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| **CLINICAL GOVERNANCE COMMITTEE** | Assynt House<br>Beechwood Park<br>Inverness IV2 3BW<br>Tel: 01463 717123<br>Textphone users can contact us via<br>Typetalk: Tel 0800 959598<br>www.nhshighland.scot.nhs.uk/ |
| **MINUTE** | **2 July 2026 – 9.00am (via MS Teams)** |

**Present**

Karen Leach, Chair
Joanne McCoy, Vice Chair and Non-Executive Director
Louise Bussell, Board Nurse Director
Graham Illsley, Non-Executive Director
Muriel Cockburn, Non-Executive Director
Seamus McMillan, Independent Public Member
Liz Henderson, Independent Public Member
Gerry O'Brien, Non-Executive Director
Arlene Johnstone, Chief Officer, HSCP

**In attendance**

Sarah Buchan, Director of Pharmacy
Nathan Ware, Deputy Head of Corporate Governance
Gillian Valentine, Associate Director of Midwifery/ Nursing for Women's Services
Andrew King, Governance & Corporate Records Manager
Elaine Henry, Operational Medical Director
Julie Gilmore, Associate Nurse Director, HSCP
Stacey Evans-Charles, Lead Nurse Tissue Viability
Elspeth Caithness, Employee Director
Paul Chapman, Associate Director AHPs
Jill Mitchell, Head of Primary Care
Stephanie Govenden, Consultant Community Paediatrician
Derick MacRae,Service Manager
Leah Smith, Complaints Manager
Jennifer Davies, Director of Public Health
Dr Claire Copeland, Deputy Medical Director (HHSCP)
Laura Neil, Associate Director of Quality and Clinical Governance
Anna Chisholm, Senior Corporate Administrator
Mirian Morrison, Clinical Governance Development Manager
James Mullins Associate Nurse Director, A&B

## 1.1 WELCOME AND APOLOGIES

Formal apologies were received from Dr Boyd Peters, Katherine Sutton, Neil Wright, Rebecca Helliwell, Dr John Rae, Kate Patience-Quate, Jo McBain, Linda Currie, Lynsey Callghan and Dr Fiona Gunn.

## 1.2 DECLARATIONS OF INTEREST

No members declared any interests.

## 1.3 MINUTE OF MEETING THURSDAY 7 MAY 2026, ROLLING ACTION PLAN AND COMMITTEE WORKPLAN 2026/2027

The Minute of Meeting held on 7 May 2026 was **Approved.** The Action Plan was discussed and updated.

S McMillan revisited a concern raised at the previous meeting regarding workforce and staffing pressures, noting that although workforce planning is not directly within the committee's remit, staffing issues are having a significant impact on multiple clinical services across NHS Highland, including Argyll and Bute.

The Chair advised that this issue had been identified for escalation and would be discussed further between committee chairs and executive leads to determine how it could be progressed through the appropriate governance routes.

The Chair noted that an action relating to this issue will return to the committee in September. An update relating to A&B would be provided through papers on the current agenda. An update was also expected through the Oral Health/Dental Services reporting.

**The Committee:**
- **Approved** the draft Minute.

## 1.4 MATTERS ARISING

The Chair invited the Committee to raise any matters arising from the minutes that were not otherwise covered in the agenda papers. No additional matters arising were identified or raised by members.

## 2 SERVICE UPDATES

## 2.1 Cancer Service – SACT – progress report

D MacRae and E Henry spoke to the circulated report, covering chemotherapy and newer targeted and immunotherapy treatments delivered across Raigmore Hospital and five satellite locations throughout Highland. The report coincides with implementation of the new national SACT framework and guidance (DL(2025)14), which came into force in June and provides a national structure against which services will be monitored and assessed. The service continues to provide safe and patient-centred care but remains fragile, with significant reliance on a small number of clinical staff and ongoing workforce challenges. Concerns were raised regarding vacancies and recruitment difficulties. Lack of permanent clinical leadership within the service. Dependence on mutual aid from other cancer centres. Increasing demand, complexity and volume of cancer treatments. NHS Highland has the smallest cancer centre in Scotland, making the service particularly vulnerable to workforce pressures. A new Cancer Clinical Director is now in post. Recruitment of a dedicated SACT Clinical Lead is underway, with protected sessions included in the role's job plan. Ongoing work is being undertaken to strengthen clinical governance arrangements, compliance with national standards, non-medical prescribing capacity, pharmacist prescribing and specialist nursing roles and national and regional support arrangements through regular mutual aid meetings.

G Ilsley noted that projections indicate activity could increase to around 2,900 appointments per year by 2030. He highlighted that, although the report stated a safe service was currently being delivered, the existing arrangements for non-medical prescribing were not fully aligned with national standards for safe practice. He asked what solutions are being considered to increase clinical workforce capacity? How the service plans to strengthen medical prescribing input and achieve compliance with national standards? What actions are being taken to support future demand growth?

G Ilsley also questioned the proposed appointment of the new Clinical Lead, noting that the report identified this role as critical to driving improvement. He asked whether the Clinical Lead would have dedicated time within their job plan for leadership responsibilities. Whether their clinical commitments would be reduced accordingly. Whether there was a risk of relying too heavily on one individual to resolve the service's challenges given the scale of work required.

E Henry confirmed that the Clinical Lead role would have protected programmed activity sessions in their job plan and would not simply be added on top of existing clinical duties. The service was exploring alternative workforce models, including increased use of non-medical prescribers, clinical nurse specialists, prescribing pharmacists and consultant radiographer roles. Additional support was being sought nationally through mutual aid arrangements and recruitment efforts. The Clinical Lead would be part of a wider leadership structure, including the Cancer Clinical Director and other senior medical support, rather than being expected to solve the issues alone.

M Cockburn asked for clarification about the fortnightly meetings referred to by Elaine Henry, specifically whether these were ad hoc meetings or part of a national multidisciplinary or mutual aid arrangement. Muriel reflected that there can sometimes be local pressure for treatment to be delivered close to home but stressed that patients generally want the best treatment available to them, even if this requires travelling to another centre. She suggested that NHS organisations may not always communicate this message effectively and that the public can be more willing to travel for specialist care than is sometimes assumed. She encouraged consideration of how the organisation communicates the balance between local access and specialist treatment, particularly as services become increasingly networked across Scotland.

E Henry explained that the fortnightly meeting is a formal standing mutual aid meeting involving cancer centres across Scotland. Mutual aid has evolved from being something used only during staffing shortages into a routine mechanism for supporting cancer services nationally. The preferred model is that patients may travel for specialist consultations or procedures, while as much ongoing treatment as possible is delivered closer to home, including within Highland. Remote consultations and locally delivered treatment supported by other cancer centres are increasingly being used.

J McCoy expressed concern about the action description table included in the paper and questioned whether the RAG (Red/Amber/Green) ratings were being used consistently. She noted that the RAG definitions appeared to differ from those used elsewhere within NHS Highland reporting. She was uncomfortable with actions described as planned being categorised as green, suggesting that green should be reserved for actions that are already underway or completed. Several actions that were shown as green would more appropriately sit under amber. The action plan lacked timescales and target dates, making it difficult for the Committee to assess progress or understand when improvements were expected to be delivered.

D MacRae acknowledged the point and explained that the reporting format had largely reflected the style used by the Nurse Consultant leading the work. He agreed that future reports should use a format more consistent with NHS Highland governance reporting, include clearer timelines and milestones and be more time-bound to support Committee assurance.

**Action: A future action plan that is aligned with NHS Highland's standard governance approach is required.**

The Committee also discussed the importance of ensuring patients understand when care may be delivered locally and when elements of treatment require attendance at specialist centres elsewhere.

The Committee accepted **Limited** assurance on the Cancer Service – SACT report.

The Committee gave **Limited Assurance** as the service continues to deliver safe, patient-centred cancer care and is making progress towards compliance with the new national SACT framework; however, significant workforce shortages, leadership gaps, service fragility and reliance on mutual aid arrangements continue to present risks to sustainability and service resilience.

### 2.2 Vascular Services – Progress Update

E Henry spoke to the circulated report, advising that vascular services have now moved into a more stable position following a prolonged period of challenge. Key improvements highlighted included recruitment of a fixed-term locum vascular consultant who had previously worked within NHS Highland. Commitment from two additional locum consultants to support the service over the next year. Increased ability to repatriate care and treatment to Highland, reducing the need for patients to travel elsewhere for vascular interventions where care can be delivered safely locally. Development of a strengthened governance framework to oversee the redesigned service. Establishment of a Pan-Scotland Vascular Governance Group, chaired by Elaine Henry, involving operational medical directors and chief officers from supporting Boards. This group will meet on a six-monthly basis to review adverse events, shared learning and service performance across Scotland.

While noting that the longer-term vascular service model remains under development, Elaine reported that the current arrangements have improved service stability and provide greater assurance that patients can access the right care at the right time.

S McMillan asked for clarification about what vascular services encompass e.g. whether they included ischaemia or DVTs. Elaine explained that vascular services relate primarily to arterial disease and the blood supply to organs and outlined why Highland is reliant on regional arrangements for specialist vascular care.

### 2.3 Dental Services and Oral Health Update

J Mitchell spoke to the circulated report, highlighting ongoing challenges with access to NHS dental care, largely driven by workforce shortages affecting both General Dental Services (independent contractors) and the Public Dental Service. It was highlighted the recruitment, and retention difficulties continue across Highland and reflect wider national workforce challenges. The Public Dental Service is increasingly required to provide care where gaps exist in independent dental provision. Some dental practices are deregistering NHS patients in favour of private provision, placing additional pressure on NHS services. Adult access to dental services remains a concern, with participation rates below the Scottish average. Waiting lists continue for dental procedures requiring general anaesthetic, although additional sessions have been introduced.
Closure of the Inverness Dental Centre for a period due to estates issues caused significant disruption to clinical services and training; services have now resumed.

It was confirmed registration rates remain relatively high, with approximately 85% of both children and adults registered with an NHS dentist. Child participation rates remain close to the national average. Oral Health Improvement teams continue preventative work in local communities. The Scottish Dental Access Initiative has successfully supported some practices to increase capacity through grant funding.

M Cockburn asked whether the service held data on participation rates for children and young people, apologising in case she had missed it in the paper. This prompted a discussion on dental attendance data, particularly whether children were accessing services despite the wider challenges around workforce and access. J Mitchell confirmed that participation data was included in the report and advised that child participation was 81.1%, compared with a Scottish average of 83%. Adult participation was 53.8%, below the Scottish average of 57%. Jill noted that the children's figures were relatively positive and reassuring, whereas adult access remained a more significant concern.

J McCoy referenced section 3.7 of the report, which identified a number of priority areas for the service, including recruitment and workforce development, digital transformation, emergency access, sustainability and capital investment. She asked whether there was a more detailed plan sitting behind these priorities and whether the Committee could receive a more detail on the actions being taken the timelines for delivery and information on how the service intended to progress these priorities. There is mention of priority areas including recruitment, workforce development, digital transformation, emergency access, sustainability and capital investment. She asked whether there was a plan with more detail that the Committee could see, including timelines for delivery.

L Henderson reinforced the point that while Limited Assurance appeared appropriate, the paper did not clearly describe what improvements would be needed to increase the level of assurance.

J Mitchell confirmed that workforce and recruitment challenges remain the major issues facing the service. There is significant reliance on national initiatives, including overseas recruitment, to improve workforce capacity. Detailed plans are available and will be shared with the Committee to provide greater visibility of intended improvements and timescales.

**Action: J Mitchell will share detailed improvement plans with the group.**

The Chair observed that the update focused primarily on dental services and did not sufficiently address the wider oral health and public health aspects previously requested by the Committee. Members agreed that future reports should better integrate dental and public health perspectives.

The Committee noted the update and accepted **Limited** assurance.

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| The Committee noted the update and accepted **Limited Assurance** due to ongoing access and workforce challenges but welcomed the actions being taken to improve capacity and service resilience. |

### 2.4 A&B Child Protection Nurse Resourcing Update

J Mullins spoke to the circulated report, highlighting significant workforce and governance risks associated with the current resourcing model. The service is heavily dependent on one Child Protection Nurse Advisor and one Child Health Manager, creating a significant single-point-of-failure risk. James noted a marked disparity compared with North Highland, where there are 6.9 WTE Child Protection Nurse Advisors, raising concerns about equity of resource and service resilience. Increasing safeguarding demand, service complexity and workload pressures are impacting the team's ability to meet requirements. Health Visiting and School Nursing staff are increasingly being diverted from preventative work to meet safeguarding demands. Risks were identified around governance arrangements, information sharing, staff wellbeing, emotional strain and burnout. A new Child and Maternal Health Governance Group has been established in A&B to strengthen oversight and governance arrangements. The first meeting had taken place shortly before the committee meeting. The group will report through Highland child health governance structures and monitor improvement actions going forward.

L Bussell welcomed the report, noting that while concerns had been known for some time, the paper provided a much clearer understanding of the specific issues requiring action.

The Chair acknowledged the seriousness of the workforce and wellbeing concerns and sought assurance that progress would continue to be monitored through A&B governance structures and the Infants, Children and Young People governance arrangements.

J McCoy asked that future updates include the actions, mitigations and timescales arising from the new governance group's work so that the Committee could track progress. James confirmed that this would become a regular item through the governance reporting process and that ongoing updates would be provided.

The Committee accepted **Limited** assurance on the update.

**The Committee noted** the update and accepted **Limited Assurance** due to workforce capacity and resilience risks within the child protection service. Members acknowledged that strengthened governance arrangements had been established through the new Child and Maternal Health Governance Group, although improvement actions remain at an early stage.

### 2.5 Pharmacy Service Update

S Buchan spoke to the circulated report, highlighting that the nine strategic workstreams are established and progressing in line with local and national priorities. The main focus of the discussion was the introduction of the new Chief Pharmacist Standards issued by the General Pharmaceutical Council. Sarah explained that all NHS Boards are now required not only to have a Director of Pharmacy in place, but also to demonstrate compliance with the standards of a Chief Pharmacist across four key domains leadership, workforce development, governance and strategic responsibility. Sarah advised that she had been working nationally with pharmacy colleagues to develop reporting templates and proposed bringing a detailed Chief Pharmacist Standards assurance report to the next Clinical Governance Committee meeting on 3rd September to provide a deeper level of assurance.

The Committee welcomed the proposal and supported a future deep-dive report. Members noted the ongoing contribution of pharmacy services to a number of key areas, including support for cancer services and wider organisational priorities.

The Committee accepted **Moderate** assurance on the update.

**The Committee noted** the update and accepted **Moderate Assurance** as progress is being made across the Pharmacy Services Strategy workstreams, with governance and improvement activity in place. Further assurance will be provided through a future detailed review against the new Chief Pharmacist Standards.

## 3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

L Bussell spoke to the circulated report, advised that NHS Highland is preparing to implement Healthcare Guardian, the new incident reporting system replacing Datix. While some implementation challenges had been encountered, work with the supplier was progressing and the first phase, covering incidents and complaints, was scheduled to go live later in July. Members noted that reporting and assurance information would change as the new system becomes established.

L Bussell also highlighted emerging concerns about variation in clinical practice across some of NHS Highland's island communities. While recognising that some variation is appropriate due to local circumstances, there is a need to ensure that governance arrangements are robust and that services remain safe and effective. The Committee noted that this would become a specific area of focus, with discussions already underway through professional governance forums.

J Davies provided an update on the introduction of the new MenB vaccination programme, which has emerged rapidly following recent public health concerns elsewhere in the UK. She assured the Committee that NHS Highland is actively involved in the national planning arrangements and is working through the practicalities of implementation.

The Chair noted particular interest in the developing work on island services and suggested there may be opportunities to learn from wider island healthcare networks. The Committee also recognised the importance of managing the transition to Healthcare Guardian and ensuring governance oversight remains strong during implementation.

**The Committee Noted** the reported position on the implementation of Healthcare Guardian, emerging governance work relating to variation in island services, and preparations for the rollout of the MenB vaccination programme.

## 4 PATIENT EXPERIENCE AND FEEDBACK – Complaints and Compliments Case Studies

M Morrison spoke to the circulated report, highlighting work underway to strengthen the use of Care Opinion and improve patient engagement. A dedicated resource has been identified within the Clinical Governance Team to support Care Opinion, with a focus on ensuring responses are provided within 48 hours and increasing the number of trained responders across services. Members noted that 83% of Care Opinion posts were positive and welcomed plans to improve reporting and organisational learning from feedback.

E Henry supported the increased use of Care Opinion and noted that it is a relatively easy platform for staff to engage with. Staff sometimes assume responding to Care Opinion is equivalent to writing a formal complaint response, but responses can be more straightforward and timelier. The system provides an early warning process for significantly adverse feedback before publication. An emerging trend of complaints appearing to be drafted using AI tools. She reported that complaints are becoming increasingly lengthy and detailed, with some extending to 18 pages. More complainants are accessing their medical records and using this information within complaints. AI-generated submissions often contain extensive references to standards, regulations and professional guidance. The increased volume and complexity of complaints is creating additional workload for staff. Elaine cautioned that sometimes the real issue or outcome that matters most to the patient can become obscured within very lengthy submissions. She advised that NHS Highland is monitoring this trend closely and continues to focus on early engagement with complainants to understand what outcome they are seeking and ensure concerns are addressed appropriately. She also noted that the SPSO had begun observing similar trends nationally.

L Smith noted that the Scottish Public Services Ombudsman (SPSO) is beginning to provide guidance to complainants on the appropriate use of AI when preparing complaints. NHS Highland may also need to consider providing guidance and support to people who choose to use AI to help submit complaints. The increasing use of AI is likely to change how complaints are received and managed, and the organisation should seek to stay ahead of these developments.

Members discussed the growing use of AI in complaints, highlighting concerns regarding the accuracy and potential over-reliance on AI-generated content. The Committee recognised the need for clear guidance on the appropriate use of AI, while emphasising the importance of understanding the underlying concerns and desired outcomes of complainants and continuing to promote accessible feedback mechanisms such as Care Opinion.

The Committee noted the report and agreed a **Moderate** level of assurance.

**After discussion, the Committee Noted** the detail of the report and **Agreed** to take **Moderate assurance** recognising improvements in patient feedback processes, including strengthened Care Opinion arrangements and effective complaints management, while noting emerging challenges associated with AI-assisted complaints that require ongoing monitoring.

## 5 CLINICAL GOVERNANCE AND PERFORMANCE DATA

M Morrison spoke to the circulated report, advising of the improvements in complaints management and ongoing work to strengthen adverse event review processes. Members noted that while complaints performance had dipped in April, the number of open complaints had reduced significantly, with more complaint responses being issued than new complaints received. SPSO cases remained stable, and recent cases had been resolved at an early stage, providing assurance regarding the quality of complaint responses. Completion times for Significant Adverse Event

Reviews (SAERs) continue to exceed the 26-week target and that overdue actions remain a challenge. To strengthen capacity, additional training had been delivered to increase the number of staff able to undertake Lead Reviewer roles, with a multidisciplinary pool of reviewers now established across services.

Members also discussed planned improvements to performance reporting, including a review of how data is presented within the IPQR to improve clarity and accessibility. Positive progress was noted in reducing overdue complaints, supported by enhanced monitoring, regular reporting and stronger clinical leadership involvement across operational areas.

The Committee noted the report and agreed a **Moderate** level of assurance.

**After discussion, the Committee**:

**Noted** the detail of the report and **Agreed** to take **Moderate assurance** reflecting improvements in complaints management and oversight, while recognising ongoing challenges in completing Significant Adverse Event Reviews within target timescales and closing outstanding actions.

## 6 OPERATIONAL UNIT REPORTS BY EXCEPTION AND EMERGING ISSUES WITH MINUTES FROM PATIENT QUALITY AND SAFETY GROUPS

### 6.1 Argyll and Bute

J Mullins spoke to the circulated report, advising of the varying assurance position across services. Moderate assurance was reported for Health and Community Care, Primary Care, Acute and Complex Care, and External Agency Environment, while Children, Families and Justice remained at Limited Assurance due to the child protection risks discussed separately. Members also heard that governance arrangements across the Partnership are being strengthened through the development of central oversight mechanisms and governance improvement work. It was confirmed of the workforce pressures and service sustainability challenges across several services, child protection and community paediatric workforce vulnerabilities, delayed discharge and patient flow pressures, service resilience issues within some GP practices and sexual health services and ongoing challenges in delivering healthcare on islands, particularly in relation to workforce and unscheduled care provision.

The Committee welcomed positive progress in governance development, inspection outcomes, complaint handling and improvement activity. Members also noted the establishment of improvement plans and governance structures to address identified risks.

L Henderson queried whether the assurance rating for Health and Community Care should remain Moderate given the concerns highlighted.

The Committee agreed that Health and Community Care should be amended from **Moderate** to **Limited** Assurance to better reflect the risks described within the report.

**After discussion, the Committee:**

**After discussion, the Committee Noted** the content of the circulated report and **Agreed** to the varying levels of assurance and amend from **Moderate** to **Limited Assurance** for Health and Community Care due to ongoing workforce, service resilience and patient safety risks, including concerns regarding community services, island provision and clinical capacity. Members noted that improvement actions and strengthened governance arrangements are in place to address these challenges.

### 6.2 Highland Health and Social Care Partnership

Dr C Copeland spoke to the circulated report, noting a mixed assurance picture across services, with substantial assurance in Mental Health, Learning Disabilities, DARS and Pharmacy Services, and limited assurance in a number of other areas. Discussion focused on governance, patient flow, service quality and organisational learning. She confirmed a new Clinical Director for General Practice has begun work to strengthen governance and quality improvement within Board-run GP practices, with the expectation of improved assurance in future reports. Continued monitoring of surge and escalation capacity, particularly within community hospitals, has not identified significant patient harm through quality and safety metrics, although members noted that traditional metrics may not fully capture patient and staff experience. Review of Significant Clinical Review (SCR) themes identified recurring issues relating to communication, escalation processes and documentation, with a multidisciplinary learning event planned to support organisational learning. Positive engagement with the Patient Safety Commissioner was noted, alongside updates on care home governance and leadership oversight.

The Committee welcomed the format of the report, particularly the clearer description of governance structures, assurance mechanisms and learning processes. Members discussed the importance of presenting unscheduled care pressures from a whole-system perspective, recognising the interdependencies between community, acute and social care services

The Committee noted the report and agreed a **Moderate** level of assurance.

**After discussion, the Committee Noted** the content of the circulated report and **Agreed** to take **Moderate assurance,** whilst noting several services continue to report limited assurance within the overall report.

### 6.3 Acute Services

E Drummond spoke to the circulated report, advising of the combination of service improvements and ongoing operational pressures. Positive progress was also reported in areas such as cancer services, CAMHS performance, infection prevention and control, complaints management and significant adverse event review capacity. The report highlighted several key clinical governance risks and challenges, including sustained capacity and flow pressures, with concerns regarding emergency department performance, ambulance offload delays and delayed discharges. Workforce and recruitment challenges affecting services such as cancer care, breast screening and planned care. Growing pressure associated with national planned care recovery programmes and the need to balance service improvement with workforce sustainability. Ongoing work to improve patient flow through data-driven improvement approaches and closer integration between acute and community services.

S McMillan asked for clarification on what was included within vascular services, specifically querying whether it covered conditions such as ischaemia and deep vein thrombosis (DVTs) and seeking a better understanding of the scope of the service. E Henry explained that vascular services primarily relate to arterial disease and the blood supply to organs, including conditions affecting major blood vessels and limb ischaemia. She noted that modern vascular care increasingly relies on specialist interventional techniques and that NHS Highland is too small to sustain a fully independent vascular service, necessitating ongoing collaboration and support from other Boards.

G O'Brien highlighted that it is important to recognise that over 95% of patients admitted to hospital are discharged without delay, and that this should not be lost in discussions about system pressures. He noted that while a relatively small number of patients experience delayed discharge, those delays can become prolonged because of the complexity of individual circumstances. Gerard also observed that the significant impact a relatively small number of delayed discharges can have on the wider system demonstrates the strain under which services are operating.

C Copeland noted that while individual reports provide updates on key pressure areas, the Committee may not always get a clear picture of how acute, community and social care services work together to manage system pressures. Claire suggested that a more joined-up approach to governance reporting could better demonstrate the patient journey and the collective work being undertaken across services. Claire highlighted that issues such as delayed discharge and unscheduled care pressures are felt most acutely within hospital services but require action across the entire system to address them effectively. She proposed exploring whether future reports could provide a clearer whole-system perspective and invited discussion with colleagues from Acute Services and A&B on how this might be achieved.

L Bussell noted that the move towards regional planned care arrangements would become a significant area of focus for NHS Highland. Consideration would need to be given to how these developments are reflected through Clinical Governance reporting. The issue was moving beyond being simply an emerging issue and would have implications for how services are planned and delivered in the future. Further thought was required regarding how the Committee receives assurance and oversight of this work going forward. Louise welcomed C Copeland's suggestion of a more integrated, whole-system approach to unscheduled care reporting and reflected on the opportunity to refresh how governance information is presented across services. She indicated support for reviewing both governance processes and reporting arrangements to better reflect patient journeys across the system.

The Committee noted the report and agreed a **Moderate** level of assurance.

**After discussion, the Committee Noted** the content of the circulated report and **Agreed** to take **Moderate assurance**, recognising progress in service stabilisation, governance, patient safety monitoring and performance improvement. However, significant pressures remain in relation to patient flow, delayed discharge, workforce sustainability, emergency care performance and planned care delivery.

### 6.4 Infants, Children and Young People's Clinical Governance Group (ICYPCGG)

L Bussell spoke to the circulated report, covering matters from two meetings since the last report to Committee. The withdrawal of Highland Council funding for CAMHS specialist support for care-experienced young people, with work underway to ensure appropriate pathways and support arrangements remain in place. The Committee also noted discussions on post-sleeping guidance and learning arising from child death reviews, which reinforced the importance of consistent messaging and safeguarding practice. The new Child Health System had successfully gone live. While some workforce and system vulnerabilities remain and a number of workarounds are still required as the system develops, governance arrangements are in place to oversee implementation and manage associated risks. The report also highlighted continuing concerns regarding A&B paediatric services, which are expected to feature as an ongoing area of focus through future governance reports. Child protection issues and workforce pressures previously discussed elsewhere in the meeting were also recognised as significant concerns for the Group.

S Govenden highlighted that the Group had also considered issues already discussed elsewhere in the meeting, particularly child protection concerns and workforce pressures, and emphasised that these remained matters of significant concern for the Group.

The Chair raised the issue of transition arrangements between children's and adult services, highlighting this as a complex area for young people, families and services. L Bussell agreed that greater visibility of transition governance would be beneficial and undertook to consider how this could be strengthened through existing governance structures.

The Committee noted the report and agreed a **Moderate** level of assurance, while recognising ongoing risks associated with digital system implementation and workforce pressures within children's services.

**After discussion, the Committee Noted** the content of the circulated report and **Agreed** to take **Moderate assurance**, recognising progress in key areas including implementation of the Child Health System, CAMHS improvement work and governance oversight of children's services. Members noted ongoing concerns relating to child protection and paediatric workforce pressures, which continue to be monitored through separate governance arrangements.

## 7 INFECTION PREVENTION AND CONTROL REPORT

L Bussell spoke to the circulated report, advising that published data for Clostridioides difficile (CDI), Staphylococcus aureus bacteraemia (SAB) and E. coli bacteraemia remained within predicted limits, although not all targets had been achieved. Members noted that NHS Highland continues to work to existing targets while awaiting confirmation of any revised national reduction trajectories. A key issue raised was the impending expiry of the ICNet contract in December. ICNet is the electronic system used to support infection prevention and control functions across NHS Highland. While a national replacement system has been identified, there remains uncertainty regarding national funding and implementation arrangements. Louise advised that extension of the current ICNet contract may be required to ensure continuity of service until a national solution is fully established. The matter has been escalated to Board Chief Executives. Louise also highlighted work underway to strengthen preparedness for High Consequence Infectious Diseases (HCIDs), including conditions such as Ebola. This work is being progressed locally and nationally and is overseen through the Infection Control Committee.

The Chair sought clarification regarding governance arrangements for HCID preparedness. Louise explained that the work spans infection prevention and control, public health and health and safety, but is currently best overseen through the Infection Control Committee due to its multidisciplinary membership and existing governance arrangements.

The Committee noted the report and agreed **varying** levels of assurance.

**After discussion, the Committee Noted** the content of the report and **Agreed** to accept the **varying levels** of **assurance** across different aspects of the circulated report reflecting generally positive infection prevention and control performance, while recognising ongoing risks associated with the future of the ICNet system and the need to maintain preparedness for High Consequence Infectious Diseases.

## 8 OPERATIONAL IMPROVEMENT PLAN UPDATE

B McKellar spoke to the circulated report, highlighting the reduction in the numbers of patients waiting over 52 weeks for outpatient and treatment services, improved CAMHS 18-week waiting time performance, progress within urgent and unscheduled care programmes, including same-day emergency care and frailty assessment services and innovation initiatives such as theatre scheduling tools, genetic testing pathways and enhanced GP service pathways. The ongoing challenges and priorities requiring further work, including development of Hospital at Home and Flow Navigation Centre services, delivery of remote and rural care models in Argyll and Bute, implementation of the national Digital Front Door programme, improvement of 62-day cancer waiting times performance and achieving diagnostic waiting time targets for key imaging and endoscopy services.

The Committee welcomed the progress made and noted that outstanding actions would continue to be monitored through the new operational improvement plan. Karen Leach recognised that achieving 45% of deliverables represented positive progress while acknowledging the importance of continuing work on the remaining priorities.

The Committee agreed that **Moderate** Assurance was appropriate.

**The committee noted:** After discussion, the Committee **Agreed** on **Moderate assurance**, recognising that 45% of OIP deliverables had been achieved and that progress had been made across planned care, CAMHS, urgent and unscheduled care, and service improvement programmes. Members noted that remaining priorities, including cancer waiting times, diagnostics and digital transformation will continue to be monitored.

## 9 SIX MONTHLY UPDATES BY EXCEPTION

### 9.1 Organ & Tissue Donation Committee Update

L Bussell spoke to the circulated report on behalf of the Organ & Tissue Donation Committee Chair. A strong performance year was noted, with 20 potential donors referred, 7 authorised donors, 5 actual donors, and 17 organ transplants resulting from those donations. This represented a significant improvement compared with previous years. A key assurance point was the achievement of a 100% referral rate, with no missed potential donors identified through audit processes. The report also highlighted an area for improvement relating to the involvement of specialist nurses during family approaches, which currently stands at 82%. Members recognised the geographical challenges associated with providing specialist nurse support across Highland and discussed opportunities to strengthen resilience through wider regional collaboration.

J McCoy asked what approaches were being taken with communications and awareness raising and whether promotional activity was being undertaken at a local level, national level, or both. Her comments prompted discussion about using national campaigns, local engagement activity and community events to maintain awareness and encourage conversations about organ donation.

M Cockburn highlighted the success of collaborative public campaigns, such as those used for Power of Attorney awareness, and suggested that a similar approach could be used for organ donation. She recommended engaging with local authorities and other public sector organisations, community Planning Partnerships and local community networks to help disseminate information more widely.

E Henry explained that specialist nurses play an important role not only in supporting families through organ donation discussions but also in helping clinical staff initiate these sensitive conversations. There has historically been a reluctance among some staff to raise organ donation with families due to concerns about causing additional distress; however, families are often receptive to these conversations and may view donation as a positive opportunity. Reliance on a single specialist nurse creates a single point of failure, and consideration should be given to embedding these skills more broadly within routine clinical roles to improve resilience. The move to an opt-out donation system may make discussions about donation more routine and easier for staff and families. Elaine noted that NHS Highland often aligns local promotional activity with national organ donation campaigns. Community engagement initiatives, including attendance at events such as Belladrum, can be particularly effective in raising awareness among younger people and local communities. Future campaigns could make greater use of opportunities such as Organ Donation Week to promote awareness and encourage conversations about donation.

The Chair recognised the success of the service and thanked the teams involved, acknowledging that organ donation takes place in very difficult circumstances for patients, families and staff. She also she supported efforts to raise awareness of organ donation and welcomed suggestions around public engagement and community-based promotion.

The Committee noted the report and agreed **Substantial levels** of assurance.

**After discussion, the Committee Agreed** on **Substantial Assurance** reflecting strong Organ and Tissue Donation performance, including a 100% referral rate with no missed potential donors and an increase in successful donations and transplants. Members noted opportunities to further improve specialist nurse involvement in family approaches and continue public awareness activity to support future donation rates.

**9.2 Information Assurance Group Update**

I Ross spoke to the circulated report, advising that the Group continues to meet quarterly with good attendance and has introduced dedicated sessions to discuss emerging issues. The report highlighted significant work across data protection, records management, cyber security and information governance. A key area of discussion was the development of governance arrangements for Artificial Intelligence (AI). Iain advised that data protection now has a formal risk register, with AI identified as a significant emerging risk. Work is underway to develop a governance framework and approval process for AI solutions, including a register of approved AI products. A draft policy has been considered by the Digital Health and Care Group and is being refined before wider implementation.

G Ilsley asked whether NHS Highland was developing an AI governance policy and whether guidance would be produced for clinical staff on the safe use of generative AI tools such as ChatGPT in clinical practice. He was particularly interested in how AI may be used in future clinical workflows.

M Cockburn asked whether there were arrangements in place to ensure consistent governance and safety standards across staff working jointly between NHS Highland and local authorities. She highlighted the importance of aligning policies and procedures across organisations to minimise risk.

J McCoy suggested that NHS Highland should also consider contractors, third-sector organisations and partner agencies, noting that they may not have access to the same level of expertise and governance support. She highlighted opportunities for wider shared learning.

S McMillan asked about the scope of AI governance and whether it would extend beyond reporting tools such as Copilot to include clinical AI applications and large language models used directly in patient care. He queried what level of monitoring and regulation would be required as these technologies become more common.

E Henry reflected on the opportunities presented by AI but cautioned against over-reliance on technology. She noted that NHS Highland would not want to reach a position where an AI-generated complaint was responded to by an AI-generated response. She emphasised the importance of maintaining quality oversight and ensuring AI supports, rather than replaces, professional judgement.

N Ware reinforced that AI should be viewed as a tool to support staff rather than replace them, highlighting the importance of appropriate training and governance. He also supported greater collaboration through Community Planning Partnerships and noted that some local authority partners may be further advanced in their Microsoft 365 and AI adoption, creating opportunities for joint learning.

The Chair welcomed the discussion and observed that AI governance is likely to become an increasingly important issue for the Committee. She reflected on the potential value of partnership working and shared guidance while also recognising the challenge of broadening governance arrangements without creating unnecessary complexity.

The Chair advised that this was Iain's final attendance at the Clinical Governance Committee and noted that he was retiring. She invited Louise Bussell to offer thanks on behalf of the Committee. L Bussell thanked Iain for his support to the Committee and the wider organisation. She reflected on the significant progress that had been made during his time with NHS Highland, particularly the move from largely paper-based systems to a much stronger digital environment. Louise described Iain as a champion for this work and thanked him for his continued support and attendance at the Committee. I Ross thanked Louise and Karen for their comments. He noted that he had worked for NHS Highland for 40 years and, despite challenges over that time, had thoroughly enjoyed working for the organisation.

He advised that his successor would bring strengths in AI and information governance and expressed confidence that the organisation and Committee would benefit from that expertise. He concluded by saying that he was looking forward to the next chapter of his life.

The Committee noted the report and agreed **Substantial** levels of assurance.

**After discussion, the Committee Agreed on Substantial Assurance,** reflecting strong performance in information governance, data protection and cyber security, including improved compliance with national assurance requirements and the development of robust AI governance arrangements. Members noted ongoing challenges relating to cyber resilience, disaster recovery planning and increasing Subject Access Requests, but were assured that appropriate controls and improvement actions were in place.

### 9.3 Transfusion Committee Update

E Henry spoke to the circulated report, advising that the Hospital Transfusion Committee is a strong example of how a well-supported governance committee can deliver measurable improvements in quality and safety. Blood transfusion is a highly regulated area because errors can have significant consequences for patients, and the Committee provides oversight of national reporting, incidents, education and staff competency. New haemorrhage protocols, safe use of blood products and staff education have been key areas of work. There had been previous concerns regarding compliance with national reporting requirements, but significant improvement had been achieved through enhanced support to the Committee and its Chair. Workforce shortages within the Blood Bank service had required an incident management approach, but this had improved through upskilling staff and strong collaboration with the Scottish National Blood Transfusion Service. The Committee was beginning to see the benefits of providing protected time for governance roles, citing the Transfusion Committee as a model that could be replicated elsewhere, including oncology services. Elaine advised that moderate assurance remained appropriate but anticipated movement towards substantial assurance as improvement work continued.

The Chair welcomed the report and commented that the appointment of an Executive Lead and provision of dedicated time for the Committee Chair had clearly made a positive difference. The additional capacity and leadership support could be seen in the quality of the report and the progress being achieved. The update demonstrated the value of investing time and leadership capacity into governance arrangements.

The Committee noted the report and agreed **Moderate** levels of assurance.

**After discussion, the Committee Agreed on Moderate Assurance,** recognising significant improvements in transfusion governance, compliance monitoring, education and leadership arrangements. While workforce and compliance challenges remain, members noted that strengthened governance, dedicated leadership capacity and targeted improvement actions are delivering positive progress and enhancing service resilience.

## 10 COMMITTEE ADMINISTRATION

### 10.1 Committee Work Plan 2026/27

N Ware spoke to the circulated report, advising that significant work had been undertaken to improve planning, scheduling and alignment of agenda items across the year. The aim is to ensure that key governance reports are considered in a more structured way, reduce the number of ad hoc items coming to Committee, and improve alignment with other governance committees and Board assurance requirements. Some items will inevitably require escalation during the year, but the intention is to manage these through the action tracker rather than repeatedly amending the Work Plan.

The Chair welcomed the work undertaken, noting the importance of achieving better alignment across governance committees, avoiding duplication and unnecessary repeat reporting, making the best use of members' and presenters' time and ensuring a clearer flow of assurance through the governance structure.

### 10.2 Committee Self-Assessment

The Chair introduced a revised approach to the Committee's self-assessment, explaining that the previous questionnaire-based process had produced limited engagement and did not provide sufficient insight into committee effectiveness. The revised approach aims to generate more meaningful feedback and support ongoing governance improvement. Members were advised that the new process will combine a facilitated discussion involving core Committee members and regular presenters, a more detailed questionnaire for wider attendees and stakeholders, independent facilitation by an Executive and Non-Executive member from another committee with a greater focus on governance effectiveness, risk oversight, assurance and committee performance. N Ware explained that the previous self-assessment relied heavily on generic yes/no questions, which did not provide sufficient qualitative feedback. The revised methodology has been designed to capture richer feedback, consider whether committee remits remain appropriate, strengthen consideration of risk and assurance and to support the wider governance improvement programme.

The Chair advised that members would be contacted with further details and encouraged participation to help identify opportunities for improvement and strengthen the effectiveness of the Committee. No concerns were raised and the revised approach was noted by members.

## 11 CALENDAR OF MEETING DATES

The Committee **Noted** the following schedule of meetings:

3 September 2026
5 November 2026
7 January 2027
4 March 2027

## 12 REPORTING TO THE NHS BOARD

The Chair confirmed that no items from the meeting required formal escalation to the NHS Board however the Committee would continue to submit its usual assurance and overview report to the Board. She was seeking members' views on whether any matters discussed during the meeting required specific escalation and advised that she intended to highlight several themes arising from the meeting, including concerns relating to capacity, flow and workforce pressures, together with other positive and challenging issues identified through the agenda discussions.

## 13 ANY OTHER COMPETENT BUSINESS

The Committee gave recognition of Mirian Morrison's 37 years of service and contribution to NHS Highland. Louise Bussell commented that Mirian had given 37 years of service to NHS Highland and had played a significant role in supporting clinical governance and organisational development. Alongside Iain Ross's retirement, the organisation was losing almost 80 years of organisational memory, highlighting the scale of experience leaving the organisation. Much of Mirian's work took place behind the scenes and was not always visible to the Committee, but it was highly valued by colleagues and had made a significant contribution to shaping clinical governance arrangements.
Mirian had consistently been supportive, responsive and positive despite the many challenges presented to her in her various roles. Louise thanked her on behalf of the Committee and the wider organisation and wished her well in retirement. Mirian reminisced about her long association with NHS Highland, recalling that she had first met Iain Ross through NHS Highland's hockey team many years earlier. She reflected on her various roles within the organisation and said it had been a great

pleasure to work with colleagues throughout her career. She also highlighted the work she had undertaken nationally as well as within NHS Highland and expressed her best wishes for the future development of clinical governance within the organisation.

## 14 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on **Thursday, 3rd September 2026** at 9.00am.

**The meeting closed at 11.50am**

| Action Number | Meeting Date | | Action | Lead | Due Date | Status | Notes |
|---|---|---|---|---|---|---|---|
| **43** | 07/11/2024 | Infants, Children & Young Peoples Clinical Gov. Group | Agreed a report on implementing structural change across NHSH in relation to wider governance arrangements. | L Bussell/B Peters | **03/09/2026** | In progress | |
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