NHS Grampian

Meeting:	**NHS Grampian Board**
Meeting date:	**2nd December 2021**
Item Number:	**9.1**
Title:	**Clinical Governance Committee Report**
Responsible Executive/Non-Executive:	**Dr John Tomlinson**
Report Author:	**Dr John Tomlinson**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to:

The Clinical Governance Committee Meeting held on the 12th November 2021.

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Operation Iris

The Committee was advised on the inter-relationship between the remobilisation plan (RMP4), Operation Iris and the developing Grampian Operational Pressure Escalation system (G-OPES). In terms of a Clinical Governance Lens, the scope of service delivery as part of RMP4 provides and ensure governance arrangements for the quality of care patients receive. Given the current position there is potential risk that may compromise quality of care and there was recognition that there may be a need to change some of the usual operational rules through a derogation matrix.

It was agreed it will be important to be explicit what the derogation is and the different consequence(s) in terms of risk. The Committee felt that the critical requirement is to evaluate this overall balance of risk, specifically considering each context and how this will be monitored. The Committee supported the proposal to bring this work to the Board and that over the next six month Operation Iris will ensure governance arrangements are formulated and how these sit with existing clinical governance arrangements.

2.2 Derogation of Infection, Prevention & Control Guidance – Physical Bed Spacing

To ensure delivery of critical and protected services and effective flow of patients throughout the system and to reduce associated patient safety risks, there was a requirement to understand the risks of returning ward bed base to pre pandemic levels/numbers and the subsequent mitigations to manage these risks. A paper was presented to the Chief Executive Team (CET) and the Ethics Committee, to inform discussion and to allow facilitation of decision making based on expert views and balance of harm. Following review of the options it was agreed to re-instate all the beds closed due to IPC guidance and carry the IPC risk and all other subsequent risks associated with managing nosocomial transmission such as patients experiencing HAI infections, ward closures, increasing staff absence and longer patient stays in hospital.

To support governance around this derogation, weekly reports of any nosocomial outbreak, specifying if there is likely to be correlation between the outbreak and the re-instatement of beds, is being taken to the Clinical Risk Meeting and shared with the CET. The Committee understood this decision did not comply with IPC guidance but supported the risk based approach to managing flow. The Committee however, did recommend that it was sighted on the benefits and potential harms of this derogation in real time to provide assurance to the Board.

2.2 Integrated Specialist Care Services Portfolio

A number of papers were put forward to the Committee for consideration. The data suggests that cancer diagnostic activity is returning to pre-pandemic levels however, the relatively rapid presentation of the backlog is believed to be, in part responsible for a deteriorating 62 day cancer performance. The unmatched co-dependent services critical to many cancer pathways will inevitably further compromise performance. However, it is important to note that to date mortality data does not indicate that safety is being compromised by service pressure. Work is under way to reconsider pathway design, match resource to demand and manage tensions between equally high priority pathways. There is an expectation that these plans and processes coming in to place will be beneficial to improving the 62-day cancer performance.

Cancer Oncology Teams are analysing any shift from early stage cancer regimes (where intent is curative) to regime of holding the position, and palliative. Whilst it is reassuring to see data on cancer pathway patients does not show an excess mortality, it is important to note that data on all-cause mortality from cancer requires detailed analysis, which is being examined.

A Route Cause Analysis was undertaken on theatre cancellations and this has resulted in a programme of projects to support improvements (e.g. pre-operative assessment where the multi-professional clinical team are now located in one fixed area; 85% of admissions are now on the day of surgery). This also highlighted the need to synchronise theatre availability and workforce with the expected impact on both the 31-day and 62-day cancer performance.

The Committee acknowledged that the Portfolio has a detailed understanding of the challenge and were assured by the detailed work being undertaken within the plan. The Chair requested that information on progress with the plan and how this is addressing the challenge returns to the Committee in February 2022.

2.3 Healthcare Associated Infection (HAI) Report

The Healthcare Associated Infection Reporting Template (HAIRT) was not available as it has not been ratified by HAI Executive Committee, and will be brought to Committee at a future date. In summary in relation to National Surveillance, NHS Grampian is in line with national levels and not an outlier in measures. The key issue highlighted by the Infection Prevention and Control Team (IPCT) to the Committee was the capacity of the IPCT to support all work related to the built environment (e.g. water safety, ventilation, new projects and builds).

The IPCT will continue to support existing projects and the main capital projects such as Baird and Anchor however, there is no capacity to support new projects. This is set against the need for IPCT to support ongoing changes to COVID-19 guidance and standards e.g. the implementation of the revised clinical respiratory and non-respiratory pathways.

A Paper has been provided to the Infrastructure Oversight Board that includes recommendations for a system for IPC project/work requests and a process for prioritisation. Sourcing staff and training is challenging due to the specialist and complex input required and necessitates a training period of approx. 1 year for new staff. From a national perspective there are similar difficulties in other Boards and a national group is working on a framework for IPC education and supporting roles. The Committee noted this and requested sight of any plan to support IPCT capacity.

The Committee noted the incidences of water safety across the estates in the previous nine month period and was advised that the IPCT is working with Scottish Government colleagues to understand the work ongoing in relation to managing this risk. One of the key actions taken by the IPCT was to provide information on the importance of water safety via video shared on social media, posters etc.

With regards to the built environment and water safety, it was noted that this is delegated to the Director of Estates and Facilities as the Responsible Officer. The Responsible Officer would then report to the Occupational Health, Safety and Wellbeing Committee and the Performance Committee. The Chair consequently noted to contact the Chair of the Performance Governance Committee to ensure a joined up approach to reporting built environment issues given the clinical governance element to this.

3 Recommendation

The Board is asked note the summary of the key points discussed at the Clinical Governance Committee meeting on the 12th November 2021.