APPROVED
Board Meeting
07.04.2022
Open Session
Item 11.2

Minute of the **Virtual** Meeting of **NHS Grampian Clinical Governance Committee to Grampian NHS Board** on Friday 17th December 2021 at 3.30 pm

Present:	Dr John Tomlinson (Chair)	Interim Chair NHS Grampian Board
	Amy Anderson (AA)	Non-Executive Board Member
	Prof. Siladitya Bhattacharya (SB)	Non-Executive Board Member
	Dr June Brown (JB)	Executive Nurse Director
	Prof. Susan Carr (SC)	Director of AHPs and Public Protection
	Kim Cruttenden (KC)	Non-Executive Board Member
	Janet Fitton (JF)	Clinical Governance Lead - Aberdeenshire
	Prof. Nick Fluck (NF)	Medical Director
	Jenny Ingram (JI)	Associate Director - QIA
	Grace Johnston (GJ)	Interim IPC Manager
	Cllr Shona Morrison (SM)	Non-Executive Board Member
	Miles Paterson (MP)	Public Representative
	Dennis Robertson (DR)	Non-Executive Board Member
	Dr Steve Stott (SS)	Associate Medical Director
Invitees:	Paul Bachoo (PB)	Medical Director - Acute
	Jenny McNicol (JMcN)	Acute Director - Nursing and Midwifery
	Janice Rollo (JR)	Quality Improvement and Assurance Advisor
In attendance:	Arlene Forbes	Quality Improvement and Assurance Administrator (Minutes)
	Laura Gunn	Quality Improvement and Assurance Administrator (Minutes)

Item Welcome and Apologies:

1 The Chair welcomed members and attendees to the meeting. With noted thanks for attendance during an exceptionally busy period for the Organisation.

Apologies were received from: Prof. Caroline Hiscox, Dr Malcolm Metcalfe, Siddharth Rananaware, Dr Noha El Sakka, Dr Shonagh Walker and Susan Webb.

2 **Minute of meeting held on 12th November 2021:** Agreed as accurate.

3 **Matters Arising and Action Log**:

Action Log: agreed, items covered in current agenda and future meetings.

Nosocomial Clinical Review ongoing and will be brought to Committee on completion with a verbal update on progress on 11th February 2022.

4 **Operation Iris and the Grampian Operational Pressure Escalation System (G-OPES)**

4.1 Update on current position
Prof. Nick Fluck provided an overview on the System Pressure Update, current Operation Iris model, G-OPES Dashboard and Omicron Planning.

The context being Remobilisation Plan 4, with particular reference to responding to demand on the Health and Care System and protecting Critical Services and reducing harm.

Operation Iris Modelling had considered GMED activity, COVID Waves (experience) and Unscheduled Care, ARI and COVID Hub Activity. Further to understanding critical planned care, particularly around surgical specialities (including modelling for individual surgical specialties), occupancy and theatre utilisations to ascertain the required operational capacity to maintain Cat0

and 1, and Cancer interventions. This requires an understanding of the entire model of Unscheduled Care throughout the system to derive what happens in Winter, to reach a single Operation Iris Planning scenario aimed at delivering RMP4. Illustrations within the modelling demonstrate that every part of the system has a capacity limit and all models predict for around month and a half where the system could go above capacity limit into the first part of 2022. Throughout Operation Iris this would mean the system would run with little operating headroom, creating pressures.

In relation to G-OPES, it is now integrated into the morning brief with a live Dashboard system, including professional judgement. There is a daily report to the System Connect Meeting, with associated actions to address flow and capacity. These actions will instigate required derogations and a system-wide table top exercise held on 13th Dec tested this model. This allowed the identification of pressures and specified those derogations that could to support a capacity response. There is recognition that the derogations carry a balance of Risk(s) within the system and this was demonstrated through the illustration of current tracking against the modelling scenarios. NF advised ARI was currently tracking just below the model. For DGH, tracking against the model at a different level, due to COVID care primarily with ARI. In summary the modelling demonstrates operating headroom had progressively declined, despite G-OPES response and some expanded surge system capacity.

Omicron is now the dominant strain currently across UK and Scotland. Advised variables for planning and models expect large winter wave, increased hospital admissions and impact on staff availability. Four harms considerations (Health, Social Care, Economic and Society). Referenced published data, and London data demonstrates exponential rise in cases, with associated rise in hospitalisations. Scotland data demonstrates community rates rising at high rate. Further referenced published models by London School of Hygiene and Tropical Medicines and how strain responds to vaccination and immunocompromised individuals, with benchmark against peak of January 2021. Gives expectation of local hospitalisations early January 2022. Advised Scottish Government strategic intent: maintain urgent and emergency care to maintain life and limb services, maximising capacity in our health and social care system and supporting our workforce. These are aligned to RMP 4 objectives, established. Scottish Government provided planning principles and Operation Iris considers requirement to understand maximal capacity, plan to deliver maximal capacity, accelerated action, tighten focus and plan for beyond capacity.

Referenced NHSG Planning intent and current Operation Iris plan is in line with delivering RMP 4 and considering Scottish Government directive. Planning for Omicron Major Incident, with a single focussed capacity response.

Chair considered clinical quality and safety lens, and NF advised there is an established mechanism within Operation Iris including monitoring and reporting associated with for e.g. derogations. In relation to a Major Incident NF advised in response to DR, delivering that type of response remains through the Local Resilience Partnership and declaring a major incident (may be local, or national). The issue of “triggering” major incident may be difficult in terms of timing, requires community support, resilience and judgement, of associated complexities. NF further stated that there will be a “time lag”, as in previous waves the peak for Grampian has been behind England and the Scottish central belt. NF advised in response to SM, planning for major incident and further planning within Operation Iris involves bed base capacity with reference to changing between the two plans, if appropriate. NF advised in response to Chair, in terms of Operation Iris approach of sourcing bed capacity from across whole system (genuine additionality) with recognition generates challenges (staffing). Major incident planning involves an entirely different model for e.g. consider delivery of care in community. This planning is developing and ongoing.

4.2 Cancer Performance Update

Paul Bachoo provided an interim update to Committee. Advised further detail would be brought to Committee in February 2022.

Cancer performance remains challenged. Assurance provided to Committee that:

- Utilisation of overall allocated theatre capacity for the services with tracked cancer pathways does not suggest concern. The allocation is not specific for Cancer surgery and includes ESCaTs 0 /1.

- During the period analysed cancelled cases did not include subjects waiting for Cancer related surgery.

Data to support was provided in the Interim Update (circulated).

The Chair referenced the Action Plan put forward at the November Committee. PB advised that this has delivered maximum capacity and productivity through available resource for elective planned care in ARI. However, of note the desired maximum bed base had not been realised, with the reductions in beds that had been in place. Derogations are now in place and all available beds open and staffed, with average bed base of 50. The model projected bed base of 60-80 beds is required to be fully operational.

DR enquired of what additional pressure occurs on the system should patients receiving cancer treatment in hospital test positive for COVID. PB advised that currently this had not occurred, where treatment had to be cancelled due to positivity. The expectation for when this occurs would be management through clinical risk assessment whether or not surgery could be deferred. The impact of deferral is slowing of the process, pathway for the patient journey and consequence on staff and other patients involved. DR noted assured that process in place through clinical risk assessment to manage this type of situation.

SB noted that as Organisation "catches up" there were challenges with new development(s) and large ripple effect (Omicron highly infectious). Options within cancer pathways and outcome data gathered prior were noted, but questioned if consideration would be given to rethinking of pathways that have surgery upfront and exchanging this for a different pathway. PB advised that discussions are taking place with cancer Leads on this issue for the Cancer Pathways. Currently, have not diverted from guidance or standard of practice for patients presenting with cancer.

PB advised in response to Chair, the backlog is decreasing and as of 5/12/2021 the backlog = 33. Due to prioritising, ring fencing capacity for cancer services however this had impacted elsewhere. Chair noted importance of not focussing narrowly on cancer services and PB advised this was presented at previous Committee and performance of cancer had to be in context of other time critical major pathologies not under the same scrutiny and framework. NF further noted requirement to broaden to other Pathways of Care that do not involve surgery. **Consideration to Committee to have surveillance on excess mortality in community profiles which could direct the lens for clinical governance over the next 12-18 months.**

PB advised in response to DR, monitoring carefully urgent symptomatic cancer pathways and within next 3 to 4 months backlog would return to 2018/19 levels. No data for how many people did not enter in to the pathways.

Recommendation: The committee are asked to note the interim report. That whilst performance remains challenged and below the national average, utilisation of available capacity is not a significant area of concern and that the capacity is not ring fenced for cancer surgery. **The Committee supported the recommendation.**

4.3 Derogations - Clinical Risk Management Update

June Brown provided an update and advised a paper would be brought to Committee in February. Advised of 4 the Derogations, stated in Operation Iris documentation.

Additional beds were put back in to environments that had initially been removed to meet IPC standards, as one of the control measures to prevent spread of COVID. This derogation is recorded through IMTs and under review to identify if this is a contributory factor to outbreaks. Learning from a recent outbreak identified additional beds as a potential contributory factor (and not reinstated to that outbreak environment). Information is shared from IMTs by the Infection Control Manager to CRM (Clinical Risk Management), held weekly. Concerns from CRM are then escalated to the Chief Executive Team (CET). The information of 1 recorded outbreak episode, was shared via Clinical Governance Committee Closed Session.

The derogation, in relation to "Corridor Care" addresses concerns around flow in hospitals and potential ambulance stacking, in terms of patient safety risk. Should the Organisation have that

risk, there is a need to ensure patients in ED and AMIA have a route to a bed in system. Following risk assessment a derogation may be in place, where a patient would wait in the corridor in a designated area with appropriate support as per the Standard Operating Procedure (SoP) until a bed was available. This information is recorded via the TRAK system and reported weekly. Should care not be delivered aligned to the SoP, information is recorded on DATIX and investigated. In terms of clinical governance this will be reviewed at CRM with concerns escalated to CET.

Derogation to staffing levels are constantly monitored, particularly nursing staff ratios which are continually risk managed. Incidents relating to staffing levels are recorded on DATIX. Reports brought to CRM with same escalation process to CET.

The final derogation relates to the handling of complaints. NHSG is currently working with the Scottish Public Services Ombudsman (SPSO) and other Boards to develop a prioritisation framework for the handling of complaints to ensure complaints for patients receiving immediate care take precedence.

Chair requested Derogations be recorded in the minutes for assurance of processes in place.

JB advised in response to DR, that a Discharge Hub and Discharge Lounge are in place and discussed potential delays to the discharge process, which may result in Corridor Care. JB advised the Discharge Lounge would be in place 7 days/week and fully supported.

Committee noted the information and assurance of the processes for managing the Derogations.

5 **Respiratory Pathways**

5.1 Winter Respiratory Guidance – Change Update
The comprehensive information pack was circulated.

Grace Johnston advised that the implementation of the guidance is progressing with support given to colleagues across the System. GJ advised in response to Chair, in relation to IPC capacity being efficient in communication by using webinars to share information. IPC priorities continue.

GJ welcomed questions be directed via email on review of information pack by Committee members.

JB noted that item return to February Committee in relation to implementation of guidance, for assurance to Board.

6 **DGH External Review**
The Review documentation and briefing had been distributed.

Jenny McNicol updated, in relation to Moray Maternity Services. Referenced Review Report timeline, and publication of Report on Scottish Government website on 6th December 2021. JMcN and Simon Bokor-Ingram led clinical staff sessions at DGH and joint discussion with NHS Grampian and NHS Highland held on 16th December 2021. A Cabinet Secretary virtual visit to Elgin would take place on 20th December to listen to service users, elected representatives and staff. JMcN advised that Cabinet Secretary Office would offer further sessions, particularly with NHS Highland and their staff.

The Review Team considered six models and within the Report the short term recommendations were to implement a Community Maternity Unit, Model 4, at DGH. Elective (planned) Caesarean sections were to be offered at DGH. More women in need of specialist care to give birth in Raigmore, rather than Aberdeen. The longer term recommendations were to consider moving to a Rural Maternity Unit, Model 5, supported by a consultant (senior doctor) and with 24/7 medical cover. The Scottish Government is to undertake a listening exercise and the decision on this is not expected until early 2022.

JMcN advised Model 4 in essence, has been the outcome to achieve through the NHS Grampian and NHS Highland Collaborative. A productive meeting was held with key members on 16th

December to discuss a way to move forward, collaboratively following the report being published. The challenges faced by NHS Highland in relation to workforce and capacity are recognised and discussion focussed on how to support these challenges. JMcN noted key recommendation, removal of life and limb aspect, for NHS Highland to lead on achieving this as intrapartum transfers would be required to go to Raigmore. It was agreed at the meeting on 16th December, a set date is required for this key recommendation to be achieved by NHS Highland.

JMcN advised a Programme Board is being set up to deliver on all aspects of the Review. Advised there needed to be clear links to the Clinical Governance Groups in NHS Highland and NHS Grampian, collaborative working, support and progression to deliver the best maternity services available to women in the North East of Scotland.

Chair thanked for the helpful update on the position, and acknowledged the prior work that had commenced. Further noted, that a clear Action Plan would be developed to support the direction, and instruction given by Scottish Government. JMcN advised of the requirement to implement a specific Project Board with links to Clinical Governance and Elective Care Oversight Group. Chair noted requirement for Committee to have oversight for Board assurance.

JMcN in response to SB, advised that there will be concentration on the short term recommendations initially, and when these are established address the position and progression of further recommendations. Cultural aspects, workforce challenges, willingness to work together innovatively and jointly to get the best outcome possible were acknowledged. Chair advised it was important to note a clear strategic intent to stakeholders.

DR referenced current staffing levels and enquired of requirements in short-term to support this work. JMcN advised from a Midwifery point of view there were no current vacancies at DGH, however this was different at NHS Highland and discussions are being held on potentially joint posts. It is important to maintain the work on The Best Start North collaboration and continuity of care teams, breaking down any potential barriers that may exist between Health Boards. This work would support NHS Highland in capacity for labour and birth however, it does not support their capacity in infrastructure and a detailed improvement plan for this is progressing. In the paper NHS Education for Scotland (NES) and the Scottish Government are asked to consider strategies to support the workforce in particular for the North of Scotland. DR noted the benefits being addressed through collaborative approach.

SM advised that the Report was well received locally with good engagement and welcomed the continuing collaborative work with NHS Highland. SM enquired of morale locally in particular midwifery staff and if discussions on budget for infrastructure of DGH had begun to take place. JMcN advised that the reaction from midwifery staff on the outcome of Review were mixed. There is some anxiety around the loss of the life and limb aspect, potentially due to midwifery staff being employed in an obstetric model and not a midwifery led model. It is important to note the strong midwifery leadership within the Team at DGH and the confidence to progress forward with good decisions being made in risk assessments, etc. The wider Clinical Team of DGH are keen to utilise the Report to maximise benefit for DGH as a whole.

JMcN advised in response to AA, all transfers currently are reviewed jointly and does not foresee any change to this process. In relation to Maternity Voices Partnership, they have been working closely with the Partnership which includes membership from Keep Mum. The aim is to continue working with the Partnership that supports communications related to women in the Moray area. Further encompasses engagement with other Voices Groups.

Miles Paterson referenced the need for future collaborative work, as a way to utilise expertise available to overall benefits for patients given limitations in resources.
Chair, to note, await further instruction from Scottish Government and assured work continuing and progressing.

7 **Reporting to the Board**
Overview of discussions held.

8 The next meeting would be held on**, 11th February 2022, 1000 – 1300 Hours, via MS Teams.**