CLINICAL GOVERNANCE COMMITTEE	Assynt House Beechwood Park Inverness IV2 3BW Tel: 01463 717123 Textphone users can contact us via Typetalk: Tel 0800 959598 www.nhshighland.scot.nhs.uk/
DRAFT MINUTE	**4 March 2021 – 9.00am (via MS Teams)**

Present
Dr Gaener Rodger, Non-Executive Board Director and Chair
Tim Allison, Director of Public Health
Jean Boardman, Non-Executive Board Director
Elspeth Caithness, Staffside Representative
Sarah Compton-Bishop, Non-Executive Board Director
Heidi May, Board Nurse Director
Margaret Moss, Chair of Area Clinical Forum
Adam Palmer, Employee Director (Vice Chair)
Dr Boyd Peters, Medical Director

In attendance
Mary Burnside, Head of Midwifery
Louise Bussell, Chief Officer, North Highland (Teams)
Fiona Campbell, Clinical Governance Manager, Argyll and Bute
Sarah Campbell, Clinical Governance Support Manager, Argyll and Bute (Teams)
Linda Currie, Occupational Therapist, Argyll and Bute (Teams)
Ruth Daly, Board Secretary (Teams)
Dr Paul Davidson, Associate Medical Director
Stephanie Govenden, Consultant Community Paediatrician (Children's Services)
Graham Hardie, Non-Executive Board Director (Observing)
Rebecca Helliwell, Associate Medical Director
Liz Higgins, Practice Education and Development, Argyll and Bute (Teams)
Donellen MacKenzie, Area Manager, South and Mid
Brian Mitchell, Board Committee Administrator
Mirian Morrison, Clinical Governance Development Manager
Kate Patience-Quate, Interim Deputy Head of Nursing
Ian Rudd, Director of Pharmacy
Bob Summers, Head of Occupational Health and Safety
Katherine Sutton, Chief Officer (Acute) (Teams)
Dr Emma Watson, Deputy Medical Director (from 9.30am)
Claire Wood, Associate Nurse Director

1 WELCOME AND APOLOGIES

Apologies were received from Alasdair Christie, Jim Docherty, Deirdre MacKay, and Simon Steer.

The Chair took the opportunity to welcome G Hardie to the meeting, with him joining the formal Committee membership from the next scheduled meeting.

1.1 Declarations of Conflict of Interest

There were no Declarations of Interest made.

2 MINUTE OF MEETING ON 14 JANUARY 2021

The Minute of Meeting held on 6 October was **Approved.**

Associated Actions were then considered as follows:

- **NHSH Response to Ockenden Report** – Members were advised this item had been deferred to the April 2021 meeting. The Ockenden report had been circulated to members, for information.
- **Infection Prevention and Control** – The Chair advised the relevant HSE Report would be sourced and circulated to members.
- **Adverse Events and SAERs** – The Chair confirmed six monthly reports had been scheduled as part of the Committee Annual Work Plan for 2021/2022. Action Closed.
- **Clinical Governance Committee Risk Register** – On agenda.
- **Raigmore QPS Group** – Radiation Exception report on agenda. HIS Report and Action Plan had been circulated to members for information as part of the supporting material pack for this meeting.
- **Recruitment of Lay Representative** – Recruitment activity was ongoing, with a date for informal discussion with interested parties having now been scheduled. It was hoped to conclude recruitment to this Committee and HHSCC by July 2021.
- **Argyll and Bute Clinical and Care Governance Group (CAMHS)** – F Campbell advised a CAMHS Service Manager had recently commenced in post. An Action Plan was in place and a report was scheduled for the next Clinical and Care Governance Group. S Compton-Bishop, as Chair of that Group, confirmed this was now a Standing Item on the agenda. The Chair advised, in relation to CAMHS overall, an update would be sought from Dr B Peters.
- **North and West QPS Group (Test Strips)** – The Chair advised she would follow up on relevant activity with a view to providing an update for the next meeting.

The Committee otherwise:

- **Approved** the Minute.
- **Noted and/or agreed** the actions, as discussed.
- **Agreed** further discussion on outstanding actions be taken out with the meeting and the relevant Action Plan be updated accordingly prior to the next meeting.
- **Agreed** Action Points be numbered on future iterations.

2.1 MATTERS ARISING

- **Covid 19 Vaccination Communications** – The Chair advised she discussed matters relating to relevant communications with R Fry, Head of Communications and Engagement who had subsequently agreed to share the circulated draft Covid-19 Communications Plan. The Plan outlined a range of proactive activities. T Allison added there had been positive feedback from local politicians and public regarding general communication levels, with no major issues having been raised. S Compton-Bishop queried how this plan related to Argyll and Bute and the Chair advised she would follow up on this with a view to providing an update for the next meeting.
- **Social Distancing Advice for those already Vaccinated** – T Allison advised that social distancing advice remained constant and was not affected by vaccination of individuals. A conservative approach was being taken, despite emerging evidence in relation to this providing protection and limiting transmissibility. There was a need to avoid complacency. During discussion, it was confirmed the circulated draft Plan related to the whole of NHS Highland, including Argyll and Bute. This would be confirmed for purposes of accuracy.

J Boardman advised she had heard from a local Argyll and Bute GP who had been expressing concern in relation to the level of vaccine supply being provided, this being lower than the associated capacity to deliver the same. It was advised NHS Highland had a minor role on vaccine distribution, with overall supply coming via national arrangements. Practice supplies in Scotland were delivered direct by a private company. NHS Highland had sought to provide assistance where issues had arisen however did not have the capacity to undertake this on its own. Both key issues were being monitored accordingly. The local impact of cancelling vaccine clinics was appreciated.

The Committee:

- **Noted** the updates provided.
- **Noted** confirmation would be sought in relation to the Covid-19 Communications Plan applicability to the Argyll and Bute area.

3 EMERGING ISSUES

3.1 COVID 19 UPDATE

T Allison provided a presentation to members advising as to the level of infection, and unfortunately the number of deaths in Highland to date, and the measures taken to tackle the virus. It was reported that there had been a series of localised clusters during late December 2020 and early January 2021. Recent levels of new infection had come down significantly. Again he highlighted the need to avoid complacency at this time. One area of interest in relation to recent clusters had been the evidence of many of these involving cases relating to new Covid variants, with the overall rate potentially due to increased local levels of socialising under Level 1 arrangements. It was reported, the recent surge in deaths in North Highland had mainly been related to outbreaks within Care Home settings. Vaccination levels across the Care Homes involved was not considered to be a contributory factor.

With regard to testing activity, it was advised this had been challenging outside of the main Highland population centres although had now been improved. Postal testing could now be accessed across Highland and bookable slots were available via a Fire Station Testing Programme across a number of locations. Additional testing had been put in place for asymptomatic individuals and additional testing had also been established for NHS, Care Home and Social Care staff members. Schools were subject to testing activity, and a work place testing programme was in the process of being introduced. NHS Highland had been working closely with both Local Authorities in all of these areas, especially in relation to asymptomatic testing. This would be valuable as lockdown arrangements were eased.

The Chair raised the issue of testing and sought clarification as to whether PCR of LFT tests were being used for work place testing and in Fire Stations. T Allison advised a mix of both was being used across the patch, with those in Fire Stations being PCR tests, as part of the UK Testing Service and examined in the Glasgow facility. The key was to utilise the most appropriate test applicable to the cohort concerned. Positive LFT testing would lead to a request to self-isolate, followed up by a PCR test. A negative LFT test resulted in no further action for the individual concerned. A precautionary approach was being maintained. The importance of strong communication in this area was emphasised. There was a clear role for the use of both test types.

The Committee otherwise Noted the position.

3.2 Update on Rollout of Vaccination Programme

T Allison advised as to the progress made against existing JCVI priority cohorts, with 105,942 first dose vaccinations having been delivered up to 2 March 2021. The delivery of second doses was now starting to come online. There had been strong uptake to date, with approximately two thirds of all vaccinations in Highland being delivered by GPs. It was reported Scottish Government had given permission, on request, to enable greater flexibility in relation to Island and isolated areas, where a community as opposed to priority group approach could be taken. The vaccination programme continued to accelerate at that time. On the matter of Clinical Governance, it was advised a monitoring system had been put in place for vaccine delivery, noting the two vaccines currently being delivered had not yet been formally licensed and were being delivered under special arrangements. There was a system for considering any Adverse Events, with a Clinical Governance Sub Group of the Vaccine Strategy Group having been established to receive reports.

The Committee Noted the position.

4 NHS HIGHLAND INTEGRATED PEFORMANCE AND QUALITY REPORT

B Peters introduced the circulated updated Integrated Performance and Quality Report (IPR), and proposed that the Committee consider one specific performance area to discuss in detail at each meeting. Direction in this area, by Committee members was welcomed. The Chair advised the relevant Clinical Governance Summary Sheet had yet to be populated and whilst most performance data was now included the format of reporting required further consideration. She welcomed consideration of individual performance areas, which given the nature of Exception Reporting would provide a focus on where performance was not as expected. She emphasised that whilst some measures would not be included within the Clinical Governance element of the report and therefore not be discussed in depth at this Committee these would nevertheless impact on wider Clinical Governance performance.

During discussion, A Palmer referenced current extended Waiting Times for treatment recognising NHS Highland was not an outlier in this respect and questioned where this data would sit within the circulated report. B Peters advised those measures would be discussed in greater detail at the Performance Recovery Board, with the circulated report providing a wider overview for readers. He advised that in respect of waiting times the headline figures did not provide the relevant context, such as the impact of Covid, and that should also be considered in terms of wider performance levels. He stated the Performance Recovery Board would enable the in depth discussion required, help set the key clinical performance metrics and provide that essential context for others. The role of this Committee was to reflect on relevant Clinical Governance activities. Many of these aspects continued to be considered at this time. B Peters also took the opportunity to advise that some procedures had necessarily ceased during the Covid period, due to patient safety among other factors, and as such the longer waits being reported were inevitable from a performance standpoint. Many services would be in the process of planning to address their respective patient backlogs at this time, with a national steer anticipated in this regard. On the point raised by the Chair in relation to Emergency Readmission rates, B Peters stated there would be merit in considering this subject in greater detail, with the Unscheduled Care Team involved in looking at this presently. He added, there were a number of contributory aspects that members would benefit from considering in more detail, in relation to this particular subject.

The Committee Considered and took relevant Assurance from the performance outcomes.

5 NHS BOARD RISK ASSURANCE FRAMEWORK

5.1 Strategic Risk 662 (Clinical Strategy and Redesign)

B Peters spoke to the circulated report outlining the background to this Risk (Very High) being included within the Board Assurance Framework and advising work had now commenced on writing the One Year NHSH Clinical and Care Strategy document. He took the opportunity to advise that ideally NHS Highland would wish to develop a minimum five year Strategy and would require strong consultation arrangements and a programme of work to achieve. A post had been created and advertised with a view to taking this activity forward. The associated Remobilisation Plan had been brought to the final draft stage and would help shape the accompanying Strategy itself.

The Chair referenced the NHSH Remobilisation Plan and Draft Remobilise, Recover, Redesign NHS Highland Strategic Direction for 2021/2022 and questioned where the one year Clinical and Care Strategy would rest in relation to these. B Peters advised many of the work streams referenced were ongoing at this time, with relevant connectivity and associated issues being actively considered. There remained an aim to achieve the development of a longer term Plan as referred to in discussion and this would likely emerge over the coming year. Clinical Governance Committee consideration had been scheduled in to the Committee Annual Work Plan.

The view was expressed that based on the existing mitigation activity and updates provided to Committee at this meeting the associated Risk around Clinical Strategy and Redesign could more appropriately be designated at a lower level. B Peters acknowledged this view, confirming the relevant Risk should certainly be maintained. Members were reminded the Committee had no locus in ascribing risk levels other than recommending EDG review where considered appropriate.

After discussion, the Committee Considered the relevant Strategic Risk and:

- **Agreed** moderate assurance could be given to the NHS Board, based on the updates provided, and evidence of activity moving in the right direction.
- **Agreed** the EDG be recommended to review the Very High Risk level in light of discussion.

5.2 Strategic Risk 659 (Public Health – Brexit)

T Allison spoke to the circulated report outlining the background to this Risk (High) being included within the Board Assurance Framework and advised many cut-off date elements had passed. Members were advised the United Kingdom had left the European Union Single Market and Customs Union. A deal between the European Union and United Kingdom had been put in place. Arrangements for the import and storage of pharmaceuticals had been working well. The arrangements for Brexit meetings as part of resilience and emergency planning had been stood down. He stated whilst Brexit still posed risk, these were of a lower magnitude in nature and as such he recommended the removal of the particular Risk from the Board Assurance Framework. Relevant escalation routes were being maintained in case required.

The Committee Considered the relevant Strategic Risk and:

- **Agreed** High level assurance could be given to the NHS Board, based on the update provided, and low level of remaining associated risk elements.
- **Agreed** the EDG be recommended to remove this Risk from the Strategic Risk Register.

5.3 Strategic Risk 715 (Public Health – Covid 19 and Influenza)

T Allison spoke to the circulated report outlining the background to this Risk (Very High) being included within the Board Assurance Framework. Members were advised there had been a hugely significant impact from COVID-19 within NHS Highland and across the world. This had affected individuals, NHS services and wider society. Control measures had been put in at all levels from guidance on personal behaviour to legislation. Vaccination had started and was progressing well and building upon the success of the influenza vaccination programme. It was stated however that the risk was still very high and resurgence of the virus with new variants was easily possible as had been shown by the large rise in cases in January 2021. He recommended the current Risk level be maintained at Very High.

The Committee Considered the relevant Strategic Risk and:

- **Agreed** High level assurance could be given to the NHS Board on the actions being taken to mitigate against this Risk.
- **Agreed** the EDG be recommended to maintain the existing Risk Level as Very High, given the current circumstances.

5.4 Additional Clinical Governance Committee Risks

M Morrison spoke to the circulated report asking the Committee to consider two Risks for inclusion within the Clinical Governance Committee Risk Register as had been identified as part of the Committee Workshop of 1 December 2020. The two Risks had been defined as follows:

Risk 1 - The Clinical Governance Committee is unable to provide assurance to the NHS Board due to its inability to effectively scrutinise Clinical Governance systems and processes across the organisation.

Risk 2 - The risk of the negative impact that the organisational change is having on the operational units' quality and patient safety arrangements.

She asked the Committee to consider the Risks as identified, whether these should be accepted or modified, identify any current activity or mitigating actions, and ascribe an initial overall Risk Rating for both. In response to a request for more detail relating to Risk 1, the Chair advised this had been raised as part of the Committee Workshop. She stated consideration was being given as to how best shape the Committee agenda and function moving forward, ensure appropriate input from all levels of the organisation and better fulfil the scrutiny function to enable appropriate assurance to the NHS Board. The aim was to make the Committee more effective in this regard.

During discussion, there was general agreement that it would be good practice to include Risk 1 as part of the Clinical Governance Committee Risk Register from a reflective standpoint. The now regular consideration of the Integrated Performance and Quality Report was acknowledged as a mitigating factor in relation to this point, as was the development of a Committee Annual Work Plan and the contribution made by both Executive members and reporting Invitees.

In relation to Risk 2, P Davidson emphasised that organisational change provided the opportunity and potential to improve Clinical Governance arrangements however acknowledged that contributory factors had resulted in slower progress than anticipated. This meant that the associated governance and assurance benefits emerging from such change had yet to be realised. He considered the level of risk to be High at this time. S Compton-Bishop suggested the Risk Descriptor may require to be amended to reflect that was the case. M Morrison stated, reflecting on discussion there may be a case for drawing out two component elements relating to completion of organisational change and subsequent embedding of relevant QPS arrangements.

The Committee Considered the two identified Risks and:

- **Agreed** Risk 1 be rated Medium (8).
- **Agreed** Risk 2 be reconsidered in terms of having two component elements and brought back to the next meeting.
- **Noted** the Risk Register would be a Standing Item on future agendas.

The Committee Agreed to consider the following Item at this point in the meeting.

6 RADIATION SAFETY COMMITTEE EXCEPTION REPORT

P Cook spoke to the circulated report providing a summary of radiation-related incidents, identified risks and a recently conducted Inspection report. It was reported the Radiation Sub Committee were looking for clarification of the requirements of and reporting route to the Clinical Governance Committee for IR(ME)R related matters with a view to updating the relevant Radiation Safety Policy. The Chair confirmed there had also been circulated the relevant Inspection Report and emergent Action Plan from the recent HIS Announced Inspection at Raigmore Hospital relating to Ionising Radiation (Medical Exposure) Regulations 2017. The final Report had yet to be published.

During discussion, clarification was sought as to whether a Radiation Safety Committee Annual Report should continue to be produced or should reporting to the Clinical Governance Committee be on an exception basis only. It was noted a number of outstanding recommendations could be tracked back to outcomes from the Radiography Short Life Working Group. In relation to future reporting the Chair stated this should move to a position where it was more proactive in nature in terms of escalating relevant key risks to Committee. Regular reporting routes were available via that provided to the Committee by the Raigmore QPS Group, and Health and Safety Team. It was confirmed the Radiation Safety Committee, as part of its standing agenda, sought to identify areas of concern requiring escalation. P Cook advised there had been work previously undertaken in relation to the development of Dashboard type approach for status updates, however the current position in relation to this was unknown.

The Committee:

- **Noted** the summary of radiation-related incidents, risks.
- **Noted** the recent HIS Inspection Report and emergent Action Plan from 1-2 December 2020.
- **Agreed** future reporting be on an Exception basis, where appropriate.
- **Agreed** clarification would be sought from the Board Secretary in relation to development of a Status Dashboard approach.

The Committee adjourned at this point in the meeting and returned following a short comfort break.

The Committee reverted to the original agenda running order at his point in the meeting.

7 EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

There were no matters discussed in relation to this Item.

8 OPERATIONAL UNIT REPORTS BY EXCEPTION AND EMERGING ISSUES

8.1 Argyll & Bute Exception Report

The Chair advised she had discussed relevant matters with F Campbell and that no Exception report had been submitted to this meeting given the lack of material progress over that formally reported to the last meeting.

8.2 North and West QPS (Parent) Group

There had been no submission to this meeting. P Davidson reiterated that relevant activity was being maintained, weekly QPS related meetings and associated Sub Groups were held and that that any concerns or issues would continue to be raised at the earliest Committee date. He confirmed there were no Exceptions requiring to be raised at this time.

8.3 Raigmore Exception Report and Minute of Meeting QPS Meeting on 19 January 2021

There had been circulated a Raigmore Hospital Exception Report and Minute of Meeting of the respective Quality and Patient Safety Group held on 19 January 2021.

The Chair noted reference to a case involving macular degeneration and sought confirmation in relation to both any associated mitigation actions and the previously notified Service Redesign activity. She asked for further information in relation to any contributory factors relating to the specified case. E Watson advised there remained wider ongoing system challenges relating to IT at this time, affecting the Macular Service and others.

8.4 South and Mid Exception Report

There had been circulated an Exception Report relating to South and Mid, the content of which was **Noted.**

8.5 Infants, Children & Young People's Clinical Governance Group Exception Report

There had been circulated an Exception Report for March 2021 highlighting activity relating to Significant and Initial Case Reviews for Child Protection, Risk Register items, Mortality and HSMR, issues of concern and other successes and areas of good practice. S Govenden referenced previous discussion in relation to CAMHS Services provision in Argyll and Bute and advised a number of recent Datix reports had been received highlighting issues relating to a lack of Paediatric Consultant Psychiatry support. An appointment had been made in relation to this aspect and was expected to take up post from 10 March 2021. R Helliwell confirmed interim plans had been put in place in the meantime. F Campbell took the opportunity to advise the Committee of an upcoming Fatal Accident Inquiry.

S Compton-Bishop referenced activity relating to child protection forensic medicals, in particular associated travel times, and sought confirmation of current arrangements within Argyll and Bute. S Govenden confirmed that all children within the Argyll and Bute area would travel to Glasgow for forensic examination purposes.

The Committee Considered the issues identified and received assurance that appropriate action was being taken/ planned.

9 INFECTION CONTROL

9.1 Infection Prevention and Control Report

There had been circulated the Infection Prevention and Control report which detailed NHS Highland's position against local and national key performance indicators to end December 2020. H May gave a brief update in relation to the figures being reported and advised that discussion was ongoing in relation to the potential to increase team capacity in relation to Infection Prevention and Control. Additional capacity had been secured during the Covid period as a result of staff being available to take up such duties however as they returned to their normal duties the issue had again arisen. Recruitment of additional Infection Control trained Nursing staff was challenging.

The Chair advised, as relevant performance was now reported via the Integrated Performance and Quality Report at every meeting, she was suggesting this report be received every two meetings moving forward. She added that the inclusion of comparative data had been very welcome. H May stated she would favour current reporting arrangements being maintained given the key role played by Infection Prevention and Control in terms of overall Clinical Governance considerations. P Davidson echoed this view and paid tribute to the work of Infection Control staff at all levels across NHS Highland at this time. He added, in relation to Antibiotic prescribing, NHS Highland had already met its relevant reduction target within Primary Care.

The Committee otherwise:

- **Noted** the update on the current status of Healthcare Associated Infections (HCAI) and Infection Control measures in NHS Highland.
- **Agreed** existing reporting arrangements be maintained going forward.

9.2 Annual Work Plan 2020/2021 Update

There had been circulated an updated Annual Work Plan 2020/2021, as at February 2021, with revised RAG Ratings.

The Committee Noted the updated Annual Work Plan document.

10 INFORMATION ASSURANCE GROUP

There were no matters discussed in relation to this Item. A formal report would be sought for the next meeting.

11 COMMITTEE GOVERNANCE AND ADMINISTRATION

11.1 Clinical Governance Committee Annual Report 2020/2021

The Chair spoke to the circulated Annual Report, which required Committee approval prior to being submitted to the Audit Committee as part of the Annual Accounts process and subsequently presented to the NHS Board. She drew the particular attention of members to the Emerging and Key Issues element of the Report outlining issues to be considered, addressed and improved over the coming year. This reflected outstanding actions as well as issues raised at the Committee during the reporting period. This had been used to help inform the development of the Annual Work Plan for 2021/2022. It was intended that Committee Self-evaluations would be tabled at the same time as Annual Reports in future years. M Morrison also took the opportunity to highlight that a number of tables contained within report were indicative of a part year position, and would be completed post financial year end. The views of members were welcomed.

The Committee Approved the Clinical Governance Committee Annual Report 2020/2021 for onward submission to the Audit Committee and NHS Board subject to addition of the relevant Attendance List and completion of post financial year end data.

11.2 Draft Committee Annual Work Plan 2021/2022

The Chair spoke to the circulated draft Annual Work Plan and advised this would be updated to reflect that Infection Prevention and Control reporting would be returned as a Standing Item in light of earlier discussion. She drew the attention of members to inclusion of Annual Reports from both Health and Social Care Partnerships in relation to which it was anticipated they be presented by relevant Chief Officers. Also highlighted was the initial inclusion of updates in relation to Clinical Governance arrangements across Acute, and Community and Care Services in relation to which the views of members were being sought. The Annual Complaints report had been included, with additional Complaints reporting at every second meeting, over and above that provided by the IPQR and the views of members on this proposed approach were sought. Public Health updates had also been included as a Committee Standing Agenda Item. The Emerging Issues Item had been maintained and merged with the Executive and Professional Leads Reports by Exception. This agenda item would provide room for urgent issues that need ot be escalated to the Committee on any matter relating to Staff Governance.

There had been discussion as to how best to ensure appropriate communication and working arrangements with lay representatives and this would be continued. H May further suggested an annual summary of patient opinion may be valuable to the work of the Committee and it was confirmed discussion was ongoing in relation to how this could be reported and utilised.

M Morrison advised future Complaints reporting could be undertaken in way that placed less focus on performance, but more in relation to emerging themes and action taken. This could be provided every second meeting. On the issue of utilising information from Care Opinion she confirmed active discussions were ongoing with Communications and Engagement Team. The view was expressed that careful consideration should be given as to how this information and that relating to patient experience more generally, could be collected and utilised. The Chair stated there would likely be a role for the Communications and Engagement Team in that regard.

After discussion, the Committee:

- **Agreed** the draft Committee Work Plan 2021/2022 document, subject to reporting on Infection Prevention and Control becoming a Standing Item.
- **Agreed** reporting of Complaints be via the IPQR report, the scheduled Annual Report and at every second meeting relating to key themes and action taken.

11.3 Committee Self-Evaluation

The Chair advised she was to prepare a Committee self-evaluation document, based on example from elsewhere. This would be issued to members via a Survey Monkey approach with a view to seeking relevant feedback ahead of the April 2021 meeting. She further asked that members also honestly reflect on the operation of the Committee during 2020/2021. B Peters referred to the current meeting schedule and urged reflection on relevant reporting requirements moving forward. In response, the Chair emphasised the need for an effective Exception based reporting process.

The Committee Noted the updated Annual Work Plan document.

12 AOCB

There were no matters discussed in relation to this Item.

13 DATES OF FUTURE MEETINGS

Members **Noted** the remaining meeting schedule for 2021 as follows:

29 April
1 July
2 September
4 November

14 DATE OF NEXT MEETING

The Chair advised members the next meeting would take place on 29 April 2021 at 9.00am.

The meeting closed at 12.15pm