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/
MINUTE	**15 January 2026 – 9.00am (via MS Teams)**

Present
Karen Leach, Chair
Louise Bussell, Board Nurse Director
Sarah Compton-Bishop, Non-Executive
Joanne McCoy, Vice Chair and Non-Executive Director
Gerry O'Brien, Non-Executive
Dr Boyd Peters, Board Medical Director
Dr Neil Wright, Non-Executive

In attendance
Isla Barton, Director of Midwifery
Stephanie Govenden, Consultant Community Paediatrician
Rebecca Helliwell, Deputy Medical Director (Argyll and Bute)
Elaine Henry, Deputy Medical Director (Acute)
Arlene Johnstone, Chief Officer (Community)
Jo McBain, Director (Allied Health Professions)
Brian Mitchell, Board Committee Administrator
Mirian Morrison, Clinical Governance Development Manager
Heather Richardson, Head of Operations
Leah Smith, Complaints Manager
Katherine Sutton, Chief Officer (Acute)
Nathan Ware, Deputy Head of Corporate Governance
Derick MacRae, Cancer Services Manager
Dawn MacDonald, Staffside Representative
Paul Chapman, Team Leader, Physiotherapy
Andrew Nealis, Information Governance & IT Security Manager
Sarah Buchan, Director of Pharmacy
Stacey Charles-Evans, Lead Nurse Tissue Viability
Jennifer Davies, Director of Public Health
Gavin Smith, Employee Director
Alison Felce, Senior Business Manager
Dr Claire Copeland, Deputy Medical Director
Julie Gilmore, Associate Nurse Director
Laura Neil, Associate Director of Quality and Clinical Governance
Anna Chisholm, Senior Corporate Administrator
Bryan McKellar, Whole System Transformation Manager
Linda Currie, Associate AHP Director
Elspeth Caithness, RCN Representative
Jenny Wares, Consultant in Public Health

1.1 WELCOME AND APOLOGIES

Formal Apologies were received from Muriel Cockburn, Liz Henderson and Seamus McMillan.

1.2 DECLARATIONS OF INTEREST

The Chair noted the recent departure of Alistair, who had previously been the individual most likely to declare interests. No members declared any interests.

1.3 MINUTE OF MEETING THURSDAY 6 NOVEMBER 2025, ROLLING ACTION PLAN AND COMMITTEE WORKPLAN 2025/2026

The Minute of Meeting held on 6 November 2025 was **Approved.** The Committee Work Plan and Action Plan – this has been substantially updated, with members thanking colleagues for the significant work involved. Early preparatory work has been carried out to ensure the Work Plan is aligned for the rest of the year and into next year. The Chair plans to meet individually with committee members before the March meeting to refine the workplan further. Members were encouraged to submit topics that should be added, particularly national developments or areas needing additional scrutiny. It was recognised that the workplan will continue to evolve as priorities shift.

The Nurse Director confirmed progress on the first outstanding action regarding structural governance changes, work is advancing however it is not complete.

Argyll & Bute related actions were referenced. Clear progress was noted, with some items still in development.

The Committee:

- **Approved** the draft Minute.

1.4 MATTERS ARISING

Women's Services Update

I Barton and H Richardson spoke to their six-monthly report covering maternity, neonatal, and gynaecology services.

Maternity and neonatal services face high national scrutiny. The service is preparing for unannounced HIS maternity inspections, benchmarking Highland against findings from other boards and developing an associated action plan.

The new Scottish Government maternity services policy was largely positive, noting good practice. Areas needing improvement include training, education data, and compliance with required modules for midwives and obstetricians. A second submission is due in March.

Workforce remains under pressure, especially in midwifery, but a recent staffing uplift has been approved. A short-life working group is addressing workforce culture, communication, roles, and escalation processes. Recruitment of an obstetric sonographer trainee was highlighted as a key step toward sustainability.

Improvements have been made to the birthing pool and labour suite rooms, though compliance with infection control remains challenging due to estate limitations.

Data show a decline in spontaneous vaginal births and an increase in caesarean sections, reflecting rising complexity among service users (e.g., comorbidities, age, mental health). Members requested deeper analysis in the next report.

Updated clinical and professional governance structures including new subgroups and cross-system alignment are now in place, with Highland showing areas of good practice in risk review compliance.

The Committee took **moderate** assurance, noting significant progress but ongoing workforce and operational challenges.

2 SERVICE UPDATES

2.1 Audiology National Review Update

A Graham advised Audiology has strengthened its patient-feedback mechanisms, including rolling out questionnaires and working directly with community partners such as Hearing Insight Care and Deaf Services to inform service improvements. The service is participating in the national ABR paediatric peer-review pilot and has focused on building in-house testing capability. As a result, reliance on external paediatric providers has been eliminated. Staff training and competency development continue as priorities. Paediatric clinic capacity has doubled, dual-trained staff have been recruited, and the service is now consistently meeting the 4- and 6-week assessment targets. Reporting is up to date and aligned with national standards. Work is underway to implement new frameworks such as AI CLIP, ISO standards, and upcoming national paediatric quality standards. Efforts continue to align service delivery across Highland and with neighbouring boards. There is active joint working with ENT consultants, including joint clinics, improved shared pathways, and reduced unnecessary MRI referrals.

The Committee gave **moderate** assurance, recognising strong progress but with further national and local work still in motion.

2.2 Cancer Services Update

D MacRae spoke to the circulated paper and reported that cancer services remain a significant area of concern, with sustained pressures across diagnostics, treatment pathways, and workforce capacity. The service is receiving weekly oversight from the Chief Executive due to operational fragility.

NHS Highland is actively engaged in the national review of oncology. The future Target Operating Model aims to reduce competition between boards for specialist staff and strengthen mutual aid. Local leaders emphasised that although full implementation may take time nationally, Highland needs TOM principles in place now due to recruitment challenges and increasing service vulnerability.

Existing mutual aid remains essential:

- Lothian and Grampian support consultant-level oncology.
- Grampian supports head and neck pathways.
- Oncology mutual-aid discussions occur weekly across Scotland.

Highland has already shifted some pathways to TOM-style shared models out of necessity.

Recruitment challenges are acute across oncology roles (consultants, radiographers, specialist nurses). Workforce gaps are increasingly affecting high-volume tumour pathways (e.g., breast, lung, prostate), not just low-volume specialist cancers.

Rising demand is adding pressure at the front end of pathways:

- Urgent suspected cancer referrals have doubled over five years.
- Radiology and labs are under strain.
- Dedicated support staff are helping guide patients through diagnosis to improve experience and communication.

Members highlighted cases where patients were unclear about their pathway. Improved communication—particularly when care involves other boards was identified as a key improvement area.

The Committee emphasised the need for:

- Clear assurance on quality and safety, not just workforce risk.
- Visibility of patient outcomes and pathway performance.
- More structured reporting, including assurance by cancer type/pathway, acknowledging some pathways are functioning well while others are under strain.

A concern was raised about possible AI generated patient letters being issued within the system. E Henry confirmed there is no policy or instruction authorising the use of AI for patient letters and committed to investigate the specific case raised.

The Committee were asked to take **limited** assurance from the report content.

After discussion, the Committee:

Noted the report content and agreed to take **Limited** assurance, reflecting ongoing vulnerabilities, operational pressures, and the need for strengthened pathway oversight.
Agreed E Henry will review the issuing of governance concerns regarding AI patient letters

3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

L Bussell noted the system wide pressures with acute, community, and social care services experiencing sustained and significant pressure, driven by winter demand, viral illness, weather-related disruption, and reduced flow across the system.
Pressures are resulting in:

- Increased escalation levels in acute care.
- Use of additional beds in six-bedded bays (placing 7 patients in 6-bed spaces).
- Compromised flow from Emergency Departments, impacting ambulance offloading times.

Senior nursing teams are carrying out daily risk assessments on overcrowded areas, focusing on falls, harm, and safety compromises. Delays in discharging patients contribute to front-door pressures, prompting calls for more distributed risk-holding across the whole system (not concentrated in ED/acute assessment areas).

Community services report a lag effect, continuing to manage the aftermath of severe weather and unmet visits, requiring “catch-up” activity while also supporting hospital flow. A multi-agency incident management approach is in place within the Partnership to maintain safe flow, manage delays, and balance workforce, acuity, and available space.

Acute and community teams face ongoing staffing constraints, resulting in difficult decisions around stepping down elective activity in some areas while protecting urgent and cancer-related work.
Improved collaboration between acute and community leadership is helping distribute workload and manage risk more consistently. Leadership teams are working collaboratively, using real-time monitoring, escalation mechanisms, and cross-sector coordination to maintain safety and flow.

The Committee acknowledged the significant operational strain and expressed appreciation for staff working in challenging and continually shifting circumstances.

The Committee Noted the reported position.

4 PATIENT EXPERIENCE AND FEEDBACK

M Morrison spoke to the circulated report providing the committee with an update on the high volume of complaints. All complaints are shared with the relevant teams, and the full dataset feeds into the annual reporting process. One negative case with clear learning was highlighted to demonstrate how feedback is driving service improvement.

Members noted the value of positive stories and discussed whether wider sharing across the organisation would help reinforce staff morale and learning which would be explored further. The Committee agreed to take **moderate** assurance.

After discussion, the Committee:

- **Noted** the detail of the report and **Agreed** to take **Moderate** assurance, recognising ongoing improvements in how feedback is captured and used.
- **Agreed** that the wider sharing across the organisation will be explored further

5 CLINICAL GOVERNANCE AND PERFORMANCE DATA

M Morrison spoke to the circulated report, advising performance remained below target, with more complaints coming in than being responded to. However, early data for the next reporting month showed an improving trend, with more responses issued than complaints received.

Activity levels were steady. The SPSO is returning decisions more quickly, and in most cases is not upholding complaints, indicating satisfaction with NHS Highland's handling processes. Two complex cases remain under active dialogue.

The number of new SAERS remained consistent, but completion within the 26-week timeframe continues to be challenging. Outstanding SAER actions remain high, though next-month data indicates a significant reduction, showing progress. National work is ongoing to improve reporting and thematic analysis.

There is a notable increase in Grade 2 pressure ulcers. A deeper analysis is underway to clarify data discrepancies—specifically, whether ulcers relate to patients known versus not known to district nursing services. National standardisation work and updated grading tools are being implemented.

Falls data was not updated in this report due to system pressures, but leadership committed to update the dataset retrospectively for committee visibility.

Members described the complaints performance as disappointing and asked for clearer thematic analysis to understand what is driving volume increases. A future thematic report will be provided.

The report proposed the Committee take **Moderate** assurance.

After discussion, the Committee:

- **Noted** the detail of the report and **Agreed** to take **Moderate** assurance, recognising improvement work underway but with clear areas requiring sustained focus.
- **Agreed** that the falls data would be deferred to the next meeting.
- **Agreed** a complaints thematic report will be required for the next meeting.

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

6.1 Argyll and Bute

R Helliwell spoke to the circulated report, summarising the period is stable with no new major service pressures. Long-standing challenges continue in care at home, ADHD, dementia/LD pathways, and links with NHS Greater Glasgow & Clyde for cancer and other services. Positive recruitment reported in Oban Hospital (consultant physicians and rural emergency practitioners), improving local quality and resilience. Regulatory reviews noted no new escalations; a recent fatal accident inquiry resulted in no criticism of NHS Highland.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

6.2 Highland Health and Social Care Partnership

C Copeland spoke to the circulated report, summarising the persistent workforce pressures across community nursing, AHPs, mental health, and primary care. A live issue in pharmacy regarding unsafe prescribing patterns at a GP practice is under active investigation, with improvement actions already underway. Deep dives into falls and tissue viability show isolated spikes rather than systemic deterioration. Work continues to strengthen interface governance between acute and community pathways.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

6.3 Acute Services

K Sutton spoke to the circulated report, summarising vascular services is showing early stabilisation: four supporting boards now in place; a new fixed-term consultant appointed; external review of DATIX entries underway and showing no significant concerns. Oncology pressures echoed earlier discussion, with strong reliance on national mutual aid and updated governance structures. The diabetes pathway improvements are progressing, with backlog vetting and additional clinics planned. Improved tissue viability and infection prevention performance highlighted (e.g., reduction in C. diff cases after unified antimicrobial stewardship).

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

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

S Govenden spoke to the circulated report, expressing concerns with NDAS, though not discussed in depth due to separate programme reporting. The child death review annual report which contains over 60 reviews has been completed, with themes too small for trend analysis at this stage. Ongoing issues include lack of a bereavement nurse and pressures on school nursing, especially related to safeguarding and vaccination work.

L Bussell advised that NHS Highland is actively reviewing how Child Death Reviews intersect with other statutory review processes, such as SAERs and health and safety in. She emphasised that in some cases, multiple review processes may be triggered for the same child. This can place unnecessary burden and distress on families, who may be asked to participate repeatedly. Work is underway with colleagues to determine when combined or better-aligned review approaches could be used to avoid duplication while still fulfilling all statutory requirements.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to take **Moderate** assurance.

7 INFECTION PREVENTION AND CONTROL REPORT AND COMMITTEE ANNUAL REPORT 2024/25

L Bussell spoke to the circulated report and advised IPC performance continues to be heavily constrained by wider system pressures, particularly lack of physical space in key hospital areas (e.g., Raigmore). These constraints limit the team's ability to maintain optimal infection-control standards. Despite interim arrangements and operational pressures, the IPC team remains stable, highly engaged, and able to provide cross-cover across both acute and community services. This continuity is helping maintain patient and staff safety.

The Committee acknowledged the varying levels of assurance across different aspects of the IPC report but recognised that the team is performing well under challenging circumstances.

The Committee:

- **Agreed** to accept the varying levels of assurance across different aspects of the circulated report.

8 ANNUAL DELIVERY PLAN 2025/26

B McKellar presented an update on the ADP and Operational Improvement Plan, confirming progress across: Access to treatment, Shifting the balance of care, Digital innovation, and Prevention. Work continues to reduce waiting times for planned care, cancer, and diagnostics, with a specific aim to ensure no patient waits more than 52 weeks by end of March, and progress is on track. Improvements highlighted in urgent and unscheduled care, including hospital-at-home, discharge-to-assess, and enhanced frailty pathways. Collaboration between acute and community services remains central. The key developments in digital and technological innovation include: a new theatre scheduling tool, work towards the national digital front door, digital solutions for dermatology and diabetes to increase access and efficiency. Ongoing pressures were noted in ultrasonography due to anticipated retirements. Mitigation includes rota redesign, short-term staffing options, and single waiting lists. Preventative work (aligned to national frameworks and the Board's renewed strategic direction) forms part of the ADP's longer-term commitments.

The committee noted substantial assurance in relation to the ADP update.

9 PUBLIC HEALTH

9.1 Joint Health Protection Plan 2025-27

J Davies and J Wares spoke to the circulated report, outlining its statutory basis and the broad scope of public-health protection activities delivered jointly with Argyll & Bute Council and Highland Council. They highlighted challenges in performance measurement, particularly around incident response, due to the complexity and breadth of public-health activity. Work is underway to develop more robust and measurable indicators for future iterations. Incident response standards were queried. It was clarified that established outbreak-management processes are in place, incident-management teams are rarely required, and a Scotland-wide approach to performance evaluation is likely needed.

The report proposed the Committee take **Moderate** assurance, with the assurance that strengthened governance mapping be undertaken.

After discussion, the Committee approved the plan and **Agreed** on **Moderate** assurance, reflecting increasing demand and the need for strengthened governance mapping.

10 SIX MONTHLY UPDATES BY EXCEPTION

10.1 Duty of Candour Annual Report

A Felce spoke to the circulated report outlining the number of cases, the review process, and legislative requirements. The number of recorded cases was similar to other boards.

Several improvement needs were identified:

- Earlier involvement of families in the process.
- Improved adherence to the 12-week completion timeframe.
- Enhanced data extraction and reporting, as the current system required manual review.
- Transition to the new Enphase system to support better reporting.

Training is on TURAS, although it is not currently mandatory. Alison confirmed that staff involved in duty of candour cases understand the requirements, and the Committee emphasised the importance of embedding this within governance and leadership development.

Members raised concerns about delays in reporting due to system limitations, the need for improved tracking of compliance. Alison addressed these, highlighting planned system improvements and interim measures.

The Committee agreed to receive a six-month interim update. Duty of Candour training will be built into the wider clinical governance workplan, supported by leadership oversight.

After discussion, the Committee:

- **Agreed** to receive a six-month interim update.
- **Agreed** Duty of Candour training will be built into the wider clinical governance workplan, supported by leadership oversight.
- **Agreed** on **Moderate** assurance.

10.2 Transfusion Committee – 6 Monthly Update

F Gunn spoke to the circulated report advising the transfusion committee continues to meet quarterly, reviewing clinical and laboratory issues, updating policies, and overseeing transfusion governance. A recent major haemorrhage protocol simulation was completed successfully. All NHS Highland sites are now using the national transfusion record (v2), which includes strengthened safety checks for pre-transfusion assessment. A key issue raised was the lack of an executive lead, as required by the Scottish Government following the infected blood inquiry. Despite previous requests, no appointment had yet been made. The Committee agreed this must be escalated urgently.

The Committee agreed moderate assurance, acknowledging robust activity within the Transfusion Committee but noting unresolved governance gaps pending appointment of the Executive Lead.

After discussion, the Committee:

- **Agreed** to escalate the lack of executive lead to the next EDG meeting, and update at the March meeting.
- **Agreed** on **Moderate** assurance, acknowledging robust activity within the Transfusion Committee but noting unresolved governance gaps pending appointment of the Executive Lead.

10.3 Information Assurance Group – 6 Monthly Update

A Nealis spoke to the circulated report advising the organisation achieved 89% compliance score in the NES Cybersecurity Audit, a 6% improvement, placing NHS Highland in the upper quartile of NHS Scotland Boards. Andy emphasised that operational practice matters more than the headline score. A short-life working group has been established to overhaul disaster-recovery plans. Documentation is actively being rewritten and strengthened, with initial work expected to conclude soon. Regulators are moving away from single-point-in-time audits toward continuous assurance, including scenario testing and stakeholder interviews. This will give a more realistic understanding of cyber-resilience. New tools for device management, monitoring and ransomware protection have been rolled out. However, the associated high alert volume is creating operational pressure for teams managing incidents. A national cyber-incident retainer is now in place, offering specialist expertise to NHS boards should a major incident occur.

The Committee recognised the significant work undertaken and noted the update as part of ongoing digital-governance assurance. The Committee agreed on **Substantial** assurance.

The committee noted substantial assurance in relation to the Information Assurance Group – 6 monthly update.

10.4 Tissue & Organ Donation Committee 6-Month Update

Consideration of this item has been deferred.

Agreed the Workplan cycle will be adjusted

11 CLINICAL RISK

Consideration of this item has been deferred to the next development session.

12 ANNUAL REVIEW OF COMMITTEE TERMS OF REFERENCE

The Chair noted no changes have been made to the Committee Terms of Reference however changes may be required when the mapping work has been completed. L Bussell suggested the inclusion of the Clinical and Care Governance and Quality Assurance Group.

N Ware will coordinate the required updates and ensure associated governance documents reflect the changes.

13 CALENDAR OF MEETING DATES

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

5 March 2026
7 May 2026
2 July 2026
3 September 2026
5 November 2026
7 January 2027
4 March 2027

14 REPORTING TO THE NHS BOARD

Discussion of relevant matters would be referenced in the Committee Summary to be provided to the NHS Board.

15 ANY OTHER COMPETENT BUSINESS

A review of the membership will be undertaken.

16 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on **Friday, 5 March 2026** at 9.00am.

The meeting closed at 12.30pm