MINUTES – Approved

Meeting of the Quality & Performance Committee
Date: Wednesday 23 August 2023
Venue: Delta House, Glasgow/MS Teams

Attendance

Evelyn McPhail	Board Member, Committee Chair
Jackie Brock	Board Member, Committee Vice Chair
Abhishek Agarwal	Board Member
Suzanne Dawson	Board Member
Gill Graham	Board Member
Duncan Service	Board Member
Carole Wilkinson	Board Member/HIS Chair
Robbie Pearson	Chief Executive (until item 2.6)

Present

Sybil Canavan	Director of Workforce
Lynsey Cleland	Director of Quality Assurance and Regulation (until item 4.4)
Ann Gow	Deputy Chief Executive/Nurse Director/Director of System Improvement
Ben Hall	Head of Communications
Diana Hekerem	Associate Director, Transformational Redesign Support
Jane Illingworth	Head of Planning and Governance
Helen Munro	Public Partner
Yvonne Semple	Scottish Medicines Consortium Chief Pharmaceutical Adviser
Chris Sutton	Chair, Clinical and Care Staff Forum
Simon Watson	Medical Director/Director of Safety

Committee Support

Pauline Symaniak	Governance Manager

Apologies

Alexandra Jones	Public Partner
Angela Moodie	Director of Finance, Planning and Governance
Clare Morrison	Director of Community Engagement and Redesign
Lynda Nicholson	Head of Corporate Development
Safia Qureshi	Director of Evidence and Digital

	OPENING BUSINESS AND COMMITTEE GOVERNANCE	
1.1	**Welcome, Apologies for Absence and Declarations of Interests**	
	The Chair welcomed everyone to the meeting, in particular: • Jackie Brock attending her last meeting of the Committee ahead of the end of her term of appointment. Thanks were extended for her contribution to the work of the Committee over several years and for her role as Vice Chair. • Chris Sutton attending her first meeting of the Committee. The apologies were noted as above.	
1.2	**Minutes of the Quality & Performance Committee held on 17 May 2023**	
	The minutes of the meeting held on 22 February 2023 were approved as an accurate record with the one amendment in the "any other business" section in relation to independent healthcare.	
1.3	**Review of Action Point Register: 17 May 2023**	
	The Committee noted that all actions had been completed.	
1.4	**Business Planning Schedule**	
	The Committee noted the Business Planning Schedule and that job titles will be updated now that the new directorates are in place.	
2.	**DELIVERING OUR ANNUAL PLAN**	
2.1	**Organisational Performance**	
	2.1.1 Performance Management Framework The Committee received a paper from the Director of Finance, Planning and Governance providing a draft performance management framework (PMF). The Head of Planning and Governance highlighted the following points: a) Creation of the PMF was an action from the internal audit report on performance management and the draft PMF closes this action. b) The PMF provides assurance internally and to Scottish Government about our performance processes. It also connects to the strategy and references best value. c) Internal audit recommended regular review of the PMF so this has been set at every three years but it will be updated as required in line with the Blueprint for Good Governance and the Scottish Public Finance Manual. In response to a question about the inclusion of staff performance, it was advised that that had originally been considered but there was a desire to avoid duplication with staff governance matters. This will be added as a high-level cross-reference in the text and added to the diagram. Subject to the above change, the Committee approved the PMF. 2.1.2 Organisational Performance Report Q1 The Committee received the quarter 1 organisational performance report from the Director of Finance, Planning and Governance. The Head of Planning and Governance highlighted the following points: a) The report continues to evolve and is now organised in four main sections. b) The strategic overview sets out how performance reporting against the strategy will be implemented. There is a mixed approach here until reporting of progress with the strategy is fully developed. There will also be a gap analysis which will ensure current work programmes align to it. c) The second section of the report provides information on key performance indicators and the status of the work programme. It also includes information on best value and in future an annual best value report will be provided to the	**Head of Planning & Governance**

	Committee at its quarter 1 meeting each year. d) The next section of the report sets out key achievements and challenges including projects at risk while the final section provides information on new commissions. The Committee welcomed the report. They noted that aspects were still in development and that a red-amber-green status would be added to the four priority areas. In response to their questions, the following additional information was provided: e) Figures will be checked in respect of the average cost of production of National Institute for Health and Care Excellence (NICE) guidelines and in respect of Scottish Medicines Consortium (SMC) information. f) The National Cancer Medicines Advisory Group is included as an example in the best value section given the savings that it is generating. Looking at best value for this work also generated ideas for other beneficial changes to the group. g) Regarding how the report demonstrates impact, a Board masterclass in October will look at measurement and this will help with defining impact for an intermediary organisation like HIS. h) Consideration will be given to including information about corrective action and what the impact might be of a target not being met. i) There are several examples of HIS collaborating on guidelines including asthma, chronic pain and long covid. The Committee examined the report and were supportive of its direction of development. They approved it for the submission of a summary to the Board.	**Head of Planning & Governance** **Head of Planning & Governance**
2.2	**Quality of Care in the System- Winter Planning and Resilience**	
	The Committee received a paper from the Chief Executive, Deputy Chief Executive-Nurse Director - Director of System Improvement and the Medical Director- Director of Safety setting out the response from HIS to the upcoming winter pressures. The following points were highlighted: a) The pressures in the health and care system at this time arise from increased levels of illness, impact of bad weather, high staff absence and turnover plus a backlog of work. b) HIS will need to redesign or pause some of its work to respond to this while still providing assurance to the public on the quality of care in the system. c) Alongside this, HIS may receive calls to redeploy staff while our staff experience the same effects of winter. d) The key HIS programmes supporting the system at this time include our work in unscheduled care, frailty and dementia, Hospital at Home and primary care. In response to a question from the Committee about balancing the focus on winter with longer term population health planning, it was advised that the HIS Executive Team is working dynamically at this time to be responsive to Boards' needs and Boards are appreciative of the fact that there is a body able to stand aside from immediate pressures and see the longer term view. The Committee discussed the update and were content with the HIS response set out. They noted that one of the members had attended that week a Winter Summit on behalf of the Chair which had featured Hospital at Home in the discussions.	
2.3	**Responsive Support to NHS Boards Update**	
	Jo Matthews, Associate Director of Improvement and Safety, joined the meeting for this item.	

	The Committee received from the Deputy Chief Executive- Nurse Director - Director of System Improvement an update on cross-organisational responsive work for two Boards, NHS Forth Valley and NHS Ayrshire and Arran. The Associate Director highlighted the following points: a) The work was in response to two safe delivery of care inspections and took a One Team approach to deliver time-bound, critical friend improvement support. Priorities for the work were agreed by clinical and executive leaders to address key safety issues arising from the inspections. b) A key enabler for the success of the work was organisational and team readiness for change, and essential for this was the right leadership culture. c) Key areas of learning from the work were: relationship building is essential; HIS can provide new perspectives on local issues; a need to be realistic about what can be achieved; director support and oversight enabled alignment to strategic priorities; a One Team approach and on-site delivery created most impact. d) Looking to the future and repeating this work, there are capacity challenges and other work has to be paused to create that capacity. There needs to be thought about what can effectively be delivered in a 12 week period and Boards have variable capacity to engage with HIS. The Executive Team added that while it is difficult to attribute impact to HIS, follow-up activity has shown improvements. The Committee welcomed the work and asked that their thanks is passed onto the team. In response to their questions, the following additional information was provided: e) If future requests for this work are received, available resources will be examined but work is already underway to look at links across the Scottish Patient Safety Programme, Excellence in Care and quality assurance activity to see where most impact can be delivered. f) Evaluation case studies are being developed. The Committee noted the update.	
2.4	**Healthcare within Justice Update**	
	The Director of Quality Assurance and Regulation provided an update on work with His Majesty's Inspectorate of Prisons for Scotland and His Majesty's Inspectorate of Constabulary in Scotland to provide assurance in respect of prisons and police custody suites. The following points were highlighted: a) There are common themes arising from these inspections and the work captures the views of those with lived experience. b) While not as high profile as our other assurance activity, the work is very important and to date progress has been made on building and embedding a One Team approach. c) There is a clear commitment to improve the health inequalities experienced by those in justice services and to use a human rights based approach. d) The transformation in the directorate will enable alignment of the work with other NHS settings. In response to questions from the Committee, the following additional points were made: e) The State Hospital sits within the NHS system rather than the justice system. f) The services are responsible for actions plans following inspections but HIS undertakes follow-up through documentary evidence or return visits. Due to pressures in the service there is an increasing need for follow-up activity but this currently applies to all our quality assurance work. The Committee considered the update provided and noted the progress.	

2.5	**Adverse Events Progress Report**	
	The Adverse Events progress report and the Responding to Concerns 6 monthly report at agenda item 4.3 were considered together under this item given a number of common issues. The Director of Quality Assurance and Regulation highlighted the following points from the Adverse Events report: a) The aim of the work is to improve the quality and consistency of reporting of Adverse Events. Boards are responsible for responding to incidents but must report them to HIS and provide us with high-level information. b) A lot of work to date has focused on achieving consistency and standardisation but there are other areas of progress including the update of the national framework, a stakeholder event the following month and good engagement with Boards via an Adverse Events network. c) The work is still progressing but there have been positive impacts for patients, families and carers. The Director then highlighted the following from the Responding to Concerns update: d) This is the regular update paper which includes details of new cases. e) Staffing continues to be the most common theme although concerns are emerging about emergency departments though the numbers are small. f) The paper details responses to concerns and how those concerns link to other areas of our work. g) There is information on operational improvements which seek to address the increasing complexity of cases. The membership of the group and the framework document are also being refreshed, and feedback is being sought from Boards. In response to questions from the Committee, the following additional information was provided: h) Staff have provided very positive feedback about being part of the Responding to Concerns group. i) Regarding the case which was a public contact, these are not usually taken forward as the process does not deal with individual complaints. However, on this occasion, a lot of information was shared that highlighted potential wider governance issues. Therefore a meeting was held and it was decided which aspects of the case were within HIS' remit to consider. j) Regarding the impact of the healthcare staffing legislation, there are sanctions provided but it is not clear yet if a person can take action against a Board using the legislation. The Committee examined both reports and were content with the progress reported. It was noted that a Responding to Concerns deep dive was planned for the Committee for 1 November and it will take account of both topics covered today.	
2.6	**Right Decision Service (RDS)**	
	This item was taken out of order and was discussed after the organisational performance report at agenda item 2.1.2. The Committee received a paper from the Director of Evidence and Digital, and the SMC Chief Pharmaceutical Officer highlighted the following: a) A transition oversight group has been operational since April and had cross-organisational representation. It is a short term group and after transition longer term governance will fit under HIS' governance structures.	

	b) Agreements for the transfer have been received and provided to the Central Legal Office (CLO) for review. Funding transfer processes are in place. c) The programme director has been seconded to HIS and recruitment is underway to support the work. d) Governance processes are being developed in relation to the contents of the platform and standard operating procedures are being updated. No issues have been highlighted and these will be signed off by the directorate management team. Any issues would be reported back to guideline authors. In response to questions from the Committee, the following additional information was provided: e) Funding is provided until March 2025 so recruitment is on a fixed term basis. Work will be done to plan how the platform can be sustainable within HIS after this date. f) If there are no issues with the transition agreements then transition is expected at the end of August. g) Regarding staffing, one of the information scientist vacancies has been filled but one has not. The Committee considered the paper and the additional information provided but were unable to gain sufficient levels of assurance based on the paper with questions in the following areas: h) The expectation of the CLO turnaround on the documentation given the completion of the transition by the end of August. i) Staffing implications including numbers of staff being recruited. j) Inclusion of the Quality and Performance Committee within the governance structure as the primary governance Committee of the Board which has oversight of RDS; how the Decision Support Advisory Board will be integrated into the governance of HIS while ensuring that its priorities are aligned to the wider strategic priorities of HIS. k) More detail in relation to the outcome of the finance work and any risks that need to be managed between now and March 2025. l) The relatively short timeframe that is outstanding for RDS to prove its value before March 2025. m) A need to review the risk register in relation to the answers in the points above. It was agreed that a further report will be provided to the Committee in advance of the next scheduled meeting on 8 November.	**Director of Evidence & Digital**
3.	**CLINICAL CARE AND GOVERNANCE**	
3.1	**Clinical and Care Governance Report**	
	The Deputy Chief Executive-Nurse Director-Director of System Improvement provided the quarterly report and highlighted the following: a) The report includes an update on progress, information about improvements and an updated clinical and care governance (CCG) framework. Update reports form directorates are also provided. b) The CCG group have discussed complaints, safety concerns in independent healthcare and clinical supervision reports. c) There is ongoing work to define risks and two new risks have been added. A deep dive will be completed at the next CCG group meeting. The Chair of the Clinical and Care Staff Forum advised that there was very positive feedback from staff about clinical supervision. In response to questions from the Committee about clinical supervision it was advised that it is challenging to deliver it in busy, acute settings and medical staff in HIS are mostly on secondment from Boards but there may not be a strong link with the Board.	

	The General Medical Council have issued new clinical practice guidelines for appraisal and assessment which apply across all of the individuals' practice meaning that HIS will need to be part of that process. The Committee considered the update and were assured by the progress reported.	
4.	**STAKEHOLDER ENGAGEMENT**	
4.1	**Complaints and Feedback Annual Report**	
	The Committee received the draft annual Complaints and Feedback Report from the Deputy Chief Executive-Nurse Director-Director of System Improvement who highlighted the following: a) The report is structured by nine key performance indicators and is based on the Scottish Public Services Ombudsman's (SPSO) model complaints handling guidance. b) 59 enquires were received and of these 26 were investigated as complaints. Some were responding to concerns matters. 19 of these complaints were closed at stage one, six were escalated to stage two and one complaint progressed straight to stage two due to complexity. HIS did not uphold 12 complaints, partially upheld three complaints and fully upheld 11 complaints. c) There was an increase in the number of complaints relative to previous years but this is likely due to improved training across the organisation as to what should be treated as a complaint. d) There is now a process in place to monitor complaints via the CCG group and learning will be taken forward. In response to questions from the Committee, the following additional information was provided: e) Consideration will be given in future to providing data about the number of complaints over previous years. f) Independent healthcare (IHC) and Death Certification Review Service (DCRS) complaints are reported separately. IHC does not fall within SPSO guidance but DCRS does. The Committee considered the report and approved it for publication.	
4.2	**Death Certification Review Service (DCRS) Annual Report**	
	The Chair advised that the report was circulated separately as there were no specific risks identified in relation to it. However it will be provided to the Board in September. The Committee noted the report and there were no questions. The Director of Quality Assurance and Regulation invited Board members to undertake a walk round of the DCRS. Further contact will be made about this.	**Governance Manager**
4.3	**Responding to Concerns 6 Monthly Report**	
	This item was considered earlier on the agenda with item 2.5.	
4.4	**Public Protection 6 Monthly Report**	
	The Deputy Chief Executive-Nurse Director-Director of System Improvement provided the 6 monthly report. It was advised that training figures have been updated but no particular risks are highlighted and an action plan is in place in response to a complex complaint. Consideration will be given to providing data on the number of complaints over previous years.	**Deputy Chief Executive-Nurse Director-Director of System**

	The Committee considered the update and were content with the information reported.	**Improvement**
5.	**RISK MANAGEMENT**	
5.1	**Risk Management:- Strategic Risks**	
	Paul McCauley, Risk Manager, joined the meeting. The Committee received a risk report from the Director of Finance, Planning and Governance. The Risk Manager highlighted the following: a) An update has been added to the safety risk. Work has been ongoing to accurately define this risk as the risk is for territorial Boards but HIS has a remit in relation to it. b) The report now focuses on risks that are out of appetite and what action is being taken to bring them closer to or within appetite while recognising that there may be tolerance for some risks that are out of appetite. c) Further work to improve risk management processes will look at two areas: a formula for testing the effectiveness of controls which will improve accuracy of scoring to better identify risks out of appetite; directors providing a level of assurance in relation to how risks are being managed. The Medical Director-Director of Safety added that the safety risk will be an agenda item for each meeting of the safety network, a cross-organisational group leading on safety. In response to a question from the Committee about the group, it was advised that the group comprised of relevant colleagues as identified by directors who were linked to the group's purpose. The Committee examined the risk register and subject to the comments above, gained assurance that the risks presented were being effectively treated, tolerated or eliminated.	
6.	**CLOSING BUSINESS**	
6.1	**Board report: three key points** The Committee agreed the 3 key points as follows: 1. Adverse Events, Responding to Concerns, Countess of Chester court case 2. Healthcare in Justice 3. Performance Management Framework, Performance Report	
6.2	**AOB**	
	The Deputy Chief Executive-Nurse Director-Director of System Improvement referred to the recent court case in relation to the Countess of Chester hospital. The case raised a number of serious concerns in relation to patient safety, nursing standards, clinical and managerial leadership, the role of regulators and the information provided to the Non-executives of the Board. Work will be done to cross-refer the issues to the HIS work programmes to identify any gaps. The outcomes of this will be reported to a future Committee meeting.	
6.3	**Feedback Session**	
	Committee members welcomed improvements in the quality of papers and felt the hybrid meeting worked well.	
7.	**Date of Next Meeting** The next meeting will be held on 8 November 2023.	

	Name of person presiding: Evelyn McPhail Signature*: Evelyn McPhail* Date: 08.11.2023	