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	**6 March 2026 – 9.00am (via MS Teams)**

Present
Karen Leach, Chair
Louise Bussell, Board Nurse Director
Joanne McCoy, Vice Chair and Non-Executive Director
Graham Illsley, Non-Executive Director
Muriel Cockburn, Non-Executive Director
Seamus McMillan, Independent Public Member
Liz Henderson, Independent Public Member
Janice Preston, Non-Executive Director
Gerry O'Brien, Non-Executive Director
Dr Boyd Peters, Board Medical Director

In attendance
Rebecca Helliwell, Deputy Medical Director (Argyll & Bute)
Elaine Henry, Deputy Medical Director (Acute)
Heather Richardson, Head of Operations
Leah Smith, Complaints Manager
Paul Chapman, Team Leader, Physiotherapy
Allyson Turnbull-Jukes, Director of Psychology
Lynsey Callaghan, Professional Lead Maternity & Child Health/Head of Midwifery (A&B HSCP)
Evelyn Gray, Associate Nurse Director (Acute)
Dominic Watson, Head of Corporate Governance
Ruth MacDonald, Interim Deputy Director, Adult Social work & Social Care Leadership Team
Sarah Buchan, Director of Pharmacy
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

1.1 WELCOME AND APOLOGIES

Formal apologies were received from Katherine Sutton, Iain Ross, Gillian Valentine, Rhiannon Boydell, Jill Mitchell, Nathan Ware and Julie Gilmore.

1.2 DECLARATIONS OF INTEREST

No members declared any interests.

1.3 MINUTE OF MEETING THURSDAY 15 JANUARY 2026, ROLLING ACTION PLAN AND COMMITTEE WORKPLAN 2026/2027

The Minute of Meeting held on 15 January 2026 was **Approved.** The Action Plan was discussed and updated.

Infant, Children & Young Person Clinical Governance Group – agree a report on implementing structural change across NHS Highland in relation to wider governance arrangements. L Bussell confirmed progress has been made through discussions with D Watson and internal colleagues together with joint work with Highland Council colleagues on their infrastructure. The work is closer to completion; a substantive update will be provided the next meeting on 7 May 2026.

Argyll & Bute Update – noted improvement update relating to child protection nurse resourcing to be provided in next report. R Helliwell advised that a child protection paper had been prepared and was initially considered for this meeting, however, it was not brought forward because it had not yet gone through the appropriate clinical governance routes within Argyll & Bute. It was agreed that the paper should first be reviewed through local Argyll & Bute governance structures before being presented to the Clinical Governance Committee at the next meeting on 7 May 2026.

Public Oral Health Update – noted update in relation to Public Oral Health will be brought to 2 July 2026 meeting.

The Committee:

- **Approved** the draft Minute.

1.4 MATTERS ARISING

Update on Executive Leadership for Infected Blood Inquiry Transfusion Activity

Dr B Peters confirmed that the named Executive Lead for this area of work should be the Medical Director with E Henry taking forward the operational work. Further updates will come in due course as the work progresses through the national programme.

The Chair gave a warm welcome to Graham Illsley who joins as a Non-Executive Director member of the Clinical Governance Committee. Graham introduced himself, with a background in medicine (trained in NHS Tayside), clinical trials, and more recent work in the third sector across marketing, communications and policy. He said he was impressed by the quality and volume of the Committee papers and the work underpinning them. He emphasised that, in reviewing papers, his key focus would be on assurance rather than reassurance specifically, clear articulation of risk, the controls in place to manage those risks and evidence that those controls are working. He indicated he was looking forward to contributing to the Committee with that assurance-focused lens.

2 SERVICE UPDATES

2.1 CAMHS / NDAS Service Update – from Work Plan

H Richardson spoke to the circulated report highlighting CAMHS remains in an escalated position, but there has been significant improvement following sustained work over the last 2–3 years. Performance is now at 88% RTT compliance, with a target of 90%. There are 99 children and young people on the waiting list across North Highland and Argyll & Bute, with 90% waiting less than 18 weeks. The service is working towards de-escalation by the Scottish Government, which requires achieving 90% RTT compliance for two consecutive quarters. Considerable effort has gone into managing and reducing the waiting list, improving flow and responsiveness and strengthening performance monitoring.

Members acknowledged the work of the teams in both areas with the improved position, however, the vulnerabilities in workforce and finance were also described. Recent feedback from Scottish Government colleagues noted the improved position in the Board compared to others.

The increased collaboration with Highland Council colleague was raised with Heather confirming there is significant system-wide collaboration with Highland Council, particularly across health, education and social care. She explained that joint work is focused on earlier intervention, aiming

to identify and support children at the earliest possible stage, before needs escalate. This includes close working with education services, speech and language therapy and educational psychology. The intention is for many children's needs to be met through local, community-based pathways, with clear routes into more specialist services (such as NDAS) only where required. Heather described this as transformational work across the whole system, not isolated to health services. She noted that recent funding discussions, including with council colleagues, have been welcomed and support this joint approach.

J McCoy noted the nursing capacity pressures due to sustained service demand and the impact of staff working additional hours. Potential effects on staff wellbeing if pressures were prolonged. Heather Richardson advised that, since the paper was written, there have been improvements in nursing capacity, including staff returning to work through phased return arrangements and realignment and reassignment of existing staff resources into CAMHS. She confirmed that capacity is improving, and pressures are easing compared with earlier in the reporting period. Workforce safety and staffing adequacy continue to be monitored using SafeCare. The approach was described as dynamic and responsive, adjusting staffing as capacity improves with a focus on ensuring services remain safely staffed, while supporting staff wellbeing.

Members welcomed the update and the reassurance provided. The discussion acknowledged that workforce pressures remain a key vulnerability but noted positive movement and active management.

NDAS Service Update

H Richardson spoke to the circulated report advising NDAS continues to face significant pressure, with in excess of 2,000 children on the waiting list. The volume of demand presents a system-level risk, requiring mitigation beyond traditional diagnostic pathways. Heather emphasised the importance of risk assessment for children waiting for assessment, aligning with the Committee's focus on assurance. Mitigations already in place include the use of independent and private sector assessments, primarily for autism and recruitment of an additional neurodevelopmental practitioner and a psychologist to complete assessments already underway. These actions are intended to reduce backlog and manage immediate risk. NDAS is being addressed as a whole-system issue, overseen by an ND Programme Board involving, NHS Highland, Highland Council, education services and third-sector partners. Work is focused on transforming pathways, so that not all children require complex diagnostic assessment and earlier, local support can be provided through education, speech and language therapy, and educational psychology. Clear routes remain into specialist services for children with more complex needs. Thriving Families was highlighted as a key partner providing direct support to families on the waiting list, supporting completion of referrals and playing a role in future profiling and survey work. Wider third-sector engagement (including Cala) was noted through integrated governance arrangements. A snapshot audit undertaken by Highland Council showed reassuring levels of support already in place for many children awaiting assessment. Scottish Government has recognised NDAS challenges as national, not unique to NHS Highland. Additional funding opportunities are being pursued, including national bids for independent assessments and potential collaboration with Malvern to provide neurodevelopmental profiling for children on the waiting list

The Committee agreed that NDAS will continue to report through the Infant, Children and Young Person Clinical Governance structure. A six-monthly update will be brought to the Clinical Governance Committee, covering both North Highland and Argyll & Bute. This was seen as balancing assurance with proportional reporting burden. The scale and complexity of NDAS pressures were fully acknowledged.

J McCoy asked about the test of change involving 18 children from a single primary school, querying whether this number was exceptional or whether some schools routinely generate higher referral volumes. Heather explained that the number of referrals from that school was not exceptional when viewed alongside wider data across schools. Larger schools and feeder patterns (e.g. into larger secondary schools) naturally generate higher absolute numbers of referrals.

Heather clarified that the school involved was selected because the head teacher was keen to be an early adopter and the school already had supportive infrastructure in place, including an Enhanced Support Needs (ESN) base. This made it an appropriate environment to test new approaches to supporting children with neurodevelopmental needs. The purpose of the test of change was to explore whether support can be optimally delivered within the school environment, assess how early, locally delivered interventions can reduce reliance on more complex specialist pathways and generate learning to inform wider system roll-out, rather than reflecting an outlier situation.

The Chair asked members would regular reports on NDAS be required going forward. L Bussell advised that NDAS is already reported regularly through the Infant, Children and Young Person Clinical Governance structure. Louise suggested that, rather than frequent reporting to the Clinical Governance Committee, it would be more proportionate to provide a dedicated NDAS report every six months. Louise highlighted the importance of ensuring reporting covers both North Highland and Argyll & Bute, rather than focusing on one geography. She emphasised balancing the Committee's need for assurance with avoiding unnecessary reporting burden on operational teams. This approach was presented as providing sufficient assurance, alongside routine oversight through ICYPCGG. The Committee agreed with Louise's proposal and confirmed that six-monthly NDAS updates would be brought to the Clinical Governance Committee, with ongoing reporting via ICYPCGG.

The Committee gave **limited** assurance, taking the active mitigation and system-wide transformation work into consideration. Six-monthly updates will be provided to the Clinical Governance Committee

2.2 SCI Gateway Referral Update

Dr B Peters and Dr C Copeland spoke to the circulated paper and reported following a significant number of digital incidents, national as well as local, responses are required with learning opportunities.

SCI Gateway is the digital system enabling communication between primary and secondary care, including referrals, results and clinical correspondence. A significant incident in 2024 resulted in the system failing, meaning referrals (including urgent and cancer referrals), results and other communications were not transmitting between primary and secondary care. The incident was described as high-impact and stressful, requiring sustained effort to resolve.

C Copeland explained that digital, clinical and operational teams worked together to manage the incident. Safeguards and mitigations were put in place while technical fixes were underway. A retrospective review was completed to trace referrals and communications that may not have transmitted. Importantly no evidence of patient harm was identified. There was no requirement for Duty of Candour, based on the findings of the review. The incident generated significant learning, which is already being acted upon, including establishment of a Primary–Secondary Care Interface Group involving clinicians and operational leads. Appointment of clinical digital leads in both primary and secondary care to strengthen digital oversight.

Dr B Peters emphasised that digital incidents are a key strategic risk, particularly in relation to cybersecurity. Such incidents require both national coordination and local response, and learning must be shared widely.

The members discussed where ownership for the learning and actions should sit. It was agreed that the learning should be shared beyond Clinical Governance, including executive leadership, potentially the Digital Healthcare Group, a forthcoming IMT infrastructure policy, which will help clarify how digital incidents are declared, managed and escalated.

L Bussell advised this paper has been taken to Iain Ross, Head of eHealth and a policy which covers IMT structures will be put in place.

Members found the paper extremely helpful and reassuring, particularly, the clarity of the narrative and the evidence of system learning.

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

After discussion, the Committee:

Noted the report content and agreed that the actions taken and learning identified provided **Substantial** assurance.

3 EMERGING ISSUES/EXECUTIVE AND PROFESSIONAL LEADS REPORTS BY EXCEPTION

Dr B Peters raised concerns about the resilience of SACT (Systemic Anti Cancer Therapy) services highlighting this as an area under increasing pressure. The pressures were attributed to a significant rise in cancer workload (around 50% over recent years) workforce shortages, particularly affecting specialist and pharmacy roles supporting SACT delivery. It was emphasised that these challenges are not unique to NHS Highland but are being experienced nationally. Increased demand is driven by improved cancer survival, meaning more patients are living longer and receiving repeat or ongoing treatments. The issue has been escalated by regional teams, indicating wider system concern. SACT pressures link closely to work underway through the Cancer Strategy Board, workforce planning and funding. Further detailed consideration and reporting will be required. A more comprehensive cancer and SACT update is planned for the 2 July 2026 Clinical Governance Committee meeting.

Members acknowledged SACT as a significant system risk, driven by demand and workforce. The issue was noted as being under active governance and escalation, with no immediate new actions requested at this meeting.

L Bussell noted the system wide pressures in North Highland with acute, community, and social care services leading to pauses in elective surgery. For assurance a new post is in place reviewing the interface across the two areas, bringing alignment in the teams.

The Committee Noted the reported position.

4 PATIENT EXPERIENCE AND FEEDBACK

L Neil spoke to the circulated report covering patient experience, complaints and Care Opinion feedback, providing both qualitative and quantitative insight into how patients are experiencing services. The patient experience and Care Opinion report included, one negative case study, with associated learning and positive case studies, demonstrating good practice. The Care Opinion data covered October to December 2025, during which, 73 stories were received, the majority (around two-thirds) were non-critical, including positive feedback. The number of stories was reported as consistent month-to-month. Work is underway to review Care Opinion as part of a wider patient experience approach, alongside other feedback mechanisms.

G Illsley commented positively on the volume of positive Care Opinion feedback and the commitment and work of staff across NHS Highland.

After discussion, the Committee:

- **Noted** the detail of the report and **Agreed** to take **Moderate** assurance.

5 CLINICAL GOVERNANCE AND PERFORMANCE DATA

L Neil spoke to the circulated report, advising complaint timeline performance remains a concern, with only 13% meeting timescales. However, it was noted as a positive that more complaints were closed than received during the reporting period. SPSO activity was described as steady, with six cases received, seven cases closed, with no further action required.

S McMillan queried why patients continue to develop pressure ulcers in hospital, including hospital acquired (denovo) pressure damage, and asked whether this reflects workload and system pressure. E Henry explained that some pressure damage is identified for the first time in hospital, even if it began in the community, as admission often includes the first full skin assessment. Early identification is a sign of good clinical practice, allowing prompt intervention to prevent deterioration. There is active monitoring of pressure damage data, particularly in the context of extra beds and increased use of escalation spaces. Specialist tissue viability nursing support is in place across the Board, providing targeted input where rates increase.

L Bussell added that there was a spike in hospital acquired pressure ulcers in December, which has since reduced, though not yet to desired levels. There has also been an increase in patients admitted with existing or emerging pressure damage, reflecting frailty and acuity on admission. Some patients will remain inherently vulnerable due to severe illness or frailty, despite best preventative care. The focus is on ensuring pressure damage occurs only where unavoidable due to clinical condition, not because of care processes.

E Gray confirmed that targeted improvement work is underway, supported by the Lead Nurse for Tissue Viability. This involves both acute and partnership services. An update on progress can be provided in a future report.

The Committee recognised the link between frailty, acuity and pressure damage and the impact of system pressure, while noting robust monitoring and specialist oversight.

Members were reassured that pressure ulcer prevention is being actively managed and learning and targeted improvement work is ongoing.

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

After discussion, the Committee:

Noted the detail of the report and **Agreed** to take **Moderate** assurance.

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 several GP practices have withdrawn services, requiring Argyll & Bute HSCP to redesign delivery models. This has driven work on new models of care, enhanced services, shifting care, and alternative staffing models, creating significant operational pressure. A critical shortfall in paediatric occupational therapists within child health services, which has worsened since the paper was written. This has been compounded by medical staffing gaps and increasing difficulty recruiting locums.

Governance arrangements for children's services are being strengthened, with closer alignment to Pan-Highland Infant, Children and Young Person Governance structures, while ensuring clearer operational oversight within Argyll & Bute, particularly where services interface with Greater Glasgow and Clyde (GGC).

A paper relating to temporary service reduction in Mid Argyll maternity services was included.

Although the governance route was initially circuitous, the paper has now gone through the correct Argyll & Bute governance process. The reduction remains ongoing, but there are positive signs, including recent successful recruitment, helping mitigate the situation.

Dementia pathways remain a known and longstanding challenge. While issues persist, work is underway on new approaches and solutions, indicating progress rather than resolution at this stage.

Hospital at Home in Oban is performing very well and described as thriving. Work is underway to expand Hospital at Home across Argyll & Bute, develop community-based models using GPs as senior decision-makers, distinct from consultant-led models elsewhere, explore island-specific models, allowing patients to be supported at home with remote clinical input, reducing the need for mainland transfers. These models were highlighted as being of national interest.

After discussion, the Committee:

Noted the content of the circulated report and **Agreed** to take **Moderate,** reflecting ongoing pressures alongside active management and improvement activity.

6.2 Highland Health and Social Care Partnership

Dr C Copeland spoke to the circulated report, summarising the improved handling of learning from Significant Case Reviews (SCRs). Clearer summaries are now provided, with greater emphasis on, identifying learning and sharing that learning across services. This was presented as part of strengthening governance and assurance rather than in response to a new incident. Several areas were acknowledged as continuing work in progress, with further assurance updates planned, diabetes pathways, vaccination services and investigation and treatment room (ITR).

These issues were described as system-wide, requiring coordinated responses rather than isolated service fixes. The committee accepted that full assurance is not yet appropriate but noted that progress is being made.

Members raised concerns about significant misinformation circulating publicly about diabetes services, with potential impact on patients and staff. It was confirmed that joint communications had been issued by NHS Highland and the Local Negotiating Committee. Patients referred into secondary care during service disruption had been clinically reviewed. Those requiring urgent input had been contacted directly, including telephone consultations and medication review. The discussion emphasised the need for proactive, clear communication and supporting staff working under scrutiny. The issue was also framed as an opportunity to develop more sustainable, person-centred models, including greater support for self-management.

The Partnership reaffirmed its focus on, compassionate, person-centred care, clear communication with patients and families and maintaining quality and safety despite system pressures.

The Committee welcomed the openness of the update and the clarity around unresolved issues.

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

6.3 Acute Services

E Henry spoke to the circulated report, highlighted significant operational pressures, particularly around emergency care, workforce constraints and cancer services, alongside examples of active mitigation, system-wide working and areas of improvement. The focus was on incident response, resilience, and recovery, rather than new unrecognised risks.

A significant escalation in Emergency Department (ED) pressure was reported, including, access block for ambulances and evidence of patient harm linked to system congestion. An incident

management approach has been implemented, with, Senior leadership involvement, including the Chief Executive. Intensive, short-term system-wide action with a strong focus on the acute–community interface to improve flow. Work is ongoing to reduce 24-hour ED waits, intervene earlier at 8- and 12-hour thresholds and stabilise patients in the community where possible.

Elective activity, including some orthopaedic and planned surgery, had been paused due to system pressure. This included difficult decisions affecting urgent and complex care, including cancer surgery. Services have since been stood back up, with, daily monitoring, weekly reporting to Scottish Government and senior management oversight to maximise capacity. Despite recent deterioration, performance remains comparatively strong nationally, with a focus on reducing long waits.

Systemic Anti-Cancer Therapy (SACT) and wider cancer services continue to face sustained workforce shortages and increasing demand due to improved survival and repeat treatments. Mitigations discussed included recruitment specialist doctors. Expanded roles for pharmacists and advanced practitioners. Strengthened leadership, including Associate Medical Directors with cancer portfolios. Regional and national collaboration is ongoing, with a deeper cancer update planned for summer.

Breast screening services were highlighted as particularly challenging, severe difficulty recruiting specialist radiologists. Mobile service logistics are especially challenging given Highland geography. Recruitment has been escalated to National Services Scotland. The limitations and future role of AI-supported image reading were acknowledged, though not yet sufficiently mature to replace clinical oversight.

Positive progress in vascular services was reported. A fixed-term consultant appointment has been made. Engagement with NHS Tayside to explore spoke-and-hub models. Immediate actions underway to strengthen vascular nursing and imaging support.

There are encouraging reductions in Clostridioides difficile infections, linked to improved prescribing practices across acute and community settings. Ongoing work in hospital mortality review, infection prevention and control and inter planning.

Podiatry services were highlighted as an important but often unseen contributor, particularly linked to vascular and community care.

The Committee recognised the scale and complexity of acute pressures and the intensity of leadership and system response.

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)

L Bussell spoke to the circulated report, noting that she authored the report due to S Govenden being on sabbatical. The update covered activity from two recent ICYPCGG meetings (December 2025 and January 2026) and focused on system-wide children's services governance, rather than escalation of new risks.

The December 2025 ICYPCGG meeting followed the group's usual governance format, addressing a range of standing issues, Child Health System (Electronic System), ongoing national and technical delays to implementation were discussed. The system had been expected to go live earlier but remains delayed, with a revised go-live date of May. The group noted the operational challenge for services in continuing to prepare for implementation while managing uncertainty and delays. This was recognised as a national issue, rather than one specific to Highland.

Updates were received on Family Nurse Partnership and school nursing services. Workforce pressures and sustainability were discussed within the wider system context. The discussion

reflected the importance of joint working with Highland Council, particularly where pressures in one part of the system impact others.

The January 2026 ICYPGG meeting was more single-issue focused, with the main item being, a detailed presentation was received on Argyll and Bute's approach to neurodevelopmental services, including the SMARTS methodology. Several committee members present at the Clinical Governance Committee had attended this session and recognised the value of the discussion.

This focus linked directly to wider transformation work discussed elsewhere in the committee, including NDAS and CAMHS, reinforcing a consistent system narrative. As previously agreed, the ICYPCG reviewed the current NDAS position. This ensured continuity of governance and alignment with pan-Highland work, cross-system transformation involving health, education, local authority and third-sector partners.
The discussion emphasised the importance of consistent oversight, rather than re-litigation of known challenges.

The discussion reinforced the ICYPCGG's role as a cross-system governance forum, providing oversight across NHS Highland, Highland Council, Argyll & Bute services, a mechanism for shared learning, consistency and alignment across geographies. Assurance to the Clinical Governance Committee that children's services issues are being considered in the round, not in isolation. No new or unmanaged risks were identified during the discussion.

Committee members welcomed the update and the visibility of cross-system working. The discussion highlighted ongoing national and workforce challenges, active management and oversight through the ICYPCGG.

The Infant, Children and Young Person Clinical Governance Group continues to provide effective cross-system governance and oversight. While national system delays and workforce pressures persist, these are actively managed through partnership working. Learning from neurodevelopmental services, including Argyll & Bute, is informing wider system approaches.

The Committee agreed **moderate** assurance.

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 she would not take the Committee through the report line by line, noting the significant level of detail within it.

E Henry had already referenced IPC earlier in the meeting, particularly highlighting positive infection trends, and Louise confirmed that she would not repeat those points unless required.

The Chair noted that reductions in Clostridioides difficile (C.diff) had been referenced earlier and asked Louise to comment further, particularly on training capacity and workforce pressures.

There has been a clear improvement in some IPC metrics, improvements were linked to changes in antimicrobial prescribing, which had been implemented across both community and acute settings. This demonstrated that targeted action had made a difference. The discussion then focused on operational pressure and training.

L Bussell acknowledged that releasing staff for training is challenging, particularly in areas experiencing high acuity and flow pressure. This is not unique to IPC training but reflects wider system pressures. However, she provided assurance that staff working in acute and high-risk areas are day-in, day-out working with IPC measures. IPC practice is very well rehearsed, particularly in

high-acuity environments. While formal training can be difficult to schedule, practice remains strong and embedded. The team looks for opportunities to deliver training when pressure allows, recognising that traditional seasonal patterns (such as a clear summer lull) are less reliable than in the past. Despite this, IPC remains a core operational priority, and staff understanding of IPC requirements is high.

The Chair reflected that the committee had discussed IPC training capacity in pre-meetings, particularly in relation to service pressure. It was helpful to hear reassurance that day-to-day IPC competence remains strong, even where training access is constrained.

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.

After discussion, the Committee Noted the content of the circulated report and **Agreed** to accept the varying levels of assurance across different aspects of the circulated report.

8 ANNUAL DELIVERY PLAN 2025/26 and OPERATIONAL IMPROVEMENT PLAN

E Skinner presented an update on the Annual Delivery Plan (ADP) and Operational Improvement Plan, confirming the OIP forms part of the ADP and tracks 20 Scottish Government deliverables due for completion by March 2026. The majority of deliverables were reported as on track, with a small number identified as delayed or at risk.

Most ADP actions are progressing as planned, with clear reporting against milestones. Delays were highlighted, particularly in ultrasound and CT. Work is underway with Scottish Government, other NHS Boards to optimise capacity and improve performance.

Recruitment challenges had caused delay however an approved recruitment plan for Raigmore is now being implemented. This area is expected to move from delayed to at risk rather than significantly off track in the next update.

Dr B Peters requested that future ADP/OIP reports include a stronger quality and safety narrative, not just delivery status. This was agreed, with a commitment to make clearer links between deliverables and patient safety and quality outcomes and improve clarity on timescales and status of key actions

Members asked for clearer confirmation of whether actions had gone live and more explicit timescales for outstanding actions. It was confirmed that imaging performance clocks start at GP referral. Future reports will improve transparency and consistency.

An initial **substantial assurance** rating was proposed however Committee members felt this did not sufficiently reflect ongoing fragilities, particularly in workforce-dependent areas.

Following discussion, the Committee agreed that **moderate assurance** was more appropriate at this stage.

The committee noted:
An initial **substantial assurance** rating was proposed however Committee members felt this did not sufficiently reflect ongoing fragilities, particularly in workforce-dependent areas.
Following discussion, the committee agreed that **moderate assurance** was more appropriate at this stage.

9 SIX MONTHLY UPDATES BY EXCEPTION

9.1 Area Drugs and Therapeutics Committee (ADTC) – 6 monthly update

S Buchan spoke to the circulated report advising the Area Drugs and Therapeutics Committee is functioning, with active sub-groups and ongoing work, but there are governance and leadership challenges that need to be addressed to maintain effectiveness. Attendance and engagement have declined, and several membership gaps were highlighted. The Chair has been absent for several months, with Sarah acting in an interim capacity.

Leadership and membership stability were identified as the main risks to the committee's effectiveness. There is concern that, without intervention, assurance could deteriorate over time, even though current arrangements remain workable. The importance of the ADTC in ensuring safe, equitable access to medicines and consistent decision-making across the Board was emphasised. Terms of Reference and Benchmarking. A review and refresh of the ADTC Terms of Reference (ToR) is planned. This will include benchmarking against other NHS Boards' ADTCs, observing how high-performing Committees operate, aligning governance arrangements with national standards and expectations. The aim is to strengthen clarity of purpose, membership, leadership and accountability.

Dr B Peters and E Henry strongly supported the proposed review, highlighting the need for clear leadership and direction, the importance of clinician engagement and ensuring ADTC priorities align with wider Board and clinical governance priorities.

The Clinical Governance Committee endorsed the approach and recognised the review as necessary and timely.

Moderate assurance was agreed:

- The ADTC is currently operating safely
- However, improvement is required to prevent future governance risk

The Committee supported:

- Proceeding with the Terms of Reference refresh
- Strengthening leadership and membership
- Bringing back updated proposals following benchmarking work

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

After discussion, the Committee Agreed on **Moderate** assurance, noting the need to refresh leadership, membership and the Terms of Reference.

10 COMMITTEE ADMINISTRATION

10.1 Draft Committee Annual Report 2025/26

The Chair invited members to review the report and raise any comments, amendments or concerns. No substantive issues or amendments were raised by committee members during the discussion.

Members were satisfied that the report accurately reflected the work, oversight and assurance activity of the committee over the reporting period. Appropriately captured the committee's role in governance, quality and safety. The report was viewed as a fair and balanced account of committee business.

The Annual Report was formally approved by the Committee. It was noted that while the Annual Report was complete, the committee work plan remains under development, with further

refinement planned and to be brought back to a future meeting, covered under a separate agenda item.

10.2 Committee Work Plan 2026/27

The Chair presented the Committee Work Plan. It was acknowledged that the Work Plan is still in development and does not yet fully reflect all current priorities and emerging risks.

Dr B Peters advised that further work is underway to refresh and refine the Work Plan. This includes removing outdated items and ensuring alignment with current Committee business, emerging system pressures and Board priorities. The refresh is intended to ensure the work plan remains dynamic and relevant and clearly supports the Committee's assurance role.

The Committee noted the current work plan and agreed that further work is required to refresh and align it with current priorities. A revised Work Plan will be brought to a future meeting.

13 CALENDAR OF MEETING DATES

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

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

14 REPORTING TO THE NHS BOARD

The Committee considered whether current service pressures, particularly in relation to cancer services, should be escalated to the NHS Board. It was agreed that further detailed analysis and assurance were required before escalation. The Committee agreed to receive further information at a future meeting before determining next steps.

15 ANY OTHER COMPETENT BUSINESS

The Committee did not have any other competent business.

16 DATE OF NEXT MEETING

The Chair advised the Members the next meeting would take place on **Thursday, 7 May 2026** at 9.00am.

The meeting closed at 11.30am

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	**07/05/2026**	In progress	
59	03/07/2025	Argyll and Bute Update	Noted improvement update relating to child protection nurse resourcing to be provided in next report. Agreed inidividual levels of assurance be provided in reports.	E Beswick	07/05/2026	In progress	
63	06/11/2025	Public Oral Health Update	Noted update in relation to public oral health be brought to July 2026 meeting.	J Lyon/J Davies	02/07/2026	In progress	