Scottish Ambulance Service
Working in Partnership with Universities

NHS SCOTLAND

NOT PROTECTIVELY MARKED

Public Board Meeting	**27 March 2024** **Item 17**
THIS PAPER IS FOR NOTING	
CLINICAL GOVERNANCE COMMITTEE MINUTES OF 13 NOVEMBER 2023 AND VERBAL UPDATE OF 12 FEBRUARY 2024	
Lead Director **Author**	Stuart Currie, Chair of Clinical Governance Committee Pippa Hamilton, Acting Board Secretary
Action required	The Board is asked to note the minutes and verbal report.
Key points	In compliance with the Service's Standing Orders, the approved Committee minutes are submitted to the Board for information and consideration of any recommendations that have been made by the Committee. The minutes of the Clinical Governance Committee held on 13 November 2023 were approved by the Committee on 12 February 2024. A verbal update of the meeting held on 12 February 2024 will be provided by the Chair of the Committee.
Timing	Minutes are presented following approval by the Committee. The Board will receive a verbal update of the most recent Committee meeting from the Chair of the Committee.
Link to Corporate Ambitions	The Clinical Governance Committee has responsibility on behalf of the Board to ensure that the appropriate work is undertaken to assess clinical governance within the Service and provide assurance to the Board that the governance arrangements are safe, effective and person centred.
Link to NHS Scotland's Quality Ambitions	The Clinical Governance Committee remit tis to monitor good clinical governance to ensure safe, effective and person centred care across Scotland/
Equality and Diversity	No issues identified.

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MINUTE OF THE NINETY THIRD (93rd) CLINICAL GOVERNANCE COMMITTEE AT 10.00AM ON MONDAY 13 NOVEMBER 2023 VIA MICROSOFT TEAMS

Present:
Stuart Currie, Non-Executive Director (Chair)
Liz Humphreys, Non-Executive Director and Whistleblowing Champion
Irene Oldfather, Non-Executive Director
Carol Sinclair, Non-Executive Director
Tom Steele, Board Chair

In Attendance:
Dave Bywater, Lead Consultant Paramedic
Keith Colver, Clinical Governance Manger – Guidelines
Iona Crawford, Interim Mental Health Lead *(for Item 05.3)*
Tony Devine, Assistant Head of Education and Professional Development
Martin Esposito, Consultant Paramedic *(for item 04)*
Sarah Freeman, Head of Infection Prevention and Control
Ayaz Ghani, Associate Medical Director
Pippa Hamilton, Committee Secretariat (notes)
Julie King, Service Transformation Manager
James Lucas, Director, KMPG (Internal Auditors) *(for item 05.1)*
Alan Martin, Patient Experience Manager
Alison Moggach, Clinical Governance Manager
Tim Parke, Associate Medical Director
David Robertson, Regional Director West
Martin Robertson, Patient Representative
Emma Stirling, Director of Care Quality and Professional Development
James Ward, Medical Director
Paul Watson, Clinical Governance Manager, Medicines and Equipment

Apologies:
Andrew Cadamy, Associate Medical Director
Shereen Cameron, Patient Safety Manager
Michael Dickson, Chief Executive
Cheryl Harvey, Associate Director of Education and Professional Development
Anne Hendry, Patient Representative
Francis Tierney, Non-Executive Director

ITEM 1 WELCOME AND APOLOGIES

Stuart Currie welcomed everyone to the meeting.

Apologies were noted as above.

ITEM 2 DECLARATIONS OF INTEREST RELEVANT TO THE MEETING

Standing declarations of interest were noted:

- Irene Oldfather in her position of Director, Scotland Health and Social Care Alliance and Vice Chair of Domestic Advisory Group (DAG) on the Trade and Cooperation Agreement (TCA) with the European Union.
- Carol Sinclair in her position as Trustee of Scotland's Charity Air Ambulance and Strategic Data Adviser, Digital Health and Care, Scottish Government
- Stuart Currie - Board Member of State Hospital Board and Vice Chair of the Independent Review of Inspection, Scrutiny and Regulation of Social Care in Scotland by the Scottish Government.
- Liz Humphreys - Non-Executive Director, Public Health Scotland, and Trustee Scottish Association for Mental Health.

Martin Robertson, Patient Representative, declared an interest as a member of Voices of Experience (VOX) Scotland.

ITEM 3 MINUTES OF MEETING HELD ON 14 AUGUST 2023

The minutes of the meeting held on 14 August 2023 were reviewed and approved as an accurate record of the meeting.

ITEM 4 HOT TOPIC – MAJOR TRAUMA UPDATE

Jim Ward introduced the Hot Topic item and advised that Martin Esposito would provide a presentation on the work ongoing within Scotland's Major Trauma Network.

Martin Esposito provided Committee with a comprehensive presentation on the Scottish Trauma Audit Group (STAG) Annual Report 2023. Committee noted that the STAG Annual Report was the tenth report since 2011 in which compliance with Scottish Trauma Network (STN) key performance indicators (KPIs), mortality and patient reported outcome measures (PROMs) are reported along with a comprehensive summary of injuries and patient journeys for both adults and paediatrics.

Martin highlighted that the STAG Annual Report was published in August 2023 and is available online to allow member to read the full report.

Martin advised that the audit was based on 7531 adult patient journeys and 215 paediatric journeys. The audit described trauma in three groups, minor, moderate, and major with the inclusion criteria being for patients who had been injured severely enough to spend a minimum of three days in hospital, be admitted to critical care or die because of their injuries.

Members noted from the presentation data from the Annual Report which included mortality, severity, location, place of injury, mechanism of injury, age, social deprivation.

Martin highlighted that:

- 19% of adult patient were classified as having major trauma.
- The Scottish Median age had risen from 60 to 67 years between 2018 and 2022 with an increase of two years since 2021.
- 76% of injuries were caused by falls, rising to 90% for patients 65 years and over.
- Significant rise (49% to 58%) in major trauma patients, conveyed by the Service being taken directly to a Major Trauma Centre.
- 21% of paediatric patients were classified as having major trauma.
- 70% of injuries were non-intentional with 17% caused by sporting activities.

- Head of limb injuries remained common injuries in the paediatric population.
- 70% of patients with major trauma conveyed by the Service were first treated at a Major Trauma Centre.

Martin highlighted that KPI 2.6 Management of patients with open long bone, mid or hind foot fractures, stated that patients with these fractures should receive IV antibiotics (IV Abx) within three hours of injury. Martin added that the Service has had a positive impact on this compliance with an increase of Service clinicians administering IV Abx in a pre-hospital setting to 40.4% in 2022 compared to 28.1% in 2021. Members noted that the Service had made IV Abx administration a focus in recent months with a number of Continuous Improvement Development (CPD) events held along with working closely with Scottish Trauma Network regional partners to share data and identify opportunities to improve.

Martin advised that in relation to KPI 1.2 Patient Arrival, Pre-alert, 66.7% of patients were pre-alerted with the hospital prior to arrival. Martin added that the Service reviewed a sample of trauma patients who were not pre-altered which found that the majority were elderly patients in the pre-hospital settings with low impact trauma such as a fall from standing, and are later found to have suffered significant trauma.

Stuart Currie thanked Martin for the comprehensive presentation. Jim Ward added that the Clinical Directorate will be developing the current Board reporting to include some of these measures which was anticipated to be introduced in 2024.

Irene Oldfather thanked Martin for the interesting and informative presentation and commented that prophylactic antibiotic approach improves services to patients and contributes to the net zero agenda. Irene asked in relation to the administration of IV Antibiotics or administration of Tranexamic Acid (TXA) for severe haemorrhage, what the numbers would look like given the increase in people self-presenting at hospital and added that presumably these people would be at a disadvantage by not getting intervention much earlier in the journey.

Martin advised that the administration of antibiotics was a clinical focus in reducing potential infection and reducing hospital stays. Martin added that in terms of TXA it was administered around 60-80 times per month.

Martin added that in terms of patients self-presenting at hospitals, they would not get access to prehospital care and would not be pre-altered to the hospital prior to arrival. Irene Oldfather asked if there was any way we could link into any data to establish why there was an increase in patients self-presenting. Martin advised that the linkage wasn't currently available, however this was being taking for discussion at STAG to see if it can be looked into given the increase being seen within this cohort of patient.

Carol Sinclair asked in relation to the identification of minor and non-minor trauma for patient who are in the <9 severity category, adding that it may be that these patients are taken to a trauma unit but then require to be transferred to a normal hospital and asked if this was something that is causing concern. Tim Parke advised that good trauma care has been estimated to potentially save £4 billion in life-time long term care costs across the NHS England, and early antibiotic administration halves a patient's time in hospital by significantly reducing risk of costly infection.

Liz Humphreys asked if what was included within the STAG report was kept under review and if feedback is provided to STAG on cases which are not included within the data, and perhaps should have been. Martin advised that the STAG inclusion criteria was for STAG to determine and that this aligns with other countries and not just Scotland.

Liz asked what the uptake had been for the available major trauma CPD courses. Martin advised that people watching the CPD courses was in the 100s, with around 300 people retrospectively viewing the recordings.

Martin Robertson asked if the Scottish Intercollegiate Guidelines Network (SIGN) guidelines are referred to in this work, advising that he noted the reference to the National Institute for Health and Care Excellence (NICE) but not SIGN. Time Parke advised that SIGN guidelines would be the first go to which are then often reference back to NICE.

Stuart Currie thanked Martin Esposito and members for the discussion.

Members discussed the timings of future "Hot Topic" agenda items and agreed that these would be given 45 minutes on the agenda to allow Committee time for full presentation and discussion.

Action:

1. **Secretariat** to ensure that future Hot Topic agenda items are allocated 45 minutes.

ITEM 5 PATIENT CENTRED CARE

ITEM 5.1 RESTRICTED - PATIENT EXPERIENCE AND LEARNING FROM ADVERSE EVENTS

Invoking Standing Order 5.22 resolution to take item in private.

ITEM 5.2 CLINICAL RISK REGISTER

Dave Bywater presented the Clinical Risk Register to members and advised that all risks had been reviewed and updated prior to presentation to Committee.

Members noted that there were currently 8 open Clinical Risks contained within the Register. Dave highlighted to members that 5 risks had been included from the Medicines Management Group (MMG) and new risk had also been included in relation to Hospital Handover Delays and since the last presentation to Committee 4 risks had been downgraded or removed.

Members reviewed and discussed the risk register and the undernoted comments/suggestions were made:

Carol Sinclair raised concern that Risk 5515 had a very high level for all 3 risk levels including tolerance and added that 5516 had a current risk level and tolerance of very high, however had a forecast risk level of low and asked that both of these be reviewed to ensure that these are correct. Dave Bywater advised that he would discuss these off line with Paul Watson and amend accordingly.

Liz Humphreys commented that there was nothing on the risk register is relation to mental health. Liz added that Committee required assurance that the right areas of risk are being monitored and asked what assurances there were that the landscape was being looked at to ensure risk areas are being caught through the National Clinical Operational Governance Group and escalated to Clinical Governance Committee.

Jim Ward reminded members that all individual subject matters within any portfolio have their own risk registers and go through PPSG or the 2030 Steering Group and in turn all high or very high risk are then presented to Clinical Governance Committee.

Action:

2. **Lead Consultant Paramedic and Clinical Governance Manager, Medicines and Equipment** to review the three risk levels (current, tolerance and forecast) of risks 5515 and 5516 to ensure these are correct and amend accordingly.

ITEM 5.3 MENTAL HEALTH UPDATE

Iona Crawford presented Committee with a paper which provided an update on the work streams and projects being undertaken to achieve the ambitions within the organisation's Mental Health Strategy. The paper highlighted updates based on the Strategy's delivery framework of Education, Leadership, Collaboration, Sharing and Listening and Research and Innovation.

Iona highlighted the undernoted areas from the paper to Committee:

- **NHS24 Warm Transfer to Mental Health Hub**
  The Mental Health Team in partnership with NHS24 were leading on a project to enable the warm transfer, via conference call, of patients in contact with the Service but who's needs may be better met by engaging with NHS24's Mental Health Hub. The project was anticipated to have three phases with the project team meeting fortnightly to progress phase one with an anticipated go live date of 23 December.

- **Mental Health Paramedic Response Unit (MHPRU) Service**
  The MHPRU service continues to operate on a substantive basis. Since the last update to Committee in April the service in Inverness had expanded to become 24/7 in partnership with regional colleagues combining demand and capacity resource with Action 15 monies. The new model had undergone evaluation which evidenced that the MHPRU service, during the pilot year, brought additional recourse, and capacity within unscheduled care across the three locations and could be understood as saving resource as the MHPRU funding was additional funding, out with unscheduled care baseline monies.

- **Psychiatric Emergency Plans**
  The Mental Health Team continue to work to review all Psychiatric Emergency Plans (PEPs) across Scotland with the majority of PEPs now being accessible to the Service, allowing the team to be actively involved in the updates of several PEPs with the aim to ensure that PEPs are consistent.

- **Pre-Registration Paramedic Input**
  Relationships have been established with all Higher Educational Institutions in Scotland who provide paramedic education to allow the Mental Health Team to input to all pre-registration paramedic courses with recent learning focusing on mental health assessment, suicide intervention and prevention, mental health aetiology and models of response for people experiencing mental ill health, distress and crisis.

Liz Humphreys commented that on a recent station visit to Fife she undertook and added that she was made aware of a new mental health car being set up there which the staff were extremely passionate about and asked if a mental health car update could be provided within the next update to Committee. Iona advised that there are currently 3 mental health cars, 1 per region which are managed regionally.

Carol Sinclair asked for narrative to be included within the next update to Committee detailing how effective the data sharing between different agencies was, what the eco system of the mental health system looks like and were we getting to the heart of providing the most effective care for these patients.

Irene Oldfather congratulated Iona and the team on the huge progress made as a Service in relation to mental health and the progress being made on Distress Brief Interventions. Irene added that at the end of September the Mental Health Quality Standards were published and these include first person ownership and asked how that would feed into the future programme and if future training be carried out.

Iona Crawford advised that the Mental Health Quality Standards would be embedded within undergraduate programmes along with the most recent update to the suicide prevention and intervention strategy.

Tom Steele commented that it was great to hear about the progress made with the warm transfer to the mental health hub, however asked how these calls would be managed at times of extreme operational pressure. Jim Ward advised that all resources are finite, however added that he hadn't had sight of the associated escalation plans. Iona Crawford added that there had been several discussions in relation to escalation process mapping with NHS24. Iona advised that discussions had also taken place in relation to a fall-back mechanism by NHS24 to ensure that mental health practitioners are ring fenced for the Service at times of operational pressure.

Members noted the paper and thanked Iona for the update.

Action:

3. **Interim Mental Health Lead** to include an update on the regional mental health cars within the May 2024 update to Committee.
4. **Interim Mental Health Lead** to include narrative within the May 2024 update to Committee detailing the effectiveness of data sharing between different agencies, what the eco system of the mental health system looks like and were we getting to the heart of providing the most effective care for these patients

ITEM 6 PATIENT SAFETY

ITEM 6.1 CLINICAL GOVERNANCE AND PATIENT SAFETY REPORT

Keith Colver presented the Committee with a report which provided an overview and assurance of current Clinical Governance and Patient Safety activities.

Keith highlighted that NCOGG were presented with the draft Principles of Safe Transfer Policy which was subsequently approved by the majority of members. Keith added that the Policy was then presented to and approved by the Clinical Assurance Group (CAG). Keith advised that the Policy takes a systems approach to provide a structure for tactical and operational managers to respond to acute delays in handover at Emergency Departments.

Members noted that the JRCALC Patient Group Directions (PGD) function was formally launched on 12 October. Work continued with the Clinical Quality Leads to support clinicians with awareness of the need to sign off their PGDs prior to administering the relevant medicines. Keith highlighted that further work was also ongoing to align electronic Patient Report (ePR) data to JRCALC data to identify compliance.

Carol Sinclair thanked Keith for the comprehensive paper and asked in relation to the Corpuls defibrillators, if the Service continues to be confident that it was receiving the best service from the contractor Ortis. Carol also asked if the Service was maximising what Ortis should be doing in terms of any required corrections to the equipment.

Keith advised that assurance was being received by NCOGG that the Service are receiving regular reporting to assist in identifying any issues. Paul Watson added that the Service was doing all it could to be in continued dialogue with Ortis to ensure mitigations were being put in place. Paul added that as a result of feedback from the Service, Ortis are changing the build design of the equipment cables.

Carol Sinclair thanked Paul and took assurance from the update, however commented that the Service should not have to work so hard with the contractor to ensure that the equipment was fit for purpose for the organisation.

Martin Robertson asked in relation to patients suffering from delirium, if the Service's process included starting with drug administration for these patients. Keith Colver advised that the first intervention for patients suffering delirium would be conveyance to an Emergency Department. Keith advised that he would discuss this offline with Martin to allow him fuller understanding of the process for the Service.

Members noted the paper and the update of the work undertaken since the last Committee meeting.

Action:

5. **Clinical Governance Manager, Guidelines** to discuss with Martin Robertson, Patient Representative the Service's process for dealing with patients suffering delirium.

ITEM 6.2 DUTY OF CANDOUR ANNUAL REPORT

Jim Ward presented Committee with the Duty of Candour Annual report 2022/23. Jim highlighted that as part of the Duty of Candour Procedure (Scotland) Regulations 2018, the Service is required to produce an Annual Report, submit the report to Scottish Ministers and publish this on the Service website.

Jim advised that between 01 April 2022 and 31 March 2023, there were 26 incidents where the Service applied the Duty of Candour legislation. Jim reminded members that in considering the incidents it was often not possible to be certain that the circumstances of the incident had a cause effect in terms of harm, however in the spirt of the legislation, cases have been included where it was not possible to determine this point fundamentally.

It was noted that the correct procedure was followed in 18 out of the 26 occasions, by the people affected being informed, apologised to and a meeting offered to them. Each case was reviewed to establish what went wrong and learning for the future taken forward.

Jim highlighted that for 2 of the incidents, family contact was carried out by a territorial board partner. For 4 of the incidents, the Service were unable to identify any family members to contact. For 1 incident it was inappropriate to make contact and for the remaining incident the procedures followed during the review process were being reviewed.

Carol Sinclair thanked Jim for the clear report presented and commented that the incidents where partner organisations made contact with patients and the incidents where the Service tried unsuccessfully to make contact with the patient or family should be counted towards the

number of occasions the Service followed the correct procedure as all of these incidents were within the scope of the guidance.

Jim Ward advised that he would pick this up with Sarah Stevenson and amend the report accordingly.

Liz Humphreys asked in relation to the backlog of Significant Adverse Events Reviews (SAERs) if there were likely to be cases within the backlog that have not yet been assessed for Duty of Candour for the 2022/23 time period.

Jim Ward advised that the current report was based on completed reviews between 01 April 2022 and 31 March 2023 and confirmed that there were some outstanding SAERs for that period which were not yet complete and added that these would be included within next year's report.

Members approved the Annual Report for publication subject to the suggested amendment to Section 4 being completed.

Action:

6. **Medical Director and Risk Manager** to include the incidents where partner organisations made contact with patients and the incidents where the Service tried unsuccessfully to make contact with the patient or family within the number of occasions the Service followed the correct procedure.

ITEM 6.3 CLINICAL GOVERNANCE FRAMEWORK REVIEW

Jim Ward presented members with the reviewed Clinical Governance Framework. It was highlighted that the key recommendations from the review of the Framework was the establishment of two new subgroups under the Clinical Governance Committee as undernoted to provide additional assurance to the Committee and Board:

- Patient Safety and Risk Group
- Value Based Health and Care Group

Jim highlighted that the Learning from Events Group was not formally a group under the Framework and advised that he and the Director of Care Quality and Professional Development continue to discuss this.

Committee discussed the reviewed Framework document and approved this and recommended it to the Board for final approval. Jim advised that it was anticipated that the first formal reporting to Committee from the two new subgroups would begin from the February 2024 Committee meeting.

ITEM 6.3 WHISTLEBLOWING QUARTERLY REPORT

Emma Stirling presented members with the quarterly Whistleblowing report. Committee noted that 3 concerns were received through the whistleblowing process within quarter 2 2023/24, 1 of which is being handled as a stage 2 concern and the remaining 2 being taken through business as usual policies.

Members noted that two virtual drop-in sessions to learn more about whistleblowing and becoming a confidential contact were facilitated by current confidential contacts during Independent Whistleblowing Officer (INWO) Speak Up Week. Emma highlighted that quarterly peer support sessions for confidential contacts were planned with the first meeting taking place on 28 November 2023.

Liz Humphreys advised that the quarter 3 report would include analysis into the two whistleblowing questions which were included within this year's iMatter Questionnaire.

Members noted the report.

ITEM 7 EFFECTIVENESS

ITEM 7.1 INFECTION PREVENTION AND CONTROL UPDATE REPORT

Sarah Freeman presented Committee with an update on Infection Prevention and Control (IPC) work since the last Committee meeting.

Sarah highlighted that the IPC team were currently monitoring the standard infection control precautions at emergency departments, with completion of this work expected by December 2023. It was noted that a review was underway of cleaning services and cleaning contracts in the East Region and in 10 stations in the West Region to ensure consistent best value cleaning services that align with the National Cleaning Services Specification (NCSS).

The Committee noted the update presented and thanked Sarah for the comprehensive paper.

ITEM 7.2 EDUCATION UPDATE

Tony Devine presented the paper which provided an update on the developments within the Education and Professional Development Department.

Members discussed and noted the paper which provided updates within the undernoted areas:

- Ambulance Care Assistant VQ Programme
- Ambulance Technician VQ Programme
- Ambulance Technician to Paramedic Progression
- BSc Paramedic Practice
- Newly Qualified Paramedics (NQPs)
- Learning in Practice (LiP)
- Migration to Turas Learn
- East Region EPDD move to NHQ

Tony highlighted that in September 2023, the Clinical Education Centre at Grangemouth was closed, with the staff and EPDD function for the East Region moving into NHQ at The Gyle. Members noted that this move had presented a significant cost saving to the organisation (circa £250k per annum) and utilises the underused space within NHQ. Tony extended an invitation to all Committee members to visit the East EPDD delivery area to meet with the team and students and see first hand the models of delivery and engagement.

Tony advised members of the challenges associated with obtaining accurate figures on the workforce due to the migration to Microsoft365. Tony added that there was duplication of those staff who were registered as bank staff and had not or will not be undertaking clinical work or LiP along with those qualified staff who hold more than one contract which results in those staff having more than one payroll number. It was noted that to ensure a more accurate picture, the Regions commenced a manual check of staff affected vs whole time equivalent regional records which will allow for clearer and accurate data on staff LiP completion.

Tony provided assurance that recent indications of LiP completion figures show that more staff have completed the programme than reported as a result of the issues highlighted above and as such it was likely that following the completion of the manual regional review, the completion numbers would increase. Tony added that with the planned LiP sessions for each Region, it is anticipated that completion of all LiP will be over 90% by the end of the fiscal year.

Carol Sinclair suggested that the Education paper presented to Clinical Governance Committee required to be reviewed to include clinical assurance rather than providing the same information which was provided to Staff Governance Committee. Tony advised that he would review the paper ahead of the next meeting to ensure more clinical focus and would do similar for the paper presented to Staff Governance Committee ensuring staff focus.

Action:

7. **Assistant Head of Education** to review the Education update paper presented to Clinical Governance Committee to ensure future reporting was more clinically focuses and carry out similar work for the paper presented to Staff Governance Committee ensuring staff focus.

ITEM 7.3 CLINICAL SERVICES TRANSFORMATION PROGRAMME UPDATE

Julie King presented Committee with a paper which provided an overview of the work underway across a range of workstreams within the Clinical Services Transformation portfolio which included highlight reports and detailed narrative aligned to the undernoted portfolios:

- Integrated Planned, Urgent and Unscheduled Care
- Preventative and Proactive

Members noted that the highlight reports presented to Committee gave an indication of the breadth of work with external stakeholders and the significant level of engagement underway. The report presented included an overview of the key workstreams together with an indication of the work planned for the coming months. Julie King highlighted that the Clinical Risk Register presented to Committee also includes an overview of the high and very high risks associated with these workstreams.

Julie King highlighted that the Integrated Clinical Hub (ICH) continued to progress with a focus on optimisation in preparation for winter including the targeted recruitment of additional GP Advisers, strengthening of the wider clinical team and the establishment of an operational management function.

Carol Sinclair suggested that it would be beneficial for the February 2024 Committee to be presented with a short term mirror reflection on how this work had impacted directly on winter planning. Julie King advised that she would include an update on this within the next report.

Members noted the work of the Drug Harm team who were working closely with the Research and Innovation team to support a clinical audit of electronic Patient Reports (ePRs) to better understand the complexity of drug harm cases and any improvements which require to be made to correctly capture drug harm patients, along with informing how complex mental health/drug harm presentations are captured.

Committee noted the report.

Action:

8. **Service Transformation Manager** to include a short term mirror reflection within the February 2024 CST Repot on how the work of the CST portfolio had impacted directly on winter planning.

ITEM 8 COMMITTEE GOVERANCE

ITEM 8.6 CLINICAL GOVERNANCE COMMITTEE WORKPLAN 2023

Members noted the Clinical Governance Committee workplan which was presented to each meeting for information with any amendments or additions since the last Committee meeting marked in red for ease.

Irene Oldfather suggested preventative care work as a future Hot Topic item for Committee in line with the 10 year population health plan. Jim thanked Irene for the suggestion and advised that he would ensure that this was picked up within next years Committee Workplan.

Action:

9. **Secretariat** to add Preventative Care as a proposed Hot Topic item on the 2024 Committee Workplan.

ITEM 8.7 ACTION TRACKER

The undernoted update was provided to Committee on item 2023/08/0.1, Action (2):

Jim Ward advised that he would ensure that percentage completeness was included within the action plan for the SAER Process Audit actions and noted that this would also be included for presentation to the Audit and Risk Committee. Jim added that in relation to adopting this approach for the outstanding SAERs progress, this would be challenging given the scale of the issue and added that the work required to be light on bureaucracy and strong on outputs.

Committee noted the following items as completed and approved their removal from the CGC action tracker.

2023/08/04	Clinical Governance Framework Review
2023/08/05.1	Action (1) Patient Experience and Learning from Adverse Events
2023/08/05.2	Patient Experience Annual Report
2023/08/05.3	Clinical Risk Register
2023/08/07.2	Education Update
2023/08/07.3	Clinical Services Transformation Update

Action:

10. **Secretariat** to update the action tracker.

ITEM 9 ITEMS FOR NOTING

Stuart Currie advised members that items 9.1 to 9.4 were the approved minutes of each Committee Sub Group and were presented to each Committee meeting for information.

ITEM 9.1 MEDICINES MANAGEMENT GROUP MINUTES

The Committee noted the minutes.

ITEM 9.2 NATIONAL CLINICAL OPERATIONAL GOVERNANCE (NCOGG) GROUP MINUTES

The Committee noted the minutes.

ITEM 9.3 PUBLIC PROTECTION ASSURANCE GROUP MINUTES

The Committee noted the minutes.

ITEM 9.4 RESEARCH DEVELOPMENT AND INNOVATION GROUP MINUTES

The Committee noted the minutes.

ITEM 9.5 CLINICAL GOVERNANCE COMMITTEE PROPOSED MEETING DATES 2024

Committee discussed and agreed the proposed meeting dates for 2024 namely:-

- 12 February 2024
- 13 May 2024
- 12 August 2024
- 11 November 2024

ITEM 10 ANY OTHER BUSINESS

Francis Tierney, Non-Executive Director
Members noted that this would have been the last Committee meeting for Francis prior to the end of his tenure with the Service. Committee passed on their thanks to Francis for his contribution to Committee, professional background and experience.

Future Committee Meetings
Stuart asked members if they would agree to future Clinical Governance Committee meetings being extended to 3 hours to allow for fuller discussion time to be allocated to agenda items. Members agreed to this approach.

Action:

11. Secretariat to extend 2024 Committee diary invitations to 3 hours.

Stuart Currie thanked everyone for their attendance, discussion, and comments throughout the meeting.

Date of next meeting 12 February 2024 10:00

The meeting closed at 12:57.