met, with a number of recommendations still outstanding. The Governance team was working with Public Health Department to bring a detailed update on plans related to outstanding recommendations.

For SIGN 169, Perinatal mental health conditions, members received assurance that the maternity aspect had been impact assessed, however, the complexity of this guideline meant that it would need to involve other clinical teams/staff, with plans in place to widen the review group and an assurance update would be provided in a future update report.

Outcome: Committee members noted the report and progress made in the implementation of SIGN guidelines within NHSAA.

8. Annual Assurance Reports

8.1 Breast screening annual report

Ms Bobbie Coughtrie, Screening Improvement and Development Manager, presented the annual report on performance of the Scottish Breast Screening Programme (SBSP) in Ayrshire and Arran.

Uptake of breast screening in Ayrshire and Arran for 2023/24 was 88% which was above the national target of 80%. Overall acceptance of screening had improved when compared to the previous year. The programme had met or exceeded the national minimum standards and national targets for cancer detection rates for invasive cancers, non-invasive cancers and small invasive cancers.

Ms Coughtrie advised that while the service had previously faced challenges in meeting the 36-month screening schedule, improved staffing levels and extended working days had allowed the service to catch up and it was now running ahead of schedule. This had allowed some mammography staff to provide mutual aid to other centres.

Ms Coughtrie set out areas of risk for the screening programme, including ongoing workforce issues and staff shortages, and mitigating actions being taken to address these areas. She reiterated that despite these challenges the programme had continued to exceed national targets.

Pan-Ayrshire work continued to address programme inequalities that prevent eligible people from accessing services. Members received a brief overview of some of the projects being taken forward with the aim to reduce programme inequalities.

Committee members were encouraged by the SBSP programme's

performance in NHSAA and the positive initiatives being progressed to address programme inequalities.

Outcome: Committee members noted the annual report on the successful delivery of the NHSAA Breast Screening Programme 2023/24.

8.2 **Pregnancy and Newborn Screening (PNBS) annual report**

Ms Bobbie Coughtrie, Screening Improvement and Development Manager, Bobbie Coughtrie provided an overview of the delivery of the PNBS programme across NHSAA in 2023/24.

The six programmes that comprise the PNBS programme continued to deliver against an increased number of national key performance indicators (KPIs) introduced in 2019.

In NHSAA there were 2,779 babies born. There were a higher number of bookings than usual due to pregnancies not resulting in birth or transferred out of board. The Board had achieved the essential targets for uptake in all six of the programmes within the PNBS screening programme.

During the reporting period, there was a recognised increase in migration to Ayrshire from out with the United Kingdom (UK) which posed some challenges and increased workload for the Child Health Department in obtaining all screening information, in addition to immunisation histories for families who had migrated into the country.

Ms Coughtrie highlighted areas of challenge identified through the local PNBS programme and mitigating actions being taken, as outlined in the report. Work is planned over the next year to continue to address programme inequalities that prevent eligible people from accessing services.

Outcome: Committee members noted the annual report on delivery of the PNBS programme across NHSAA in 2023/24.

8.3 **Winter Vaccinations Programme update**

Ms Jennifer Reid, Senior Programme Manager, Vaccination, provided an update on the 2024/25 winter vaccinations programme up to 13 October 2024. The programme commenced on 16 September 2024, including the health and social care worker element, with the majority of the programme to be delivered by 8 December 2024.

The report provided detailed information about uptake of COVID-19, Flu and Child Flu vaccinations. NHSAA's average uptake for winter vaccinations was similar to the Scottish average. Uptake among older people and care home residents and health and care workers was higher than the Scottish average for both vaccinations. For

other cohorts, a number of appointments had still to take place and uptake was expected to increase, with details to be include in future reports.

Members were advised that a potential postage issue had been identified as people who would have expected to receive a letter had not. This had been raised with national vaccination scheduling colleagues and the national contact centre. People who did not attend their appointment would be contacted to understand the reason and to offer a future appointment.

NHSAA was above the Scottish average for childhood Flu vaccination. A pilot had taken place in Maybole and Annbank which had increased uptake from 25% to 70%. The pilot would be evaluated and discussed with the HSCPs to see if this was something they would like to explore further.

Ms Reid highlighted the inclusivity work taking place, with a dedicated team supporting work with locality partners to support the travelling community, homeless people and those with addictions to receive vaccination. During 2024/25, a number of community pharmacies had offered to vaccinate homeless people and those with substance misuse issues and uptake information would be provided in future reports.

Outcome: Committee members noted the update on the delivery of the Winter Vaccinations Programme 2024/25.

8.4 **Scottish National Blood Transfusion Service (SNBTS) annual report**

Ms Alison Hanlon, Lead Scientist Blood Transfusion, presented the SNBTS annual report which gave a summary of projects progressed over the year.

Training and education had been taking place to ensure transfusion in hospital was safely delivered according to national regulations and standards.

Governance and regulation for SNBTS was through the Haematology and Transfusion Scotland network, Organ Donation Committee and the UK Accreditation Service (UKAS). The UKAS annual inspection would take place in February 2025 and preparatory work was ongoing.

The report set out areas of challenge facing the team, mitigating actions and future plans.

Ms Hanlon advised in response to a question from a member that the additional blood fridge provided at Arran War Memorial Hospital would provide a back-up as part of cold chain monitoring should there be any issues with the existing blood fridge.

Outcome: Committee members noted the SNBTS annual report and commended the team for the good work done and achievements over the last year.

8.5 **Duty of Candour (DoC) annual report 2023/24 addendum**

The Director of Clinical Care and Governance, Ms Geraldine Jordan, provided an addendum to the DoC annual report to give assurance that all reports were being followed through to conclusion and the Board was meeting it duties in relation to DoC.

The addendum provided data from October 2024 when the number of events where DoC applied increased from 122 to 138. 30 events resulted in the commissioning of a Significant Adverse Event Review and 108 events resulted in the commissioning of a Local Management Team Review. An additional five outstanding incidents were still to be concluded and reviews were underway.

Outcome: Committee members received the addendum to the Duty of Candour annual report which would be published on the Board's public website in line with Scottish Government guidance.

8.6 **Duty of Candour (DoC) retrospective reviews**

The Director of Clinical Care and Governance, Ms Geraldine Jordan, provided an assurance report on DoC retrospective reviews undertaken related to some historic reviews, primarily in Acute Services, that had not been completed as a result of backlog issues and due to the length of time since the event happened. The report outlined learning and improvement identified and processes put in place to ensure the organisation complies with DoC legislation.

Ms Jordan confirmed in response to a question from a member that the operational risk related to completion of historic reviews sat within Acute Services. Fortnightly updates were being provided through the Adverse Event Review Group to monitor progress with this work. A local DoC policy and toolkit was being developed to support Acute Services colleagues to ensure compliance with DoC legislation. An improvement plan was being developed with Acute colleagues to manage the backlog of DoC reviews.

Outcome: Committee members acknowledged and supported the progress being made to address this issue.

9. Risk

9.1 **Healthcare Governance Committee Strategic Risk Register Quarter 2 report**

The Director of Clinical and Care Governance, Ms Geraldine Jordan, presented the HGC strategic risk register report.

Ms Jordan advised that three risks had been reviewed during the reporting period, with no change to the risk scores. At the Risk and Resilience Scrutiny and Assurance Group meeting on 25 October 2024 there were two operational risks approved for escalation to the HGC strategic risk register. One very high Risk ID 784, related to lack of community accommodation – community midwife impact and one high Risk ID 787, related to children and young people's speech and language therapy provision. There were no risks proposed for termination.

The Committee discussed Risk ID674, GP sustainability. In reply to a question from a member, the Nurse Director, Ms Jennifer Wilson, advised that she would discuss with the Director of East Ayrshire HSCP to ensure that the risk reflected patient/service user experience, for example, difficulty in accessing GP appointments and impact in terms of long term health care provision and health inequalities. **JW/CMcA**

Members discussed Risk ID784 and requested that narrative be reviewed under additional comments/supporting statement section to clarify the background issues, premises gaps and actions being taken to mitigate the risk, to enable HGC to monitor progress. **GJ**

Outcome: Committee members noted the HGC strategic risk register report and took assurance from work being done to manage strategic risks which fall under the HGC's governance remit.

9.2 **Significant Adverse Event Review (SAER) Quarter 2 report**

The Director of Clinical and Care Governance, Ms Geraldine Jordan, presented the SAER Quarter 2 report.

For the period July 2024 to September 2024, there were six reports presented for final closure, as detailed at Appendix one of the report, with learning summaries provided as appendices.

The report detailed SAER reports on target and overdue by Directorate. Ms Jordan advised that while this demonstrated a significant challenge in meeting timeframes for report submission and approval, the Board was not an outlier compared to other Scottish Boards. The report detailed action plans on target and overdue. Members received assurance that addressing these areas will be a focus for the improvement plan for the management of SAERs. All Scottish Boards would meet with the Scottish Government at end-November 2024 to see what additional support might be needed to tackle the backlog of SAERs.

Ms Jordan reiterated that while NHSAA was not an outlier compared to other Scottish Boards, the Board wanted to ensure that these reports were concluded in a timely manner with high quality outputs which could be shared with patients and families. Focused work was taking place to prioritise completion of the longest overdue reports. An improvement plan was being progressed within Mental

Health Services to improve performance in the completion of reviews, with an update to be provided later in the meeting.

Ms Jordan advised in reply to a question from a member that following discussion with the interim HGC Chair, it had been agreed to provide a more concise HGC report, with a more detailed report including overdue reports to be provided at RARSAG. Members discussed HGC reporting and it was agreed that more detailed information be provided to HGC, including on overdue reports, on a six monthly basis. **GJ**

Outcome: Committee members received the report and assurance that appropriate governance is in place for these Reviews, and that action plans have been scrutinised by local Directorate governance groups with multidisciplinary attendees. Members requested that more detailed reporting, including on overdue reports, be provided on a six monthly basis going forward.

9.3 **Management of Adverse Event (AE) Policy review**

The Director of Clinical and Care Governance, Ms Geraldine Jordan, provided an update on NHSAA's AE Policy and Guidance which had been reviewed, updated and approved at RARSAG on 25 October 2024.

Key changes were outlined in the body of the report. Revisions had been made to reflect the revised Healthcare Improvement Scotland (HIS) framework to ensure consistency in approach to the national standard. The National Framework for Adverse Events was due to be published next year and it was proposed that the local policy undergo interim review at that point.

Ms Jordan advised that while Duty of Candour (DoC) remained in the guidance, as reported earlier in the meeting, a draft DoC policy document was out for consultation and a toolkit was being developed. Once the DoC policy had been approved, the position would be reviewed to see where this guidance should sit.

Committee members discussed the policy and provided comments in relation to governance and timescale for completion of reports. Dr Hopkins advised that the Area Clinical Forum and Professional Committees would be able to provide advice on the policy from a professional perspective as required. Ms Jordan thanked members for their contributions. She would review the policy again to ensure this was comprehensive and further discussion would take place at RARSAG. The updated policy would then be e-mailed to HGC members. **GJ**

Outcome: Committee members received the report and took assurance from the review undertaken that NHSAA AE Policy and Guidance meets the requirements of the HIS framework.

Members looked forward to receiving the updated policy out with the meeting once this had been reviewed and approved by RARSAG.

9.4 **Mental Health Services (MHS) Significant Adverse Event Reviews (SAERs)**

The Associate Nurse Director and Lead Nurse, NAHSCP, Mr Darren Fullarton, presented a report on activity to ensure all SAERs commissioned within MHS were completed appropriately and timeously. As discussed above, NHSAA's AE Policy and Guidance for the management of AEs had recently been reviewed.

Mr Fullarton advised that the number of SAERs in MH had increased over the last 10 years, with MHS accounting for 45% of all SAERs commissioned in NHSAA. Since 2019, on average two SAERs were commissioned per month by MHS, with the majority from community MH services. The majority of SAERs commissioned in MHS followed suicide or suspected suicide from people open to MHS at the time of their death or known to MHS in the 12 months prior to their death.

Since 2019, there had been an increase in the number of staff trained to undertake SAERs. There had been significant improvements made at each stage of the SAER process, as well as considerable improvement in the average time taken to complete and issue SAERs. While good progress had been made, further work was required. The report set out the range of improvement work being done to further improve the position.

Mr Fullarton updated that there were currently 36 SAERs underway where it had been 90 days since the review was commissioned. The MH Adverse Event Review Group (AERG) had a planner in place for review leads to present and had scheduled for all outstanding SAERs to be presented to the AERG for approval between October and December 2024.

Mr Fullarton clarified in response to a question from a member that SAERs did not include suicide of people not known to MHS. Suicide Locality Review Groups set up across the three HSCPs reviewed every suicide in Ayrshire and Arran.

In response to a question from a member, Mr Fullarton advised that since each locality was now appointing lead reviewers from their own HSCP leadership team for SAERs commissioned for their locality, lead reviewers were now being identified in a matter of days.

Outcome: **Members noted the update on activity to ensure all SAERs commissioned within MHS are completed appropriately and timeously. Members acknowledged the good progress made, as well as challenges faced, and endorsed the approach being taken to support SAER activity**

within MHS.

9.5 **Risk issues to report to the Risk and Resilience Scrutiny and Assurance Group (RARSAG)**

There were no risks to report to RARSAG.

10. Corporate Governance

10.1 **Minutes – to note**

10.1.1 **Acute Services Clinical Governance Group** – Members noted the approved minutes of the meeting held on 16 August 2024.

10.1.2 **Area Drug and Therapeutics Committee** – There were no minutes to report.

10.1.3 **Paediatric Clinical Governance Group** – Members noted the draft notes of the meeting held on 11 October 2024.

10.1.4 **Prevention and Control of Infection Committee** – Members noted the draft minutes of the meeting held on 26 September 2024.

10.1.5 **Primary and Urgent Care Clinical Governance Group** – Members noted the approved minutes of the meeting held on 30 July 2024 and draft minutes of the meeting held on 8 October 2024.

10.1.6 **Research, Development and Innovation Committee** – Members noted the draft minutes of the meeting held on 11 September 2024.

11. Points to feed back to NHS Board

11.1 The Committee agreed that the following key items be raised at the NHS Board meeting on 2 December 2024:

- Update on Aspergillus outbreak
- Update on front door overcrowding concerns
- Cervical screening exclusion national audit outcomes
- Duty of Candour and SAERs backlog
- Operation Koper

12. Any Other Competent Business

12.1 The interim Chair, Mrs Joyce White, thanked the Nurse Director and other colleagues for the support she had received in her role as interim Chair, as well as other colleagues for their contribution at the meeting.

13. Date and Time of Next Meeting
Monday 13 January 2025 at 9.30am, MS Teams

Signed by the interim Chair, Mrs Joyce White Date: 13 January 2025